HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Wednesday, 2nd March, 2022

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Wednesday, 2nd March, 2022, 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
Labour (1):	Ms K Constantine
Liberal Democrat (1):	Mr D S Daley
Green and Independent (1):	Mr S R Campkin
District/Borough Representatives (4):	Councillor D Burton, Councillor J Howes, Councillor M Peters and Councillor P Rolfe

UNRESTRICTED ITEMS

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

Item		Timings*
1.	Substitutes	
2.	Declarations of Interests by Members in items on the Agenda for this meeting.	
3.	Minutes from the meeting held on 26 January 2022 (Pages 1 - 10)	
4.	Maidstone and Tunbridge Wells NHS Trust - Clinical Strategy Overview - Cardiology Reconfiguration (Pages 11 - 22)	10:05
5.	Maidstone and Tunbridge Wells NHS Trust - Mortuary Security (Pages 23 - 28)	10:20
6.	Covid-19 response and vaccination update (Pages 29 - 40)	10:40

7. Transforming mental health and dementia services in Kent and Medway (Pages 41 - 54) 11:00

8. Urgent Care Review programme - Swale (Pages 55 - 62) 11:20

9. Provision of GP Services in Kent (Pages 63 - 96) 11:35

10. Work Programme (Pages 97 - 100) 12:05

11. Date of next programmed meeting – 11 May 2022

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

22 February 2022

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 Wednesday, 26 January 2022.

PRESENT: 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, Mr A R Hills, Mr S R Campkin, Cllr J Howes and Mr I S Chittenden

IN VIRTUAL ATTENDANCE: Ms K Constantine

IN ATTENDANCE: Mrs K Goldsmith (Research Officer - Overview and Scrutiny), Mr M Dentten (Democratic Services Officer) and Dr J Jacobs (Local Medical Committee)

UNRESTRICTED ITEMS

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

(Item 2)

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

46. Minutes from the meeting held on 11 November 2021

(Item 3)

RESOLVED that the minutes from the meeting held on 16 September 2021 were a correct record and they be signed by the Chair.

47. Phlebotomy Services at Deal Hospital

(Item 4)

Bill Millar (Primary Care Commissioning at Kent & Medway CCG) was present for this item.

1. The Chair welcomed Mr Millar and explained to the Committee that the closure of the phlebotomy unit at Deal Hospital had been brought to his attention by three local Members. Mr Millar provided an overview, explaining that the Kent Community Health NHS Foundation Trust (KCHFT) was no longer providing blood tests at either Victoria Hospital in Deal or Queen Victoria Memorial Hospital in Herne Bay. However, as phlebotomy services were part of the routine care provided within general practice it was established, in consultation with local practices, that the equivalent capacity could be delivered by current providers (i.e. GPs). He noted there had been positive public reaction.

2. The Chair invited local member Mr Trevor Bond to speak on the issue. Mr Bond spoke of a lack of public consultation and increased pressure on other primary care services. He noted the impact in particular on those who required frequent blood work and highlighted a public petition on the topic that had received in excess of 3,000 signatures.

3. Mr Millar was not aware of the petition but reaffirmed that it was the choice of general practice to offer blood services, they were not required to do so. A public consultation had not been carried out because equivalent provision remained in the surrounded area. He affirmed that the CCG would continue to monitor the situation and encouraged patients to talk to their GP with any concerns. He encouraged Members to relay any specific issues to the CCG.

4. Members were concerned about a lack of communication and engagement with residents leaving to confusion and speculation on social media. They were concerned similar issues could occur elsewhere in the county. Mr Millar took the comments on board and endeavoured to clarify the situation with the public.

5. Rachel Jones, Executive Director Strategy and Population Health at K&M CCG, reassured the Committee that the CCG had heard the concerns raised today and action could be taken to address those concerns. Whilst noting the service change under discussion did not meet the threshold for formal public consultation, she recognised a need for more engagement and responding to resident concerns.

6. A Member asked if Patient Participation Groups (PPGs) could be utilised to provide feedback and share information in their communities. Mr Millar confirmed he would be updating the Committee on PPGs at the next meeting under the “access to GP services in Kent” item.

7. The Chair thanked Mr Millar and Ms Jones for responding to the Committee’s concerns.

8. RESOLVED that the Committee note the report.

48. Covid-19 response and vaccination update
(Item 5)

Paula Wilkins, Chief Nurse and Executive lead of the vaccination programme, and Caroline Selkirk, Executive Director of Health Improvement, K&M CCG were in virtual attendance for this item.

1. Ms Wilkins introduced the agenda report and provided an updated on the number of vaccinations carried out in Kent and Medway, highlighting that 3.75m vaccines had been administered in total. She drew the Committee’s

attention to an error in the report at section 1.2 – the wait between infection and vaccination for under 18s was 12 weeks. She affirmed that, in line with Government policy, the 3 February was the latest date by which frontline NHS staff required a vaccine before risking their employment. Vaccination inequalities were being focussed on, with work being undertaken to reach those groups that were typically hard to reach, had accessibility issues or had low confidence in the vaccine programme. She was keen to hear if Members could support or recommend any groups that needed tailored engagement.

2. Ms Selkirk explained that over the months of December and January, hospitals had been busy with covid-19, winter pressures and elective care. The number in hospital in covid was falling and the Nightingale hub set up at William Harvey Hospital (for use if Omicron had led to a high increase in cases) had not been required. She recognised the continued pressure on elective waiting lists and confirmed these would be the focus as covid pressures continued to decrease.

3. A Member questioned the apparent alignment between lower vaccine uptake and deprivation. Ms Wilkins acknowledged deprived areas tended to have a lower uptake but explained that was just one of many factors. There were more ways to book a vaccine that just online, and the CCG had been carrying out door to door visits accompanied by a vaccination bus. Lessons were continually being learnt, such as methods that worked for the 1st and 2nd dose did not always work for the booster.

4. In response to a question about vaccinations in the gypsy, roma and traveller community, Ms Wilkins confirmed that a lot of work had been carried out in this area.

5. Looking ahead, Ms Wilkins confirmed a fourth dose for the clinically vulnerable was being rolled out, and the CCG didn't expect to use the mass vaccination centres going forward. It was being considered how the covid and flu vaccination programmes could be joined together to become more sustainable.

6. Asked about the national "no jab no job" policy, Ms Wilkins explained that vaccine hesitancy was the main reason for staff not getting vaccinated. This often stemmed from cultural and background factors. The CCG would be able to provide a clearer picture on numbers after the 3 February 2022 deadline. Impact assessments were being carried out on a service by service basis. They were not anticipating having to close General Practice surgeries or the number of beds available but that would be covered by the risk assessment if necessary.

7. A Member questioned the recording of covid on individual death certificates, asking about comorbidity data along with requesting a breakdown of covid

case rates per hospital. Ms Wilkins explained that only the cause of death would be recorded on a death certificate, regardless of if the person had covid at the time. Ms Selkirk provided the web address https://coronavirus.data.gov.uk/ which contained hospital level data.

8. Answering a question about transfer of care from hospital to domiciliary care, Ms Selkirk agreed there were challenges due to the workforce shortage and short-term impact of covid isolation rules. The CCG worked with the hospitals to manage capacity and reduce the number of patients staying longer than necessary in acute care. Kent and Medway had not reached the NHS England South East target of discharging 30% of fit patients in acute hospitals by early January 2022 but neither had many others in the region.

9. Asked what support was in place for staff providing vaccines, Ms Wilkins explained that KCHFT had led the workforce during the early stages. They maintained a bank of staff which allowed for rotation. CCG and clinical staff had been released to work in that area also. Guidance had been shared with staff to assist with their response to “anti-vaxxers”, and the CCG had worked alongside NHS England and Borough Councils for extra security when needed.

10. Dr Jacobs from the Local Medical Committee spoke on GP pressures, explaining that the “no jab no job” policy would affect the 190 practices across Kent and Medway, he estimated around 2-3% of staff were affected but the granular detail was important. There needed to be clarity on what “frontline” meant, as many staff working in GP surgeries would come across patients during their day due to the nature of the job and layout of the buildings.

11. Members thanked the continued efforts of local NHS staff in delivering services and their work on the vaccination rollout.

12. RESOLVED that the Committee note the report.

49. Dental Services in Kent
(Item 6)

Mark Ridgeway, Senior Commissioning Manager (Dental), NHS England & NHS Improvement - South East, was in virtual attendance for this item.

1. The Chair welcomed Mr Ridgeway and asked him to introduce his report, with a focus on access to services during the pandemic. He also asked if there was any information about how the Government announcement of an additional £50m for the sector would help local services.

2. Mr Ridgeway explained that the £50m funding was for urgent appointments nationally but it was too early to say how that would have an impact locally. There was a backlog of need and workforce capacity was a concern.

3. He explained that health profiles of local areas were underway, and they would be shared with the committee once available. These would analyse service demand and would provide a breakdown by age.

4. Mr Ridgeway understood that around 48% of dental patients were NHS as opposed to private. He did not have data on the number of people who didn't access any dental services.

5. Asked about water fluoridation, Mr Ridgeway commented that this was not the responsibility of the NHS. The Chair advised the Member contact the Public Health team.

6. Asked how private and NHS dental treatment compared, Mr Ridgeway stated that NHS dentistry provided patients with the treatment they required. Where perceptions of quality differ, that may be down to private dentists spending more time with individual patients but that should not detract from the quality of the service.

7. In response to a question from a Member of the Committee, Mr Ridgeway acknowledged the difficulties faced by some Thanet residents in accessing an NHS dentist. He explained that some existing contracts had been increased during 2019 but the pandemic and associated lockdowns had closely followed meaning that the positive effects from that increase had not been realised yet.

8. One Member asked if a marketing strategy could be introduced that promoted the benefits of young people accessing NHS dentistry as opposed to cosmetic alternatives offered via social media. Mr Ridgeway said marketing was agreed by the national team but offered to investigate if this was a local issue that needed addressing.

9. The Chair thanked Mr Ridgeway for his time.

10. RESOLVED that the report be noted.

50. Hyper Acute Stroke Units - implementation update
(Item 7)

Rachel Jones, Executive Director Strategy and Population Health at K&M CCG and Ray Savage, Strategic Partnerships Manager (Kent & Medway, East Sussex) at South East Coast Ambulance Service NHS Foundation Trust) were present for this item. Claire Hall, Specialist Paramedic (Urgent and Emergency Care), Clinical

Pathways Lead, South East Coast Ambulance Service NHS Foundation Trust was in virtual attendance.

1. The Chair welcomed the speakers and asked Ms Jones to introduce the item. She provided a brief history, citing a CCG decision 3 years ago that was placed on hold pending the outcome of 2 Judicial Reviews and a referral to the Secretary of State. Those outcomes had been finalised and the proposal to create three HASUs in the County could be implemented.

2. During the three-year pause, stroke services had needed to be consolidated on three sites (Dartford, Maidstone and Canterbury). That arrangement had contributed to the rating of stroke services improving across Kent and Medway. She was clear that the three temporary sites were not HASUs, which would now begin to be implemented and were due to improve care even further.

3. Mr Savage gave an overview of ambulance response times. Stroke patients fell under category 2 calls, and nationally those response times during the pandemic had not been good, though SECAmb had performed relatively well. Response times were improving, and the Business Intelligence team analysed response times daily along with mapping future demand.

4. Ms Hall spoke about the innovation and change experienced within SECAmb. The introduction of telemedicine for example had resulted in around 50% of patients that would previously have been sent to a stroke unit be diverted to alternative provision. That change in patient flow had allowed stroke patients to be seen by a specialist quicker, thus reducing the “door to needle” time. Members were concerned that there could be misdiagnoses but Ms Hall provided reassurance that steps were in place to reduce the chance of this happening (for example governance meetings reviewing individual cases). Ms Jones confirmed that all stroke patients would go directly to a specialist unit and not through an A&E department. The long-term vision was for each HASU to be available 24 hours a day 7 days a week but this was not the case currently due to workforce constraints.

5. University College London (UCL) had carried out an in-depth 2-year evaluation into the use of telemedicine and the early data supported the view that no patient harm had occurred and that response times had improved.

6. A Member asked if telemedicine was replacing the need for a scan to confirm diagnosis. Ms Jones confirmed that was not the case – before telemedicine, the first contact with a specialist used to be once the patient arrived at hospital. Now, there was an early conversation between a doctor and a patient which allowed the doctor to eliminate stroke imitations. Scans would always be used for those suffering from a suspected stroke. Ms Hall explained that if a

paramedic could not make contact with a stroke doctor the patient would be taken to a stroke unit.

7. Ms Hall suggested a stroke doctor provide a briefing for Members to provide assurance about the telemedicine system. Where the FAST assessment (Face, Arms, Speech, Time) was inconclusive, guidance was being updated accordingly.

8. Concerned about costs for families in visiting stroke patients, Members asked what work was being done to support this group. Ms Jones acknowledged the concerns and explained that three travel advisory groups would be re-established across Kent and Medway. Residents would be listened to and strategies put in place to address concerns.

9. Ms Jones explained that there was an active Patient Participation Group (PPG) and liaison with Healthwatch. Whilst the focus had been on the implementation of the HASUs the overall aim was to improve stroke care.

10. A Member drew the Committee's attention to the performance metrics included in the agenda pack, in particular the improvement of Darent Valley Hospital from a D to a C rating, compared to Maidstone Hospital and East Kent Hospitals where the rating had improved to an A. Ms Jones answered that there was no definitive answer but factors included infrastructure constraints; Dartford seeing an increase in patients from London as hospitals in that region faced pressure; and workforce availability. In particular, Maidstone Hospital and Kent and Canterbury Hospital had benefited from a consolidation of staffing from other sites within those Trusts – Darent Valley was the only acute hospital under that provider. Ms Jones committed that within six months of HASUs being operational, each of the three units would be A rated (this would be evident after 9 months due to 3 month lag in data, so December 2023).

11. Asked why the Kent and Canterbury Hospital had been used as a stroke unit during the pandemic, Ms Jones explained that it was deemed the safest location for patients because it was being maintained as a covid-free site. It was not suitable as a long term solution because it did not have the necessary co-located services.

12. RESOLVED that the report be noted and the CCG be invited to return with an update at the appropriate time.

51. Children and Adolescent Mental Health Service (CAMHS) Tier 4 provision *(Item 8)*

Alison Nuttall (Provider Collaborative Program Director) and Nina Marshall (Provider Collaborative Program Manager for Kent and Sussex CAMHS In-Patient and Eating Disorder) from the Sussex Partnership NHS Foundation Trust were in virtual attendance.

1. Ms Marshall provided an overview of the agenda report and confirmed there were no significant changes since publication. Sussex Partnership NHS Foundation Trust (SPFT) had been the lead provider of Tier 4 Children and Adolescent Mental Health Service (CAMHS) since 1 October 2021 though existed in shadow form before.

2. A clinical activity panel was in operation, allowing for multi-professional discussions to ensure clinical decisions were in the best interests of the patient.

3. Services were provided at three sites: Kent and Medway Adolescent Hospital in Staplehurst, Chalkhill, and Elysium Brighton and Hove (a specialist eating disorder service). Tier 4 services were inherently offered over a larger geography than other services due to their specialist nature, but Ms Nuttall said the aim was always to keep patients as close to home as was possible.

4. Asked how quickly rapid response could be remobilised, Ms Marshall confirmed it was at pace and would require one or two days.

5. In terms of the relationship between Tier 4 services and a young person's education setting, Ms Nuttall explained that general support would be provided through the local CAMHS service. SPFT would however liaise with a patient's school to ensure the education provided at the facility was consistent with their current learning. Case Managers were appointed to each young person so they could monitor progress and oversee discharge.

6. Ms Nuttall explained that the increased demand was anticipated to last for at least two years. This was subject to both national modelling (supported by local monitoring) and funding. The service offered in the community needed to improve but the expectation was that additional Tier 4 beds would come into use.

7. Members commended the 81% reduction in waiting times.

8. A Member confirmed that the Health Reform and Public Health Cabinet Committee would be receiving a paper about access to mental health services, and HOSC Members were welcome to attend.

9. RESOLVED that the report be noted.

52. Maternity Services at East Kent Hospitals University NHS Foundation Trust - written update

(Item 9)

1. The Chair explained that no representatives were present for the item, which was subject to an independent investigation.

2. A Member raised concerns about midwifery staffing levels at the Trust and the subsequent suspension of the home birth service. The Chair confirmed that the Trust would be invited to attend once the investigation had concluded. He asked that any questions in the meantime go through the clerk to the committee.

3. RESOLVED that the report be noted and East Kent Hospitals University NHS Foundation Trust (EKHUFT) be invited to return at an appropriate time.

53. East Kent Transformation Programme - written update

(Item 10)

1. The Committee were presented with the paper that had gone to the Kent and Medway Joint Health Overview and Scrutiny Committee (JHOSC) in December.

2. RESOLVED that the update be noted.

54. Work Programme

(Item 11)

1. The Chair informed the Committee that the upcoming meeting dates had changed to 5 May and 7 July. It was commented that 5 May was the date of local elections for some district councils in the region.

2. RESOLVED that the work plan be agreed.

55. Date of next programmed meeting – 2 March 2022

(Item 12)

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

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Item 4: Maidstone and Tunbridge Wells NHS Trust – Clinical Strategy – Cardiology Services

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 2 March 2022

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

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

The Committee has already decided these proposals do not constitute a substantial variation of service.

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1) Introduction

a) At its meeting on 21 July 2021, the Committee received a paper about the clinical strategy reconfiguration at Maidstone and Tunbridge Wells NHS Trust (MTW). It also received a paper about a workstream that fell under that reconfiguration, cardiology services.

b) Specialist and inpatient cardiology services are currently offered from both Maidstone Hospital and Tunbridge Wells Hospital. The Trust proposes to consolidate these onto one site and create a specialist cardiology service. The case for change was set out in the paper presented to HOSC on 21 July 2021 (see here).

c) Following discussion, the Committee believed that whilst the proposals were significant, they did not constitute a substantial variation of service.

d) A follow up paper was received on 11 November 2021 notifying HOSC that a 12-week engagement exercise had commenced and was due to finish on 14 January 2022. The Trust have asked to present an update to the Committee at today's meeting.

2) Recommendation

RECOMMENDED that the Committee note the report.

Background Documents

Kent County Council (2021) 'Health Overview and Scrutiny Committee (21/07/21)', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8758&Ver=4

Item 4: Maidstone and Tunbridge Wells NHS Trust – Clinical Strategy – Cardiology Services

Kent County Council (2021) 'Health Overview and Scrutiny Committee (11/11/21)', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8760&Ver=4

Contact Details

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HOSC – 2nd March 2022

To update HOSC on the engagement activities relating to the proposed cardiology inpatient and cardiac catheter laboratory reconfiguration and to confirm the recommendation to MTW Trust Board on the preferred site

Amanjit Jhund, Director of Strategy, Planning and Partnerships

1. Introduction and Background

In July 2021 MTW outlined to HOSC the proposed cardiology inpatient and cardiac catheter laboratory reconfiguration to enable the service to:

- develop to deliver the GIRFT recommendations where, of the 25 standards MTW currently fail to deliver in nine
- develop the service to improve recruitment and retention of critical cardiology specialist staff
- improve the quality of service for our patients and support the delivery of the Trust clinical strategy aspirations

To do this MTW was proposing that inpatient cardiology services and both cardiac catheter laboratories were based on one site, with outpatient services and outpatient diagnostics remaining unchanged. The centralisation options were either on the Maidstone or Tunbridge Wells site and on there was recognition that the choice either site could create a geographical challenge for some patients, members of the public and staff. However, MTW considered that the improvements and benefits would outweigh the challenges, and that those challenges could be mitigated with partnership working and clear and robust protocols for the management of the cardiology patient pathway.

HOSC were supportive of the approach and considered agreed to a 12 week period of engagement with the public and key stake holders to improve understanding and elicit the level of support.

The following report outlines the engagement process and the impact of the process on the overall options appraisal and recommendation to MTW Trust Board on 24th February 2022.

2. The Engagement Process and Outcome

The engagement process ran from 22nd October 2021 to 14th January 2022. Originally 12 weeks this was extended to 14 weeks due to the festive holidays. The engagement process used a variety of research, engagement, and involvement methodologies to elicit views, feedback, and ideas in response to the cardiology proposals as detailed below and also supported by the pre-engagement activities undertaken by Engage Kent during the summer of 2021. The engagement activities are detailed below:

1. Survey.
2. Targeted engagement
3. Online public listening events
4. Telephone interviews
5. Pop-up stands x5 across geographies
6. Direct stakeholder feedback and individual responses
7. Staff feedback

Analysis of the engagement responses demonstrates there is a clear understanding, and support for the clinical case for change and agreement that the consolidation of services on a single site will bring benefits to patient care and outcomes. The importance of improving cardiology services at MTW has widespread and unequivocal support from respondents with the majority favouring the consolidated service at the Maidstone hospital site. The engagement process was positively received by those who did respond in terms of the clarity of the case and raising awareness. The full report of the survey analysis is at **appendix 1**.

1. Survey

From the survey, of the 98 respondents 62 (63%) expressed preference for the Maidstone site, with 24 (24.5%) expressing preference for the Tunbridge Wells site and 8 (8%) preferring no change. There was a similar outcome in the targeted engagement with broad support for the case for change and with a total of 62% supporting either option 2 or 4 (consolidation on the Maidstone site), 14% supporting option 3 (consolidation on the Tunbridge Wells site), 10% supporting option 1 (do nothing) and 14% wanting another option.

2. Targeted engagement

An independent agency (EK360) recruited 52 individuals to ensure a representative mix of the general public and the following seldom heard groups totalling 28 responses with the remainder from the general public. The gender mix of the feedback was male – 23, female 28 and transgender 1. The seldom heard group mix is detailed below:

- people with a physical disability (8)
- people from ethnic minority backgrounds (8)
- people from the LGBTQIA+ community (6)
- people living in areas of multiple indices of deprivation (6)

This targeted engagement was undertaken through conversations and meetings where reactions to the case for change and the options were explored. Themes have been identified with a similar response to the survey on the options with 62% supporting options 2 or 4 (Maidstone site), 10% opting for options 1 (do nothing), 14% wanting option 3 (Tunbridge Wells site) and 14% another option.

