HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Wednesday, 30th November, 2022

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Wednesday, 30th November, 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 J Howes, Councillor P Rolfe, Councillor K Tanner, and 1 vacancy

UNRESTRICTED ITEMS

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

Item		Timings*
1.	Substitutes	10:00
2.	Declarations of Interests by Members in items on the Agenda for this meeting.	
3.	Minutes from the meeting held on 7 July 2022 (Pages 1 - 8)	
4.	Hyper Acute Stroke Unit (HASU) implementation update (Pages 9 - 16)	
5.	Maternity Services at East Kent Hospitals University NHS Foundation Trust (Pages 17 - 22)	10:30
6.	Stroke rehabilitation services (Pages 23 - 30)	11:10

7. Provision of Ophthalmology Services (Dartford, Gravesham and Swanley) (Pages 31 - 36) 11:30

8. Recruitment of nurses (Pages 37 - 46) 12:00

9. Community Diagnostic Centre (Medway and Swale) (Pages 47 - 158) 12:30

10. Sexual Assault Referral Centre (SARC) - Kent (Pages 159 - 164) 12:50

11. Learning from the closure of Cygnet Hospital, Godden Green (CAMHS tier 4 provision) - written item (Pages 165 - 168) 13:10

12. Work Programme (Pages 169 - 172)

13. Date of next programmed meeting – Tuesday 31 January 2023

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 November 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 Thursday, 7 July 2022.

PRESENT: Mr P Bartlett (Chair), Mr P V Barrington-King, Mr P Cole, Ms S Hamilton (Vice-Chairman), Mr D Watkins, Ms K Constantine, Cllr J Howes, Cllr P Rolfe and Cllr K Maskell

PRESENT VIRTUALLY: Mr N Chard, Mr J Meade, Mr T Hills

ALSO PRESENT: Mr R Goatham and Dr C Rickard

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

UNRESTRICTED ITEMS

78. Membership

(Item 1)

1. The Committee noted the change in Borough and District Council membership. Cllr Marilyn Peters and Cllr David Burton had stepped down and Cllr Tanner from Tonbridge & Malling Borough Council had been appointed. There remained a vacancy from Tunbridge Wells District Council.

2. AGREED that the Council note the update.

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

(Item 3)

None received.

80. Minutes from the meeting held on 11 May 2022

(Item 4)

RESOLVED that the minutes from the meeting held on 11 May 2022 were a correct record and they be signed by the Chair.

81. South East Coast Ambulance Service - provider update

(Item 5)

In attendance for this item: Ray Savage, Strategic Partnerships Manager (Kent & Medway, East Sussex), Matt Webb, Associate Director of Strategic Partnerships and System Engagement, South East Coast Ambulance Service

1. Mr Savage highlighted salient points from the agenda report. He acknowledged the challenges being experienced with 999 and 111 calls, confirming that the Trust's performance was in line with, or better than, national performance. He accepted more needed to be done.

2. An area of concern, and therefore focus, was the call abandonment rate.

3. 111 was seeing success in the following areas:

    - The direct booking facility.
    - High clinical contact with low emergency department referrals.
    - Low transfer to ambulance rate.
    - Easing the burden on 999 service.

4. 999 performance was not performing as well. Demand for category 2 and 3 calls was high and there were problems with handover delays.

5. He expressed concern and disappointment at the recent CQC report, though also highlighted positive aspects, such as staff professionalism and compassion. The 111-service remained "Good".

6. The Trust CEO had recently resigned, and an interim officer was in post. A webinar around culture had also been offered to staff.

7. A Member sought data around ambulance waits for those with a suspected stroke who were waiting for a scan, as they knew the call to needle time was important. This fell under a category 2 call. Mr Webb confirmed the call to needle time was the point at which an ambulance received the call to the moment the patient received care in hospital. Ambulance Quality Indicators included measures on stroke patients, though Mr Webb only held data on the ambulance to hospital times, not what happened once that patient was in hospital care. He offered to look into this and report back to the Committee.

8. A Member asked about the state of the Trust's equipment. Mr Savage confirmed there were no supply chain issues and the Trust continued to maintain the fleet to a good standard.

9. Responding to a question about future population forecasts, Mr Savage explained the Trust worked closely with their lead commissioner, taking into account new housing developments and possible impacts on services, to ensure they were resourced accordingly. The Member was particularly concerned about demographic changes brought about since the pandemic, and their impact on the population modelling for the HASU project. The Clerk was to ask the point to be covered in October's HASU update.

10. A question was asked around the use of staff overtime and subsequent impact on wellbeing, as well as how recruitment was going generally. Mr Savage acknowledged the concern and accepted the use of overtime could be counter productive in some cases. He highlighted the improved wellbeing support offered to staff, as well as the expectation that the use of overtime was not "business as usual". The use of overtime was targeted to days when it was known there would be a shortfall in cover. The scheduling team worked closely with managers and staff to ensure staff were not being burnt out.

11. Mr Savage went on to explain there was an ongoing recruitment campaign. The Trust was recruiting new entrants at emergency care support worker level as well as offering development training to those already in post. There was a need to ensure sufficient funding was in place to fund the staff levels. Long term there was a need to work more collaboratively with partners to remove overlaps and ensure patients went to the right place first time.

12. Mr Webb said that sickness and accrued annual leave continued to effect resourcing on a daily basis. He also explained that retention was more of a challenge that recruitment, but the hope was the new Integrated Care System would allow for increased opportunities for job rotation across health. An improvement programme with recruitment as a key focus had been established. In addition, an association of ambulance trust chief executives was looking nationally at recruitment challenges and the best way of communicating this to government.

13. Speaking about the e-vehicles, Mr Webb confirmed they were not yet in use for frontline services in SECAmb. The Trust was looking at how best they could be utilised and how partners such as the police used them. A Member requested that district councils be involved in any discussions around charging points, as they were setting up charging locations across the county.

14. A Member asked if it was possible to pinpoint an area of particular challenge. Mr Savage explained significant work was underway with system partners, and SECAmb needed to be promoted as a key partner in delivering care. He noted that not all patients needed an acute setting, and around 50% of callers could be treated within community settings. The newly established Integrated Care Board (ICB) provided an opportunity for system working. 111 was seen to many as a single point of access and acted as a gatekeeper to wider health services. Their role was in triaging, referring appropriately and signposting as necessary, and their value was getting it right first time to avoid delays.

15. Mr Webb explained the importance of system flow. If the acute flow was not working, for example if there were delays with discharging patients, there were direct consequences for the whole system. Funding wise, demand was higher than expected but this was a national issue and it needed to be addressed as such. Since October 2021, there had been an uplift of calls by 15%.

16. There was a question around bidding for the Community Infrastructure Levy (CIL) and ensuring adequate money was supplied for new services. Mr Savage expressed the importance of truly understanding if the services on offer were being targeted in the right places and whether they were the right services. Where possible, it was important to identify patients before they got to the stage of needing an ambulance or acute care. It was anticipated that the Integrated Care Board would result in a more holistic and joined up approach.

17. Asked what work was underway to inspire younger generations into a career with the Trust, Mr Webb explained a number of methods, including:

    a. direct entry university programmes.
    b. Vocational options such as apprenticeships.
    c. Working with higher education colleges on paths of development, and engaging schools in the work they do.
    d. Concentrating on international recruitment for past 12 months.

18. Recognising the high demand for dental services, particularly during the pandemic, Mr Goatham from Healthwatch asked what the impact on 111 had been. Mr Savage said the Trust had employed dental nurses in response to dental services being closed during covid lockdowns. These nurses sat in the Clinical Assessment Service and were able to signpost to services as appropriate. He acknowledged there were not always enough appointments slots on offer and that the area needed more work.

19. A Member asked why it was not possible to provide patients with real time information on expected ambulance arrival time. Mr Webb explained that waiting lists were constantly updating, impacted by other calls which may be higher priority. Call handlers were able to track locations and link incidents together, recognising that some incidence may receive more than one call and a patient may phone from multiple phone numbers. Undertaking this work took capacity away from new, inbound calls.

20. The Chair thanked Mr Webb and Mr Savage for their time.

RESOLVED that the report be noted.

82. Podiatry Services
(Item 6)

In attendance for this item: Simon Pendleton (Head of Podiatry Services) and Dr Mark Johnstone (Director of Dental and Planned Services), Kent Community Health NHS Foundation Trust.

1. Dr Johnstone introduced the paper, setting out the plans in place to improve the delivery of podiatry surgery which was currently delivered from Foster Street, Maidstone. The proposal was to move the service to the Churchill Centre at Preston Hall, Aylesford as well as a site in Coxheath. Both sites offered better facilities with easier parking. Whilst the Churchill Centre was accessible by bus it would require a 10-minute walk from the bus stop. Staff had been engaged and were enthusiastic. He confirmed that patients would be able to choose which site they went to.

2. The Chair expressed his view that the change was not a substantial variation of service because there would be an improved service for patients, as well as increased patient choice, and staff had been engaged and were supportive of the proposals. He asked for a report on any further issued raised during ongoing engagement and mitigations that would be put in place.

   RESOLVED that
   (a) the relocation of podiatry services is not a substantial variation of service.
   (b) NHS representatives be invited to attend HOSC and present an update at an appropriate time.

83. Kent and Medway Integrated Care Board
(Item 7)

Mike Gilbert, Executive Director of Corporate Governance, NHS Kent and Medway (ICB), was in attendance for this item.

1. Mr Gilbert introduced the report and explained that the Integrated Care Board (ICB) had been in formal operation for 6 days, and the former CCG dissolved. A new Constitution was in place. He set out the fundamental differences between the ICB and CCG – namely that the ICB's membership, as a statutory board, involved individuals from a number of healthcare partners, including KCC. Decisions would be made by those professionals, with joint decisions being allowed, and work should undertaken in a more streamlined fashion than before. There was a focus on reducing inequalities. The ICB had taken on the commissioning of three additional services from NHS England (pharmacy, optometry and dentistry).

2. A Member questioned why service users were not represented on the Board. The Chair explained that was the role of elected councillors, to represent their communities. Mr Gilbert explained that Healthwatch were represented, and there would be a People and Communities Forum / Citizen's Panel which would feed into the ICB and Integrated Care Partnerships (ICPs). The Chair requested that the details of the Forum be circulated to HOSC members.

3. Building on the above, the member went on to ask how patient rights were enshrined. Mr Gilbert explained that it was a national requirement to

demonstrate user involvement, though raising issues with the Board was a permission as opposed to a right.

4. The ICB would have a Medical Director (unlike the CCG) and under that directorate there would be clinical professionals as well as those with a background in social prescribing.

5. Data sharing agreements were already in place, and Mr Gilbert confirmed the ICB did not hold patient data other than that belonging under the “continuing healthcare” umbrella.

6. In terms of GP relationships, the ICB was responsible for commissioning GP services though NHS England continued to manage the complaints process (that might be delegated in 2023). The Local Medical Committee (LMC) had established a GP Board and that was represented on the ICB. The GP Board would communicate on behalf of the 190 local GP surgeries.

   RESOLVED that
   a) The report be noted
   b) The ICB return in 6 months with a progress update.

84. Learning from the closure of Cygnet Hospital, Godden Green - written item
(Item 8)

1. The Chair explained that the item was a written update and there were no guests in attendance.

2. A Member had the following questions that required clarity:

   a. What areas were covered by the 186 CAMHS tier 4 beds in the South East region?
   b. Did the 186 include the removal of the 20 beds taken out of service at St Mary Cray?
   c. What was the breakdown of tier 4 beds by county and how many were vacant?
   d. Why were the additional 6 beds at Kent and Medway Adolescent Hospital (KMAH) still not available?
   e. Was it accurate that there was an eating disorders day clinic at Haywards Heath but it was almost impossible to get there by public transport?

3. The Chair requested that the clerk seek a written response to the above questions.

   RESOLVED that the report be noted.

85. Work Programme

(Item 9)

1. The Chair informed the Committee that a briefing would be held in September for HOSC members regarding the upcoming EKHUFT maternity report. An item would be on the 6 October 2022 agenda, and to ensure representation from the Trust the Chair had agreed the meeting would commence at 9.30am.

2. The Chair informed the Committee that Rachel Jones had commenced working for Maidstone and Tunbridge Wells NHS Trust and her former work with the CCG would be allocated appropriately.

3. A Member asked that “call to needle” times be included as part of the HASU update on 6 October. They felt it was vital that population information was available as decisions were currently based on historic estimates.

4. The Chair confirmed that a formal request had been submitted to the Scrutiny Committee to look at the health inequalities of the gypsy, roma and traveller communities. He felt HOSC should work with the ICB to look into adult suicide rates we well as increasing the take up of childhood immunisations.

   RESOLVED that the work programme be agreed.

86. Date of next programmed meeting – 6 October 2022

(Item 10)

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Item 4: Reconfiguration of Acute Stroke Services

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 30 November 2022

Subject: Reconfiguration of Acute Stroke Services

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

It provides background information which may prove useful to Members.

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1) Introduction

a) The Kent and Medway Integrated Care Board is establishing three Hyper Acute Stroke Services (HASUs) to serve Kent and Medway. These will be located in Maidstone, Ashford and Dartford.

b) The implementation follows a long period of planning, consultation, and challenges. A summary timeline was set out in a paper to HOSC in January 2022.

c) Officers from the Kent and Medway CCG attended HOSC on 26 January 2022 setting out how the units would be implemented. They were accompanied by colleagues from South East Coast Ambulance Service (SECamb) who spoke about their role in caring for stroke patients. Key points of the discussion included:

i) Stroke services were consolidated on three sites in the county (Dartford, Maidstone and Canterbury).
ii) Three travel advisory groups were to be re-established, which would listen to the concerns of patients and families and put strategies in place to address these concerns.
iii) Ms Jones (Executive Director Strategy and Population Health at K&M CCG) 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 a 3 month lag in data, so December 2023).
iv) The use of telemedicine had reduced the number of non-stroke patients being sent to a stroke unit which had resulted in improved patient flow.

d) The Kent and Medway ICB has been invited to attend today's meeting and provide an update on the implementation of the HASUs. In the past, Member concerns have centred on travel times; staffing levels over the long-term; and inequalities.