3. Online public listening events

Two online public listening events took place during the engagement period on 9 and 15 December 2021. Although the listening events did not specifically ask for views on the options, the feedback received supported the direction of travel to consolidate the cardiology inpatient and cardiac catheter lab services on one site. While only two attendees came to the sessions, the quality of the feedback and the depth of understanding and engagement with the proposals, meant the sessions were highly useful in drawing out detailed responses to the proposals. Points and views raised by attendees at both meetings and in follow-up correspondence via email included:

- Broad support and understanding for the service consolidation 'case for change' – *'this is the right approach'*
- Questions about the practicalities of implementation for patients and staff including the transfer of patients across sites.
- Support for the consolidation approach with one attendee supporting the Option 2 proposal: *'I can see that better recruitment and retention, better training & support, and the general move towards a centre of excellence can only be positive news for the team, the hospital, and eventually, the patients.*

- Feedback on the clarity of the case for change and engagement approach and materials: *'…you are to be congratulated for pulling together an ambitious plan and for explaining it so clearly and rationally to all stakeholders'*

4. Telephone interviews

A specialist independent research agency (DJS Research) was commissioned to conduct a telephone survey that collected the views of a representative sample of 200 residents across the engagement catchment area. The fieldwork took place between 24 November and 15 December 2021 and the full complement of 200 interviews were completed. The full report and analysis from the telephone polling research is included as **appendix 4.**

Key findings were that the proposals are generally very well received; however, there are some concerns, mainly relating to the additional travel required to access a different facility.

- There is strong support for the idea of **consolidating some specialist care at one hospital**, agreeing that the plans would improve the care and experience of inpatients.
- There is also strong support for the idea of **bringing specialist and inpatient cardiology services together onto one hospital site**.
- When asked to think about the most important factors to consider when evaluating the options, the fact that it provides **the best clinical outcome for patients** far outweighs any other factor. Travel time is a concern for around half of the people interviewed
- Potential advantages of bringing services together focused on **receiving specialised services in a single location** and no changing between hospitals.
- Potential disadvantages of bringing services together focused by far on **the distance to each site** – this was an equal concern for both Maidstone and Tunbridge Wells postcodes.
- The hospitals/Trust could reduce the impact of the disadvantages of bringing the services together on one site by **improving transport offerings** (e.g. taxi, shuttle bus, etc).
- Other potential options that would address the need to change include **better access to GPs/quicker appointment times**.
- **Participants like to be consulted/listened to,** so this needs to continue throughout the process.

5. Pop-up stands x5 across geographies

Five pop-up stands with information on the proposals, manned by programme representatives, were held during December 2021. Royal Victoria Place in Tunbridge Wells on 26th November, Crowborough Town Centre on 3rd December, Bligh's Walk Meadow in Sevenoaks on Friday 10 December, Fremlin Walk Maidstone, Wednesday 15 December and High Street, Uckfield on Thursday 16 December.

The nature of the engagement means that the primary function is to provide information and more than 300 A5 flyers were handed out. Ad hoc feedback from approximately 50 people who representatives spoke to on the days suggested:

- an understanding of the clinical case for change
- agreement that consolidation would lead to improved outcomes for patients
- concerns about the impact of additional travel times for patients and families in peripheral areas and the availability/cost of public transport within these areas

Programme representatives took the opportunity to visit community areas such as shops, pharmacies, and vaccination centres during these times to hand out leaflets and information to residents.

6. Direct stakeholder feedback and individual responses

Feedback was received via the dedicated email address from six key stakeholders and the programme team met with two Patient Participation Groups (PPG) as well as receiving a written response to the proposals from one PPG. The stakeholder feedback is summarised below with the key themes being consistent with the other engagement activities:

- five out of the six stakeholders understood the reasons behind the proposed change
- one stakeholder would prefer the service to be developed with compromise to the delivery of all standards but keep services across both sites
- there was support for the Maidstone site.

Concerns were raised about travel and accessibility for patients and visitors from the Weald and Sussex areas and emergency management of patients should they present to the non-inpatient site. These did not detract from the recognition of the need undertake the reconfiguration rather to ensure the Trust takes these issues into account and mitigating actions are in place to support patients from these areas. Suggestions made about travel improvement and the use of technology will be considered in development of the case.

7. Staff feedback

Staff feedback from three staff sessions held on 17th November (10 staff), 22 November (35 staff) and 1st December (two members of staff) and the proposals were welcomed with the key themes outlined below:

- There is a clear case for change and staff welcome being involved in the development of the proposals
- The location of non-clinical staff if Option 4 was to go ahead was raised.
- Maidstone was felt to be geographically well-placed for other cardiology services across the area and this may be the same for this proposal
- Consolidating services at a single site may help with ongoing workforce issues around recruitment and staff could see the benefits of this approach however the question was raised as to whether three rather than two cath labs had been considered
- Attendees requested reassurance that staff would continue to be involved and kept up to speed as plans developed
- Participants agreed with the 'case for change' and saw that in order to meet the 'gold standard' of patient care, that consolidation is necessary
- Questions were asked about the location of a new build at the Maidstone site under Option 4
- Ongoing challenges with recruitment and retention of staff were highlighted with questions asked as to how the proposals might help with these issues
- The importance of educating patients that this is happening so that they understand the benefits for their own care and treatment
- Feedback included the comment that it would be important to see the plans as *'an exciting opportunity and challenge as well as a change'*.

Overall analysis

The engagement process was, on the whole, received positively by those who did respond in terms of the clarity of the case and raising awareness. MTW is delighted to have been nominated for a Healthwatch award for the quality of the engagement we undertook on our proposals for the future of inpatient cardiology and cardiac catheter laboratory services.

Analysis of the engagement responses is summarised in the table below. Overall responses demonstrate there is a clear understanding of the clinical case for change and agreement on the whole that the consolidation of inpatient and cardiac catheter lab services on a single site will bring benefits to patient care and outcomes. The importance of improving cardiology services at MTW has widespread and unequivocal support from respondents with the majority favouring the consolidated service at the Maidstone hospital site. The engagement was focussed on the cardiology inpatient and cardiac catheter lab services although some responses assumed the changes affected outpatient services as well. Should the Board agree to go ahead with the proposal, we will ensure the post-decision communication is clear on this point.

The main challenges and concerns regarding the reconfiguration are:

- Travel times and access for patients and visitors from Sussex and the northwest of Kent. In this instance public transport is sporadic and travel times may be longer so increased costs of driving and parking are a concern
- Clinical safety of the site without the inpatient service
- Travel between sites if patients present to ED on the site without the inpatient service.

In mitigation of these concerns the Trust will developing the business case with the following considerations:

- Travel plans which allow patients from these outlying areas to use Trust inter site transport
- Work with the bus services to extend the free bus travel with a Trust letter
- Consideration of visiting times to allow visitors to use public transport
- A review of car parking arrangements for specific patient and visitor groups
- A robust protocol with ambulance services to support decision making to take patients to the correct site. This may involve the use of telemedicine which has been successfully implemented in the stroke service
- Robust protocols for the management of patients who present on the non-inpatient site or those who become unwell with a cardiac condition while in hospital for another condition. These will be supported by staff development on a rolling basis on the non-inpatient site.

Media	Volume of Responses	Main themes	Mitigations
Survey	98	**Advantages:** • Improved staffing ratios • Improved staff retention • Improved quality of care for patients. • Efficient and cost effective use of resources • Reduced waiting times and a reduced need to travel between the two current sites **Disadvantages:** • Increased journey time • Increased distance for some patients and relatives • Lack of public transport • Impact on some staff and patients and relatives	• Travel plans which allow patients from these outlying areas to use Trust inter site transport • Work with the bus services to extend the free bus travel with a Trust letter • Consideration of visiting times to allow visitors to use public transport • A robust protocol with ambulance services to support decision making to take patients to the correct site. This may involve the use of telemedicine which has been successfully implemented in the stroke service. • Robust protocols for the management of patients who present on the non-inpatient site or those who become unwell with a cardiac condition while in hospital for another condition. These will be supported by staff development on a rolling basis on the non-inpatient site.
Targeted Engagement	52	**Advantages:** • Improved quality of care for patients • Reduced need to travel between the two current sites. • Benefits to finance and staffing. **Disadvantages:** • Journey times and distance will increase for some, • Potential disadvantages for staff who live further away • Concerns about finance and disruption to services.	As above
Online Public listening Events	2	**Advantages:** • Support for the clinical case for change and consolidation approach • Better recruitment and retention of staff **Disadvantages:** • Practicalities of implementation for staff and patients and patient transfers	As above
Telephone interviews	200	**Advantages:** • The plans would improve the care and experience of inpatients and improve clinical outcomes • Receiving specialised services in a single location and no changing between hospitals **Disadvantages:**	As above

Media	Volume of Responses	Main themes	Mitigations
		• Distance to each site and impact on patient and family travel and transport	
Pop up stands	Approximately 50 interactions and 300 flyers distributed	**Advantages:** • Agreement that consolidation would lead to improved outcomes for patients **Disadvantages:** • Impact of additional travel times for patients and families in peripheral areas and the availability/cost of public transport within these areas	As above
Stakeholder feedback	7 (KCHFT's response is counted under the survey response)	**Advantages:** • Improvement to patient care, experience, and outcomes • Opportunity for MTW to provide an enhanced range of interventions • Reduction in length of stay • Opportunity to further develop community-based services **Disadvantages:** • Travel, transport and accessibility for patients and families, especially those coming from peripheral areas • Impact on volunteer driver services • Opposition to the proposal and a request to consider improving services at both sites • Emergency transfers of patients arriving at the non-specialist site and potential confusion for both staff and patients	• As above, plus ongoing dialogue with clinical commissioning group colleagues across the catchment area, regular engagement with, and reporting to, council scrutiny colleagues and the offer of further meetings to explore specific issues with Wadhurst and Ticehurst PPG.
Individual responses	2	**Advantages:** • Improved quality of care for patients. efficient and cost effective use of resources, staffing levels and staff retention • Reduced waiting times and a reduced need to travel between the two current sites **Disadvantages:** • Increased journey times, transport and distance to travel • Impact on staff, use of resources and physical space within hospital sites internal transfers between sites • Negative impact on patient care	As above
Staff feedback	47	**Advantages:** • Opportunity to meet 'gold standards' of patient care, experience and outcomes • Help with staff recruitment and retention, making it a more attractive place to work **Disadvantages:** • The need for three rather than two cath labs • Impact on staff if changes are made and how will this be managed • Lack of understanding by patients and carers as to the changes and how they will help improve patient care and outcomes	• As above plus ongoing engagement and dialogue with all staff, especially those affected by the proposals and the inclusion of staff concerns within implementation planning for the changes/transition should the proposal go ahead.

3. Recommendation

The cardiology reconfiguration is assessed against a number of criteria including the outcome of the engagement process. These are listed below.

1 Meet non-compliant GIRFT recommendations in full
2 Provide more efficient and integrated approach to patient care
3 Improve patient flow and patient experience.
4 Deliver value for money
5 Create capacity to support the Trust clinical strategy aspiration.
6 Travel for patients within catchment area to be accepted by public.
7 Clinical acceptability – must be accepted by the clinical team as a reasonable and safe adjustment to the service
8 Sustainability
9 Achievability
10 Outcome of the engagement feedback

MTW has reviewed each of the four options against all criteria and has recommended to the Trust Board on 24th February, that the Maidstone site (options 2 and 4) is the preferred site for the reconfigured services.

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Item 5: Maidstone and Tunbridge Wells NHS Trust – mortuary security

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 2 March 2022

Subject: Maidstone and Tunbridge Wells NHS Trust – mortuary security

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

It provides background information which may prove useful to Members.

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1) Introduction

a) In November 2021, evidence came to light of many crimes committed by David Fuller whilst employed as a maintenance supervisor at MTW.

b) MTW initiated an independent investigation into the specific offences but on 8 November the Secretary of State announced this was being overtaken by an independent inquiry led by Sir Jonathan Michael. The Inquiry will consider issues including:

i. the circumstances surrounding the offences committed at the hospital, and their national implications,
ii. understanding how these offences took place without detection in the trust,
iii. identifying any areas where early action by this trust was necessary, and
iv. consideration of wider national issues – including for the NHS.

c) The inquiry's website expects an interim report (into the activities carried out at MTW) to be published during 2022 with a final report (into the broader national picture and wider lessons) published in 2023.

d) Whilst the inquiry is ongoing, there is a limit on the extent of HOSC's scrutiny into this area. The Committee also cannot investigate individual cases. However, the Chair has asked the Trust to provide an update on progress made to date in improving security at its mortuaries. This is in light of recent news stories about the Trust's services in this area.

2. Recommendation

RECOMMENDED that the Committee consider and note the report.

Item 5: Maidstone and Tunbridge Wells NHS Trust – mortuary security

Background Documents

Independent Inquiry into the issues raised by the David Fuller case, https://fuller.independent-inquiry.uk/

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Update on MTW mortuary for Kent HOSC meeting on 2 March 2022

Background

David Fuller received two whole life prison sentences at Maidstone Crown Court on 15 December 2021 for the murders of Wendy Knell and Caroline Pierce in Tunbridge Wells in 1987. He also received a concurrent 12-year term for a number of other crimes, including sexual offences carried out in hospital mortuaries. These were committed while Fuller worked as an NHS maintenance supervisor at the Kent and Sussex Hospital and then as an employee of Interserve/Mitie at the new Tunbridge Wells Hospital.

Family and staff support

The Trust's priority has been to work with the Police and Victim Support to offer whatever help or assistance the families of Fuller's victims may need. We have put in place a substantial package of support and have been in contact with all the families and met with a number of relatives. The support we are offering to families is open-ended. We have also put a range of welfare measures in place to support staff who may have been impacted by Fuller's crimes and the trial.

Public comment

At the conclusion of the trial in November last year the Trust issued an apology to the families of Fuller's victims and a media statement (below).

Miles Scott, Trust Chief Executive, said: "I want to say on behalf of the Trust, how shocked and appalled I am by the criminal activity by David Fuller in our hospital mortuary that has been revealed in court this week.

And most importantly, I want to apologise to the families of those who've been the victims of these terrible crimes.

We've been working with a team of specialist Police Family Liaison Officers to offer these families whatever help or assistance they may need.

I am confident that our mortuary today is safe and secure. But I am determined to see if there are any lessons to be learned or systems to be improved.

Sir Jonathan Michael – a Fellow of the Royal College of Physicians – has been commissioned to independently chair an investigation into how this could have happened and to identify anything we could or should have done to avoid it.

Sir Jonathan has begun work on his investigation and once completed I'll be able to say more.

I will ensure that staff at our hospitals are supported as they also process this shocking news. Our mortuary team have been particularly distressed to learn about what has been revealed over the course of this trial.

My immediate priority, though, is to ensure the families of Fuller's victims are given the time, space and privacy to come to terms with what they've learned – and that they receive all the care and support they need."

Following the sentencing hearing on 15 December 2021 the Trust issued the following statement to the media.

Miles Scott, Chief Executive, said:

"Today in court we heard many deeply distressing accounts of the impact that David Fuller's crimes have had on the families of his victims. I would like to apologise once again for the hurt that has been caused to families as a result of these appalling crimes.

We have been in contact with the families affected in recent weeks and our priority continues to be to provide them with any help or assistance they may need for as long as they may need it.

As requested by the Secretary of State, we will work with the families and NHS Resolution to agree a compensation scheme without the pain and delay that may be caused by individual claim action.

We remain committed to complete openness and transparency around the criminal activities committed by Fuller, as we support Sir Jonathan Michael's investigation. We will make any further improvements recommended from the Independent Inquiry, and we have undertaken a risk assessment of our mortuary including assuring ourselves against existing Human Tissue Authority guidance."

While the Trust wants to make public as much as we can when we can there are two important considerations that limit what we can say at the present time. We have a duty to support Sir Jonathan Michael's independent inquiry and to allow him to publish his interim report before making any further public comment. Additionally, the Police investigation into Fuller is ongoing and we cannot do or say anything that may prejudice future legal proceedings."

Inquiry

In February 2021 the Trust commissioned an investigation into the mortuary offences, independently chaired by Sir Jonathan Michael. Sir Jonathan is a Fellow of the Royal College of Physicians and was an NHS chief executive for 20 years, leading three of the largest university hospital trusts in the country.

Following the trial in November 2021 the Secretary of State for Health and Social Care, Rt Hon Sajid Javid MP, announced that a non-statutory inquiry will replace the Trust commissioned investigation and will report directly to the Secretary of State. The inquiry continues to be led by Sir Jonathan. Phase one will focus on what happened in our hospital mortuaries and then determine any questions that arise for the NHS more widely and for other settings such as undertakers and non-NHS mortuaries. Phase two will address those broader national questions. The Trust has already shared all the material from our own internal inquiry with Sir Jonathan and we will continue to give his inquiry our full support and co-operation.

Sir Jonathan is seeking the views of the families affected by Fuller's crimes on the Terms of Reference which will be published once finalised.

The Inquiry will publish its initial report on the offences in the mortuaries this year and its final report, looking at the broader national picture and the wider lessons for the NHS and other settings in 2023.

In February 2022 solicitors acting for some of the affected families applied for a judicial review of the Secretary of State's decision to hold an independent inquiry. A decision on the application is pending.

Compensation scheme

The Trust is working with the victims' families and NHS Resolution to quickly establish a fair and proper process for compensation and to agree the compensation scheme.

NHS England mortuary review

In October 2021 NHS England asked all trusts with mortuaries or body stores to review their ways of working and security practices. The Trust has returned its submission to NHSE and is fully compliant with the guidance issued by NHSE.

Summary

The Trust has made it clear in discussions with families and the media that we intend to be completely open and transparent on Fuller's criminal activity. We have worked closely with Kent Police from the outset of their investigation and are now supporting the independent inquiry led by Sir Jonathan Michael and commissioned by the Secretary of State for Health & Social Care.

We will continue to provide support to victims' families and effected staff and offer help for as long as they may need it.

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Item 6: Covid-19 response and vaccination update

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 2 March 2022

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.

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1) Introduction

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

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

2) Previous monitoring by HOSC

a) HOSC received its most recent update in January 2022, where it received an update on vaccination numbers, the requirement for frontline NHS staff to be vaccinated and pressures across the system.

b) Following the discussion, the Committee resolved to note the report. The CCG has been invited to attend today's meeting and provide an update.

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

Kent County Council (2021) 'Health Overview and Scrutiny Committee (21/07/21)', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8758&Ver=4

Kent County Council (2021) 'Health Overview and Scrutiny Committee (16/09/21)', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8759&Ver=4

Kent County Council (2021) 'Health Overview and Scrutiny Committee (11/11/21)', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8760&Ver=4

Kent County Council (2022) 'Health Overview and Scrutiny Committee (26/01/22)', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8761&Ver=4

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Covid-19 update for Kent Health Overview and Scrutiny Committee – March 2022

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.

1 Vaccination programme

1.1 SUMMARY OF PROGRESS

Official figures on vaccine progress are published nationally each Thursday. As of 17 February 2022, the position in Kent and Medway was:

- 3,817,619 vaccines in total
  - 1,425,156 first doses
  - 1,333,260 second doses
  - 1,059,203 third/booster doses

From local data the latest highlights are:

- 90% of people in the top nine priority groups have had a booster.
- 71% of all groups aged 18-49 have had a booster
- 84% of all eligible groups have had a booster

Current uptake for under 18s is:

- 16 to 17 years: 71% first dose, 51% second dose
- 12 to 15 years: 61% first dose, 26% second dose
- 12 to 15 years at risk: 63% first dose, 31% second dose

1.2 VACCINATION AS A CONDITION OF EMPLOYMENT

The Government has confirmed its intention to withdraw the legislation that requires staff deployed to patient facing NHS roles to be double vaccinated. A Government consultation on revoking vaccination as a condition of deployment across all health and social care ran from 9-16 February 2022. We await further information from Government on next steps.

The large majority of NHS staff have already taken up the offer of vaccination and we continue to encourage everyone working in health and social care to use the vaccine to protect themselves and others.

1.3 VACCINATION INEQUALITIES

The vaccination programme is continuing to reach out to those who have not taken up the vaccination or not completed the full course. Medway Council's Public Health team has helped the programme identify priority cohorts where up-take is lowest and we have a vaccine inequalities task and finish group in place. Priority groups for our inequalities work include:

- People who are homeless
- People with learning disabilities
- People who are pregnant
- Care workers
- Under 30s
- People from Black ethnic groups
- People from Eastern European backgrounds
- Areas of deprivation with low uptake.

Using £100k from NHS England, we have targeted our audience and have been:

- working with 18 to 29-year-olds, the highest number of individuals who haven't received the first dose of the Covid-19 vaccine
    - Key messaging: Don't miss out because of Covid-19. The vaccine reduces the chances of you getting ill, it's also needed to travel to some countries.
    - Overarching comms: Facebook, Instagram, podcasts, Spotify, digital display (YouTube and Snapchat to be confirmed)
    - Targeted work in Canterbury, Medway and Thanet – working with primary care networks, councils, community groups and education providers to host:
        - pop-ups in key locations, targeted communications being planned – text messaging and leaflet drops
        - pop-ups supported by vaccine ambassadors
- working with staff from food banks to provide education and vaccine opportunities for people using their services – in a staged approach
- held a clinic specifically targeting people with learning disabilities
- working with homeless people, starting in Medway, to education and provide vaccine opportunities – in a staged approach
- carrying out a door-to-door knocking pilot, with the ability to provide translations
- continued promotion of the vaccine to pregnant women, including a Facebook live event.

1.4 VACCINATING HEALTHY FIVE TO 11-YEAR-OLDS

On Wednesday, 16 February, the Government announced that all healthy 5 to 11-year-olds will be offered two paediatric doses of the Pfizer Covid-19 vaccination, with a rollout start date of April 2022.

We are now finalising the delivery plans for this age group, which are mainly expected to be outside of school hours. We are not yet inviting healthy five to 11-year-olds to clinics, but the programme for clinically extremely vulnerable children in this age group is under way.

1.5 TREATMENTS FOR PEOPLE AT HIGHEST RISK OF COVID-19

The NHS is offering new antibody and antiviral treatments to people with Covid-19 who are at highest risk of becoming seriously ill. From 10 February 2022, eligible people can now use a positive lateral flow test (LFT) to be referred for treatment; previously a positive PCR test was required. It is important that the treatment starts within five days of a positive test.

Most people who have conditions that put them in the highest risk category will have been contacted directly through nationally co-ordinated messages with information about how to get these treatments if needed. The CCG and our partners across the NHS have also been promoting the treatments through external channels.

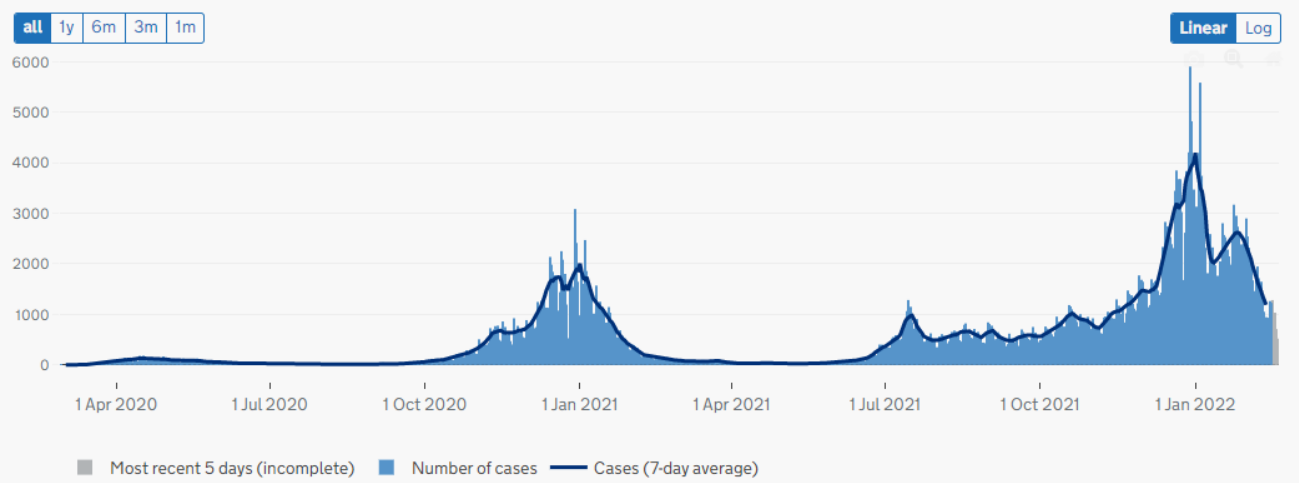
1.6 SPRING BOOSTERS

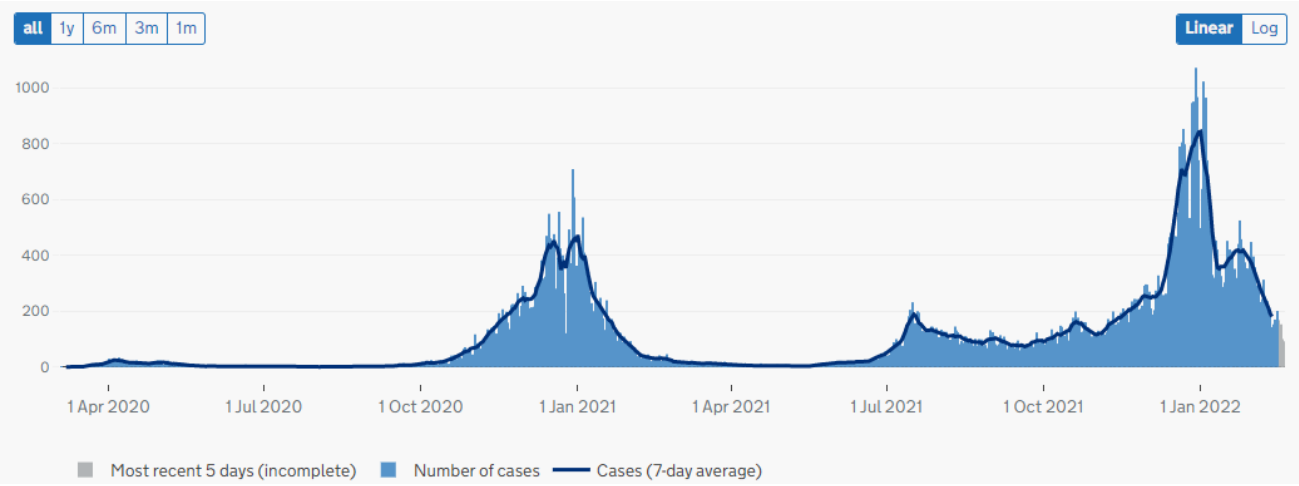
The Government announced on 21 February that a further booster will be offered to all those aged 75+ and those who are aged 12+ and are at greater risk from Covid-19.

2 Covid-19 cases and deaths

Cases of community infection increased significantly with the Omicron variant, but rates are now falling. For 21 February, infection rates per 100,000 were 524 in Kent and 455 in Medway (compared to around 1,000 in mid-January).

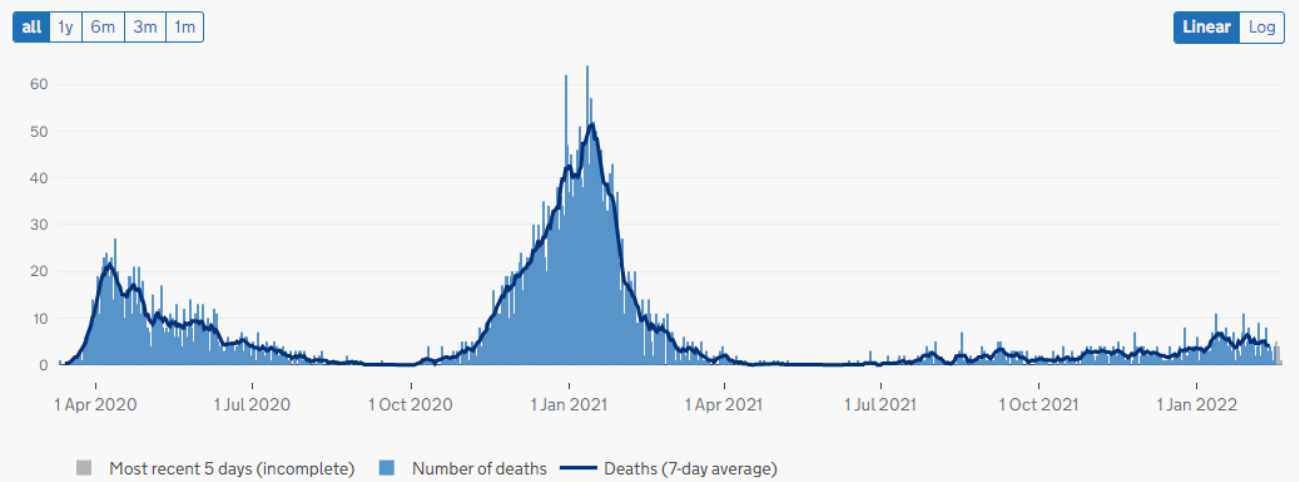
The graphs below show the trend in **daily confirmed cases** over the duration of the pandemic (Kent first graph and Medway second graph):

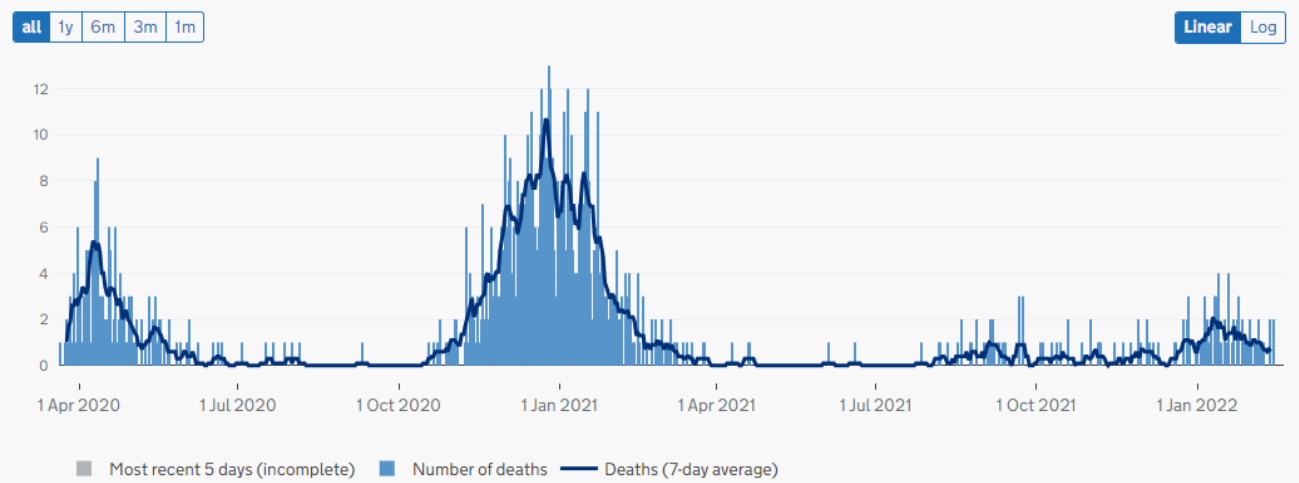




Source: 21 February 2022 https://coronavirus.data.gov.uk/details/cases

Deaths linked to Covid-19 remain relatively low as shown by the graphs below (Kent first graph and Medway second graph):





Source: 21 February 2022 https://coronavirus.data.gov.uk/details/deaths

As of 21 February 2022, cumulative Covid related deaths from the start of the pandemic are:

	Deaths within 28 days of positive test	Covid-19 recorded on death certificate
Kent	4570	5,071
Medway	873	903
Total	**5,443**	**5,974**

3 Hospital pressures

Through December and January hospitals have been extremely busy with a mix of Covid-19, the usual winter increases in demand, and the on-going work to address planned treatment backlogs.

The sheer number of infections in the community and the infection moving into older age groups meant hospitalisations increased considerably from the position of around 200 in November to 460 in early January. Through February we have seen Covid-19 related hospital admissions reduce again. On 21 February 2022 there were 280 Covid-19 patients in hospitals across Kent and Medway; of which 8 were in intensive care.

3.1 Nightingale Super Surge Hub at William Harvey Hospital

Nightingale Hubs were created to provide additional capacity for local services in the event they came under very intense pressure linked to the Omicron variant. Preparing super surge units was the right thing to do; but thankfully they unit at William Harvey Hospital has not been needed. NHS England has confirmed that the structure will be removed by 31 March 2022; in line with units in other parts of the country that have also not been needed.

4 Elective care treatments

All local hospitals worked to maintain elective treatments through December and January despite significant pressure from Omicron and other urgent care demands. The latest figures show that despite this pressure positive progress was made on reducing the number of people waiting longest and other measures of elective waits were maintained at broadly similar rates as November.

4.1 December performance

Latest figures for elective care waiting lists were published on 10 February, providing data for December 2021. Compared to November, the figures show a reduction of 183 Kent and Medway patients waiting over 52 weeks (compared to an increase of over 1,000 patients across the whole South East Region in the same period). The average waiting time has increased by just over one week, and the percentage of people treated within 18 weeks of referral fell by 2.2%.

	Total incomplete pathways	Total within 18 weeks	% within 18 weeks	Average waiting time (weeks)	Total 52 plus weeks
April 2021	143,974	92,867	64.5%	10.7	7,963
May 2021	150,752	103,028	68.3%	10.5	6,815
June 2021	153,366	108,888	71.0%	9.9	6,010
July 2021	160,380	113,860	71.0%	10.2	5,765
August 2021	162,175	113,778	70.2%	10.8	5,757
September 2021	168,618	116,997	69.6%	11.1	6,093
October 2021	170,307	116,497	68.4%	11.3	6,225
November 2021	171,344	118,025	68.9%	10.8	5,948
December 2021	**172,207**	**114,816**	**66.7%**	**11.9**	**5,765**
SE England Nov 21	812,356	537,772	66.2%	11.8	28,828

Source: National Consultant-led Referral to Treatment Waiting Times Data 2021-22, 10 February 2021
https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2021-22/

The table below provides the Kent and Medway level data for December 2021 on the ten specialties with the highest number of 52+ week waits:

Treatment Function	Total number of incomplete pathways	Total within 18 weeks	% within 18 weeks	Average (median) waiting time (weeks)	92nd percentile waiting time (weeks)	Total 52 plus weeks
Trauma and Orthopaedic	23,015	13,923	60.5%	13.1	50.4	1,709
General Surgery	20,047	12,300	61.4%	13.2	49.2	1,397
Ear Nose and Throat	15,418	7,806	50.6%	17.6	47.3	996
Gynaecology	14,718	9,495	64.5%	12.5	38.0	569
Urology	10,106	6,547	64.8%	11.9	39.3	388
Other - Surgical	10,046	7,081	70.5%	11.1	34.7	177
Ophthalmology	16,541	11,151	67.4%	12.1	30.0	162
Plastic Surgery	1,773	1,048	59.1%	14.9	42.9	91
Gastroenterology	11,377	7,550	66.4%	12.1	32.5	50
Cardiology	7,082	4,893	69.1%	11.3	32.7	45

4.2 NHS Elective Recovery Plan

This section provides an update on the NHS England *Delivery Plan for Tackling the COVID-19 Backlog of Elective Care* published on 8 February 2022*.* All figures in this section and references to 'we' refer to the NHS as a whole, not Kent and Medway specific services.

The local requirements to meet the plan's objectives are being reviewed and will be reported to HOSC in a future meeting.

The plan sets out how the NHS will tackle the backlog in the months and years to come, focusing on four areas of delivery:

- Increasing health service capacity
- Prioritising diagnosis and treatment
- Transforming the way we provide elective care
- Ensuring better information and support to patients

The scale of the challenge and impact on patients and staff

6 million people are now on the elective care waiting list, up from 4.4 million before the pandemic. These patients are at various stages of their treatment 'pathway', with approximately 4 in 5 waiting for care that does not require admission to hospital, such as diagnostic tests or outpatient appointments.

In addition to the known waiting list, estimates suggest that during the pandemic, over 10 million patients did not come forward for treatment when they may have needed it, including those worried about cancer symptoms. It is impossible to know whether these people do need treatment and, if they do, when they will seek it, making it difficult to estimate the impact this will have on both their outcomes and the overall waiting list. The size of the waiting list is likely to increase, at least in the short term. If around half the 'missing demand' from the pandemic returns over the next three years, particularly if this is earlier in the period, then NHS England expect the total national waiting list will be reducing by around March 2024.

The pandemic has shown how NHS staff can rise to major challenges, and how they can deliver transformational change for patients rapidly when needed. However, any solutions for tackling the Covid-19 backlog cannot rely on making the same staff work harder and harder.

It is critical that our delivery plans for elective recovery focus on building a bigger, more flexible and more engaged workforce. The pandemic has also shifted public expectations of accessing services, seen in the uptake of digital health. Where possible we need to build on this and offer more convenient solutions.

Targets set out in the delivery plan

The Plan sets out how the NHS will deliver nine million more tests and checks per year by 2025. This means that over a three-year period, patients will be offered around 17 million more diagnostic tests – an increase in capacity of a quarter compared with the three years prior to the pandemic.

This expansion in diagnostic capacity will mean 95% of patients receive a test within six weeks of referral, while no patient will wait more than a year for elective surgery by March 2025. And by March 2024, 75% of patients will either have a diagnosis or have their cancer ruled out within 28 days of being urgently referred by their GP.

Local systems have also been asked to return the number of people waiting more than 62 days from an urgent referral back to pre-pandemic levels by March 2023.

To reach these targets, more than 100 diagnostic centres will be rolled out, and more surgical hubs will also be added to the network of 122 already operating across the country. The hubs focus on high-volume routine surgery so more patients can get seen more quickly, making efficient use of taxpayer resources, and creating extra capacity so emergency cases do not disrupt operations and cause cancellations or delays.

Investing to support recovery

The NHS nationally has been supporting local teams to access funding to implement their own plans to boost elective treatment over the last year. Additionally, the Government has committed more than £8 billion of additional revenue funding in the three years from 2022-23 to 2024-25, supported by a £5.9 billion fund available for capital projects. This is in addition to the £2 billion Elective Recovery Fund and £700 million Targeted Investment Fund (TIF) already made available to systems this year to help drive up and protect elective activity. Under the TIF, the NHS is investing in over 870 schemes across more than 180 hospital trusts to increase capacity through expanding wards, installing modular operating theatres, upgrading outpatient spaces, expanding mobile diagnostics for cancer, upgrading MRI and screening technology, to tackle cancer and elective waiting lists and reduce waiting times. The £5.9 billion capital investment over the same period includes:

£1.5bn	towards expanding capacity through new surgical hubs, increasing bed capacity and equipment to help elective services recover
£2.1bn	to modernise digital technology on the frontline, improve cyber security and improve the NHS's use of data and redesign care pathways
£2.3bn	to help increase the volume of diagnostic activity and further reduce waiting times

The strategy

Based on these challenges and the investment available, the Delivery Plan for Tackling the Covid-19 Backlog of Elective Care details action for the NHS in four key areas, summarised below.

Increasing capacity

While it is beneficial for both patients and the NHS to provide more care in or closer to patients' homes, many patients still require hospital care. We will put in place:

- Targeted plans to accelerate growth of the workforce, identifying gaps across key staff groups and sectors;
- International recruitment of more than 10,000 nurses this year, in particular those with experience in critical care and theatres and recruitment of 5,000 healthcare support workers. We will also continue to utilise the successful medical support workers scheme, enabling a wider range of doctors to contribute to service and expand the future medical pipeline
- The continued deployment of the 17,000 reservists in eight pilots
- Support the use of effective digital and data-driven solutions to speed up tests, freeing up clinical time and making full use of theatre capacity and other resources available, and;
- Make full use of capacity in the independent sector, through a national framework which ensures local teams can buy services at the same price as NHS hospitals are paid.

Prioritising treatment

The NHS is committed to tackling the longest waits, but also ensure that those in the greatest clinical need get the treatment they need quickly. To achieve this we will therefore:

- Task local systems to analyse waiting list data so they can identify and address any inequalities, expediting treatment for those who need it most;
- Develop a national network to offer patients who have been waiting a long time a choice of alternative locations to receive their treatment, with financial support for travel available to those who need it, and;
- Continue to invest in symptom awareness campaigns for cancer to encourage people to come forward to be checked out as early as possible.

Transforming the way we provide elective care

Patients told us when developing this strategy that they want flexibility, ease of access and more control over how they interact with healthcare services. We will achieve this by:

- Expanding Community Diagnostic Centres to provide more convenient options for people to get important tests and scans away from hospitals;
- Increasing surgical capacity through Surgical Hubs, and;
- Making outpatient care more flexible, giving patients and their carers the ability to access, specialist assessments and appointments at home, and arrange follow-ups as and when they need them.

Better information and support for patients

Engagement with patient groups has clearly indicated the need for improving communication to people while they wait. We will therefore shortly launch a new 'My Planned Care' online platform to, over time, provide:

- Information on their elective wait, including the waiting list size and average waiting times for their specialty at their provider;
- Support for patients to maintain or achieve their fitness to ensure their surgery can go ahead safely, and therefore reducing the number of operations which need to be cancelled, and;
- Patients taking up appointments away from their local hospital will be offered a comprehensive support package including travel and accommodation where necessary.

5 Conclusion and recommendation

The vaccine programme continues and overall take-up rates across Kent and Medway are positive. Planning for offering further doses is underway alongside continued delivery of the current schedule; however significant updates to the programme are unlikely until there are national announcements on next steps. We should be able to update the May 2022 HOSC meeting on how local vaccination services will be running the programme on a 'business as usual' basis.

All NHS services expect to remain very busy through the rest of the winter and in most cases throughout the next year, though the majority of the demand is not directly linked to Covid-19 infections. The whole health and care system is continuing to work together to respond in the most effective ways possible to maximise the quality and timeliness of care. This effort is increasingly focused on recovery of the backlogs and responding to high levels on non-covid demand.

For the reasons above we propose stopping these overview reports on Covid-19 (which have focussed on vaccination progress and hospital pressures). Instead, issues such as elective recovery progress and vaccine business as usual model can be addressed as topic specific papers agreed as part of the regular agenda setting discussions.

The majority of the data included in these reports continues to be publicly available for information and scrutiny; with updates published daily, weekly or monthly depending on the data set:

- **Covid-19 vaccination rates** – published weekly on Thursdays at https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-vaccinations/

- **Covid-19 infection rates, deaths, hospitalisations** – updated daily at https://coronavirus.data.gov.uk/

- **Elective waiting time data** – published monthly on second Thursday of the month at www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2021-22/ This data will also be presented in a more public friendly way through the *My Planned Care* website launching in late February 2022. We will provide the website link when it is available

Recommendation

HOSC is asked to note the report and agree that the Covid-19 update in this current format be stopped; with topic specific papers being agreed for future meetings.

Covid response / recovery lead:

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

Covid vaccine programme lead

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Executive Chief Nurse
Kent and Medway NHS
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Item 7: Transforming Mental Health and Dementia Services in Kent and Medway

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 2 March 2022

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

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

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1) Background

a) The Kent and Medway CCG are undertaking several strands of work to transform the way local mental health and dementia services are provided. This will be supported by funding and investment of £51m over five years and is being coordinated by the Kent and Medway Mental Health Learning Disability and Autism Improvement Board – bringing together representatives from NHS, local authorities, social care, and the voluntary and community sector.

b) The workstreams under development include:

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

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

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

iv. Eradicating outdated and unsafe dormitory wards.

v. Redesigning community mental health services.

2) Previous monitoring by HOSC

a) The Committee has received papers in relation to the following proposals:

i. 4 March 2021 – Improving care for people living with dementia and complex needs – the Committee did not feel there was enough information available to determine if the proposals constituted a substantial variation of service.

ii. 10 June 2021 - Transforming Mental Health and Dementia Services in Kent and Medway – an overview paper. The Committee decided to make

decisions on whether individual workstreams were a substantial variation of service on a case-by-case basis.

iii. 10 June 2021 – Eradicating Dormitory Wards – the Committee decided the proposal was not a substantial variation of service.

iv. 16 September 2021- Eradicating Dormitory Wards – a written update was presented setting out progress made and expected timescales.

b) The KMCCG has asked to attend today's meeting and provide an update on the overall mental health and dementia services transformation.

2) Substantial variation of service

a) HOSC has agreed to receive updates on the progress of the overall transformation, as well as accepting individual reports on each of the workstreams at the appropriate time. This allows the Committee to determine if each item is a substantial variation of service and proceed accordingly.

4) Recommendation

RECOMMENDED that the Committee note the report

Background Documents

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

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

Kent County Council (2021) 'Health Overview and Scrutiny Committee (16/09/21)', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8759&Ver=4

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KENT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

2 March 2022

Transforming Mental Health and Dementia Services in Kent and Medway – Update

Report from: Karen Benbow, Director of System Commissioning
Taps Mutakati, Deputy Chief Operating Officer, KMPT

Author: Andy Oldfield, Deputy Director Mental Health and Dementia Commissioning

1. Introduction

1.1 Following a presentation to the Kent HOSC in June 2021, this paper provides an update on the following areas:

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

2. Current Activity

2.1 In June 2021, we updated the committee on the increased demand for mental health services in the context of the COVID-19 pandemic. Kent and Medway NHS Partnership Trust (KMPT) continue to experience increased demand for services. It is unclear if this will continue post the lifting of Covid restrictions however indications nationally are that that this will be a sustained increase.