2. Recommendation

RECOMMENDED that the Committee consider and note the report and that the ICB be invited to return with an update at the appropriate time.

Background Documents

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

Contact Details

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

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

NOVEMBER 2022

A SUMMARY OF PROGRESS FOR THE RECONFIGURATION OF ACUTE STROKE SERVICES IN KENT AND MEDWAY

Report from: NHS Kent and Medway Stroke Programme

Introduction

The purpose of this document is to provide an update to the Committee on the reconfiguration of acute stroke services in Kent and Medway.

Background

Kent and Medway are committed to improving sustainability, quality, and access to specialist care for stroke patients across the county. The implementation of HASUs through the centralisation of stroke services at a smaller number of hospitals will have numerous benefits including improved clinical and patient outcomes as well as financial savings. Since 2014, Kent and Medway have confirmed the case for change, developed the clinical model and undertaken significant stakeholder and public engagement. The focus is now on the transition to implementation with a strategic objective to deliver three co-located hyper acute stroke/acute stroke units (HASU/ASU's) at Darent Valley Hospital, Maidstone General Hospital and William Harvey Hospital (Ashford).

To note, the stroke review was paused during the system wide response to the COVID-19 pandemic which impacted deadlines and milestones. The management of COVID-19 in East Kent resulted in the temporary transfer of current acute stroke services to Canterbury in April 2020. The move was aimed at freeing medical inpatient capacity for COVID-19 patients on the Queen Elizabeth the Queen Mother, Margate and William Harvey, Ashford sites. The acute stroke service provided by MFT was transferred to Maidstone Hospital and Darent Valley Hospital in July 2020 on quality and safety grounds due to staffing shortages.

The interim arrangements for delivering Kent and Medway acute stroke services are outlined below:

Provider	Site	Catchment Areas (by HCP)
Dartford and Gravesham NHS Trust	Darent Valley Hospital	Dartford, Gravesham & Swanley Medway and Swale
Maidstone Tunbridge Wells NHS Trust	Maidstone Hospital	West Kent Medway and Swale
East Kent Hospitals University Trust	Kent and Canterbury Hospital (William Harvey future HASU)	East Kent

Progress to Date

Pre-hospital:
Patients with a suspected stroke have a video triage consultation with a stroke specialist in the back of the ambulance. This means that 1) patients are directed to the right hospital to meet their needs 2) Stroke teams are pre-alerted that the stroke patient is arriving, optimising time critical intervention when they reach the stroke hospital

Pathway improvement:
Work across stroke and non-stroke providers to improve access and effectiveness of stroke and TIA pathways is being undertaken, including access to scanning, thrombolysis and mechanical thrombectomy.

HASU update

Timescales

Details of the planned timescales for developing the three hyper acute stroke units (HASUs) in Kent and Medway is shown below

Site	Investment is for:	Approved full business case by	Timescale for delivery from contract award
Ashford – William Harvey Hospital	New build forward extension	Feb 2025	19 months
Dartford – Darent Valley Hospital	Refurbishment of existing and additional space	June 2023	13 months
Maidstone – Maidstone Hospital	Refurbishment of existing and additional space	June 2023	13 months

Activity and bed modelling

The original stroke activity assumptions and bed modelling was completed in 2017.

Due to the delays in the stroke review, the activity assumptions are being reviewed to ensure they remain robust and to finalise the business cases. This includes a review of the movement assumption of the Bexley activity from the Princess Royal University Hospital (PRUH) to Darent Valley Hospital (DVH).

Updated activity between 2019-2021is shown below:

Year	MFT (est)	DGT	PRUH	MTW	EKHUFT
2019	487	489	172	766	1,218
2020	244	524	186	874	1,192
2020 – Covid adjustment (11%)	8	16	5	26	37
2021	0	708	188	1,172	1,354
MFT closure	(739)	132	0	607	0
Updated three-year average	0	623	184	1,148	1,267

Call to needle times

The Sentinel Stroke National Audit Programme (SSNAP) collects data on quality and organisation of stroke care by individual trusts. It is the single source of stroke data in England.

Currently call times are not available via SSNAP. However, EKHUFT has identified that from 2018 there would be around 588 SSNAP records from EKHUFT postcodes thrombolysed who attended via ambulance.

Discussions are taking place through the National Stroke Programme regarding development of a dashboard that enables full pathway view of stroke patient journey. This includes a recommissioning of the SSNAP dataset, expected by Spring 2022.

Rehabilitation and life after stroke services

During the review of urgent stroke services, Kent and Medway made an explicit commitment to ensure appropriate stroke rehabilitation services will be up and running at the same time as the new acute stroke service goes live. Inpatient rehabilitation beyond that provided in the Acute Stroke Units (ASUs) will be delivered in the community.

A work plan has been developed to scope the requirements for a Kent and Medway Integrated Community Stroke Service, including needs led stroke rehabilitation and life after stroke support. A business case to establish these services is being developed with community and acute providers, the third sector and patient representatives. The timeline for approval of the business case is Q1 2023/24. 'Mini business cases' are currently being developed by each community provider to secure investment for 2023/24 ahead of submission of the main business case.

Stroke recovery beds at Maidstone (transferred from the Acute Trust building to the Community Trust)

The closure of acute stroke services at Medway Maritime Hospital in July 2020 resulted in approx. 80% of their activity being transferred to Maidstone Hospital. To accommodate the increase in activity, MTW increased their acute bed base capacity through the introduction of new stroke rehabilitation pathways away from the acute site.

Two 6-month pilot pathways were implemented in November/December 2020:

a) home care rehabilitation service (10-16 places) in collaboration with Hilton Nursing Partners

b) community hospital inpatient 8-bedded specialist stroke rehabilitation facility at Sevenoaks Hospital

Early outcomes suggested the pilots improved bed capacity and patient flow for the Acute Stroke Unit at Maidstone with a total of 112 patients being cared for on the new pathways during the pilot, releasing 2351 bed days for the stroke unit and reducing the length of stay for stroke patients in the first year.
An initial review demonstrated, both pilot pathways delivered improvements within clinical service delivery, outcomes, patient and staff experience and financial performance, were identified. This has been supported through the executive team

at MTW for inclusion in their established stroke pathway, and pilots across other stroke pathways in Kent and Medway are now under development.

Workforce

Work is progressing to explore opportunities to introduce innovative roles for stroke services, including Physicians Associates, Advanced Clinical Practitioners and Stroke Support Workers. New ways of working across the pathway and across specialties to improve patient outcomes and pathway effectiveness are being piloted across services.

However, challenges remain across both acute and community pathways to meet the national specification due to workforce supply, recruitment, and retention.

Winter planning

Fixed term funding has been allocated to support winter pressures, with a particular focus on patient flow between acute hospitals and community services. It is hoped that this will help improve emergency care capacity; deliver improvements and sustainability to time critical stroke intervention.

Kent and Medway Integrated Stroke Delivery Network (ISDN) have identified interventions that could help improve flow within stroke services which in turn could increase urgent care capacity for non-stroke patients. The stroke winter proposals being explored are:

a) Stroke bridging service. The proposal would scale up the current model run by EKHUFT in collaboration with KCHFT and replicate across other points of the stroke pathway to support admission avoidance and early/timely discharge. In turn, this would improve length of stay and release community rehab capacity. To date, the pilot outcomes have shown to have a positive impact on operational performance, outcomes, and patient experience.

b) Stroke enablement pathway. The proposal would be to extend the current MTW in partnership with Hilton Stroke Rehabilitation and Care pilot across Kent and Medway to support timely and effective discharge from both acute and rehabilitation inpatient beds. To date, the pilot has suggested a positive impact on patient outcomes and patient experience. There were no delays between in the 6-month period (23/11/20-31/05/21) when discharging patients to the Hilton pathway.

Next Steps

Deliverable	Target for completion
Development of EKHUFT outline business case	April 2023
Development of DGT full business case	April 2023
Development of MTW full business case	April 2023
Local assurance of business case (tbc)	June 2023
National assurance of EKHUFT outline business	January 2024

case	

Item 5: Maternity Services at East Kent Hospitals University NHS Foundation Trust

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 30 November 2022

Subject: Maternity Services at East Kent Hospitals University NHS Foundation Trust

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

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1) Introduction

a) A report of the Independent Investigation into East Kent Maternity Services was published on 19 October 2022. A link to the report can be found below.

b) Whilst the investigation was ongoing, HOSC's ability to scrutinise EKHUFT's maternity services was restricted but at their meeting on 17 September 2020 the Committee requested the item return once the final investigation report had been published.

c) Following media coverage earlier in the year, the Trust provided a written update to the Committee on 26 January 2022. Concerns were raised about midwifery staffing levels at the Trust and the subsequent suspension of the home birth service.

d) Representatives from the Trust have been invited to attend today's meeting to discuss the findings of the Report and provide detail on improvements that have been, and will be, made in response to concerns raised.

2. Recommendation

RECOMMENDED that the Committee note the update and the Trust be invited to return at an appropriate time.

Background Documents

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

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

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

Independent Investigation into East Kent Maternity Services, https://iiekms.org.uk/about-the-investigation/

Reading the signals - Maternity and neonatal services in East Kent – the Report of the Independent Investigation (2022), https://www.gov.uk/government/publications/maternity-and-neonatal-services-in-east-kent-reading-the-signals-report

Contact Details

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

East Kent Hospitals Update for Health Overview and Scrutiny Committee Maternity and Neonatal Services: 21 November 2022

1. Introduction

1.1. This paper summarises the work underway to improve maternity and neonatal services at the Trust and the key findings and actions arising from the *Reading the signals*: maternity and neonatal services in East Kent report, published on 19 October 2022.

1.2. The report follows an investigation into maternity and neonatal services at the Queen Elizabeth The Queen Mother Hospital (QEQM) in Margate and the William Harvey Hospital (WHH) in Ashford, between 2009 and 2020. Some 202 cases were assessed by the panel, led by Dr Bill Kirkup.

1.3. While this paper focuses on maternity and neonatal services, we recognise that learning from this report is relevant to every part of our Trust. We recognise themes, such as workplace culture and listening to patients, are areas we need to improve across all our services and we are committed to addressing this.

2. 'Reading the signals: maternity and neonatal services in East Kent'

2.1. This report details systemic failures in care that led to significant harm, a failure to listen to families and staff, actions which made families experiences unacceptably and distressingly poor, and a series of missed opportunities to tackle the problems effectively.

2.2. It finds that had care been given to the nationally recognised standards, the outcome could have been different in 97 of the 202 cases assessed by the Panel (48% cases) and the outcome could have been different in 45 of the 65 baby deaths (69% cases).

2.3. The panel was unable to detect any discernible improvement in outcomes or suboptimal care, as evidenced by the cases assessed over the period from 2009 to 2020.

2.4. The report identifies four areas for action for the Trust and wider NHS:

- identifying poorly performing units
- giving care with compassion and kindness
- teamworking with a common purpose
- responding to challenge with honesty

2.5. In addition, a key recommendation for the Trust is to accept the reality of these findings; acknowledge in full the unnecessary harm that has been caused; and embark on a restorative process addressing the problems identified, in partnership with families, publicly and with external input.

2.6. We fully accept the report's findings and apologise unreservedly for the harm and suffering experienced by women and babies who were within our care, together with their families. We recognise that families came to us expecting that we would care for them safely, and we failed them.

2.7. We are determined to learn from and act on this report; for those who have taken part in the investigation, for those who we will care for in future, and for our local communities.

3. Improvements to date

3.1. Around 6,500 women give birth each year at maternity units at QEQM and WHH and at home.

3.2. Below are some of the improvements that we have been working on since 2021. We recognise there is much more for us to do, as outlined in sections 4 and 5.

Listening to women and families

3.3. Since May 2022, women are offered a follow-up call with a midwife six weeks after delivery to ask them what went well and what needs to improve. Calls last approximately 30 minutes to enable sufficient time for a detailed conversation about all aspects of their and their baby's care, with birthing partners also invited to participate.

3.4. We have spoken to 1,770 women between May and October 2022, in October:

- 90% would be happy to return to the Trust
- 90% were positive about their antenatal care
- 91% were positive about their care during labour
- 82% positive about post-natal care.

3.5. This approach provides rich and detailed feedback which enables both opportunities for staff recognition and learning. Key themes for improvement raised include delays to care, improving access to pain relief, being listened to by staff, feeling looked after and having enough staff. There are clear action plans for each of these areas as part of the overarching maternity improvement plan, examples include reviewing the bereavement and antenatal pathways.

Listening to our staff

3.6. We have introduced a dedicated Freedom to Speak Up Guardian for maternity and neonatal services, providing a dedicated route for staff to voice concerns in a confidential and supportive manner.

3.7. The Executive Maternity Safety Champion visits labour wards weekly and staff forums, including for community staff, and Band 7 midwives, take place monthly.

More staff available to run services

3.8. We have invested £1.6m in midwifery staffing since 2021 which, combined with additional national funding, resulted in an additional 38 midwife and 11 specialist/leadership midwife posts, including specialist bereavement midwives and a dedicated neonatal bereavement key worker.

3.9. We offer permanent posts to all our student midwives following completion of their training - 22 newly qualified midwives joined us last year and a further 18 started in September 2022.

3.10. Obstetric consultants are resident in the hospital and available to the labour ward 24/7 at WHH and until at least 22.00 at QEQM Hospital, supported by 24/7 on call. WHH has more births and takes known complex deliveries as it hosts East Kent's Neonatal Intensive Care Unit.

3.11. We have invested in additional paediatric and neonatal consultant posts and improved cross-site working, for example, with a "grand round" where complex cases are regularly discussed to ensure better oversight of patients' care.

Staff training

3.12. We have improved mandatory training compliance. Monthly multidisciplinary teaching takes place with a focus on communication, team working, recognition of the deteriorating patient and escalation.

3.13. All locum doctors undertake introductory training and supervised day shift.

Improving our culture

3.14. A culture and leadership programme is underway which includes vision and values workshops, staff drop-in sessions and a leadership development programme where teams learn together.

3.15. We have appointed a Lead Professional Midwifery Advocate to support and guide midwives to provide high quality safe care and support service users

Improved governance and learning from incidents

3.16. The Trust Board has oversight of performance, learning from serious incidents, training compliance, progress against national reviews and Care Quality Commission actions.

3.17. The Board reviews key quality and performance data monthly using the nationally-recognised perinatal quality surveillance tool to monitor serious incidents, training compliance (e.g. fetal monitoring and newborn life support) and feedback from families, as well as staff.

3.18. A strong culture of reporting incidents is important for the safety of our patients and to this end we are encouraging staff to report all incidents, regardless of their severity.

3.19. We have strengthened the quality of investigations and learning from incidents. For example, we have introduced a rapid review process to review potential serious incidents and ensure immediate safety actions have been taken.

Investing in our estate

3.20. We are currently investing £1.6m in maternity services at WHH and QEQM and £1.7m in the Special Care Baby Unit at QEQM.

3.21. We are seeking additional investment to expand and refurbish both units, including for a second obstetric theatre at QEQM hospital and to increase the number and size of rooms available for women and their families.

4. Next steps – implementing the recommendations

4.1. While progress has been made, we recognise that there is much more for us to continue to do. The Board is determined to use the report's recommendations to make lasting changes to ensure that we are providing the safe, high-quality care our patients expect and deserve.

4.2. This includes work to tackle our culture and behaviours, upholding professional standards, team working, listening to and acting on patient feedback and responding to challenge with honesty.

4.3. The Board will ensure progress against the five key action areas set out in the report, which include 1) reducing harm and monitoring safe performance 2) upholding standards of clinical behaviour 3) team working 4) organisational behaviour and 5) patient and family voices.

4.4. This will include obtaining assurance in relation to the delivery, evidence, sustainability and impact of the implementation of the report's recommendations, including a clear timeline for completion, which will be scrutinised in public. Operational oversight for the development and delivery of this work will be through the Trust's Clinical Executive Management Group

4.5. Listening and working with families, patients and staff to co-design solutions is at the heart of our approach. We have started with listening events with maternity and neonatal staff and we are in contact with a number of families who have told us they would like to be part of developing long-lasting solutions.

4.6. The Board of Directors will dedicate sufficient time at its Board meetings to enable this work to be appropriately considered in keeping with its critical importance.

5. Independent care reviews

5.1. Prior to the publication of the report, we wrote to all families registered with our maternity services, notifying them of the publication of the report and providing contact details in the event of any immediate concerns or questions. This included details of a dedicated enquiries line to which we have received 54 responses to date.

5.2. There is an open invitation to families to meet with representatives of the Trust about their care, regardless of whether or not they participated in the investigation. If any families have concerns, we invite them to contact us and we will support an independent review of their care.

5.3. An independent panel is being established to undertake care reviews requested by families, regardless of whether their care has been previously investigated by the Trust.

5.4. Cases will be reviewed by a panel comprising three independent expert clinicians, including a Consultant Obstetrician and Gynaecologist, Consultant Neonatologist and Director of Midwifery. Executive oversight will be provided by the Chief Nursing and Midwifery Officer supported by the Strategic Maternity Programme Director, reporting monthly to the Trust Board.

Item 6: Stroke Rehabilitation Service – Maidstone and Tunbridge Wells

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 30 November 2022

Subject: Stroke Rehabilitation Service – Maidstone and Tunbridge Wells

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

It provides background information which may prove useful to Members.

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1) Introduction

a) The way stroke rehabilitation is provided across the Maidstone and Tunbridge Wells footprint is changing. Historically the service was provided by MTW in an acute setting but in future it will be provided in the community by Hilton Nursing Partners or Kent Community Health Foundation Trust (KCHFT).

b) MTW have asked to attend today's meeting and answer the Committee's questions about the changes.

2. Recommendation

RECOMMENDED that the Committee consider and note the report.

Background Documents

Non

Contact Details

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

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Maidstone and Tunbridge Wells NHS Trust

Kent Health Overview Scrutiny Committee

Stroke Rehabilitation Service

Situation and Background:

Stroke rehabilitation is most commonly provided in a community setting however Maidstone and Tunbridge Wells NHS Trust (MTW) has historically provided it from the acute bed base. When the COVID pandemic struck the NHS was asked to consider moving all non-essential activity out of hospital. In addition, in July 2020 Medway Maritime's acute stroke service closed with 78% of the activity transferring to Maidstone Hospital. It was therefore imperative to introduce new stroke rehabilitation pathways away from the acute site so that MTW could expand its' existing acute bed base.

Two new pilot pathways were developed and started taking patients in November/ December 2020 for a 6-month period. The pathways are an innovative home care rehabilitation service (10-16 places) in collaboration with Hilton Nursing Partners and a community hospital inpatient 8-bedded specialist stroke rehabilitation facility at Sevenoaks Hospital, which is part of Kent Community Health Foundation Trust (KCHFT). It was agreed that the Home Stroke Rehabilitation pathway would be the default pathway, with patients requiring more complex or intense rehabilitation needs being transferred to Sevenoaks Community Hospital.

The home service has 3 levels of support delivered through an integrated care model comprising Hilton staff, MTW staff and KCHFT staff.

Support Category	Level of Care
Recovery	Requires up to 4 daytime visits of less than one hour each
Moderate	Requires double handed visits and may require night support to a designated time
Intensive	Requires 24 hours support for an anticipated time of up to 7 days then steps down support. In the event a longer period of time is considered appropriate the Trust's lead therapist can agree a further 48 hours. Thereafter a further increase in 24 hours care will need to be agreed with the MDT and the patient pathway reviewed.

The pathway was designed for a maximum of six weeks home support with a sliding scale of input over the period (intensive, moderate and recovery as described above), although patients could enter the pathway at any stage. Patients were discharged into the care of their GP as they were

deemed medically fit for discharge. Home care is provided by Hilton and patients were discharged with an MTW prescribed therapy plan with clear goals.
MTW therapists worked with the patients and carers virtually or by face to face contact in the home to deliver, supervise and monitor the therapy inputs and achievement of goals. Virtual Therapy sessions were managed using the Attend Anywhere software. KCHFT (Kent Community Health Foundation Trust) and CNRT (Community Neuro Rehabilitation Team) were involved in the pathway to ultimately take over care once the rehabilitation phase was over.

A community hospital inpatient 8-bedded specialist stroke rehabilitation facility was set up at Sevenoaks Hospital to provide stroke rehabilitation to the more dependent stroke patients including those with severe cognitive and/or physical impairment and dysphasia. Nurse staffing was provided by Kent Community Health Foundation Trust (KCHFT) and was supported by a senior nurse from MTW as well as a regular presence from the stroke CNS team members. Therapy and medical support were provided by MTW therapists and stroke consultants. A consultant ward round is undertaken twice weekly on site and weekly MDT meetings are in place. MTW Therapy staff are on site at Sevenoaks to work with patients and nursing staff. Governance is managed between KCHFT and MTW to ensure all elements of the service provision (nursing, medical cover, therapies, IT, recording, imaging, support services and training) were in place. It is to be noted that the 8 beds at Sevenoaks were not new capacity but part of the rehabilitation bed base already in play at Sevenoaks hospital. It is imperative that the MDT (which included KCHFT) ensured the beds were used effectively. Social services and CNRT were involved in the pathway to support ongoing care

Assessment:

The pilots were initially evaluated in June 2021 using 5 key criteria:

- financial performance;
- clinical service delivery;
- quality of care;
- patient experience; and
- stakeholder feedback.

The pilots improved bed capacity and patient flow for the Acute Stroke Unit at Maidstone. A total of 112 patients were cared for on the new pathways during the period of the pilot (72 at home and 40 at Sevenoaks). This released 2351 bed days for the stroke unit, reducing the length of stay for MTW stroke patients and releasing capacity in the acute Trust to manage flow more effectively.

Patient and staff feedback were positive overall and the quality of care and patient outcomes were good. Challenges identified included the speed of the implementation during a Covid-19 pandemic; delays in discharges from the pathway due to Social Services referrals and Kent Enablement at Home (KEAH) capacity and processes; developing changes in decision-making processes within the MDT and board rounds; therapy and nursing staffing models and record keeping and sharing across I.T. systems.

	Home Rehab (23.11.20 – 31.5.21)	**In-patient Community Hospital** (7.12.20 – 6.6.21)	**Totals**
Number of patients in the service each week	10-12	8/9	18-21 per week
Total number of admissions	72 Recovery 54 Moderate 10 Intense 8	40	112 patients
Total discharges	61	31	92 patients
Total number of bed days	1307	1044	2351
Average Length of Stay (days)	21.4	34 Range 7-71	
Wasted beds days per month (delays from referral to actual transfer)	Unknown	64 Av. 3.5 days per patient based on May data	
Delays to discharge from service (no. of patients)	6 patients Total of 68 days Bridging required due to delays in POCs. Range 2-33 days per patient.	11 patients No. of days unknown 4 waiting nursing home, 6 POCs, 1 housing	17 patients
Number of patients transferred back to	7 patients Decline in health/	11 patients 0-2 per month	18 patients

MTW	mobility/infection		
Failed referrals to service	4 (total) (not medically fit for discharge or alternative social care provider) 93.5% conversation rate	Estimated 3 per month (Based on May data - discharged 7/8 days after MFFD to Home Pathway)	
Number of complaints	0	1 Resolved	
Number of incidents	8 Falls x 5 Skin integrity x1 Other 2	8 Falls x 5 Food/swallowing x2 Pressure ulcer x 1	No serious incidents

A presentation of the pilot scheme and evaluation was given to the Integrated Stroke Delivery Network Stroke Rehabilitation Sub-Group on 1st September 2021.

Recommendation:

Subsequently MTW decided to formalise the new pathways and went through a procurement process. Both pathways remain in place and are fully funded. The challenges identified above have been the focus of the improvement work over the last year with positive outcomes. For example, MTW and KCHFT now use the same bed management system, the MDT meetings have been streamlined with all partners attending and all staff have undertaken stroke competency assessments. Patient and staff feedback continue to be positive and regularly monitored. These pathways are now embedded and viewed as business as usual. Other acute providers are now considering the home rehabilitation service and are being supported by the ISDN.

Rachel Jones
Executive Director Strategy, Planning & Partnerships
November 2022.

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Item 7: Local provision of ophthalmology services (Dartford, Gravesham and Swanley area)

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 30 November 2022

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

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by Kent and Medway Integrated Care Board (ICB).

The Committee has already determined the changes do not constitute a substantial variation of service.

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1) Introduction

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

b) The Kent and Medway CCG (K&M CCG) and Maidstone and Tunbridge Wells NHS Trust (MTW) attended HOSC in July 2021 to update the Committee on plans for the ongoing provision of ophthalmology services in Dartford, Gravesham and Swanley.

c) Following the withdrawal of a London Provider (Moorfields) to patients in Dartford, Gravesham and Swanley, K&M CCG took action to ensure those patients continued to have access to services. MTW provided interim care. Cataract surgery, which represents the majority of treatments affected by the service transfer, were at the time of the meeting being carried out at an independent sector site in Gillingham using MTW clinicians. The long term aspiration was to develop a centre of excellence within the footprint of Dartford, Gravesham and Swanley.

d) Following the discussion, the Committee resolved that:

a) the Committee does not deem the proposed changes to ophthalmology services to be a substantial variation of service.
b) the report be noted.
c) an update on the effectiveness of the service changes be received at the appropriate time.

e) The ICB has been invited to attend today's HOSC meeting and provide an update in relation to item (c) above.

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

2) Recommendation

RECOMMENDED that the Committee note the report.

Background Documents

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

Contact Details

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

NHS
Kent and Medway

Update Report for Kent HOSC November 2022

Date:	30th November 2022
Title Report:	Provision of Ophthalmology Services (Dartford, Gravesham and Swanley)
Lead Director:	Lee Martin, Chief Delivery Officer,
Authors:	David Peck, Director of the Dartford, Gravesham and Swanley Health &Care Partnership

Summary:

Moorfields Eye Hospital served notice in February 2020 on the Kent and Medway system of their intent to discontinue providing ophthalmology services from Darent Valley Hospital leading to the former CCG having to identify a new Provider at pace and putting in place measures to facilitate the safe and effective transfer of patients during the COVID-19 pandemic.

This paper sets out the steps that are being taken by the Integrated Care Board to identify a permanent solution that would enable the re-provision of some acute ophthalmology services within the footprint of Dartford, Gravesham and Swanley.