2.2 Whilst contacts to the open access crisis line provided by KMPT were very high during the early stages of the pandemic (with increases up to 65%), numbers began to stabilise from April 2021. The crisis line is now receiving an average of just over 3000 calls per month. This is a rise of 23% when compared to January 2020. This change was to be expected as the crisis line moved to be a public facing service

rather than solely a referral access point for KMPT; investment was made to ensure the service can operate safely.

2.3 Following the increase in demand, there has been significant transformation of the crisis line service. Additional capacity has been created through expansion of the workforce alongside redesign of the clinical model. A number of initiatives have been put in place to improve the caller experience on the line and call performance has significantly improved in the past year. For example, in February 2021 there were rates of abandoned calls up to 50%. However, from April to December 2021 there was an average rate of abandonment of just 4%.

2.4 All sectors of the NHS are experiencing delays in discharging patients from inpatient care as the impact of the pandemic affects the ability to secure care packages in the community. KMPT are working closely with local authority colleagues and have implemented several measures to ensure significant overview of any delayed transfers of care. Key actions:

- Twice weekly meetings with the Social Care inpatient in reach teams
- Daily escalation reports highlighting delayed social care cases across the system.
- Appointed a dedicated Older Adult Senior Discharge Coordinator.
- Co-funding a Project Manager with KCC to support reducing the number of Social Care/Joint (Heath and Social Care) delays
- Hosting a Multi-Agency Discharge Event (MADE) to review each discharge plan and identify areas for review and improvement going forward.

3. Inpatient Transformation

3.1 Eradicating Mental Health Dormitory Wards – Following a programme of formal public consultation in 2021, plans are being implemented to relocate Ruby Ward, an old style dormitory ward for older adults currently based at Medway Hospital, to a purpose built facility in Maidstone. Construction work is due to start on the site in March 2022, with the new unit open and operational in early summer 2023.

3.2 Therapeutic Acute Mental Health Inpatient Care - The therapeutic offer from inpatient mental health services is being improved through increased national investment; this will see improved therapeutic outcomes for people requiring admission or Home Treatment

Some changes are already in place such as expert gym instructors and further workforce plans are in development with particular focus on increasing access to ward based psychological therapy

3.3. As a result, patient outcomes and experience in hospital will likely improve and contribute to:

- Improved clinical outcomes and reduced readmission rates;
- A reduction in length of stay in adult acute inpatient mental health settings;
- Fewer out of area (acute) placements for people with specialist care needs where there are no Kent and Medway commissioned services.

4. Community Mental Health Transformation

4.1 The Community Mental Health Transformation Framework for Adults and Older Adults aims to enhance and improve the quality and experience of care for some of the most vulnerable people in our communities by involving all aspects of community support through the voluntary and community sector, social care, primary and secondary health care services. This programme will see community mental health teams transformed, working alongside local authority and third sector services in new and innovative ways.

The transformation programme is a national requirement of the NHS Long Term Plan for Mental Health. Following a deep dive in February 2022, NHSE gave the programme a positive report stating it was meeting the requirements at a strategic level.

4.2 Since the last report to committee key progress points include:

- Workshops and focus groups have taken place and engagement with service users to develop the core model, ensuring care is centred on the person, their family and local community.
- The governance, as a provider collaborative model, is in place to ensure well documented decision making across providers and in collaboration with commissioners in Kent and Medway
- Progress is being made on a number of key work streams including the Complex Emotional Difficulties pathway, Service User Network (SUN) model, Eating Disorders and Community Rehabilitation services

4.3 The programme is about to roll out implementation with three Primary Care Networks (Medway Central, Sittingbourne, and Medway South and Rochester) in the Medway/Swale Health and Care Partnership area from April 2022.

As the programme moves into different areas of Kent and Medway, this will allow for localisation of the model bringing GPs and lived experts into consideration of meeting local need.

5. Improving Mental Health Urgent and Emergency Care

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

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

5.3 **Section 136 detentions –** A significant success of the collaboration across organisations, especially the police and KMPT, is the reduction in the number of Section 136 detentions under the Mental Health Act.

5.15 The impact of this work has seen a sustained and statistically important downward trend in use of Section 136 by the police; it equates to a 27% decrease in S136 detentions compared to 2020 and a 36.6% decrease compared to 2019. 2021 has recorded the lowest figures since 2017. The table below shows the changes over time.

S136 figures from January 2018 - December 2021				
Month	**2018**	**2019**	**2020**	**2021**
Jan	117	152	146	110
Feb	101	148	155	144
Mar	152	155	138	132
Apr	147	161	113	99
May	141	205	160	125
Jun	146	149	150	128
Jul	159	200	189	117
Aug	166	194	201	112
Sep	146	196	157	96
Oct	156	200	150	89
Nov	139	170	125	84
Dec	127	136	114	74
Total:	1697	2066	1798	1310

5.4 **Open Access Crisis (NHS 111 and 24/7 Mental Health Triage) –** Building on the development of the Open Access Crisis Line, phase 2 of this work is for NHS 111 to be the first point of contact for anyone in a mental health crisis. The development

is a joint piece of work with SECAMB, commissioners, councils, third sector and KMPT which aligns to national requirements set out for delivery of urgent crisis pathways for whole populations. A key aim will be to bring all the open access crisis services into a clear, comprehensive pathway to eradicate confusion for the public and professionals when there is a need to access advice, guidance and expertise regarding mental illness at a time of crisis

5.5 A new development, using winter funding, has been the Professional Bypass Line, delivered by KMPT in the open access crisis service, for Urgent Treatment Centre and SECAmb clinicians. The bypass line is available as a direct route for a clinician to clinician discussion. The KMPT clinician offers a brief screening of presentation and immediate risk and provides advice and/or signposts to another service or can accept a referral for KMPT services. The service is under review as funding ceases at the end of March and a decision needs to be made if use of the line has met the required outcomes set out against this project against the spend.

5.6 **Community Crisis Alternatives -** project to expand community alternatives for crisis response across Kent and Medway. In addition to the five Safe Havens operating in 2021/22, additional investment was secured from NHSE to sustain and develop:

- Staying Alive App,
- SHOUT Text Service, and
- 24/7 Mental Health Matters Helpline (additional 10,000 calls)

5.7 **Participation Workers (18-25 year olds)** were launched November 2021. The project is committed to ensuring that it works across the statutory, voluntary and community sectors to listen to as broad and diverse a group of people as possible.

5.8 This has been largely successful, with many organisations keen to work collaboratively to hear the experiences of the 18-to-25 group and to co-produce changes within Crisis Services.

5.9 Examples of organisations actively worked with:

- Porchlight's BeYou Team,
- Canterbury Christ Church University – Suicide-Safer Community Group,
- Kent and Medway Suicide Prevention Team and the Kent and Medway Suicide Prevention Network,
- Medway Council Participation Team,
- Living Words and Living Warriors Project,
- Emotional Wellbeing Participation Team (KCC), and

- We Are With You

5.10 **NHS Safe Havens Safe Havens**. Safe havens operate from 6-11 pm, seven days a week and are currently available in:

  - Canterbury
  - Maidstone
  - Medway
  - Thanet
  - Folkestone – now accessible for 16+

Other key offers include:

- Kent Refugee Action Network (KRAN)
- PALS Teams across Kent and Medway
- Involve Kent
- Mind groups across Kent and Medway

5.11 **Peer Support Service for people with Autistic Spectrum Conditions** in mental health crisis was introduced in August 2021, and since that time the service has developed a model which provides effective, flexible, and scalable crisis alternatives support to adults aged 18 and over, living in Kent and Medway who have a diagnosis of, or are awaiting assessment for, autism/Asperger's. The Touch Base service is delivered by Advocacy for All. To date, the service has supported almost 30 individuals, with a blend of one-to-one self-advocacy and peer support groups.

5.12 **The Liaison Mental Health Services (LMHS)** are provided by KMPT and commissioned to operate 24/7, as an on-site distinct service in general hospitals with an Emergency Department. They provide a response within one hour to emergency referrals from wards or the Emergency Department and within 24 hours for urgent referrals from inpatient wards.

5.13 An audit was completed in July 2021 to identify compliance with nationally recognised service standards. The recommendations from the recent audit are currently being actioned and focus on:

- Workforce (structure and skill mix in line with NICE guidance)
- A consistent approach to recording and reporting data response times:
- Alignment of historical commissioning agreements to ensure a consistent approach across Kent and Medway.

6. Deep Dive - Transforming Dementia Services

6.1 In response to the decision made at HOSC to ensure a full overview of all mental health provision across Kent and Medway, aligned to the Mental Health, Learning Disability and Autism Improvement Board, this paper provides a comprehensive overview of work underway to transform dementia services.

The progress to transform dementia services across Kent and Medway falls into four categories:

- The development of a system wide Dementia Strategy
- Improving Diagnosis
- Support after Diagnosis
- Care at Home, in Hospital and in Care Homes

6.2 **Dementia Strategy**. A strategy has been drafted following significant engagement with a range of stakeholders, including workshops with specific communities, i.e. care homes, BAME and learning disability, to hear from them about any specific challenges or issues in obtaining a diagnosis or post diagnostic support and how these processes may need to tailored to their specific needs.

6.3 Key points which came out of the wider consultation include:

- Ensuring that there are appropriate services for people with young onset dementia (Kent and Medway has a higher rate of young onset dementia, when compared to the national average).
- The importance of care co-ordination and a single point of contact post diagnosis, for both the person with dementia and their families.
- Providing good support for carers, including short breaks, both in and away from the home and crisis support.
- Ensuring access to appropriate dementia awareness training for anyone who comes into contact with people with dementia, which includes care homes, domiciliary providers, health professionals and also carers.
- The need to explore the greater use of technology.

6.4 It is intended that the strategy is joint strategy between the CCG, KCC and Medway Council and is in the process of going through the various organisations' governance arrangements, with a final strategy being ready for implementation by May 2022.

6.5 **Improving Diagnosis** Progress continues to be made in the standards that relate to dementia diagnosis and the national dementia diagnosis rate (DDR) target (67% of people with dementia should have a diagnosis). In April 2021, Kent and

Medway's DDR was 54.16%. This has increased to 57.1% in January 2022 (the South East region rate is currently 60.18%).

6.6 There are a number of initiatives in place to increase the diagnosis rate:

- **Transformation of memory assessment pathway** to enable the majority of people to receive a diagnosis within six weeks of referral. This will be work across primary care and KMPT. From May 2022 KMPT Memory Assessment Service aims to provide a "one stop shop"; this will see assessment and diagnosis being made at the same appointment for as many people as possible. The approach will not be appropriate for everyone as some people's diagnosis can be more complex and need further investigation. Also, some people may find receiving a diagnosis in one appointment more stressful and may wish to take longer.

- **GPs with an enhanced role (GPwER) with a special interest in dementia**. 10 GPs were recruited last year for this role; the GPs are currently undertaking a (virtual) course at Bradford University to enable them to make a diagnosis of dementia. On completion of the course in May 2022, they will be able to diagnose less complex dementias in primary care which will reduce the system wide memory assessment waiting list which currently sits with KMPT alongside support the system to reach the nationally prescribed dementia diagnosis rates.

- **The Enhanced Health in Care Home (EHCH) framework** was developed at a national level and had the aim of strengthening the support to people who live and work in care homes. Additional funding has been provided to Primary Care Networks (PCNs) who have signed up to deliver the EHCH service. It is estimated that 70-80% of people in care homes have dementia and the Kent and Medway service specification encourages the use of DiADeM, a tool to support GPs in diagnosing dementia for people living with advanced dementia in a care home setting. It has been developed by the Yorkshire and Humber Dementia Strategic Clinical Network and is supported by the Alzheimer's Society. Two evening sessions have also taken place to introduce the use of DiADeM to GPs and to highlight the benefits of having a diagnosis.

- **Data Harmonisation.** In a number of cases individuals have received a diagnosis, but this does not appear on GP practice's dementia register because the diagnosis has not been coded correctly, A data harmonisation tool which identifies uncoded diagnosis, has been developed and has been shared with primary care to ensure their data is as up to date as possible.

- **Neuro-Imaging**. An MRI scan is usually used to support a diagnosis of dementia, but the pandemic has created a backlog of people waiting for this investigation at the various acute trusts across Kent and Medway. Individuals who are referred to KMPT for a dementia diagnosis are being offered the opportunity to access an MRI scan at a private provider where the waiting time is significantly less.

6.7 Support after Diagnosis - Dementia Co-ordination - Engagement with people with dementia and their carers had highlighted that once a diagnosis has been received, it is often very difficult to access the right services at the right time, partly due to lack of knowledge of local services. In response to this, a dementia co-ordinator service aligned to the PCNs is being commissioned that provides a consistent point of access from the point of referral to end of life for the person with dementia and their carer. The co-ordinator's knowledge of local services will ensure that the right service can be accessed at the right time.

6.8 A joint tender with KCC to procure a dementia co-ordinator service and a post diagnostic service (see below) has recently been completed and will go live from 1 April 2022.

6.9 The successful providers of the dementia co-ordinator service will be:

Area	Provider
West Kent	Alzheimer's & Dementia Support Services
East Kent	Age UK Herne Bay & Whitstable
Dartford, Gravesham, Swanley, Swale and Medway	Alzheimer's & Dementia Support Services

6.10 **Support after Diagnosis - Post Diagnostic Support.** Providing good support following diagnosis can help people with dementia remain independent for longer and can greatly improve the quality of life both for the person with dementia and their families. As indicated above, part of the recent joint tendering process with KCC, was the re-procurement of post diagnostic support commissioned by KCC.

6.11 The aim of the new service is to deliver a holistic service which supports people with dementia to continue participating in activities that they enjoy, and to maintain or establish new networks and support systems. However, whilst there will be flexibility in the delivery of the service specification, there will be a requirement to deliver the following:

- Dementia cafes for Individuals living with dementia and their carers;

- Dementia peer support groups where Individuals in the early to middle stages of their condition can meet and share experiences and offer mutual support and advice;
- Social opportunities (including day services – excluding where directly funded by Adult Social Care); and
- Befriending services

6.12 The post diagnostic support service will go live on 1 April 2022 and the successful providers of this service will be:

Area	Provider
West Kent	Age UK Herne Bay & Whitstable
East Kent	Age UK Herne Bay & Whitstable
Dartford, Gravesham, Swanley and Swale	Alzheimer's & Dementia Support Services

6.13 **Carers Support - Admiral Nurses** Admiral nurses in Kent and Medway are employed by KMPT. However, there are now a number of models nationally which locate Admiral nurses in the community or in primary care. Therefore, it is planned to review the Kent and Medway service to ensure that the service is delivered in the most effective way, particularly in light of other services which have now been commissioned more recently. The review will also seek to ensure equitable provision across Kent and Medway.

6.14 **Carers Support – Carers Strategy** KCC have also started a consultation on a revised Carers Strategy, which is being supported by the CCG. The consultation is due to end on 22 February 2022, with the aim of having a completed draft strategy by early Spring.

6.15 **Crisis Support in the Community -** the aim of this project is to implement an integrated service which can support both physical and mental health needs.

6.16 A pilot is being implemented in east Kent to test out an integrated approach to supporting people with dementia who need urgent care support. The pilot is a partnership between KMPT and Kent Community Healthcare Trust (KCHFT) and the proposal is to include mental health practitioners in KCHFT Home Treatment Team. The Home Treatment Team provide support to frail, elderly people in their own homes and in care homes, with the aim of preventing a hospital admission, where possible. The pilot will be small to begin with, targeting care homes in two areas in east Kent. Recruitment is currently in progress, although a consultant psychiatrist for older people is already in place and his early intervention has already prevented a small number of hospital admissions.

6.17 **Step-Down Beds for People with Dementia and Complex Needs -** The modelling work undertaken to support the development of a model of care for people with dementia and complex needs, identified the need for a number of step down beds which people could access for assessment and management of their longer term needs. This could be up to a period of six months.

6.18 A draft outline business case has now been produced which proposes establishing this provision at Broadmeadow, near Folkestone, which is an inhouse facility provided by KCC which provides beds for rehabilitation, respite and dementia. Although based in east Kent, the beds could be accessed from anywhere in Kent. Agreement is currently being sought from both KCC and CCG to consider the feasibility of the service and proceed to the development of a full business case.

6.19 **East Kent Rapid Transfer Service** - This service comprises a small number of dementia specialists who are employed by Kent and Medway Partnership Trust (KMPT) and work in East Kent Hospitals University Foundation Trust (EKHUFT) alongside Kent Community Healthcare Foundation Trust's (KCHFT) Rapid Transfer Service. The main aim of the team is to provide support for the transition of dementia patients to spot purchase beds in care homes for further assessment, for a period of up to six weeks. Whilst measurable data has been hard to obtain, anecdotally the introduction of the team has reduced length of stay in, and re-admissions to, the acute trust. The care homes are also more willing to accept transfers of care of people with dementia, because they are able to access support when necessary. The possible introduction of similar models across Kent and Medway will be explored with the Health and Care Partnerships at a workshop on 17 March 2022. A range of key stakeholders will consider and agree how responding to a patient with dementia in crisis can be integrated with existing crisis response work programmes for the frail elderly.

6.20 Whilst this dementia services transformation programme as set out above continues, the Frank Lloyd Unit in Sittingbourne remains closed. We recognise that this is a valuable community asset. As agreed, we will continue to update the HOSC on progress and detail how our changing model of care supports dementia patients with complex care needs in the community.

7. Conclusion

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

8. Recommendations

The HOSC is asked to:

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

Item 8: Urgent Care Review Programme - Swale

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 2 March 2022

Subject: Urgent Care Review Programme - Swale

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

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

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1) Introduction

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

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

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

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

2) Previous visits to HOSC

a) HOSC has received updates about the urgent care review programme since 2014. Its last update was on 10 June 2021.

b) Swale CCG had initially considered a “minimal change” clinical model, but this was discontinued in November 2018 after it was deemed unaffordable. It was decided a full-service specification/ clinical model review was necessary, and this was taking place in late 2019. Under the NHS Long Term Plan, urgent care proposals were due to be in place by autumn 2020.

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

c) At its meeting on 4 March 2021, HOSC were notified that the project was still in its early stages with little progression since the previous update in September 2019, in part due to the onset of the pandemic.

d) KMCCG returned to the Committee on 10 June 2021 and explained that the expectation was to introduce an Urgent Treatment Centre model, with a GP-led Urgent Care Centre (UTC) model offering an integrated service. An interim service was anticipated to be in place by October 2021 with a full UTC service from July 2022.

e) Following discussion, the Committee agreed to note the report and invited the CCG to provide an update at the appropriate time.

3) Potential Substantial Variation of Service

a) The Committee has yet to determine if the Swale and Medway Urgent Care Review Programme proposals 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.

4) Recommendation

<u>If the proposed change to urgent care in Swale is *substantial*:</u>

RECOMMENDED that:

(a) the Committee deems proposed changes to urgent care in Swale to be a substantial variation of service.

(b) Swale CCG be invited to attend this Committee and present an update at the next meeting.

<u>If the proposed change to urgent care in Swale is *not substantial*:</u>

RECOMMENDED that:

(a) the Committee does not deem the proposed changes to urgent care by the Swale CCG to be a substantial variation of service.

(b) the report be noted.

Background Documents

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

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

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

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

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

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

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

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

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

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

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Kent Health Overview and Scrutiny Committee

Briefing Note: Swale Urgent Treatment Centre (UTC) Model (Feb-22)

Background

Within Swale there are two Minor Injury Units (MIUs), one based at each community hospital (Sheppey Community Hospital and Sittingbourne Memorial Hospital) that are provided by Kent Community Health NHS Trust (KCHFT) and a GP Walk In Centre (WIC) based at Sheppey Community Hospital.

The UTC national guidance was published in July 2017 which set out a core set of standards for UTCs to establish as much commonality as possible. In response to the national system pressure, NHS England prioritised development of UTCs and the enhancements of UTC standards to decompress both Type 1 and ambulance activity. They have shared an updated *"Urgent Treatment Centres - Principles and Standards"* document to reflect changing ways of working, and the importance of UTCs as part of an NHS 111 First model of care.

As a result, the requirement to develop the MIUs and WIC into a UTC model within Swale that meets the 34 standards, is fit for purpose and ensures equitable access to the Swale community is not only a local system priority but a national requirement.

At the previous update to this committee in June 2021, a phased approach was outlined. As part of phase 2 of Swale's UTC development, Minster Medical Group (MMG) were awarded the contract to provide an interim GP WIC service at Sheppey Community Hospital, to replace DMC Healthcare's Alternative Provider Medical Services (APMS)contract that ended in October 2021.

MMG seamlessly launched the service on 1 November 2021, which included enabling patients to physically walk in and not having to wait for telephone triage first (DMC Healthcare instigated telephone triage as part of their response to the pandemic) and more recently enabling NHS111 Direct Access Booking.

Current position

The transition to develop the MIU and WIC into a UTC is underway, and the services currently work together to support each other and ensure patients are seen by the most appropriate clinician for their needs. This will continue, as the service develops and begins to meet more of the national standards, providing quality care, closer to home for the residents of and visitors to Swale.

Some minor building works to the existing area used by the WIC is underway and once complete, the MIU team will move across to enable the services to operate as one within an improved, safe and secure unit. The pandemic has resulted in issues sourcing materials which has caused a delay to this move but this is expected to be completed within the next 2 months.

There has been a delay to the timeline described in June 2021 due to wave 3 of the pandemic and the subsequent mandated requirement to put on hold any work that was not critical to vaccination, flow and surge or a statutory requirement. As the MIU and WIC services were functioning well together, further enhancements to these services were not critical, given the unprecedented pressure within the system.

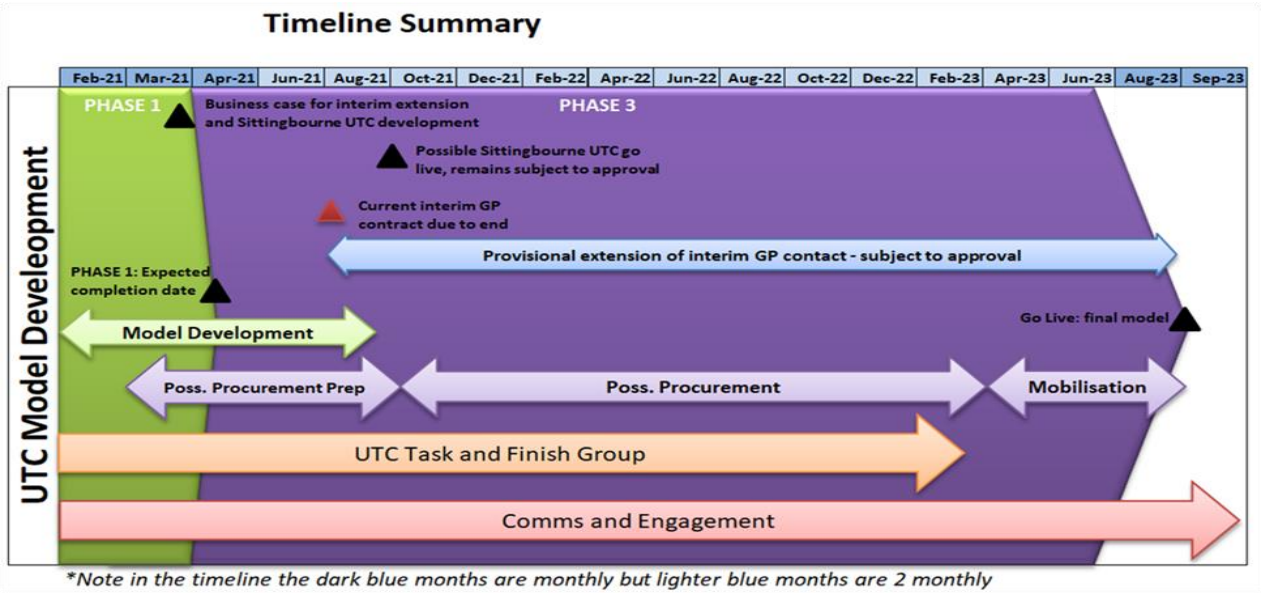
This work is now being prioritised by the CCG to ensure that Swale residents will benefit from the UTC model. Provisionally the interim arrangements in Sheppey are likely to be extended until August 2023 and include potential development of the Sittingbourne UTC (subject to business case approval), with the final model commencing September 2023.

UTC Model Timeline

The timeline of the project is divided into three phases as detailed below. Phase 1 is partially complete, building works have delayed final completion but this is expected in the next 2 months. Phase 2 is complete, with Phase 3 the longer term development of the final model.

Phase	Description	Development Period	Go Live
Phase 1	The alignment of the existing MIU and WIC services, this could result in some minor contractual changes	Apr 21 – Apr 22	Expected by April 22*
Phase 2	The provision of an interim service that will 'replace' the WIC element of the service when the WIC contract expires at the end of September 2021	Completed	Completed 1 Nov 21
Phase 3	This is the final UTC model that is required for the Medway and Swale system. This element is likely to include to procurement hence time has been built in to allow for the right engagement, time for procurement and mobilisation. If a risk is taken and procurement option not selected time may reduce	Apr 21 – Aug 23* (incl. procurement)	1 Sep 23

**subject to building works completion, delayed due to pandemic causing issues sourcing materials*



Next Steps

- Complete integration of Sheppey MIU and WIC to UTC
- Business case to the CCG to agree update timeline, possible extension of interim service and development of Sittingbourne MIU into a UTC
- Updated Communication and Engagement Plan
- Further updates will be provided to HOSC as the model is developed

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Item 9: Provision of GP services in Kent

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 2 March 2022

Subject: Provision of GP services in Kent

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

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1) Introduction

a) HOSC has raised concerns about the provision of GP services locally. Members have raised concerns about the quality of services, the use of virtual instead of face-to-face appointments, and access issues.

b) A background report was presented to HOSC at its September 2021 meeting, setting out how GPs work, what issues have been recognised nationally, and suggestions for lines of enquiry the Committee may wish to pursue.

c) Representatives from the Kent and Medway CCG and the Local Medical Committee attended a meeting on 11 November to answer the Committee's questions. Key discussion points included:

i) The benefits and drawbacks of virtual appointments.
ii) The GP contractor model versus salaried doctors.
iii) The workforce.
iv) The use of technology and social media.
v) Interaction between NHS 111 and GPs.

d) Following the discussion, the Chair requested that a follow up report be brought to the Committee in March, to include the following items:

a) Detail around how contracts for new GP surgeries were awarded.
b) More information around the closure of practices over lunch.
c) A quantified analysis of unmet need in primary care.
d) Primary care estates information, including the use of Section 106 money and role of councillors in securing new provision.
e) An update on the rollout of the Primary Care Network and development of the General Practice Strategy.
f) The GP Estates strategy*.
g) How e-consult might be better utilised, and what role personal fitness devices might play in the future.
h) The role and importance of PPGs and whether they were all running again.

e) Representative from the K&M CCG and LMC have been invited to attend today's meeting for further discussion.

**The GP Estates Strategy document was shared with Members of the Committee via email on 14 February 2022.*

2. Recommendation

RECOMMENDED that the Committee consider and note the report.

Background Documents

Kent County Council (2021) 'Health Overview and Scrutiny Committee (16/09/21)', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8759&Ver=4

Kent County Council (2021) 'Health Overview and Scrutiny Committee (11/11/21)', https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8760&Ver=4

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Kent and Medway
Clinical Commissioning Group

General Practice update

Kent Health Overview and Scrutiny Committee, 2 March 2022

1 Background

The CCG attended HOSC in November 2021 to provide an overview of general practice; this raised several further requests for information in the form of a report to the March meeting namely;

a. an update on access and appointment availability
b. more information around the closure of practices over lunch
c. a quantified analysis of unmet need in primary care
d. primary care estates' information, including use of Section 106 money and the role of councillors in securing new provision
e. an update on the rollout of the Primary Care Networks
f. training for practice receptionists
g. the GP Estates Strategy
h. how e-consult might be better used
i. the role and importance of patient participation groups (PPGs) and whether they were all running again
j. detail around how contracts for new GP surgeries were awarded.

This paper seeks to provide an update on capacity in general practice, as well as address the questions listed above.

The CCG is developing a strategy that will pull together many of these themes and address them as part of a plan for the next three years. The purpose is to provide an overview of the status of general practice across Kent and Medway, identify the key challenges facing the sector and to identify key priorities for the next three years.

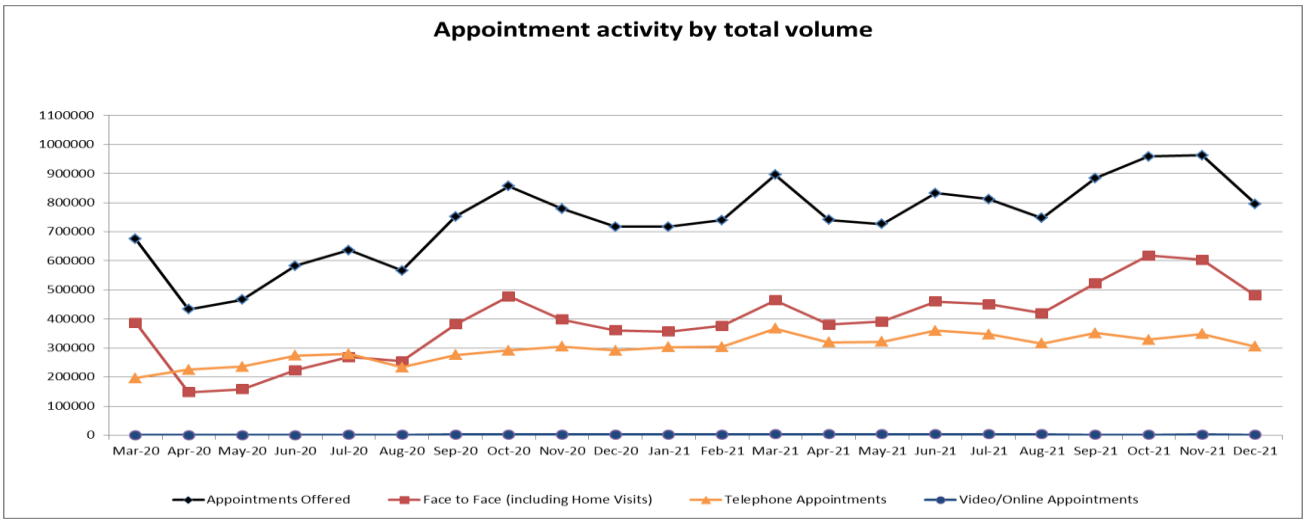
2. Capacity in general practice

2.1 Latest appointment data

The graph below shows how general practice appointments changed when the pandemic hit. It shows:

- since August 2021 there have been more face-to-face appointments per month than before the initial wave of the pandemic (March 2020)
- significant increases in face-to-face appointments between August and October 2020 and again between August and October 2021.
- the total number of appointments of all type has been at or above pre-pandemic levels since September 2020.

The very latest data for December 2021 shows a decrease from November 2021, this is attributable to the booster push practices focused on and the fact there are fewer working days in December. We expect activity to rise again in January data.



The latest general practice appointment figures show that 752,333 appointments were carried out in Kent and Medway in December 2021. This is in addition to GP teams giving more than 300,000 vaccinations/boosters in the same month.

Data released from NHS England shows nearly 445,000 face-to-face and home visits were carried out, despite additional bank holidays and the Christmas period; this demonstrates general practice is very much open for business and very busy.

There was a decrease in the number of people not attending their appointments, with 42,347 appointments not attended in December.

In September, we were successful in bidding for £8million from the Government's Winter Access fund. This fund is supporting a range of improvement programmes until March.

In all, 125 practices, including five primary care networks (PCNs), are now engaged with improving access plans - aiming to deliver an additional 100,190 general practice appointments, as well as improvements to the face-to-face appointment ratio, addressing

NHS111 and A&E use and overall access experience improvements.

We have also been working on at scale access plans. Same day access plans have been approved in all health care partnerships areas, including an East Kent respiratory hub aiming to deliver 37,500 additional same day appointments.

2.2. GP Practice phones

We recognise one of the most significant challenges patients face is getting through on very busy general practice phone lines. The volume of phone contacts is putting considerable strain on all practices - particularly those with older analogue phone systems. For patients and reception staff alike, this can be a source of huge frustration. Given the range of phone systems in use across 192 practices, we are not able to quantify the level of unmet demand in terms of people who do not get through and seek alternative options.

In all, 54 per cent of our GP practices have moved to cloud-based telephony systems, which provide more lines for inbound and outbound calls.

This technology can provide data about patient demand to help give feedback about performance and inform practices about the level of administrative support they may need for call handling.

The CCG is using some of the Winter Access Fund to enable all remaining GP practices, which wish to move to this new technology to be able to do so. So far, there are 84 practices we are working with to make the necessary changes. We anticipate this will be completed in the next three to four months. We continue to work with the remaining six practices to bring them on to the programme.

These phone systems will:

- provide more lines into and out of the practice
- allow the practice to manage those lines more effectively – including giving messaging about alternative ways to contact, if appropriate
- provide data on call volumes and peak demand times (including unmet need) to allow the practice to manage staffing.

3 Practice opening times

There are 153 providers of primary medical care services (GP practices) in Kent, and 39 in Medway.

The General Medical Services (GMS) Regulations require GP practices to deliver services within core hours, '*as are appropriate to meet the reasonable needs of patients*'.

Core hours for GP practices are between 8am and 6.30pm, Monday – Friday, excluding weekends and bank holidays.

The GMS regulations do not require practices to be always open during core hours or deliver all services at all times when they are open, however GP practices are required to have access arrangements in place for their registered practice population throughout core hours.

In December 2017, NHS England issued supplementary guidance, which provided an expectation of services are to be delivered within core hours.

The services listed below are examples of what is to be delivered but is not exhaustive.

- Ability to attend a pre-bookable appointment (face-to-face).
- Ability to book / cancel appointments.
- Ability to collect/order a prescription.
- Access urgent appointments / advice as clinically necessary.
- Home visit (where clinically necessary).
- Ring for phone advice.
- Ability to be referred to other services, where clinically urgent (including for example suspected cancer).
- Ability to access urgent diagnostics and take action in relation to urgent results.

The GP contract provides detail of the essential services to be delivered within core hours https://www.england.nhs.uk/gp/investment/gp-contract/.

PCN arrangements should be in place to offer additional appointments between 8am and 8pm under improved access arrangements.

The CCG is responsible, as part of delegated commissioning, for the quality, safety and performance of services delivered by the GP practice providers. There is a statutory duty to conduct a routine annual review of every primary medical care contract that is held. This is performed through the General Practice Annual Electronic Declaration (eDEC). Part of this declaration includes opening hours. This is a contractual requirement for GP practices to comply with.

Failure to complete the return may result in the CCG issuing the provider with a breach notice against the GP contract held.

In 2020/21[1] the following declaration of opening hours was made by GP practices in Kent[2] -

[1] 2021/22 eDec results not yet available for analysis
[2] In 2020/21 there were 156 GP providers in Kent (not including Medway providers)

- 92.3 per cent (144) of GP practices in Kent declared that they are adhering to the core hours.
- 16.6 per cent (26) of GP practice in Kent declared that they closed for lunch time during the defined core hours and did not provide access to reception or the phone lines for their registered patients.
- 4 (2.56 per cent) GP practices failed to make the return by the deadline due to covid pressures and change to practice staff.

GMS regulations allow GP practices to decide which services to provide and when, to meet the needs of their patients. However, GP practices should provide evidence, if requested by the CCG, they have engaged with their PPG to check arrangements are meeting their reasonable needs and are addressing any areas of concern.

If a GP practice was not meeting the reasonable needs of their registered patient population during core hours, the CCG may consider action against the practice by issuing a remedial breach notice, which could - in extreme cases - lead to the removal of a GP contract.

4 General Practice Estates Strategy

A General Practice Estates Strategy was approved by the CCG Primary Care Commissioning Committee in August 2021. A copy of the strategy was provided to the HOSC, as requested, at the last meeting.

This strategy is intended to be an enabling strategy to support and inform discussions about capacity and estates strategies for core primary medical care services with general practices in primary care networks (PCNs). The strategy will also feed into the wider health and care partnership discussions (across all four HCPs) to highlight estates' challenges and seek opportunities, where applicable, for primary medical care services within an area.

The strategy details that a 'planning for growth' approach at PCN level will support the CCG's obligation to understand and secure provision for primary medical care services. It will be informed by understanding the ambitions of existing general practices to support the expected growth in population and the requirements, from a premises perspective. The strategy explains there would be discussion with all practices on a PCN basis, to use the latest growth assessments to review and refresh existing plans, consider where any gaps may exist and potential responses to this.

The CCG's Primary Care Estates Team has met the majority of PCNs between September 2021 and January 2022. It is important to emphasise this is a programme that will continue to evolve and a single meeting was not intended to provide all responses to the strategy. You can find the latest estates update given to our February Primary Care Commissioning

Committee here: Primary Care Commissioning Committee (Part 1, Open) (17/02/2022) (kentandmedwayccg.nhs.uk), from page 84.

Premises development proposals that have started progression through CCG governance (in line with the CCG GP Premises Development Policy) are detailed within the relevant section of the strategy. As plans are developed and considered through governance, new schemes will continue to be added to the premises development and improvement requirements for each area as a response to the GP Estates Strategy. A number of schemes have been supported by the Primary Care Commissioning Committee since the strategy was approved.

Approvals include some smaller improvement schemes and additional space requests along with the following premises development schemes:

- Stage one approval (Sept 21) for Chestnuts Surgery, Sittingbourne to develop plans for a new surgery. Plans are now being actively developed.
- Stage one application approved for Pelham Medical Practice, Gravesend (Oct 21) to develop plans to relocate to new premises – site options are being explored with a third-party developer.
- Stage one approval (Oct 21) for Lonsdale Medical Centre, Tunbridge Wells to develop a scheme for a new medical centre; includes opportunity for a development to also include another Tunbridge Wells practice and PCN space. Site options are being explored.
- Stage one approval (Oct 21) for West Malling Group Practice to develop plans for a large two-storey extension to the Kings Hill site – plans are being actively developed with landlord.
- Sittingbourne PCN (lead Practice Grovehurst Surgery) – additional space request for use of Bramblefields Clinic (former Swale CCG building) supported to provide clinical and admin space. Supported at PCCOG and approved via Executive Officer Authority to Act (Oct 21).

Premises development schemes take time to work up, especially between Stage one project initiation document (PID approval) and Stage two (outline business case). There are several schemes in this phase and the Primary Care Estates Team is in contact with the project teams to discuss and support progress and make sure all project development milestones are met to progress through CCG governance. As schemes are developed, engagement will be done with patients and local stakeholders, including local councillors.

The following provides a summary of some key points relating to funding of premises plans:

- GP contractors are responsible for providing suitable premises to deliver services from – if work is required or new premises development plans supported, they are responsible for sourcing capital funding.
- Alongside GP partners securing their own funding, other options may include CCG/practice bidding for NHS capital, landlord investment or a specialist medical centre developer for a new build.
- S106 and community infrastructure levy (CIL) contributions are sources of capital that can contribute to part funding a general practice premises improvement or development (to support growth); the CCG, as the commissioner, makes the application for use of funding.
- The CCG holds the revenue budget for re-imbursement of rent, business rates, water rates and clinical waste.

4.1 Planning and S106 contributions

Regular liaison meetings continue to take place between the Primary Care Estates Team and local council planning leads in each area. These cover strategic and operational updates.

The CCG team formally responds to Local Plan consultations with a specific focus on general practice. Engagement with local councils through local plan review processes has enabled specific requirements for health infrastructure (for general practice specifically) to be detailed within local plan policies; either as land/building for a medical centre or a financial contribution to expanding existing healthcare infrastructure. The CCG also contributes to and engages in the refresh of infrastructure delivery plans, again with a specific focus on general practice.

The CCG team provides responses to relevant planning applications, specifically where S106 funding contributions are being requested or to identify specific requirements to mitigate the impact, such as the need for land to be safeguarded for a medical centre. Responses are provided in line with the CCG S106 and CIL principles and process document.

The CCG is aware of all S106 funding contributions held by councils and those secured (but not triggered) and the specific requirements of the S106 legal agreements. Regular updates are received from councils and the CCG uses this to inform discussions with general practices. Following the more recent round of meetings, some practices have signalled an interest in exploring use of S106 as a contribution towards a premises project.

The CCG will also seek to pool S106 contributions for larger premises projects, where possible; two examples in the Maidstone area are Staplehurst Health Centre (reconfiguration to create additional capacity) and the new build medical centre for Greensands Health Centre, Coxheath where c£200,000 and c£480,000 S106 contributions are being used respectively.

Depending on the timeline of planning approvals, the commencement of a development and the triggers for release of funding in the S106 agreement, the secured funding may not be available until many months or even years following approval. The CCG also recognises some developments that are approved may not progress or may not reach the triggers in the agreement and so the contribution will not become available. For this reason, secured S106 contributions cannot therefore be assumed as funding that will be received at a point in the future.

Regarding CIL, the CCG engages with councils through the infrastructure delivery plans to identify key schemes and will submit bids for funding in line with the local council process. Last year CIL funding was secured via the Sevenoaks District Council process as a contribution to an extension of a local practice.

5 Primary care networks (PCN)

This section updates the HOSC on the status, role and plans of primary care networks across Kent.

A primary care network (PCN) consists of groups of general practices working together, and in partnership with community, mental health, social care, pharmacy, hospital and voluntary services in their local area, to offer more personalised, coordinated health and social care to the people living in their area.

There are 42 PCNs in Kent and Medway with 35 in Kent. These are detailed with the clinical directors and member practices below in appendix 1. Their boundaries are shown in appendix 2. PCNs are aligned to a health and care partnership supporting them to work more closely with other health, care, voluntary sector and local authority partners in the area.

PCNs build on the core of primary care services and enable greater provision of proactive, personalised, coordinated, and more integrated health and social care. Clinicians describe this as a change from reactively providing appointments to proactively care for the people and communities they serve.

PCNs were established from 1 July 2019 and based on GP registered lists, national guidance suggested these networks would serve natural communities of around 30,000 to 50,000. They should be small enough to provide the personal care valued by both patients and GPs, but large enough to have impact and economies of scale through better collaboration between practices and others in the local health and social care system. Locally, we do have some PCNs serving smaller communities and some supporting larger communities as well.

PCNs form a key building block of the NHS long-term plan. Bringing general practices together to work at scale has been a policy priority for some years for a range of reasons, including improving their ability to recruit and retain staff; to manage financial and estates'

pressures; to provide a wider range of services to patients and to more easily integrate with the wider health and care system. In addition, PCN funding provides the opportunity to recruit a more diverse skill mix into general practice, through recruitment of roles, such as first contact physiotherapists, social prescribers and physician assistants

Since 2019, PCNs across Kent have been working together to provide more services outside the routine surgery opening hours. A large part of the Covid-19 vaccination programme has also been co-ordinated by PCNs across Kent.

5.1 Network Contract DES and Funding

The main funding for PCNs comes in the form of the PCN Directed Enhanced Services (DES) contract, which is an extension of the core GP contract and must be offered to all practices. This will be worth up to £1.8billion nationally by 2023/24. It includes funding to support the operation of the network and up to £89million to help fund additional staff, through an additional roles' reimbursement scheme.

Additionally, individual practices within the PCN also receive a network participation payment: a payment of £1.76 per weighted patient made to recognise an individual practice's commitment to being part of a PCN.

Practices work collaboratively within primary care networks (PCNs) or have an arrangement in place to make sure services available under the Network Contract DES (Directed Enhanced Services) are delivered to their registered patient population.