Overview:

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

Acute ophthalmology services are now provided by Maidstone and Tunbridge Wells NHS Trust (MTW), who took on the role of providing those services. The ICB remains grateful that they stepped in and took on this role following Moorfields Eye Hospital serving notice on their contract and stopped supplying services from the Darent Valley Hospital (DVH) site. The transfer of patients was a significant undertaking and led to significant operational pressures for MTW and it provides a positive reflection on the Trust that this was done in a safe and effective manner. At the time, MTW were unable to commit to provide services from the DVH site due to workforce issues recognising that services were already delivered over multiple sites for West Kent also Medway patients.

Dialogue have been on-going with Dartford & Gravesham NHS Trust regarding the possibility of providing space for ophthalmology outpatient services and surgical procedures to be re-provided on the DVH site. The space that was originally used by Moorfields has been re-allocated and it is not currently possible to re-provide that space without having an impact on clearing the backlog that has arisen as a result of the pandemic. Moreover, the unprecedented levels of demand arising from non-elective admissions has led to outpatient space being temporarily converted to bedded escalation areas on a number of occasions this year and it is likely that the temporary re-purposing of outpatient space for escalation beds will continue in line with surges in demand. It is not realistic that any space

can be provided on the DVH site for the foreseeable future.

In order to provide the additional activity arising from MTW taking on the previous activity from MEH, additional theatre space was commissioned from the independent sector, whereby NHS staff operate on patients at an independent facility in Gillingham. This arrangement has ring fenced theatre space specifically for ophthalmology patients, who may have been at risk of cancelled procedures or a longer wait if that activity had taken place at an acute hospital where consideration is given to treating those with the highest level of clinical need first. Whilst this arrangement has led to patients having to travel, they undoubtably have been treated much sooner than if they would have otherwise been operated on at a NHS site.

The Integrated Care Board (ICB) has worked with MTW to identify solutions to enable the re-provision of some ophthalmology activity within the footprint of Dartford, Gravesham and Swanley (DGS). The ICB identified an existing NHS site that could be re-purposed and obtained capital funding that would have enabled a new ophthalmology centre to have opened, which would have provided both an ophthalmic theatre and some outpatient rooms. However, MTW were unable to proceed as a result of concerns at the time that they would not be able to staff the facility. The ICB is working with MTW to re-examine whether that concern is still valid now that 6 months have passed since. MTW is working with the ICB to identify a permanent solution to securing the theatre capacity needed for the medium to long term. Work is also underway to consider the future provision of outpatients at a sub speciality level with the aim to provide high volume services, such as glaucoma, locally.

Kent & Medway ICB have developed an Ophthalmology Strategy that outlines the ambition to redesign models of care, which will enable more patients to be seen within community settings. Dartford, Gravesham and Swanley have comparatively fewer community Providers than other parts of Kent and Medway and recent market testing has indicated that there are many potential Providers who could provide community services within North Kent. K&M Ophthalmology Service Improvement Group are developing full models of care for each tier of service delivery and it is anticipated that a procurement exercise will follow the completion of that transformative work. The aim is to utilise the wide range of existing skilled workforce in primary & community care; for example, many Optometrists on the high street have extensive equipment that can be utilised within a commissioned service that will support acute services and reduce the need for patients to travel to main acute sites. Digital technology is enabling much more shared care and virtual consultations, based on the diagnostics done in primary care a consultant can provide treatment plans without seeing the patient face to face. This will not only improve both the patient pathway and accessibility, it will also reduce the footfall through the acute sites and improve capacity for the more complex patients.

Commentary:

The commitment remains to ensure that some ophthalmology outpatient provision is re-provided within the footprint of Dartford, Gravesham and Swanley. However, this can only realistically be achieved through identifying an estates solution, securing the capital funding required and through securing the commitment of MTW to provide those services, whilst acknowledging that securing the workforce to do so will be a challenge. All relevant endeavours are being undertaken to take this forward.

The use of Independent Sector theatre capacity has minimised the impact of the pandemic on the waiting list size for ophthalmology patients. Trends seen around the country show that ophthalmology has been the most challenged specialty for having an increased backlog arising from the pandemic. However, it is acknowledged that the current solution is not viable in the longer term. Nonetheless, providing theatre capacity at an existing acute hospital will reduce the overall capacity in the system to provide theatre capacity for other procedures, which will impact on the imperative to reduce the backlog for elective procedures, which could take several years to return to pre-pandemic levels. Work is on-going to identify what site options exist, which includes re-evaluating whether it would now be viable to provide an ophthalmology centre within the site that was identified previously.
Recommendation:
The members of the HOSC are asked to note the challenges faced in securing a longer term solution that would enable the re-provision of acute ophthalmology services within the footprint of Dartford, Gravesham and Swanley, as well as the commitment from both the ICB and MTW to agree a solution.

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Item 8: Recruitment of nurses

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 30 November 2022

Subject: The recruitment of nurses

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

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1) Introduction

a) A committee member requested that HOSC scrutinise the recruitment of nurses. This falls under HOSC's remit to review and scrutinise matters relating to the operation of local health services.

b) The Integrated Care Board (ICB) has produced the attached paper, which covers the acute provider Trusts (i.e. not primary care).

2) Useful Data

a) The data below provides some background which may be useful to members in their scrutiny of nurse recruitment in Kent.

b) Data relating to acute trusts and community healthcare providers (i.e. not GP Practices):

i. In June 2022, there were 356,346 individuals employed as nurses and health visitors by the NHS in England. This was 2.8% increase on the year before.[1]

ii. The full time equivalent (FTE) figure for nurses and health visitors in June 2022 was 319,481. This was a 3.0% increase from June 2021.[2]

iii. The number of people employed as nurses and health visitors in the South East (June 2022) was 47,833, with the FTE equivalent being 42,926.

iv. In June 2022, there were 8,764 individuals employed as nurses and health visitors across Kent and Medway. The table below provides a breakdown of these figures. The equivalent FTE figure is 7,978.

v. The number of vacancies (FTE) for registered nurses working in acute settings in the South East region was 4,009 as at June 2022. This was an increase on the year before (3,774).[3]

[1] NHS Digital (29 Sept 2022), NHS Workforce Statistics - June 2022, Table 1
[2] ibid
[3] NHS Digital (Sept 2022) NHS Vacancy statistics April 2015 – June 2022 – experimental statistics

vi. The vacancy rate for nurses in acute settings in the South East region was 9.9% in June 2022, compared to 9.8% in June 2021 (these were experimental statistics).[4]

vii. The number of nurses employed in each of the local hospital trusts and community health services (excluding GPs) is shown in the table below:

Trust	**Nurses and health visitors (headcount) June 22** [5]	**Nurses and health visitors (FTE) June 22**[6]
Dartford and Gravesham NHS Trust	1,187	1,082
East Kent Hospitals University NHS Foundation Trust	2,488	2,292
Maidstone and Tunbridge Wells NHS Trust	1,619	1,476
Medway NHS Foundation Trust	1,238	1,148
Kent Community Health NHS Foundation Trust (KCHFT)	1,266	1,083
Kent and Medway NHS and Social Care partnership Trust (KMPT)	911	845
Kent and Medway ICB	55	51
Total	**8,764**	**7,978**

Nb. Figures for South East Coast Ambulance Service (SECamb) are not included as the Trust provides services across a larger geographical footprint than just Kent and Medway.

3. Recommendation

RECOMMENDED that the Committee consider and note the report.

Background Documents

NHS Digital (29 Sept 2022), NHS Workforce Statistics - June 2022, https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/june-2022

NHS Digital (1 Sept 2022), NHS Vacancy Statistics England April 2015 – June 2022 Experimental Statistics, https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey/april-2015---june-2022-experimental-statistics

[4] ibid
[5] NHS Digital (29 Sept 2022), NHS Workforce Statistics - June 2022, Table 2
[6] NHS Digital (29 Sept 2022), NHS Workforce Statistics - June 2022, Table 3

Contact Details

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

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KENT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

NURSING STAFFING LEVELS

Report from: Eileen Sills, Chief Nurse, NHS Kent and Medway
Becca Bradd, Chief People Officer, NHS Kent and Medway

Author: Tara Laybourne, Deputy Chief Nurse, NHS Kent and Medway

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Summary

This report will provide the Kent Health Overview and Scrutiny Committee (HOSC) with an overview of the nursing staffing workforce position across Kent and Medway; the actions being taken by the Kent and Medway Trusts and the Integrated Care Board to ensure safe staffing levels and to attract, develop and retain the nursing workforce.

The report is provided following the request from HOSC members to understand acute Trust's nursing staffing, following East Kent Hospitals business case to increase nurse staffing by four hundred whole time equivalent (wte) earlier this year.

1. National context

1.1 Nursing staffing levels, as evidenced in the Royal College of Nursing (2021) *Guidance to safe nurse staffing levels in the UK report,* link directly to patient outcomes. Demonstrating sufficient staffing is one of the essential standards that all health care providers (both within and outside of the NHS) must meet to comply with Care Quality Commission (CQC) regulation.

1.2 There are currently an estimated 47,000 nursing vacancies in England (June 2022). NHS England have set a target to grow 50,000 nurses and although there are several initiatives in place including international recruitment, there are record numbers of nurses leaving the profession.

1.3 In 2016, the National Quality Board published *Safe staffing for nursing in adult inpatient wards in acute hospitals* which set out standards for safe staffing. Supporting tools and metrics were introduced to provide a standardised and systematic approach and measure of nurse staffing levels at ward level and provide recommended staffing levels.

1.4 These included the Safe Nursing Care Tool (SNCT) which assesses levels based on patients' needs (acuity and dependency) and Care hours per patient day (CHPPD), a recommended metric to provide a single consistent way of recording and reporting staff deployments and assessing productivity for acute and mental health Trusts. Other tools are used for district and mental health and whilst there is currently no national community nursing staffing tool, Kent Community Health NHS Foundation Trust (KCHFT) are participating in a national pilot to understand staffing level requirements.

1.5 All metrics are used alongside other quality metrics enabling nursing leaders to make safe and informed decisions regarding staff deployment in both registered nursing and health care support workers.

2. Kent and Medway context

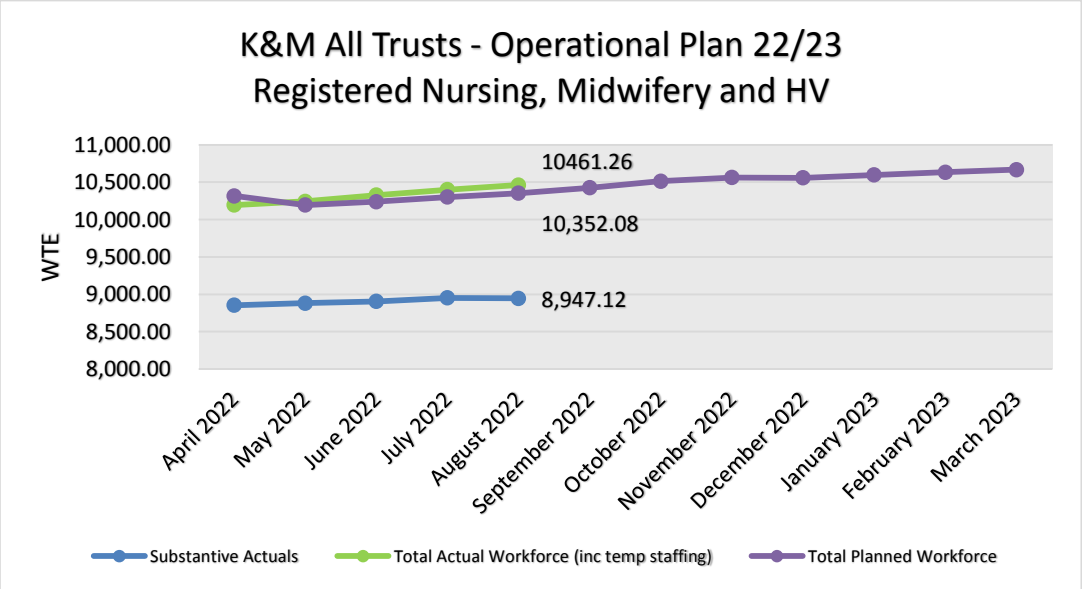
2.1 In Kent and Medway, the Integrated Care Board and NHS Trusts are committed to ensuring that we have sufficient nurses to safely staff our NHS services and use safe staffing tools to monitor this.

2.2 Currently across Kent and Medway there are:

- 1620 wte (15%) registered nursing vacancies in the acute Trusts (August 22)
- 13% turnover rate for registered nursing (August 22)

2.3 Included in the current vacancy rates for registered nurses, is an increased investment in nursing following the safe staffing reviews using the tools above, of an additional 520 nurses this year.

2.4 The graph below shows the total planned and actual nursing, midwifery, and health visitor workforce, showing that whilst the substantive vacancy gap remains, these vacancies are covered by temporary staffing to maintain safe staffing levels with all acute Trusts above plan, with Kent and Medway NHS and Social Care Partnership Trust (mental health) using just below plan and KCHFT (community Trust) below plan due to lower temporary staffing usage.



3. Growing our nursing workforce

3.1 Growing the nursing workforce is a key priority for both organisations and the Integrated Care Board. This is being undertaken through a number of different short and long term actions to create a sustainable nursing pipeline.

International recruitment

3.2 International recruitment is the main area of registered nursing growth in the short term across our acute providers. 844 international recruits were planned for 2022. As of August 2022, 342 wte (41%) nurses had arrived and were in post with a pipeline of nurses appointed awaiting start dates with ongoing active provider international recruitment plans to deliver the trajectory by December 2022. There is guidance from the Department of Health and Social Care (DHSC) which describes the code of practice for recruiting international nurses which ensures ethical recruitment is undertaken; Kent and Medway is fully compliant with this guidance.

Domestic recruitment

3.3 All Trusts have active recruitment campaigns and local engagement with schools and education. Whilst the domestic recruitment is smaller than the international recruitment, there is a steady pipeline of domestic recruits into nursing at all Trusts.

Careers in nursing

3.4 The Integrated Care Board has been working with partners to develop a Kent and Medway Health and Care academy, to maximise promotion of opportunities for health and care careers and engagement with education and wider partners to capture the interest of children and young people from an early age. This includes increasing the Kent and Medway Nurse ambassadors to support the development of this work aligned to the National 'Next gen' programme for 15 to 18 year olds and increasing our collective careers engagement with schools and wider education.

3.5 £1.038m investment has been made in nursing workforce development this year through Health Education England (HEE) monies to continue the placement expansion team and support the development of students in schools and colleges. As part of the Kent and Medway academy, resource will be provided to support T-Levels and apprentices working with local colleges and schools to ensure we are capturing students in their early years to promote the profession. Further work is ongoing with HEE to support trainee nursing associates whilst collaborating with partners to ensure that our workforce modelling supports the ability to offer suitable employment at course completion.

3.6 The nursing profession already offers a wide diversity of careers and career opportunities, and we are working together to make these more transparent and accessible through out academy. Expanding our current and future workforce includes new roles and ways of working including development into advanced clinical practitioners and nurse consultant roles as well as expansion of entry roles into nursing.

3.7 Registered nurses are supported by health care support workers (HCSWs). Early career progression for HCSW's is being offered as trainee nursing associates and apprenticeships. The focus not only on creating a pipeline of future nurses but also to support the development of the support workforce.

3.8 We are also working in partnership with HEE, Higher Education Institutes (HEi's) and providers to improve attraction, attrition, and experience of our student nurses and we are increasing placement capacity by exploring the opportunities of diverse placements and working with students and the student council to support the student voice and lived experience.

National 50,000 programme

3.9 The National programme (running from September 2019 to March 2024) focuses on key areas of international and domestic supply to increase registered nursing numbers by 50,000 wte. This includes national recruitment campaigns. In August 2022, Kent and Medway had achieved 90.7% of their allocated target with 17 months remaining in the programme and is expected to meet the allocation.

4. Working Differently

4.1 It is recognised that to grow our nursing workforce and have a sustainable model for the future, we need to work differently and across organisations. Our ambition is to grow our own domestic supply including opportunities for new career routes, ways of working and roles, reducing our reliance on international recruitment and creating great places to work where our colleagues are looked after and supported to retain our valued workforce.

4.2 We are also looking at opportunities to work differently together. An example is the investment being made to standardise enhanced care (care that is provided for patients who need additional support for their physical and, or mental health). This ensures that patients receive the right level of support, by staff who have the right skills, releasing nursing time, and is affordable. Significant funding (£400,000) from the ICB workforce development fund has been allocated to support a 12-month project to deliver a standardised model.

4.3 We are also working in collaboration with leaders from the Capital Nurse programme, which was developed across London to create a 'Kent & Medway Nurse', attracting and retaining colleagues to work across the county, with a focus on developing innovative career pathways across organisations, delivered flexibly. This is part of a wider system workforce programme for nursing.

4.4 There is also work underway to support nursing colleagues with their wellbeing within organisations and enhanced offers of support through the Talking Wellness service.

4.5 The Trusts are also working collaboratively on the five national high impact interventions which have been shown as key features of retaining nurses in the

workplace. This includes sharing and learning across the system to drive best practice, working with the Integrated Care Board and the regional team.

4.6 Alongside the national development of the NHS workforce plan and the HEE Framework 15 which are being produced to set the long- term plan for workforce development including nursing, we are developing a people strategy for Kent and Medway which is being co-designed with partners and will be drafted by early 2023.

5. Conclusion

5.1 We have a duty of care to provide safe staffing to our patients and this is being undertaken currently with the support of our temporary workforce. There are national workforce shortages due to the increased demand for nursing to support the acuity of patients in hospital. In Kent and Medway, we are working in partnership to not only attract our nursing workforce but also to grow, develop and retain the nursing workforce now and for the future.

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Item 9: Medway and Swale Community Diagnostic Centre

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 30 November 2022

Subject: Medway and Swale Community Diagnostic Centre

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by Medway and Swale Health and Care Partnership.

It provides background information which may prove useful to Members.

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1) Introduction

a) The Medway and Swale Health and Care Partnership have asked to present the attached report, setting out the plans to develop two community diagnostic centres in Swale (the hub) and Medway (the spoke).

b) The plans will provide additional diagnostic provision across Swale and Medway and they fall under an NHS England national programme to create such centres.

2) Potential Substantial variation of service

a) The Committee is asked to review whether this proposal constitutes a substantial variation of service. There are no formal criteria setting out what a substantial variation of service is, and it is down to the Committee to decide.

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

c) Where the Committee deems the proposed changes as being substantial, the NHS must consult with it prior to a final decision being made, though the NHS always remains the decision maker.

d) Once the final decision has been reported to HOSC, the Committee shall decide if it supports the decision, does not support the decision, and/or provide comment on it. Where it does not support the decision, the Committee can refer it to the Secretary of State.

3. Recommendation

If the proposals relating to the creation of two Community Diagnostic Centres in Medway and Swale are deemed substantial:

RECOMMENDED that:

(a) the Committee deems that the creation of two Community Diagnostic Centres in Medway and Swale is a substantial variation of service.

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

If the proposals relating to the creation of two Community Diagnostic Centres in Medway and Swale are not deemed substantial:

RECOMMENDED that:

(a) the Committee deems that the creation of two Community Diagnostic Centres in Medway and Swale is not a substantial variation of service.

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

Background Documents

None.

Contact Details

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

HEALTH AND OVERVIEW SCRUTINY COMMITTEE

30TH NOVEMBER 2022

MEDWAY & SWALE HEALTH AND CARE PARTNERSHIP, COMMUNITY DIAGNOSTIC CENTRE BRIEFING REPORT

Report from: Nikki Teesdale, Director of Delivery, Medway and Swale Health and Care Partnership

Author: Nikki Teesdale, Director of Delivery, Medway and Swale Health and Care Partnership

Summary

This Community Diagnostic Centre (CDC) briefing paper sets out plans to develop community diagnostic centres in Medway and Swale. The plans are to establish a hub, based at Sheppey Community Hospital (SCH) and a spoke, based at Rochester Healthy Living Centre (RHLC). The provision of imaging, physiological measurement and pathology tests and scans at these sites, over the next three years will deliver significant additional diagnostic capacity in the system, which will help to support COVID 19 recovery plans as well as future growth in demand. Increased diagnostic provision in the community will utilise existing NHS estates and improve access particularly for communities facing the highest level of health inequalities.

1. Background

1.1 In October 2020 Professor Sir Mike Richards published Diagnostics: Recovery and Renewal which identified a number of recommendations including the development of Community Diagnostic Centres (CDCs) to significantly increase extra diagnostic capacity and to separate diagnostic settings for elective and non-elective patients/ pathways. The recommendations have been accepted by NHS England and a national programme is in place to award funding to Systems and thereafter support the development of CDCs. CDCs will provide a broad range of elective diagnostic services away from acute settings, providing easier and quicker access to tests and greater convenience to patients, as well as relieving pressure on acute sites by reducing outpatient referrals and attendances.

1.2 The Kent & Medway Imaging Network was formed in line with the Long-Term Plan and the release of the Richard's Review. As part of this new governance structure, CDCs were included within the remit of the Kent & Medway Imaging Network, clearly recognising the alignment to the core modalities and the need to connect to the wider diagnostics.

1.3 On the 13th October 2022, the Medway and Swale Health and Care Partnership were informed that a bid to support additional diagnostic capacity across

the locality had been successful. Whilst there is flexibility in the how we as a system design the clinical pathways at a local level there is strict criteria with regards to what constitutes a CDC and therefore what we have to deliver in order to obtain the national funding.

Each CDC in England must:

- Be a digitally connected, multi-diagnostic facility that can where appropriate, be combined with mobile / temporary units. CDC provision should be located separately from the main acute hospital facilities and sited in locations that are more easily accessible, and closer to patients' homes.
- Contribute to six primary aims – improve population health outcomes, increase diagnostic capacity; improve productivity and efficiency; reduce health inequalities; improve patient experience; and support the integration of primary, community and secondary care.
- Deliver a minimum set of diagnostic tests
- Receive referrals from a range of healthcare professionals across the system, book and prepare patients; deliver coordinated testing and provide timely reporting.

1.4 By redesigning the clinical pathways, the CDCs will be expected to increase and optimise diagnostic capacity, improve efficiency, and improve patient outcomes assuring accessible sustainable pathways for our local population. The approval for funding in the Medway and Swale locality follows the early adopter Hubs situated in West Kent and East Kent. Through the CDC pathway design cross border working is a requirement in order that all areas benefit from the additional capacity.

1.5 The development of CDCs will further support the recovery of elective and diagnostic services that were impacted during the pandemic, which will in turn reduce waiting times and diagnostic backlogs. There will not be a reduction in activity at the acute hospital site, the CDC will provide additional activity to support both recovery of services and unmet demand.

1.6 Current diagnostic provision in Medway and Swale in the main is largely provided by Medway NHS Foundation Trust (MFT) on the acute hospital site. Due to the impact of COVID-19, however, there has been a shortfall in diagnostic provision across the Medway and Swale health system which is still significant. Over the last couple of years compliance with national standards and diagnostic waiting times at MFT have fluctuated considerably due to the COVID-19 pandemic. In order to support recovery additional sustainable diagnostic provision is required in Medway and Swale to address the backlogs and the future projected demand.

1.7 A Medway and Swale CDC Working Group was established with representatives from key stakeholder organisations including Medway NHS Foundation Trust, Medway Council, Kent County Council, Swale Borough Council, Medway Community Healthcare, HCRG and the Integrated Care Board (ICB). Key work stream leads were identified including Workforce, Estates, IT, Health Inequalities, Communications and Finance. The focus for all leads was to support the development of the business case and work collaboratively to deliver a local CDC plan.

1.8 A phased approach has been agreed based on the areas experiencing the greatest inequalities, with the roll out of services planned to span a three-year period before the CDC is fully operational. To inform the direction of travel for the Medway and Swale CDC model, a stakeholder workshop was held which focused on key local issues for consideration. Subsequent design meetings using a Logic model approach helped to refine and finalise the model. Approval of the model followed Health and Care Partnership governance processes.

Phase 1

The immediate priority is to extend MRI capacity to support MFT to achieve diagnostic compliance and elective recovery (post Covid-19) during 2022/23. Whilst application for temporary MRI units that are managed and therefore not impact on existing MFT workforce were requested at both sites, funding for 22/23 was only agreed for the Sheppey site due to national cuts in the funding and the inequalities identified in Sheppey. Funding for permanent MRI scanners going forward has been agreed for both sites.

Phase 2

Longer term, the plan is to reconfigure both Sheppey and Rochester Healthy Living Centre (RHLC) to deliver diagnostic services according to local need. During 2023/24 and 2024/25, a phased approach will be taken to commence diagnostic provision at both sites.

1.9 At Sheppey, work will include reconfiguration of current space to build a new static MRI and CT suite, as well as redesign and upgrade the existing diagnostic services already located in this area. The diagnostics available in Sheppey will be extended to include a wide range of services as prescribed by the national team for inclusion in a hub in the second and third year of mobilisation.

1.10 Within RHLC work will take place to reconfigure existing space to accommodate a static MRI and a mobile CT suite along with a wide range of diagnostics as identified in the local area needs assessment. Whilst RHLC has been identified as the most feasible option for a spoke site due the central location and public access routes, the planning teams are aware of current access and parking restraints. Mobilisation plans will include exploring the wider infrastructure including land owned by property services that is currently not utilised.

1.11 In addition, through a work programme aligned to the Cancer Alliance, we have had funding agreed for an additional CT scanner for which we intend to commence Targeted Lung Health Checks (TLHCs) for early lung cancer detection from spring 2023, which further enhances the diagnostic and screening provision. The Cancer Alliance funded CT scanner will be located at the Sheppey site and a mobile CT scanner not funded by Cancer Alliance, will be located in Rochester with the intention of rotating staff and services as appropriate or where access is more difficult.

In summary, this scheme will deliver:

- Two community diagnostic centre sites - A CDC hub site located at Sheppey Community Hospital.

- A CDC spoke site located at Rochester Healthy living Centre.
- In the first year (2022/23) additional capacity via rented and staffed mobile MRI scanning facilities will be delivered at the Sheppey site, creating more space at MFT to support recovery of the backlog. The mobile unit will be in place whilst the transition to the longer-term hub and spoke site is developed and implemented (i.e., built, staffed, pathways implemented etc.)
- The CT scanner procured through the Cancer Alliance will also support the delivery of additional activity outside of the days/hours allocated to TLHC.
- Dedicated resource for delivering the community diagnostic programme, including clinical time, project management, business intelligence, communications and engagement, workforce planning etc. have been accounted for, which will not remove capacity from existing diagnostic services.
- Efficient use of void spaces available within existing NHS estates at hub and spoke locations.
- Robust workforce plan, linked into the system diagnostics workforce strategy, for key staff groups required to deliver CDCs.
- Digital operability across the local infrastructure

Work will begin in the autumn of 2022 with a phased roll out of increased diagnostic provision at both sites, working towards achieving a seven-day service over a 12-hour period by 2025. The start date for the specific diagnostic modalities is dependent upon recruitment, completion of building works and lead in times for equipment delivery.