Table 1: Primary Care Network DES payments

Payment details	Amount
Core PCN funding	£1.50 per registered patient per year
Clinical director contribution	£0.722 per registered patient per year
ARRS roles	Actual salary plus employer on-costs to the maximum reimbursable amount for each role
Extended hours access	£1.44 per patient
Care home premium	£60 per bed for the period 1 October 2020 to 31 March 2021 £120 per bed per year from 1 April 2021
PCN support payment	£0.27 per weighted patient for 1 April 2020 to 30 September 2020
Investment and Impact Fund	£150m Nationally for 2021/22 incentivising delivery of objectives set out in the NHS Long Term Plan
Leadership and management	£43m Nationally for 2021/22 to create additional leadership and management capacity
PCN Development Fund	£935k for KM PCNs allocated per PCN weighted list size

The network contract DES outlines service requirements:

Extended hours access	Additional clinical appointments for urgent, same day, or pre-booked.
Structured medication review and Medicines Optimisation	For a range of care home and patients in their own home, reviewing complex or polypharmacy, common mediation errors or addictive medications.
Enhanced health in care homes	Care homes aligned to PCNs and lead GP (or GPs) with responsibility for the Enhanced Health in Care Homes service requirements.
Early cancer diagnosis	Review referral practice for suspected cancers, contribute to improving local uptake of screening programmes.
Social Prescribing Service	Provide patients with access to a social prescribing service.
Cardiovascular Disease (CVD) Prevention and Diagnosis	From October 2021, the requirements on PCNs now focus solely on improving hypertension case finding and diagnosis. From April 2022, diagnosis of atrial fibrillation, familial hypercholesteremia and heart failure introduced.
Tackling neighbourhood health inequalities	From 1 October 2021, identify and include all patients with a learning disability on the learning disability register. To identify a population experiencing health inequalities and to co-design an intervention to address the unmet needs of this population. Delivery of this intervention will commence from March 2022.
Anticipatory care	By 30 September 2022, required to agree a plan for delivery of Anticipatory Care with their ICS and local partners.
Personalised care	From April 2022, there will be three areas of focus for personalised care: further expansion of social prescribing, supporting digitised care and support planning for care home residents.

5.2 Additional Roles Reimbursement Scheme

This scheme gives PCNs extra funding to support recruitment of new additional staff to deliver health services.

The new additional staff recruited by a PCN or provided under contract as a service from a third-party organisation are fully reimbursed up to a maximum salary as stated in the Network Contract DES and each PCN has a maximum allocation of funding based on list size.

PCN additional roles that can be recruited include the following (the number in brackets denotes those employed in Kent):

- Clinical pharmacist (71)

- Advanced practitioner (3)
- Pharmacy technician (21)
- Social prescribing link worker (64)
- Health and wellbeing coach (10)
- Care Coordinator (36)
- Physician's associate (11)
- First contact physiotherapist (25)
- Dietician (**)
- Podiatrist (1.5)
- Occupational therapist (3)
- Trainee nursing associate (6.5)
- Nursing associate (1)
- Paramedic (13)
- Mental health practitioner (11).

So far, we have recruited 275 additional roles in Kent. Having these additional roles allows people to be seen in general practice by other specialists, increasing the available workforce.

These include 11 new **adult mental health practitioner (MHP)** roles, employed by Kent and Medway NHS and Social Care Partnership Trust (KMPT), but working whole time in an individual PCN. These roles started in post from January 2022.

There are also plans to be finalised to recruit up to 10 children and young people MHP PCN roles under the additional roles reimbursement scheme, employed by North East London NHS Foundation Trust (NELFT), but working whole time in an individual PCN in a similar way to the adult MHPs.

Recruitment barriers to additional roles include:

- understand the benefits of new roles
- employment liabilities
- availability of ARRS roles and
- accommodating additional staff in existing premises.

The CCG and the three local primary care training hub teams are supporting PCNs to address these issues and encourage recruitment to the breadth of roles and maximum allocated funding.

Bids from PCNs, which have recruited to their maximum allocation against the system underspend, have been sought and agreed to bring forward recruitment of additional roles. This is sustainable because the PCN maximum funding allocations will increase for 2022/23.

5.3 Primary care network development and plans

In all, £935,000 of additional funding was made available to Kent and Medway PCNs for PCN Development. The Kent allocation was £793,164, based on weighted list sizes which, on average, was £22,000 per PCN.

The release of PCN development funding was dependent on PCNs completing a survey to assess their maturity and development requirements and submit an assurance plan detailing how they would spend the funding. There were criteria issued on use of funding and plans were required to support internal PCN development and delivery of Kent and Medway Integrated Care System priorities.

Themes from the Kent PCN development assurance plans against the national criteria are shown below.

National & ICP criteria	PCN development area
Recruitment and retention	Staff training and development (management, clinical and GP trainers), clinical supervision and peer support for ARRS roles, workforce planning including for succession and forecast retirement
Enhance integrated working	Improving communications and relationships with Health and Care Partnership including community pharmacies, dentists, councils, voluntary sector including development of MDTs and developing networks across PCN boundaries
Reducing health inequalities	Population approaches to reducing health inequalities with specific schemes around increasing Covid-19 vaccination in hard-to-reach groups, adult and child obesity, diabetes, hypertension, frailty, cancer, mental illness and learning disabilities
Delivering effective out of hospital care	CVD prevention including enhanced atrial fibrillation and hypertension case finding, increasing access to primary care through both digital and face-to-face appointments and mapping capacity and demand

5.4 Population health management

Dover Town, Garden City and Ramsgate, alongside Medway Central PCNs, have just completed a National 22-week population health management (PHM) programme focusing on improving health outcomes in the cohorts given below:

PCN	Cohort details	Cohort size
Dover Town PCN (East Kent)	Aged 40-69 yrs, who are obese, hypertensive with depression with mid-level complexity across all deprivation scales	131
Garden City PCN (DGS)	Aged 40-60 yrs, obese with anxiety and smokers across all deprivation levels	137
Ramsgate PCN (East Kent)	All age-groups, with diabetes and housebound; all levels of complexity and deprivation	118
Medway Central PCN (Medway and Swale)	Aged 20-39, obese and hypertensive across all deprivation levels. Target those at risk of diabetes (pre-diabetic)	166

Following these initial pilots, the next steps will be to finalise the integrated care system PHM roadmap, which will also include a spread and sustain plan to support the next phase of the PHM programme.

In addition to the PCN development schemes above, there are also other available PCN support offers and opportunities and PCNs are encouraged to take advantage of these. They include:

- **Time for Care** is a bespoke development programme for PCNs that is not limited to a particular time and The Marsh, Dover Town, Ramsgate, CARE Kent, Total Health Excellence East, Canterbury South, Canterbury North, Herne Bay, Dartford Central PCNs are engaged with the programme to develop the ARRS workforce.

  A Time for Care development advisor is assigned to the PCN to develop an appropriate programme of work and continuing virtual support, for example:

  - to maximise the effectiveness of ARRS roles
  - to help understand and manage demand and capacity, including recovery and managing backlogs
  - to improve processes to save time, resource and improve efficiency.

- The CCG's estates and workforce teams are supporting PCNs to use **estates and workforce toolkits** to fully assess their existing estate against its local clinical vision, service strategy and forecasted demand.

  The estates toolkit also considers population health management data while the workforce toolkit follows a similar approach to determine what primary care workforce is required to meet demand and address health inequalities that PHM

analysis has identified. The workforce toolkit will aim to maximise the efficiencies of additional roles (ARRS) and other primary care workforce to increase capacity and access.

- The **NHS England PCN survey,** which was completed by all PCNs in Kent and Medway, has provided a rich source of information around the maturity of PCNs and what areas of support and development they would most benefit from.

  These survey responses have been analysed at Kent and Medway level so regional, as well as CCG offers, can be developed. We also have raw PCN data available to identify specific PCN challenges and tailor more local support offers.

- The NHSE offer under development includes an NHS Futures website for the south east to host a range of support and development tools, information resources and a model PCN community of practice database of case studies and initiatives PCNs have implemented across Kent, Surrey and Sussex to benefit both PCN development and health outcomes for patients.

The menu of support also focuses on supporting PCNs around the following areas:

- Leadership training and development for Clinical Directors and other staff.
- Development of a central procurement hub for externally contracted services, such as HR, Health and Safety and Legal Services.
- Equality, Diversity and Inclusivity Team to support PCNs in customising service design and delivery to address equality, diversity and inclusion needs.
- Support in managing patient expectations, for example on demand and capacity and access, through collaborative communications approaches for practice and patient-facing platforms.

6 General practice workforce

Table 3 below demonstrates the GP to patient ratios, as well as the wider primary care workforce to patient ratios across Kent and Medway that are:

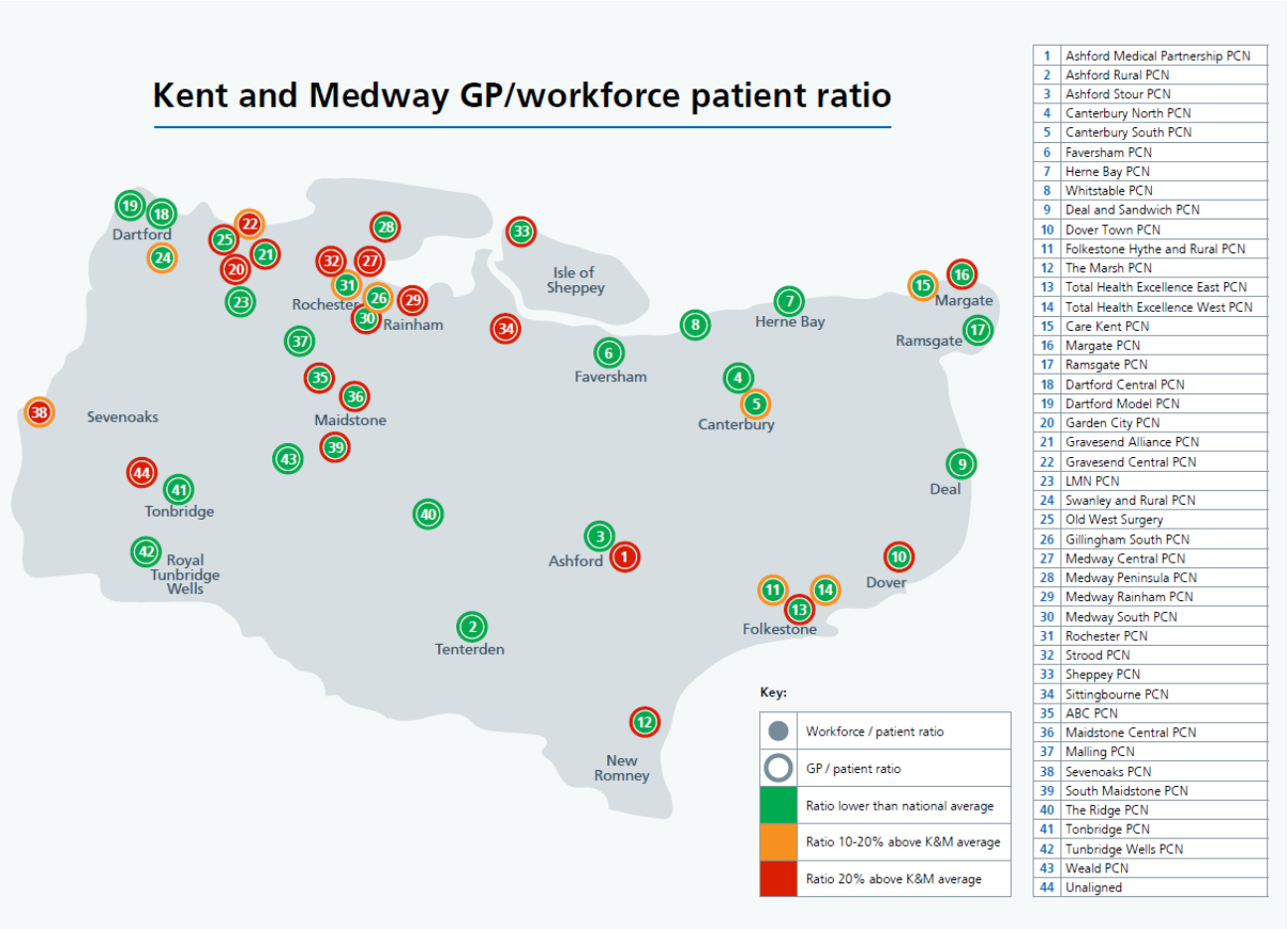
- lower than national average (performing well)
- 10 to 20 per cent above Kent and Medway average (areas to review)
- 20 per cent above Kent and Medway average (areas to support)

The circles represent individual PCNs. The outer ring RAG rating shows the GP/patient ratio, while the circle centre RAG rating shows the wider workforce/patient ratio. The

workforce/patient ratio includes clinical and non-clinical roles that support GPs, including additional (ARRS) roles and better reflects the total practice and PCN workforce providing services to patients.

The areas showing red are a focus for the CCG's workforce and training hubs to improve recruitment and retention through numerous initiatives for GPs and other clinicians.

Table 3 – Kent & Medway GP/workforce patient ratio



The unaligned practice shown as 44 in table 3 is Wish Valley Surgery, which has since merged with another practice to form the Weald View Medical Practice.

The following charts below shows the changes in Kent and Medway primary care workforce full-time equivalent (FTE) posts and headcount from September 2015 to November 2021**.** The CCG recognises more work is needed in recruiting more GPs, but also acknowledges the increases in primary care registrars, nurses and direct patient care staff reflecting the current and varied primary care workforce.

Chart 1 - Summary of Kent and Medway Primary Care Workforce Nov 21

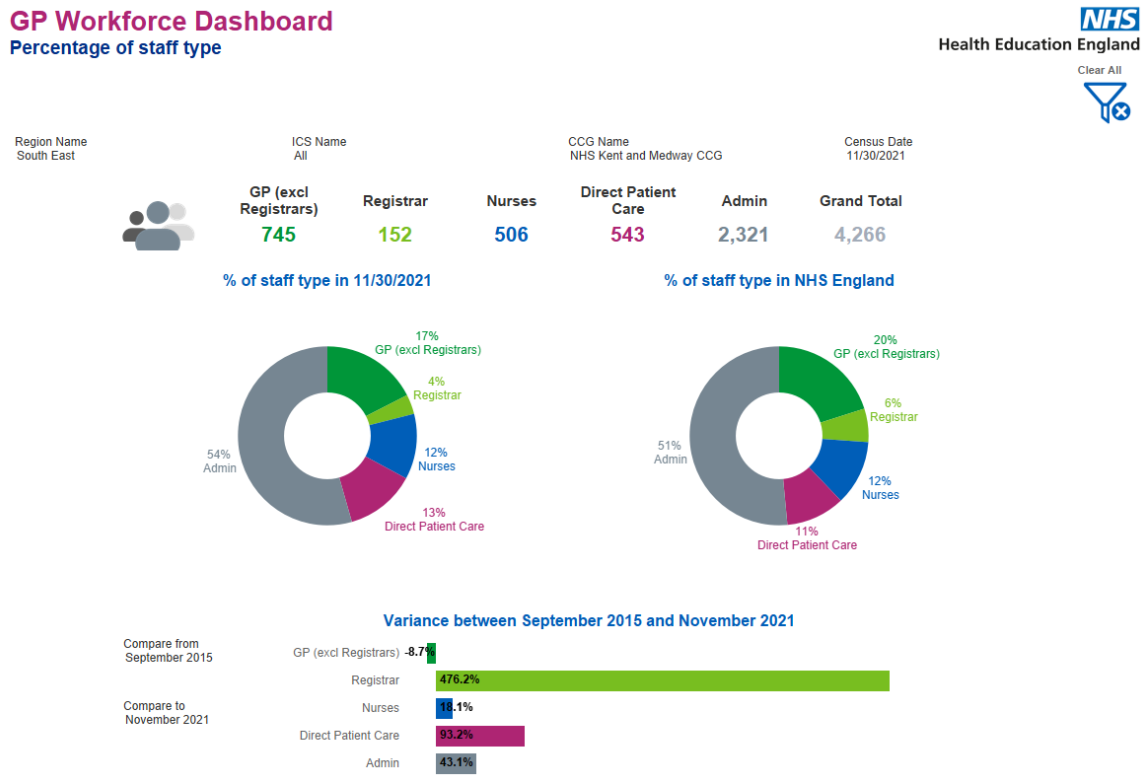


Chart 2 – Kent and Medway GP workforce trend (Sep 15 to Nov 21)

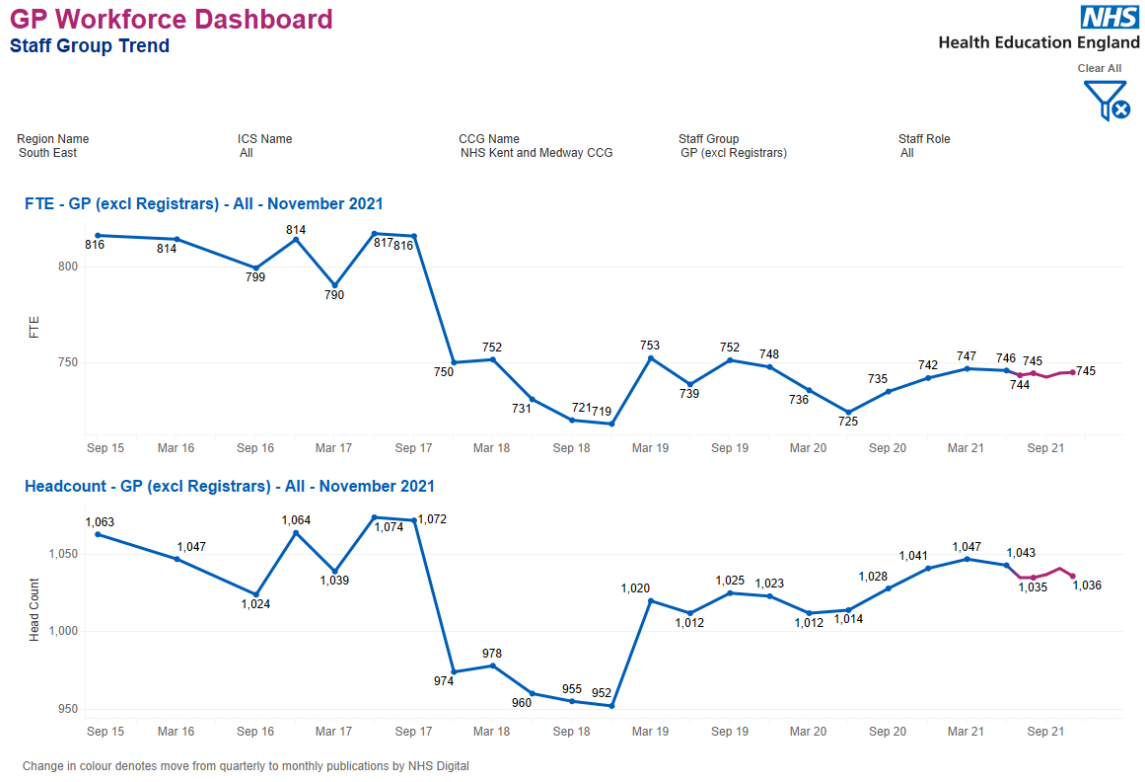


Chart 3 – Kent and Medway primary care registrar workforce trend (Sep 15 to Nov 21)

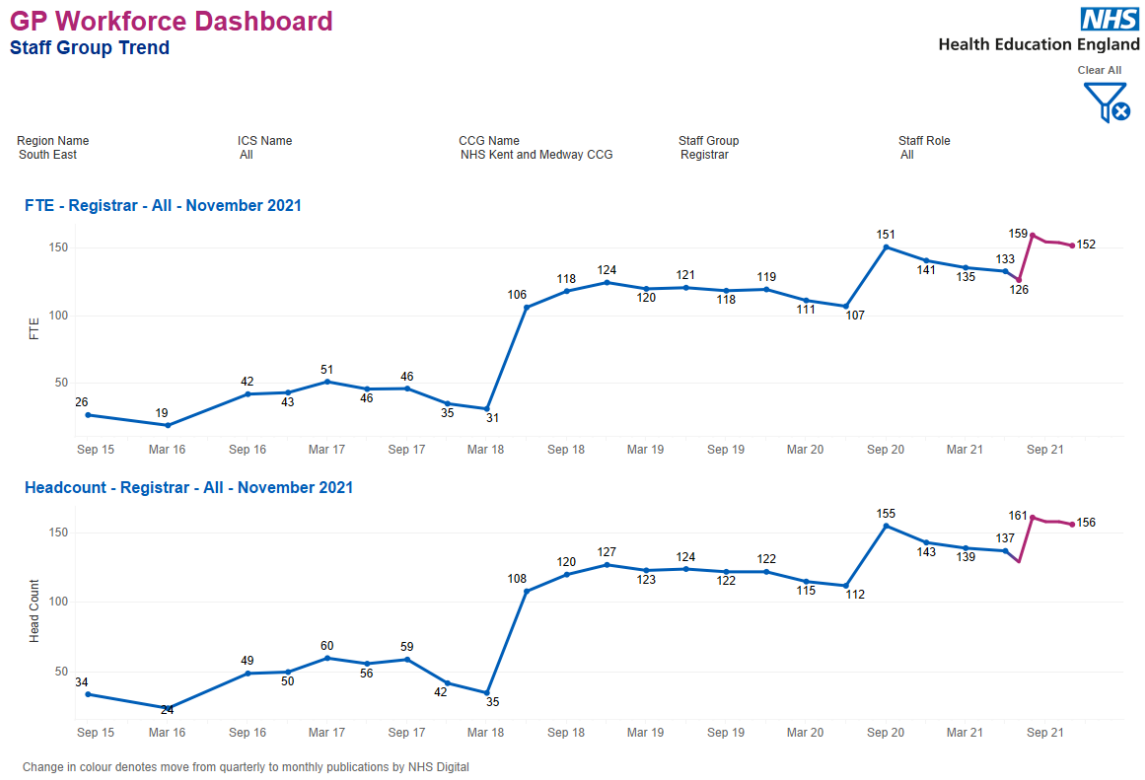


Chart 4 – Kent and Medway primary care nurse workforce trend (Sep15 to Nov 21)