2. Options

2.1 The preferred option for the Medway and Swale CDC is a two-site hub and spoke model. This model has been chosen as a result of stakeholder engagement and is the favoured model for a number of reasons. Firstly, Medway and Swale are a large geographical area covering a population of about 427,000 people. Some areas such as Chatham and Gillingham are very densely populated, and others such as the Hoo peninsula and Sheppey by contrast, are quite remote with access to services often difficult for patients; therefore, having a single site was not seen as a viable solution.

2.2 In addition, Medway and Swale has some of the highest levels of deprivation in the UK with some wards being in the 20 per cent most deprived areas in the country. Twenty-three per cent more people have an unplanned admission for a chronic condition that could be managed out of hospital, compared to the national average and one-year cancer survival rates are five per cent lower than the national average.

The following information taken from the Medway and Swale H&CP profile and Swale's Dominant strategy, demonstrates wider determinants and poor health outcomes.

- The rate of adults (aged 18+) classified as overweight or obese in Medway and Swale is worse (70%) than England (63%).
- The percentage of physically inactive adults in Medway and Swale is worse (25%) than England (23%).
- Deaths from all cancers in Medway and Swale under 75 years is worse than England. Although rates for screening in Medway and Swale appear to be in line with England, there are still areas with low take up for cancer screening i.e. Medway Central.
- For every mile travelled between Sittingbourne (Woodstock Ward) and Sheppey (Sheppey West Ward), the life expectancy reduces by 255 days. This results in 8.3 years difference in life expectancy between the two areas.
- 48.8% of people in Sheppey are economically inactive compared to the UK national average of 21%. Economically inactive means that people (aged 16-64) are not involved in the labour market – they are neither working or actively seeking employment. For example, includes long term sick, caring for family, early retirement, students etc.
- Across Sheppey, the percentage of people having 'very good health' is lower than the national average. Only 34.6% people have very good health in Sheppey East Ward, and 38.9% in Sheerness Ward, compared with the national average of 53%.
- In some schools, 90% of students are leaving without sufficient Level 3 skills (grade 5 or above in English and Maths GCSEs)
- By 2038, 25.3% of homes in Swale will require an adaption to deal with health and care demands

2.3 The proposal to establish a two-site hub and spoke model, therefore, will provide more equitable access to diagnostic services in a greater number of areas and will reduce travel time for patients. The two-site hub and spoke model will offer a central hub providing a full range of co-ordinated services for patients that require multiple diagnostic testing, with the spoke offering additional capacity, similar to the hub to meet the needs and requirements of the local population

2.4 Options for estates considerations have been reviewed with working group members as well as estates leads. There are a number of community sites across Medway and Swale that would lend themselves to potential CDC sites but following review many were discounted as not meeting the CDC requirements. In addition, a number of the existing estates (both Healthy Living Centres and community hospitals) have limited scope for internal redevelopment and reconfiguration, as there is minimal void space to use as most centres are heavily utilised by the community providers.

3. Advice and analysis

3.1 The Public Health Primary Care Network profiles and the diagnostic services data (Appendix 1) gathered to date has been informative in relation to helping pinpoint areas of greatest deprivation and areas of need. The two areas in Medway and Swale that are consistently identified as being the most deprived areas (lowest 20% of the Index of Multiple Deprivation) are Medway Central and Sheppey. These two areas see a number of poor health outcomes for people living there.

3.2 The public health inequalities data collated to date, alongside other estates intelligence has been considered as part of an early feasibility exercise, which concluded that Sheppey Community Hospital should be the hub location for the Medway and Swale CDC. With regards to this site, an options appraisal was undertaken with stakeholders whereby all possibilities were considered and worked through for example, access to car parking if additional activity is to be delivered at this site, availability of clinic space and potential space for locating mobile units such as cancer screening (i.e., lung, cervical and/or breast) as well as imaging units (i.e. MRI or CT) on site.

3.3 The agreed CDC hub at the Sheppey Community Hospital site will provide accessible services to populations that have high levels of deprivation and issues with access due to a combined lack of access to own transport, poor public transport, or financial constraints. These services will be combined with a strategy collaboratively developed with partners to target inequalities experienced by communities who do not access services or present very late. The site also represents good use of existing NHS sites, and is co-located with other services including primary care, a planned Urgent Treatment Centre, community, and acute outreach activity offering excellent opportunities to Make Every Contact Count (MECC).

3.4 In addition, a spoke will be created at Rochester Healthy Living Centre (RHLC). This site was considered the most feasible option for the location of an MRI scanner because it already has pads on site which are utilised by the breast screening service for three months of the year. The site is centrally located with good access to public transport, parking and is the nearest feasible and most accessible site to central Medway which has the population facing the greatest health inequality. The longer-term priorities for this site are also the same as the hub site.

4. Risk management

Risk	Description	Action to avoid or mitigate risk	Risk rating
Workforce and staffing capacity	A national shortage in radiographers could lead to delays in recruitment of the future workforce required and could reduce the capacity	MRI is the most urgent priority. A staffed temporary MRI unit (at Sheppey) providing additional capacity will not impact on current MFT workforce and will address DM01 compliance	Likelihood (B - high) Impact (2 - critical)

	available at the hub and spoke	and recovery, waiting lists etc. Other HR/ workforce initiatives being implemented include: - Accelerated HR processes for CDC workforce. -International recruitment – there have been several recent successes. - Rotating apprenticeship schemes - Use of agency staff as temporary cover, using a mixed staffing model.	

5. Consultation

5.1 Kent and Medway ICS communications and engagement plan has been developed to support the roll out of the CDC programme across the system. This is being adapted at locality level to meet the specific requirements of local communities.
In the two existing CDCs in Kent and Medway – (in Maidstone and Buckland Hospital in Dover, East Kent), engagement with patients has already been undertaken. Learning from this patient experience exercise has informed the development of the CDCs in Medway and Swale.

5.2 In Medway and Swale, our aim is to consult and co-design a fluid engagement strategy that can respond to the needs of the communities impacted by change. The Medway and Swale H&CP are committed to work in co-production where possible, demonstrated by the concordat' in place with the VCSCE sector. This brings community organisations into the partnership as equal partners with statutory bodies. The aim is to work with partners to reach into communities to establish people's views on accessing diagnostic services.

5.3 We plan to target people who have traditionally experienced barriers to accessing diagnostic services including people on the autism spectrum and people who have learning disabilities. Furthermore, we plan to undertake targeted engagement with people who are less likely to keep their appointments – to examine how we can support people to attend crucial diagnostic tests.

6. Climate change implications

6.1 Adopting a solution to repurpose existing facilities rather than building new will limit the carbon footprint of the CDC scheme relative to that option. It does however introduce challenge in creating a carbon efficient environment and this challenge is within the scope of the design.

6.2 These schemes, as relatively small areas of redevelopment within much larger facilities, cannot materially influence the carbon strategy for these sites in isolation. The broader redevelopment schemes are seeking to address the requirements for carbon reduction and these facilities will benefit from that site wide improvement. As both sites will require a power upgrade, we will look to procure green electricity as part of this process from which the diagnostic facilities will benefit.

6.3 In addition, providing CDC sites within areas of high deprivation will reduce the patient travel to the acute sites. Future work on pathway redesign and the development of a one-stop shop approach will reduce the number of visits, by having several tests done within the same visit.

6.4 Access to local bus services will reduce the carbon footprint and discussions with local councils via the Transport and Infrastructure Task and Finish Group will focus on improving these services.

6.5 In addition, MFT's Green Plan 2021 – 2026 has identified carbon reduction and sustainability as its key objectives. Sustainability will be a consideration in the procurement of diagnostic equipment, alongside cost and clinical functionality, hence working towards achieving BREEAM certification.

7. Financial implications

7.1 There are no financial implications for Kent County Council as the work is being funded by NHS England, with monies being coming down directly to MFT.

8. Legal implications -

8.1 There are no legal implications for Kent County Council.

9.Recommendations

9.1 It is recommended that the committee support and approve the plans for the CDC hub site at Sheppey Community Hospital as outlined in this briefing paper. The hub will provide additional diagnostic services for Swale residents which will help to ensure patients have easier and quicker access to these essential services in the community.

Lead officer contact

Nikki Teesdale – Director of Delivery, Medway and Swale Health and Care Partnership.nikkiteesdale@nhs.net Contact number: 07506105281

Medway and Swale
Health and Care Partnership

Appendices

1. CDC Service Activity Mapping
2. Medway and Swale Health and Care Partnership profile

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Community Diagnostic Hubs Service Activity Mapping

Produced by

Medway Council

Public Health Intelligence Team

DRAFT

Medway and Swale
Integrated Care Partnership

Introduction and Methods

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Medway and Swale
Integrated Care Partnership

Introduction

Aim

- To map current diagnostic services in Medway and Swale ICP

What we have done previously:

- Mapped health inequalities and conditions across Medway and Swale

What we will present today:

- Mapped activity of diagnostic services 2019/20

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Data

Pathway	Diagnostics	Data Available	Data Status	Notes
Rheumatology	X-Ray	MFT and community hospitals		Presenting
	DEXA	MFT only		Presenting
Cardiology	Echo	MFT only		Presenting
	ECG	TBC	No data yet	Not presenting
Other	CT	MFT only		Presenting
	MRI	MFT only		Presenting
	Doppler	MFT and community settings	No community data	Not presenting
	NOUS	MFT and AQP	AQP data not complete	Not presenting

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Patient Settings for MFT Data

- Admitted Patient Care – Inpatient
- Admitted Patient Care – Day Case
- Outpatient
- GP Direct Access
- Emergency Care Department
- Other Health Care Provider
- Other
- Unknown (only assigned to Echo)

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Methodology: Data Sources

Data Sources

- Hospital diagnostic service activity data: MFT (2019/20)
- LSOA population counts: Office for National Statistics (2019 mid-year estimates)
- GP population counts: People registered at a GP Practice, NHS Digital (April 2020)
- Deprivation scores: Indices of deprivation (IMD2019)

Deprivation Quintile Assignments

- National deprivation quintiles were calculated by ranking all LSOAs in England and then assigning them to five groups depending on their ranking. Quintile 1 represents the most deprived LSOAs and quintile 5 the least deprived.

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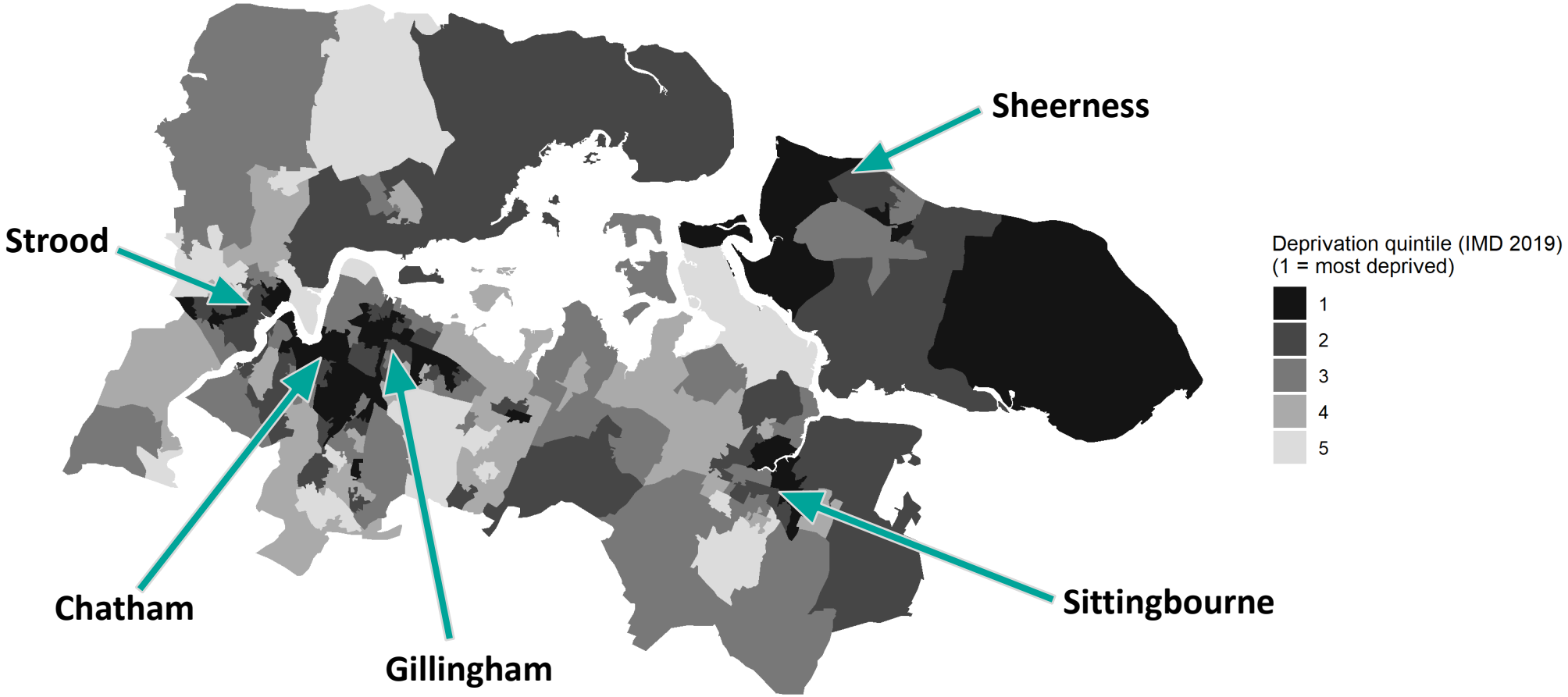
Medway & Swale ICP: Areas of Deprivation

LSOAs shaded by national quintile



Source (data): Indices of Deprivation 2019, MHCLG
Source (mapping): Office for National Statistics licensed under the Open Government Licence v3.0
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Methodology: Mapping

Data are presented by LSOA

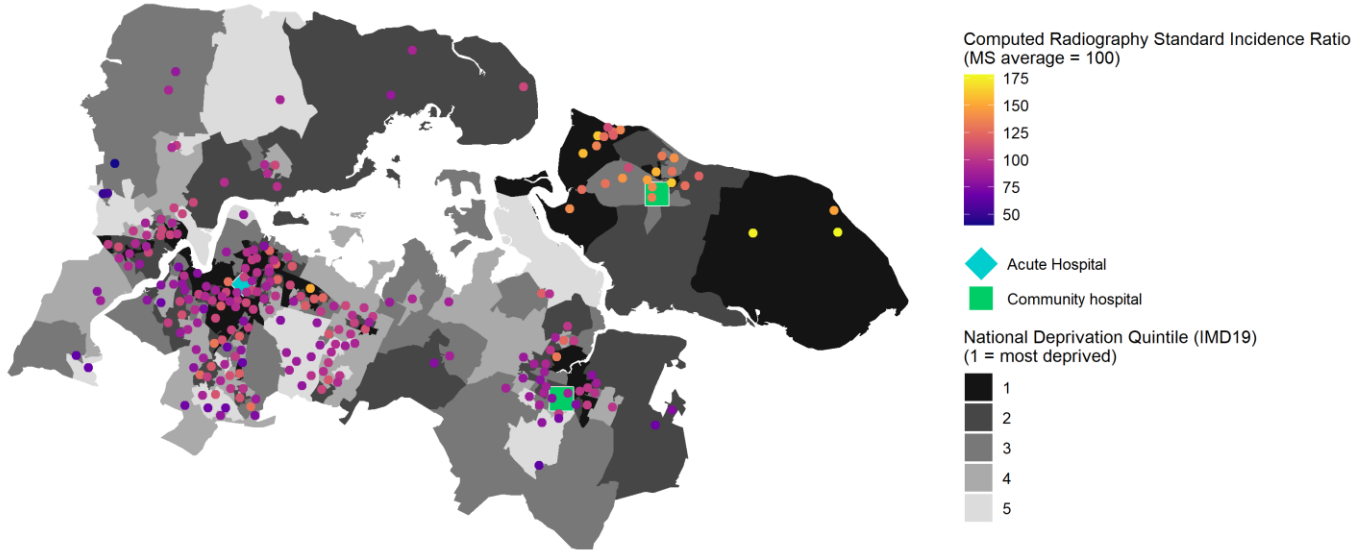
- Each dot represents the population weighted centroid for each LSOA

Age Standardisation and Standard Incidence Ratio

- Age standardised rates are calculated using the indirect method
- SIR are the ratio of the number of observed incidences of activity to the number of expected incidences
- If the SIR is above 100, there are more incidences than expected
- The reference population was Medway and Swale as a whole

Computed Radiography: age-standardised activity rates by Lower Super Output Area in Medway and Swale

Examinations performed between April 2019 and March 2020
Dots represent population weighted centroids for LSOAs



Source (activity data): Medway NHS Foundation Trust
Source (deprivation data): Indices of Deprivation 2019, MHCLG
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Computed Radiography (X-ray)

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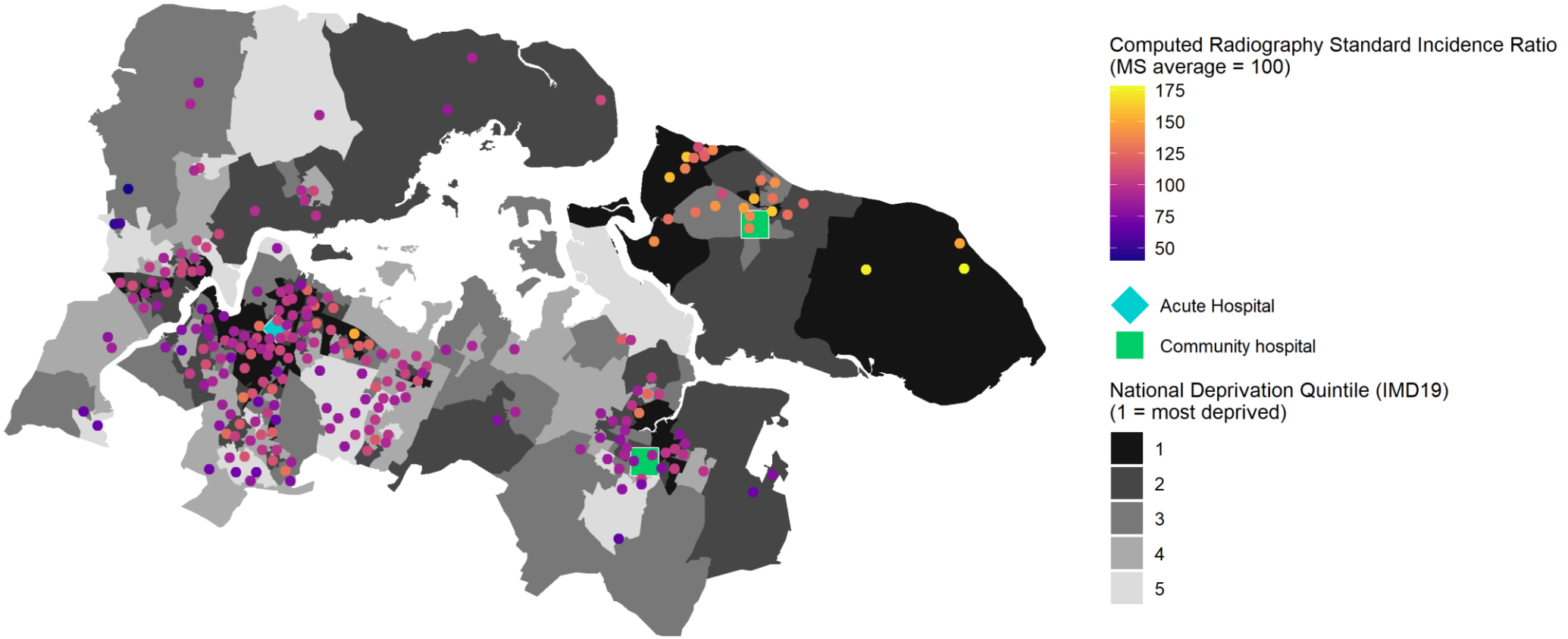
Medway and Swale
Integrated Care Partnership

Computed Radiography: age-standardised activity rates by Lower Super Output Area in Medway and Swale

Examinations performed between April 2019 and March 2020
Dots represent population weighted centroids for LSOAs



Source (activity data): Medway NHS Foundation Trust
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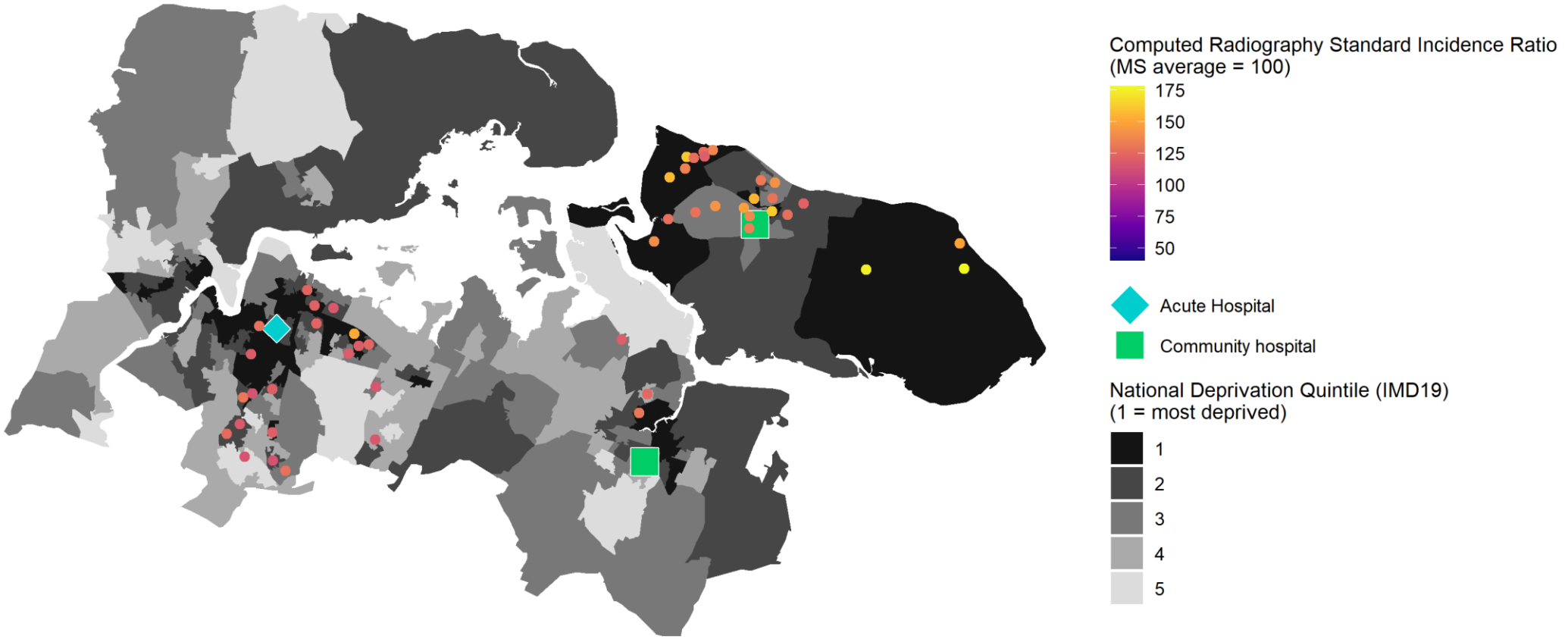
Medway and Swale
Integrated Care Partnership

Computed Radiography: top fifth (20%) of LSOAs in M&S with highest age-standarised activity rates

Examinations performed between April 2019 and March 2020
Dots represent population weighted centroids for LSOAs



Source (activity data): Medway NHS Foundation Trust
Source (deprivation data): Indices of Deprivation 2019, MHCLG
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Medway and Swale
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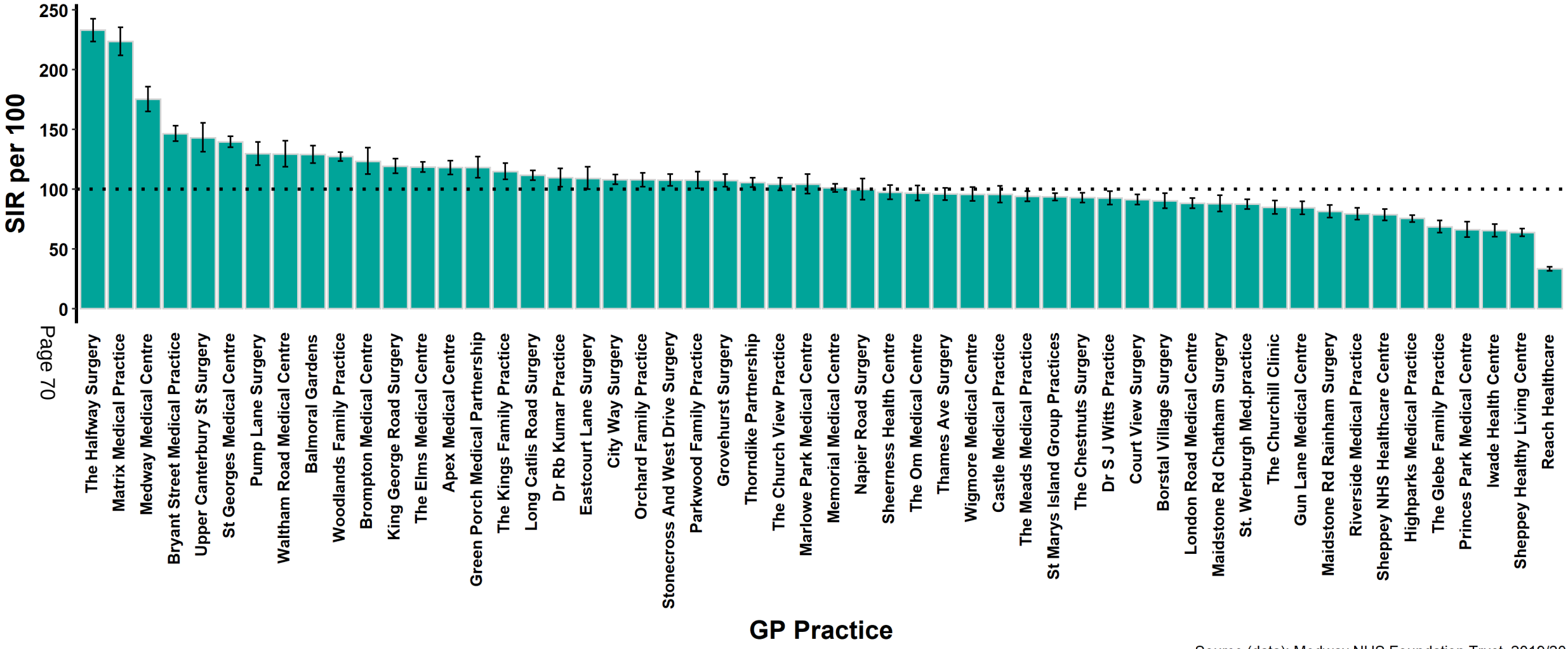
Computed Radiography: age-standardised activity rates by GP Practice in Medway and Swale; M&S average = 100 (- - -)