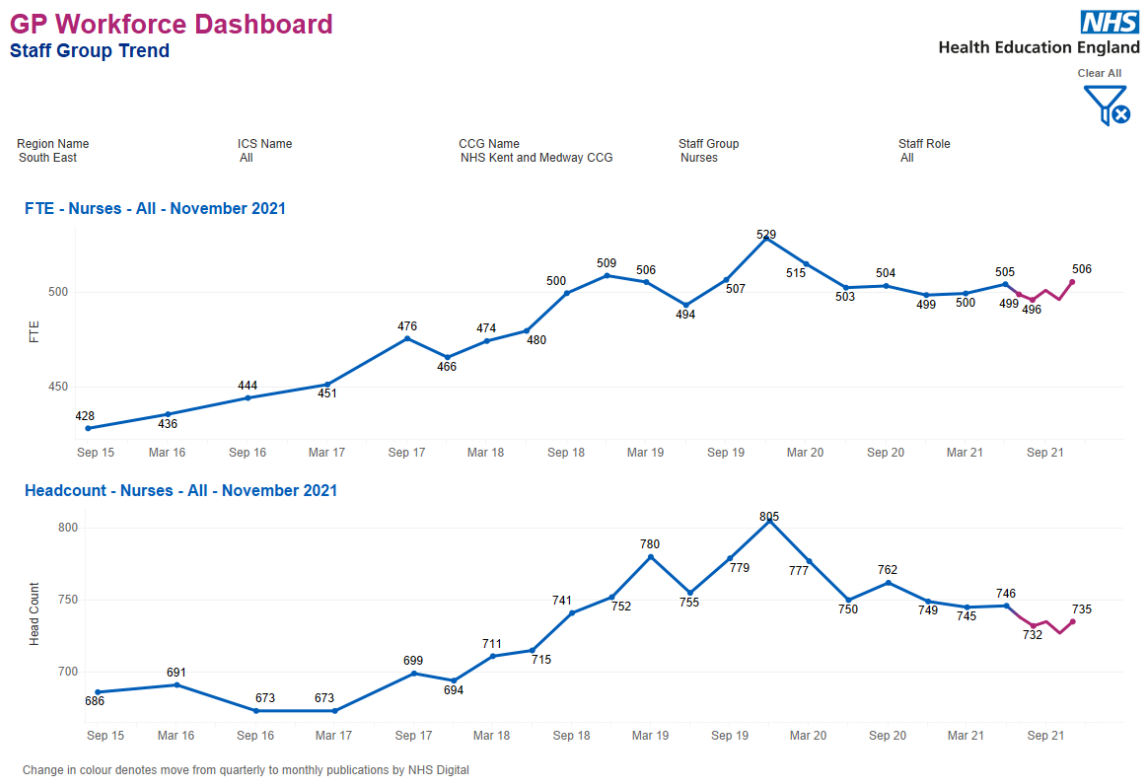


Chart 5 – Kent and Medway primary care direct care workforce trend (Sep15 to Nov 21)

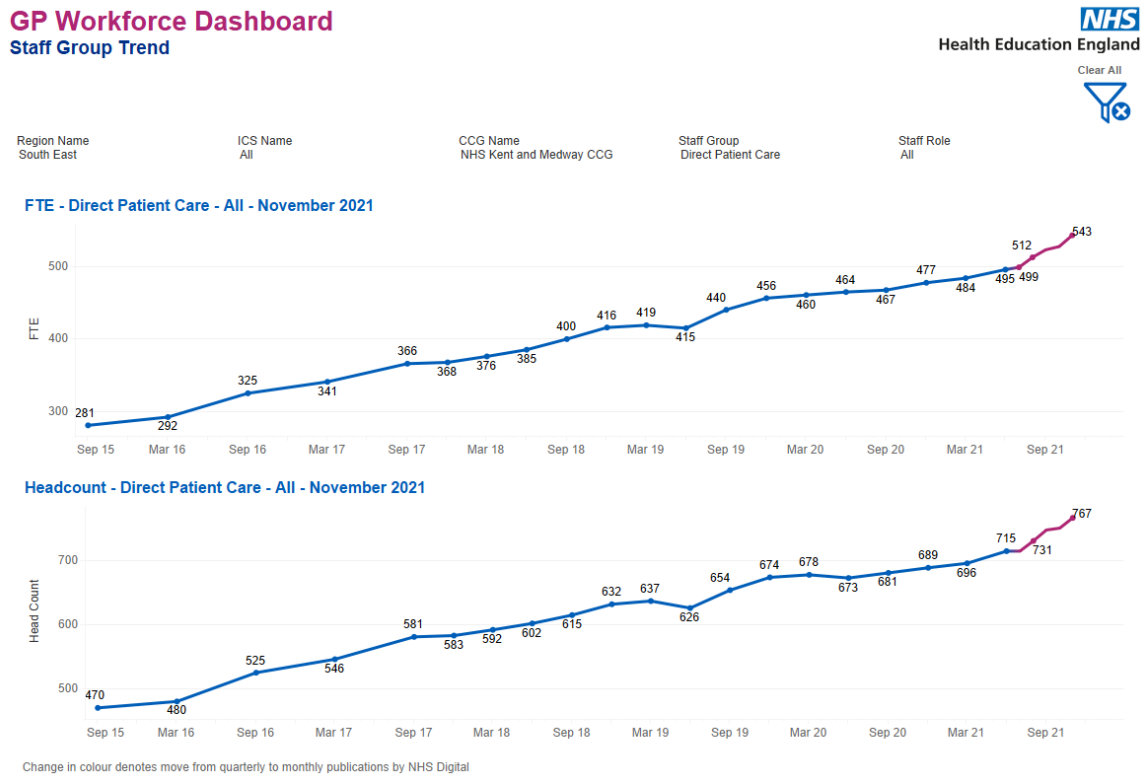
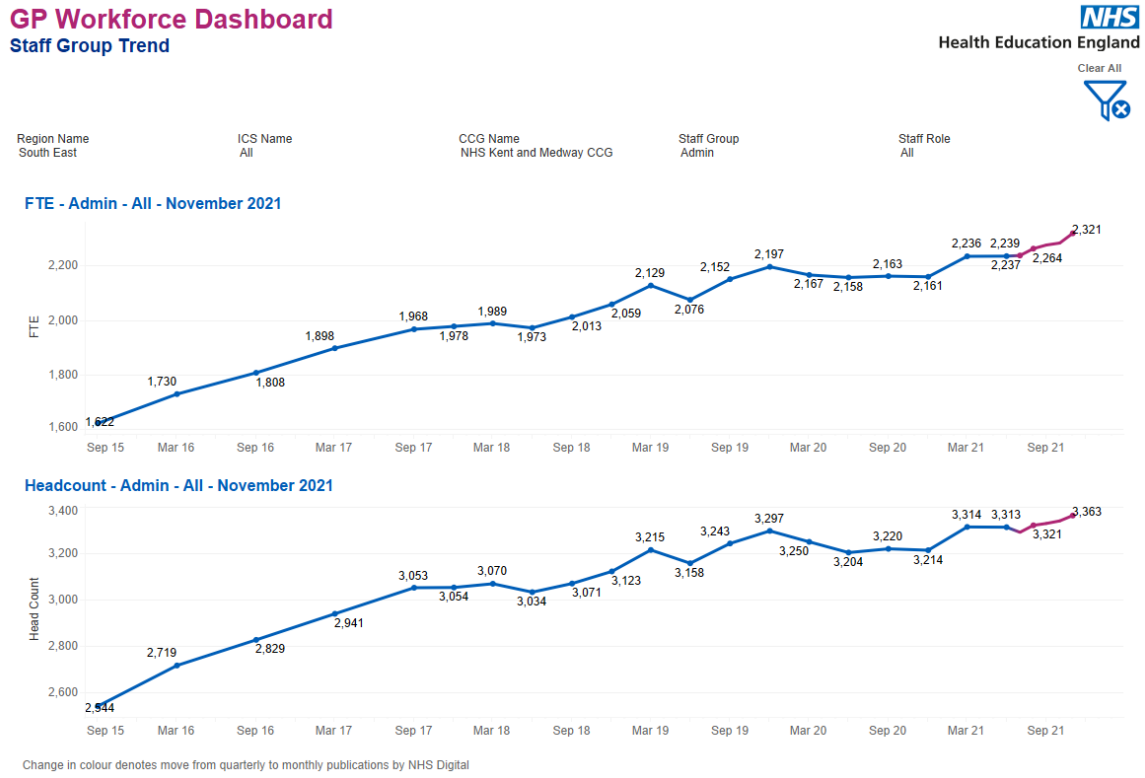


Chart 6 – Kent and Medway primary care admin workforce trend (Sep15 to Nov 21)



6.1 Recruitment and retention

The additional roles being recruited into general practice mean looking at GP numbers alone do not give an accurate picture of the available workforce in general practice. However, recruitment of GPs remains a priority and we know Kent, particularly its coastal communities, suffers from difficulties in this area.

The CCG has been working with other CCGs to understand best practice in recruitment and to look at ways we can improve the offer and make Kent an attractive place to be a GP.

We are working on a pilot project where PCNs, practices and our training hubs are developing a package of support and training, alongside a financial incentive. As Medway has some of the worst workforce ratios in the county, we are working on the pilot with Medway Council to understand how it can help us through their economic development, housing and education teams to attract clinicians to the area. A report will be presented to our Primary Care Commissioning Committee on 17 March with further details of this proposal. Once we start to develop a model, we will look to roll this out to other areas with difficulties recruiting, such as Swale and Thanet. We understand to retain clinicians, we need to offer a supportive environment where they can learn and develop. We are looking at how we work with partners at in community and in acute settings to develop attractive portfolio careers, alongside our development offers such as fellowships.

7 Training for practice receptionists

Kent and Medway GP partners – together- centrally fund a training offer for all their practice staff; this is unique to Kent and Medway. The GP Staff Training Team provides courses, such as mandatory training in health and safety, fire safety training, equality and diversity, infection prevention control, control of substances hazardous to health and basic life support. The offer goes beyond core requirements with additional optional courses, such as conflict resolution, customer service, complaints training, understanding investigations for receptionists, and a reception masterclass for new staff.

8 eConsult

eCconsult is an online service which enables patients to contact their GP practice and give an overview of their symptoms or concerns. This online form is submitted to the practice, where it is reviewed and the clinician chooses the best next steps for you. This might not mean a GP appointment, but the patient will be contacted within a specified time to let them know what happens next.

The eConsult service is not intended for urgent or emergency requests. If a patient triggers a red-flag question, they are shown an immediate message to take the relevant action.

Using eConsult starts a similar process to calling the practice. You are registering a health concern or issue for the practice to determine the best way to respond.

Although the process of reviewing econsultations varies between practices, whoever reviews them will have been trained to do so and will not make clinical decisions if they are not a clinician. It is like speaking to a patient co-ordinator at a practice reception.

People staffing modern GP practices are trained to make sure people can get to the right help as quickly as possible.

Feedback from patients continues to be positive overall, the following information is reflected from patients using the service between Sept 2021 to Jan 2022

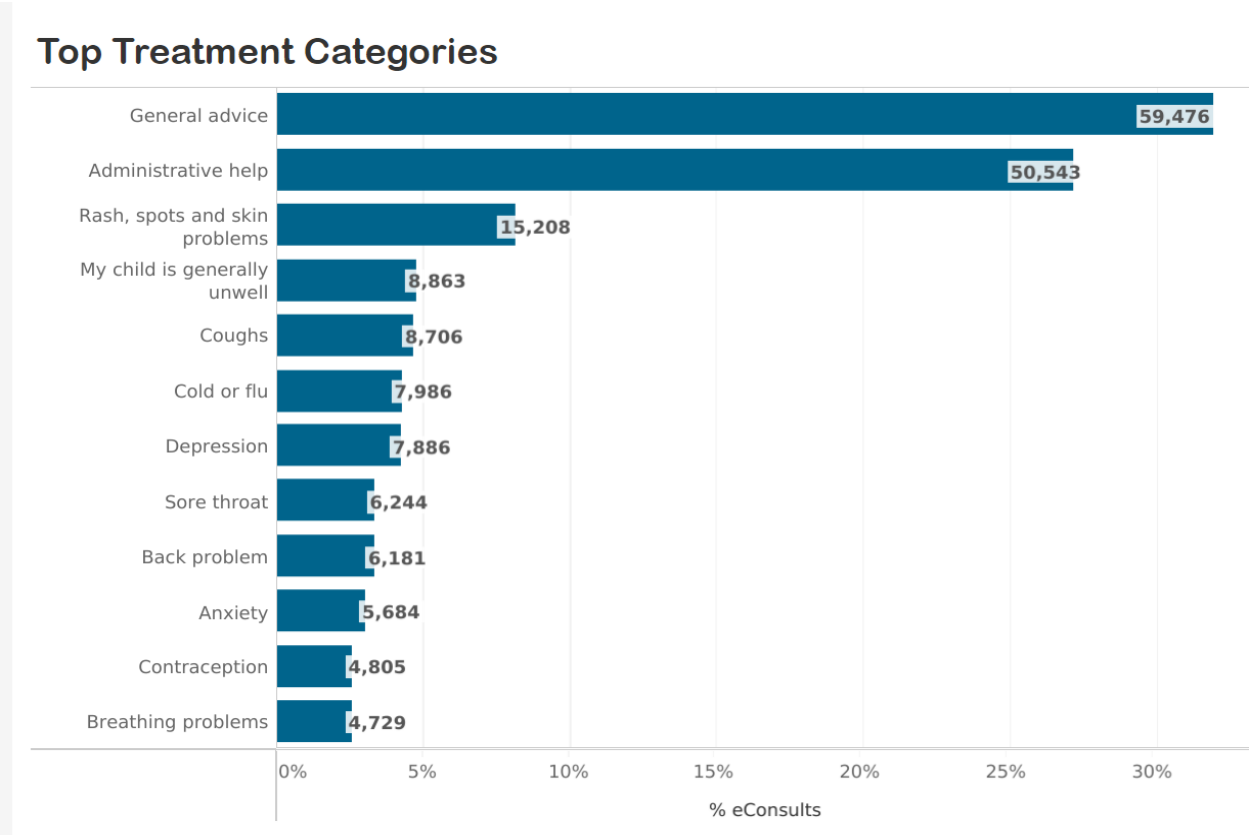
Of those users surveyed, 1,700 people (43 per cent) expressed satisfaction with the service, 802 people (20 per cent) were fairly satisfied, with 428 (11 per cent) neither satisfied nor dissatisfied and 990 people (25 per cent) fairly dissatisfied or very dissatisfied.

Patients who used the service were asked would they use the service instead of face-to-face appointment. The response was 2,270 patients says yes (58 per cent), 790 said no (20 per cent) and there were 880 (22 per cent) who indicated they were not sure.

When asking the question that if the eConsult service had not been available, what would you have done about your health problem. The following feedback was received:

In all, 1,779 (45 per cent) would request a phone conversation with their doctor, 1,305 (33 per cent) would request a face-to-face appointment with their doctor, 172 (four per cent) would call NHS111, 154 (four per cent) would request an appointment with their practice nurse.

The table below summarises the top treatment categories for patient’s accessing econsultation from 01/10/21 to 06/02/22)



The CCG recognises there continues to be a variation between practices about whether the service is available, as there are times GP practices have sought the service to either be temporarily switched off or that it is available for limited times of the day. One potential solution being piloted is e-hubs, which enable practices across primary care networks – which were managing their online consultations at an individual practice level - to come together and create a centralised model of online consultations. It is important that we can have a consistent service to patients before exploring additional patient monitoring arrangements. The evaluation of the pilot will is expected in the autumn of 2022.

9 Patient participation groups

Engaging with local communities is essential to effective delivery of primary care services. A patient participation group (PPG) is one way for GP practices to find out what matters to patients and work together to make improvements. PPGs also support practices through volunteering, as we have seen during the pandemic.

The General Medical Services sets out a requirement to ‘establish and maintain’ a PPG made up of registered patients at the practice, enabling the practice to obtain feedback from patients. Membership must be regularly reviewed to make sure it is representative of its practice patients. The contractor must regularly engage with the group to obtain feedback and make reasonable efforts to implement improvements. As we start to move forward with

'business as usual' work, the CCG's Contracting Team will carry out ad hoc reviews, which will include provision of effective PPG groups.

The CCG encourages practices to set up effective PPGs and supports continuing dialogue through seven local area patient groups, to which chairs of PPGs are invited.

Some PPGs found it hard to maintain momentum and meet during the pandemic but, anecdotally, we understand a significant number have continued to meet virtually to address issues patients are facing in accessing services and are working with their practices to improve services.

The CCG has continued to hold its local area patient group meetings throughout the pandemic, which are chaired by our independent lay associate members. These meetings are supported by members of the CCG Communications and Engagement Team and have been a means of sharing information with PPGs for local cascade, of seeking their views on local health and care plans and for PPGs to share feedback on services. PPG chairs are also invited to quarterly Kent and Medway-wide network meetings, chaired by the lay member for patient and public involvement, to meet commissioners, hear about service planning and delivery and give the CCG their views.

PPGs have shared their experiences of working with GP practices throughout the pandemic. Many have reported that contact with their practices has been reduced, that it has been difficult to run meetings or events and that recruitment of members has been challenging. However, a number have continued to hold virtual or face-to-face meetings and have been actively involved in essential work to feedback experience and to support their practices. Examples of recent PPG activity include:

Newton Place Surgery, Faversham meets virtually every month. The PPG was involved with recruitment of a new practice manager in the autumn and has been helping with flu and Covid vaccination clinics.

Otford Medical Practice, west Kent meets monthly or bi-monthly online and the practice manager and GP attend their meetings. It produces regular newsletters and carries out an annual survey with patients. It has become a registered charity so it can buy kit to make patients' lives easier, such as portable blood pressure monitors.

The Oaks Partnership, Swanley has a patient voice committee, which regularly meets GPs and staff, as well as a wider patient reference group. In November 2021, the committee helped co-ordinate an annual health event discussing health and wellbeing issues and providing advice.

Headcorn Surgery, west Kent is active via email and also holds meetings to discuss issues. which are important to patients. A practice member attends each meeting and the PPG feels it has a collaborative relationship with the surgery. PPG members have recently been involved in:

- supporting flu clinics - marshalling and admin support and ensuring wider patients and public in our community to get involved
- distributing PPE
- the Covid vaccination programme – more than 400 volunteers were involved across three vaccination sites.

The CCG is aware some GP practices find patient engagement a challenge. In February 2022, the CCG surveyed all GP practices about their communications and engagement needs. We wanted to find out what kind of support practices felt they needed in areas, such as website development, strategic communications planning and engagement. In total, 56 practices responded to the survey. Engaging with patients and with PPGs was one of the top areas where practices felt they needed support with 45 out of 56 practices telling us they were ‘extremely’ or ‘very’ interested in receiving training in this area.

To respond to this need, the CCG is including a plan to provide training and support for practices in the engagement strategy it is preparing for 2022. Working with the Primary Care Team, PPGs and patient groups, Healthwatch, the LMC and our associate lay members, we will determine specific need, develop a toolkit for engaging with local communities for PCNs and GP practices and deliver training sessions as well as targeted direct support to GP practices. The aim will be to increase the volume and quality of local patient engagement in primary care.

10 How contracts for new GP surgeries are awarded

10.1 What types of GP contracts are there?

Every individual or partnership of GPs must hold an NHS GP contract to run an NHS-commissioned general practice.

There are three different types of GP contract arrangements used by NHS commissioners in England:

The General Medical Services (GMS) contract is the national standard GP contract. This contract is negotiated nationally every year between NHS England and the General Practice Committee of the BMA, the trade union representative of GPs in England. It is then used by clinical commissioning groups to contract local general practices in an area. These contracts run in perpetuity, which means they run forever and only end when they are terminated (either by the commissioner or by provider by way of serving notice). Around 98 per cent of all contracts in Kent and Medway are GMS.

The Personal Medical Services (PMS) contract is another form of core contract, but unlike the GMS contract, is negotiated and agreed locally by CCGs or NHS England with a general practice or practices. This contract offers commissioners an alternative route with more flexibility to tailor requirements to local need while also keeping within national

guidelines and legislation. The PMS contract is being phased out and there are no PMS contracts within Kent and Medway CCG.

The Alternative Personal Medical Services (APMS) contract offers greater flexibility than the other two contract types. The APMS framework allows contracts with organisations (such as private companies or third sector providers) other than general practitioners/partnerships of GPs to provide primary care services. APMS contracts can also be used to commission other types of primary care service, beyond that of 'core' general practice. These contracts are time limited, normally for up to five years, and then need to be recommissioned. This can be disruptive for patient and usually cost more than GMS due to the nature of the contract. There are four APMS contracts in Kent and Medway.

10.2 What's in a GP contract?

The core parts of a general practice contract include:

- agreeing the geographical or population area the practice will cover
- requiring the practice to maintain a list of patients for the area and sets out who this list covers and under what circumstances a patient might be removed from it
- establishing the essential medical services a general practice must provide to its patients
- setting standards for premises and workforce and requirements for inspection and oversight
- setting out expectations for public and patient involvement
- outlining key policies including indemnity, complaints, liability, insurance, clinical governance and termination of the contract.

Requirements within the core contract are not always explicit, with individual practices able to interpret them to reflect local circumstances. This does mean there will be variation between practices. This can be perceived by patients as inequalities or that some practices are not delivering what should be expected. An example is around public and patient involvement, where the contract requires practices to have a patient participation group but does not specify in any detail how the group should be convened, what responsibilities it should have etc.

In addition to these core arrangements, a general practice contract also contains optional agreements for services that a practice might enter into usually in return for additional payment. These include the nationally negotiated **Directed Enhanced Services (DES)** that all commissioners of general practice must offer to their practices in their contract and the

locally negotiated and set **Local Enhanced Services (LES)** that vary by area and the National Quality and Outcomes Framework – (QOF) the objective being to improve the quality of care patients are given by rewarding practices for the quality of care they provide to their patients, based on a number of indicators across a range of key areas of clinical care and public

10.3 GP Practice contract variation / award

GP partners are not just clinicians but also small business owners and employers.

This comes with challenges, for example, the need to manage and optimise complicated income streams and personal liability for financial risks.

It also means partners have a strong vested interest in maintaining and developing their practice.

GMS contracts run in perpetuity, which means they last forever. These contracts also allow contract holders to pass on contracts to other GPs by way of a contract variation. This is done by notifying the commissioner, however as long as those being added to the contract are eligible to hold a GMS contract then the involvement of the commissioner is minimal – the CCG does not have the authority or responsibility to approve or reject such changes.

10.4 Options available to a commissioner when a contract is handed back

There are occasions when the partners of a general practice decide to ‘hand back’ their contract – effectively closing their practice.

Under delegated primary care commissioning arrangements, the CCG is responsible for ensuring its resident population is able to access GP services. If a contract is handed back national guidance dictates that the CCG has two commissioning options:

Option one: To carry out a procurement process to award a new Alternative Provider of Medical Services (APMS) contract to deliver care to the patients.

Option two: To allow the contract to expire and to support patients to register at another local practice (list dispersal) which can in some circumstances include taking over an existing building as an additional site.

10.5 Assessment of suitability of new providers

When a contract is handed back and a new provider needs to be put in place, whether a procurement is needed, the CCG has developed a framework of assurance for assessing new providers to ensure they are the most suitable and qualified to take on a contract.

The assurance process includes a qualification stage to ensure only suitable providers can be considered.

There is also a technical stage which includes, but is not limited to:

- quality
- patient focus and engagement
- clinical services and governance
- workforce
- organisation good standing
- premises and estates issues
- information technology and management
- mobilisation
- finance.

As per the CCGs delegated agreement with NHS England, all contract decision-making must pass through a Primary Care Operational Group and then a Primary Care Commissioning Committee

These committees are appropriately serviced by individuals who are suitably qualified to inform commissioning decisions

Primary care networks and membership (Kent) **Appendix 1**

Dartford Central PCN	**Gravesend Alliance PCN**
Drs Siva Nathan & Adekemi Osadiya	**Drs Nigel Sewell & Stefano Santini**
Redwood Surgery (Dartford West Health Centre)	The Shrubbery and Riverview Park Surgeries
Horsman's Place Surgery	Oakfield Health Centre
Temple Hill Group	Springhead Health Limited
Garden City PCN	**Dartford Model PCN**
Dr David Payne	**Dr Julie Taylor**
Downs Way Medical Practice	Dr Shimmins and Partners (Dartford East Health Centre)
Swanscombe Health Centre	Lowfield Medical Practice
Parrock Street Surgery	Maple Practice
Pilgrims Way Surgery	The Orchard Practice
Gravesend Central PCN	**Swanley & Rural PCN**
Drs Yvonne Abimbola & Lorraine Okeze	**Dr Elizabeth Lunt**
Chalk Surgery	The Cedars Surgery
Gravesend Medical Centre	Devon Road Surgery
Pelham Medical Practice	Farningham (Braeside) Surgery
Rochester Road Surgery	The Oaks Partnership
LMN Care PCN	**ABC PCN**
Dr Krish Bhanot	**Dr Peter Hanrath & Min Ven Teo**
Jubilee Medical Practice	Aylesford Medical Centre
Meopham Medical Practice	Blackthorn Medical Practice
	The College Practice
Maidstone Central PCN	**Maidstone South PCN**
Drs Garry Singh & Tony Jones	**Dr Anne-Marie Keeley**
Bower Mount Medical Centre	Albion Place Medical Practice
Brewer Street Surgery	Greensands Health Centre
The Medical Centre Group (Northumberland Court Surgery)	Mote Medical Centre
The Vine Medical Centre	Wallis Avenue Surgery
Tonbridge PCN	**The Ridge PCN**
Dr Ginny Winstanley	**Dr Faye Hinsley**
Hadlow Medical Centre	Bearsted Medical Practice
Hildenborough Medical Group	Headcorn Surgery
Tonbridge Medical Group	Langley Surgery (The Orchard Surgery)
Warders Medical Centre	Len Valley Practice
Woodlands Health Centre	Sutton Valence Group Practice
Malling PCN	**Sevenoaks PCN**

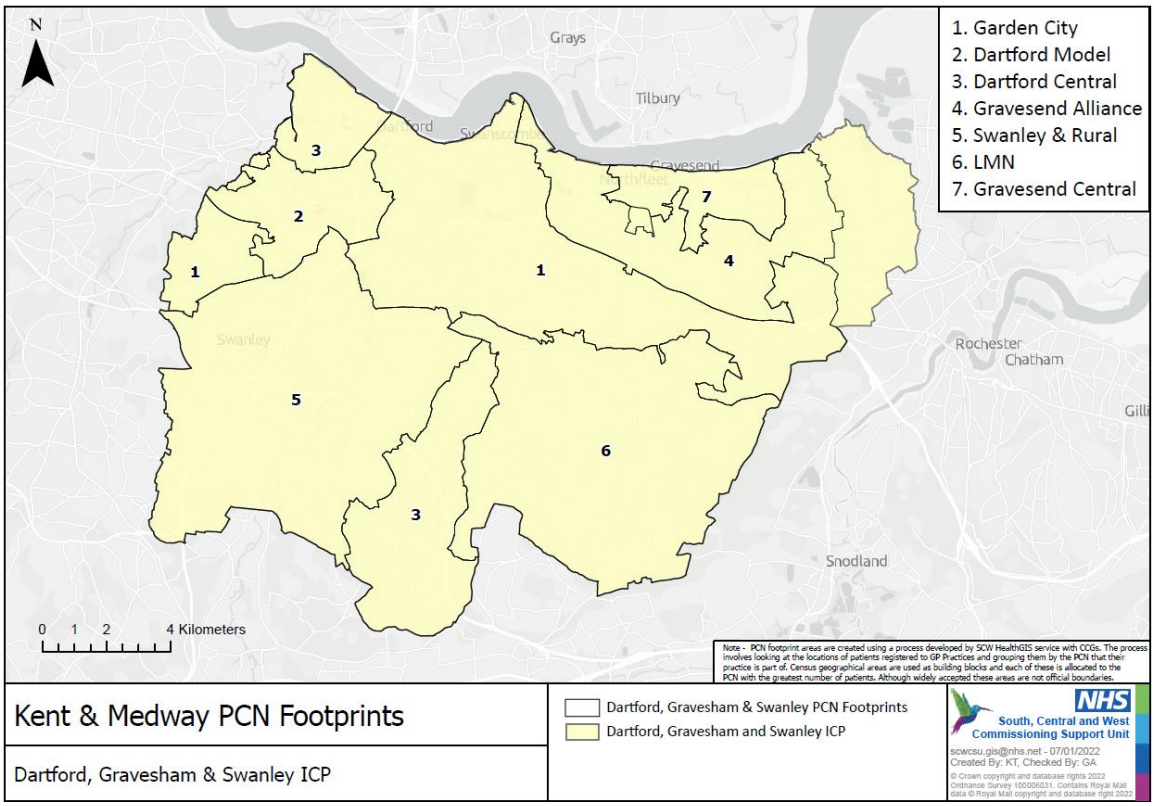
Dr Claire Cochrane-Dyet	**Drs Anjali Melethil & Anna Malan**
Phoenix Medical Practice	Borough Green Medical Practice
Snodland Medical Practice	Edenbridge Medical Practice
Thornhills Medical Practice	Otford Medical Practice
Wateringbury Surgery	South Park Medical Practice
West Malling Group Practice	St John's Medical Practice
	Town Medical Centre
	Westerham Practice
Tunbridge Wells PCN	**Weald PCN**
Dr Nick Robinson	**Dr Justin Charlesworth**
Grosvenor and St James Medical Centre	Malling Health Four (Staplehurst Surgery)
Wells Medical Practice	Howell Surgery
Kingswood Surgery	Lamberhurst Surgery
Lonsdale Medical Centre	Marden Medical Centre
Rusthall Medical Centre	Old Parsonage Surgery
Speldhurst and Greggswood Medical Group	Old School Surgery
St Andrews Medical Centre	Orchard End Surgery
Waterfield House Surgery	The Crane Surgery
	Weald View Medical Practice
	Yalding
Sittingbourne PCN	**Sheppey PCN**
Drs Paul Staker & Reshma Syed	**Drs Sabarirajan Kannapiran & Sanjiv Patel**
Sheerness Health Centre (Dr Patel)	Chestnuts Surgery
Dr S J Witts Practice	Iwade Health Centre
Sheppey Healthy Living Centre (Dr Shah)	London Road Medical Centre
St Georges Medical Centre	Meads Medical Practice
The Om Medical Centre	Memorial Medical Centre
	Dr RB Kumar Practice
	Milton Regis Surgery
	Grovehurst Surgery
AMP PCN	**Whitstable PCN**
Dr Amir Naky	**Dr Richard Brice**
Ashford Medical Partnership	Whitstable Medical Practice
Canterbury North PCN	**Canterbury South PCN**
Dr Ross Lindsay	**Dr Ray Mulvihill**
Canterbury Health Centre	Canterbury Medical Practice
Northgate Medical Practice	New Dover Road Surgery
Old School Surgery	University Medical Centre
Sturry Surgery	
Ashford Rural PCN	**Ashford Stour PCN**
Dr Rosalyn Dunnet	**Dr Sadia Rashid**
Charing Surgey	Hollington Surgery
Hamstreet Surgery	Kingsnorth Medical Practice

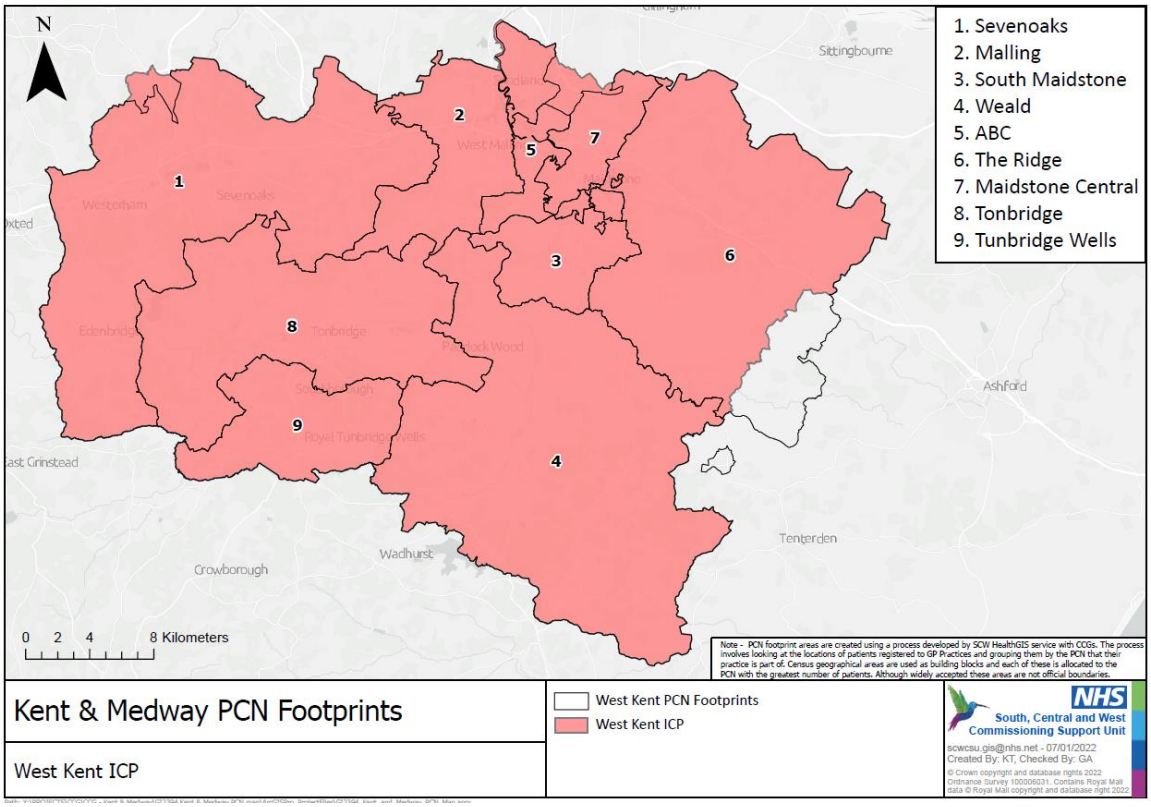
Ivy Court Surgery	New Hayesbank Surgery
Woodchurch Surgery	Sellindge Surgery
	Sydenham House Medical Centre
	Wye Surgery
Care Kent PCN	**Deal & Sandwich PCN**
Dr Andrew Walton	**Dr Ian Sparrow**
Ash Surgery	Balmoral Surgery
Birchington Medical Centre	Manor Road Surgery
Broadstairs Medical Practice	Sandwich Medical Practice
Minster Surgery	St Richard's Road Surgery
St Peter's Surgery	The Cedars Surgery
Westgate Surgery	
Dover Town PCN	**The Marsh PCN**
Kieran Sohail & Dr Julian Mead	**Dr Neil Poplett**
Buckland Medical Practice	Church Lane Health Centre
High Street Surgery	Martello Health Centre
Peter Street Surgery	Oak Hall Practice
St James' Surgery	Orchard House Surgery
Total Health Excellence East PCN	**Total Health Excellence West PCN**
Dr Abiola Idowu	**Dr Tuan Nguyen**
Aylesham Medical Practice	Guildhall Street Surgery
Lydden Surgery	Manor Clinic
White Cliffs Medical Centre	Sandgate Road Surgery
Pencester Surgery	The New Surgery
Herne Bay PCN	**Faversham PCN**
Dr Jeremy Carter	**Drs Shariq Lanker & Daniel Moore**
The Heron Medical Practice	Faversham Medical Practice
Park Surgery	Newton Road Surgery
Margate PCN	**Ramsgate PCN**
Dr Ganapathi Subbiah	**Jenny Bostock**
Bethesda Medical Centre	Dashwood Medical Centre
Mockett's Wood Surgery	East Cliff Medical Practice
Northdown Surgery	Newington Road Surgery
The Limes Medical Centre	Summerhill Surgery
	The Grange Practice

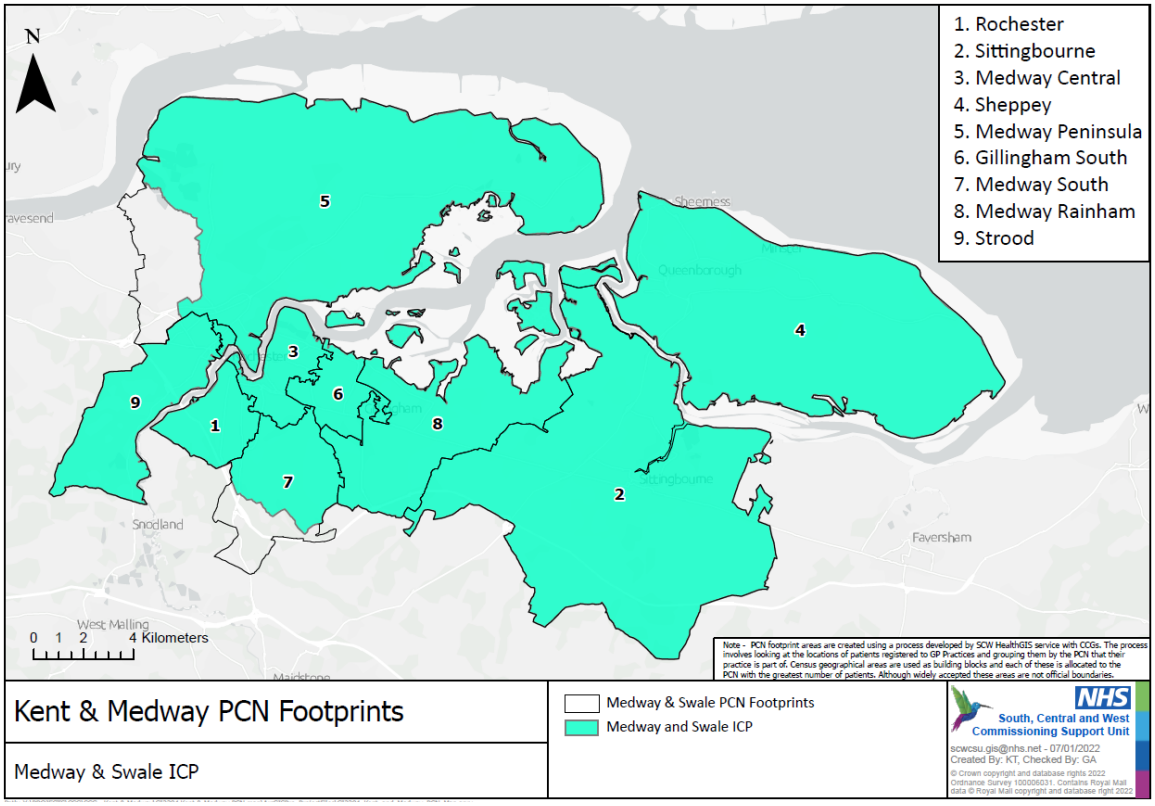
Folkestone, Hythe & Rural PCN	
Drs Aravinth Balachandran & Rosalind Powell	
Church Road Practice	Oaklands Health Centre
Folkestone Surgery	Sun Lane Surgery
Hawkinge and Elham Surgery	White House Surgery
New Lyminge Surgery	

Primary care network maps

Appendix 2






N
1. Rochester
2. Sittingbourne
3. Medway Central
4. Sheppey
5. Medway Peninsula
6. Gillingham South
7. Medway South
8. Medway Rainham
9. Strood
Sheerness
Queenborough
Snodland
Faversham
West Malling
0 1 2 4 Kilometers
Note - PCN footprint areas are created using a process developed by SCW HealthGIS service with CCGs. The process involves looking at the locations of patients registered to GP Practices and grouping them by the PCN that their practice is part of. Census geographical areas are used as building blocks and each of these is allocated to the PCN with the greatest number of patients. Although widely accepted these areas are not official boundaries.
Kent & Medway PCN Footprints
Medway & Swale ICP
Medway & Swale PCN Footprints
Medway and Swale ICP
NHS
South, Central and West Commissioning Support Unit
scwcsu.gis@nhs.net - 07/01/2022
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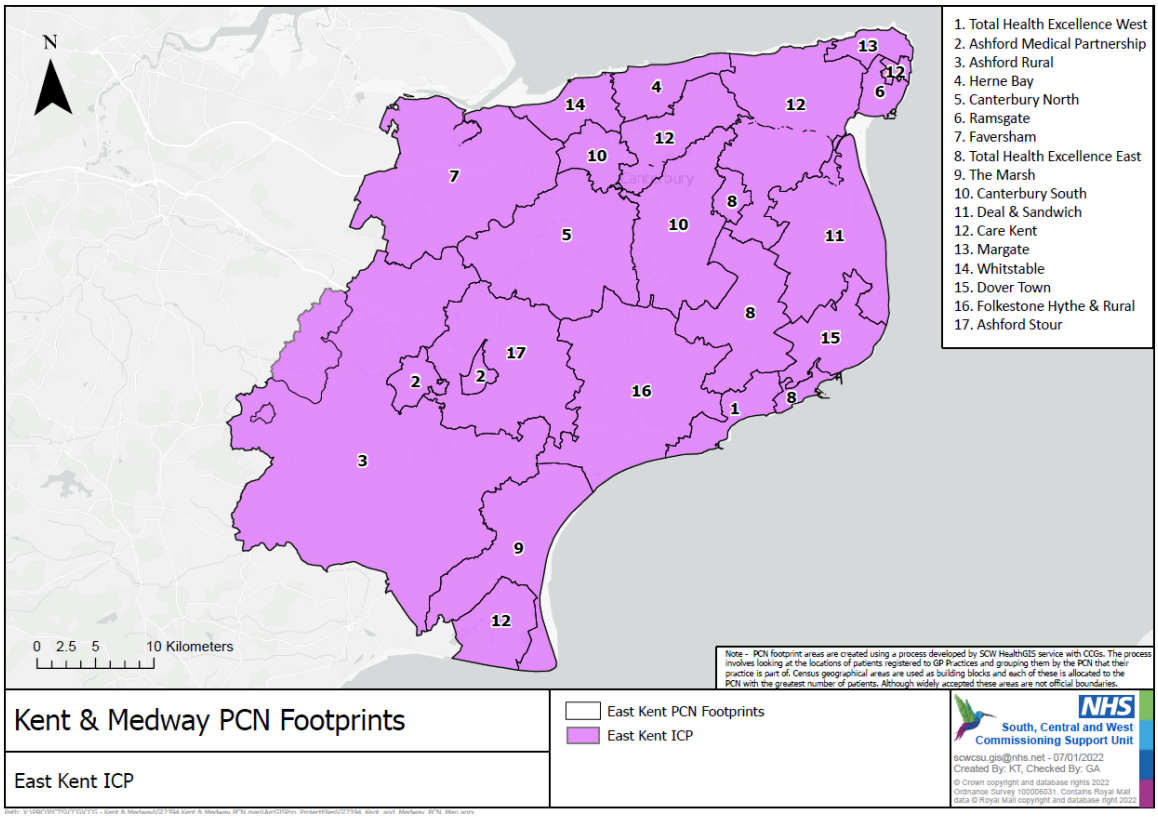
N
1. Total Health Excellence West
2. Ashford Medical Partnership
3. Ashford Rural
4. Herne Bay
5. Canterbury North
6. Ramsgate
7. Faversham
8. Total Health Excellence East
9. The Marsh
10. Canterbury South
11. Deal & Sandwich
12. Care Kent
13. Margate
14. Whitstable
15. Dover Town
16. Folkestone Hythe & Rural
17. Ashford Stour
0 2.5 5 10 Kilometers
Note - PCN footprint areas are created using a process developed by SCW HealthGIS service with CCGs. The process involves looking at the locations of patients registered to GP Practices and grouping them by the PCN that their practice is part of. Census geographical areas are used as building blocks and each of these is allocated to the PCN with the greatest number of patients. Although widely accepted these areas are not official boundaries.
Kent & Medway PCN Footprints
East Kent ICP
East Kent PCN Footprints
East Kent ICP
NHS
South, Central and West Commissioning Support Unit
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Item 10: Work Programme 2022

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 2 March 2022

Subject: Work Programme 2022

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

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1. Introduction

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

b) HOSC is responsible for setting its own work programme, giving due regard to the requests of commissioners and providers of health services, as well as the referral of issues by Healthwatch and other third parties.

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

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

2. Recommendation

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

Background Documents

None

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Work Programme - Health Overview and Scrutiny Committee

1. Items scheduled for upcoming meetings

11 May 2022 (previously scheduled for 5 May)		
Item	**Item background**	**Substantial Variation?**
Burns service review	To receive information about a review of burns services by NHS England Specialised Commissioning	TBC
Provision of Child and Adolescent Mental Health Services at the Cygnet Hospital in Godden Green	Postponed item from 16 September. 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 Mental Health Services	To receive an update on the provision of services.	-
Access to health services by the Gypsy, Roma and Traveller Community	To understand what is being done to improve the access to health services by this community. (This was a member request).	-

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
Provision of Ophthalmology Services (Dartford, Gravesham and Swanley)	During their meeting on 21 July 2021, Members asked for an update on the effectiveness of the service changes be received at the appropriate time.	

East Kent Maternity Services – outcome of the independent enquiry.	Following the discussion on 17 September 2020, Members requested the item return once the Kirkup report has been published (expected 2022).	-
Maidstone & Tunbridge Wells NHS Trust - Clinical Strategy Overview	To receive updates on the Trust's clinical strategy and determine on an individual basis if the workstreams constitute a substantial variation of service. The following items have been to the Committee and not deemed to be substantial: Cardiology Services, Digestive Diseases Unit.	TBC
Hyper Acute Stroke Units - implementation update	Following their discussion on 26 January 2022, Members asked to be kept informed on the implementation of the new stroke services.	No
Transforming mental health and dementia services in Kent and Medway	To receive information about the various workstreams under this strategy.	TBC
Orthotic Services and Neurological Rehabilitation	To receive information on the provision of these services in Kent for adolescents. (This was a member request).	-

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