Examinations performed between April 2019 and March 2020



Source (data): Medway NHS Foundation Trust, 2019/20
Source (population): Patients Registered at a GP Practice, NHS Digital, April 2020
Medway Public Health Intelligence Team, Medway Council 2021-09-17

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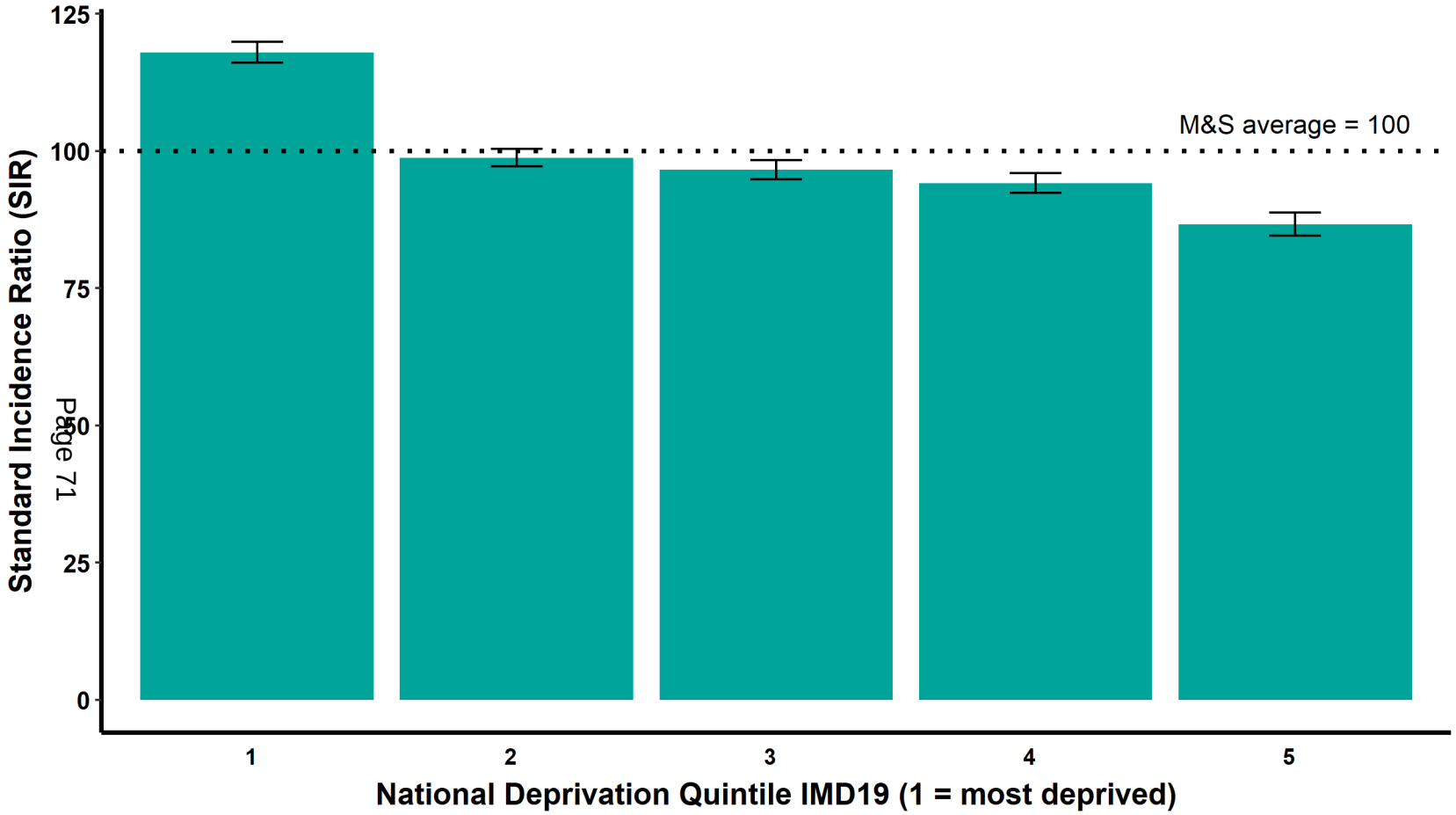
Medway and Swale Integrated Care Partnership

Computed Radiography

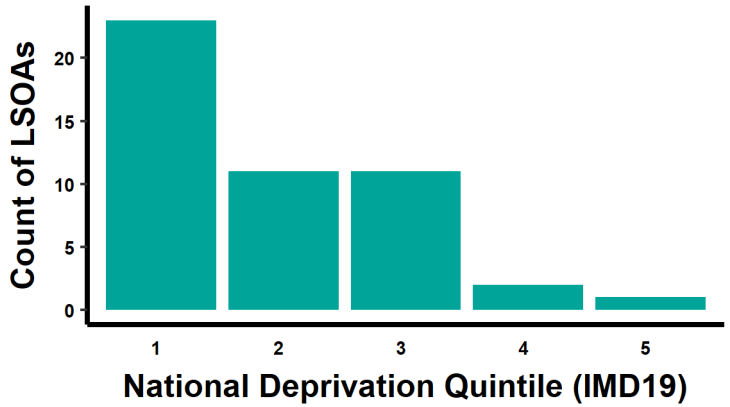
SIR by national deprivation quintile in Medway and Swale
Examinations performed between April 2019 and March 2020



Source (activity data): Medway NHS Foundation Trust
Source (deprivation data): Indices of Deprivation 2019, MHCLG
Medway Public Health Intelligence Team, Medway Council 2021-09-17

Top 20% of LSOAs with highest activity

Count of LSOAs by deprivation quintile



Top 15 LSOAs ordered by SIR

LSOA	PCN	SIR	Dep Quintile
E01024580	Sheppey	177.4	1
E01024618	Sheppey	174.1	1
E01024621	Sheppey	162.5	1
E01024614	Sheppey	161.1	1
E01024615	Sheppey	156.8	1
E01024585	Sheppey	154.8	1
E01016160	Gillingham South	151.6	1
E01024581	Sheppey	148.9	1
E01024619	Sheppey	148.4	3
E01024595	Sheppey	142.6	3
E01024588	Sheppey	141.4	3
E01024597	Sheppey	139.6	1
E01032653	Sheppey	137.3	3
E01024610	Sheppey	136.0	1
E01024616	Sheppey	135.1	1

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Medway and Swale
Integrated Care Partnership

Dual-Energy X-ray Absorptiometry (DEXA)

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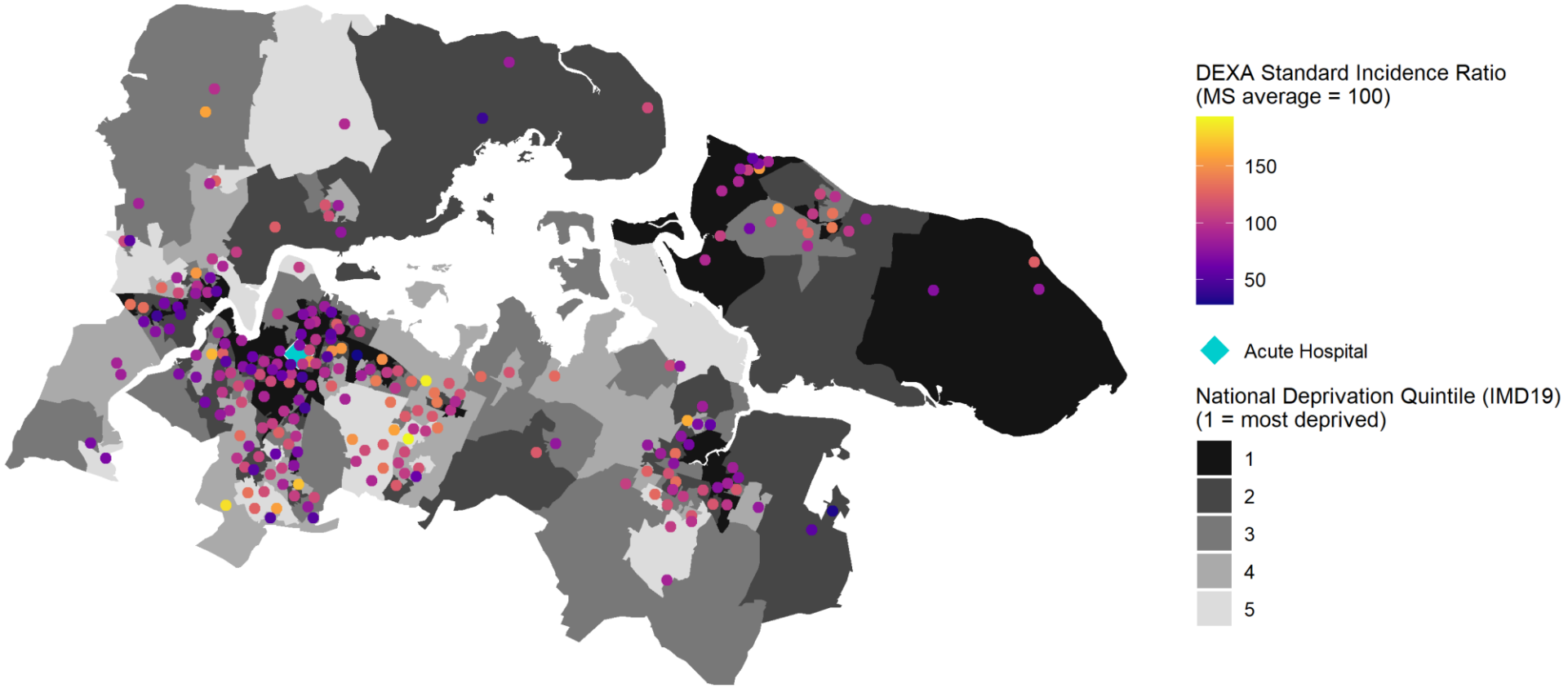
Medway and Swale
Integrated Care Partnership

DEXA: age-standardised activity rates by Lower Super Output Area in Medway and Swale

Examinations performed between April 2019 and March 2020
Dots represent population weighted centroids for LSOAs



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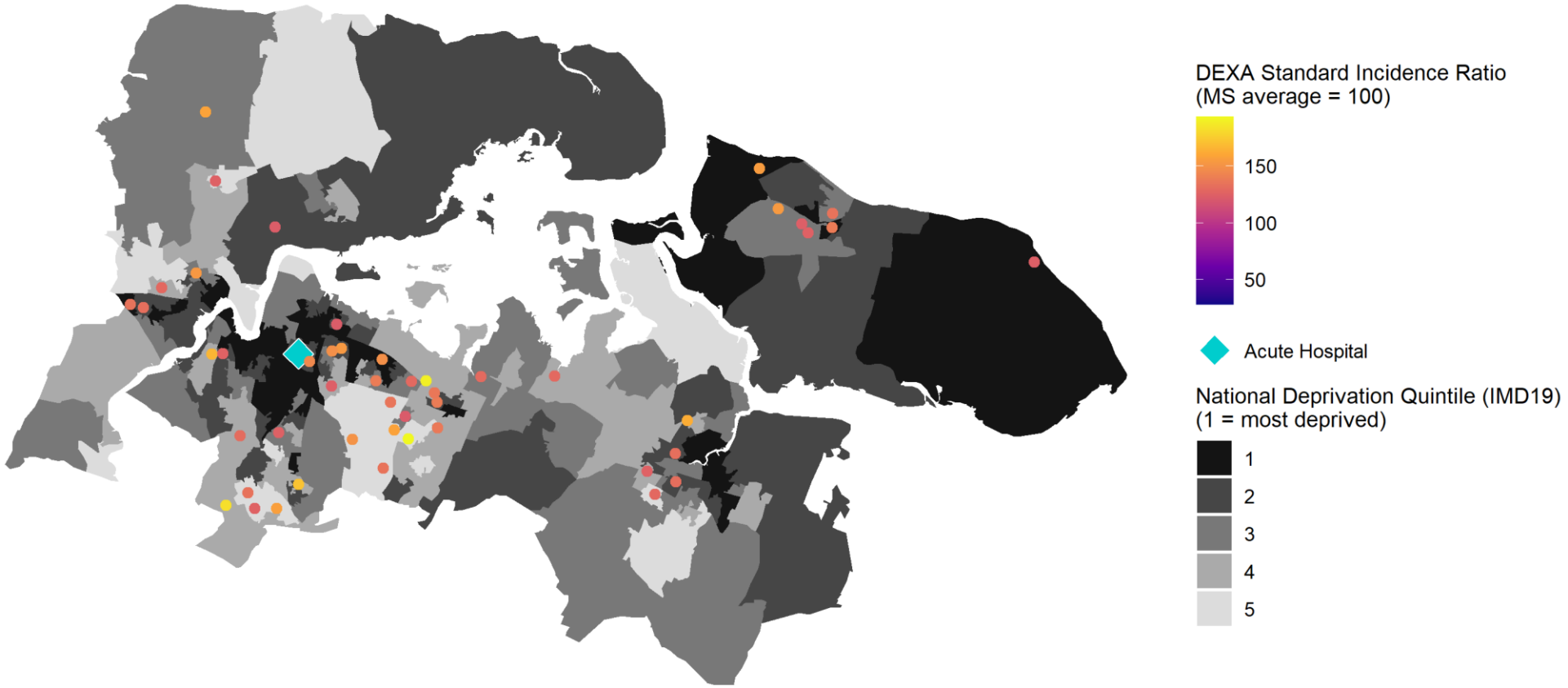
Medway and Swale
Integrated Care Partnership

DEXA: top fifth (20%) of LSOAs in M&S with highest age-standarised activity rates

Examinations performed between April 2019 and March 2020
Dots represent population weighted centroids for LSOAs



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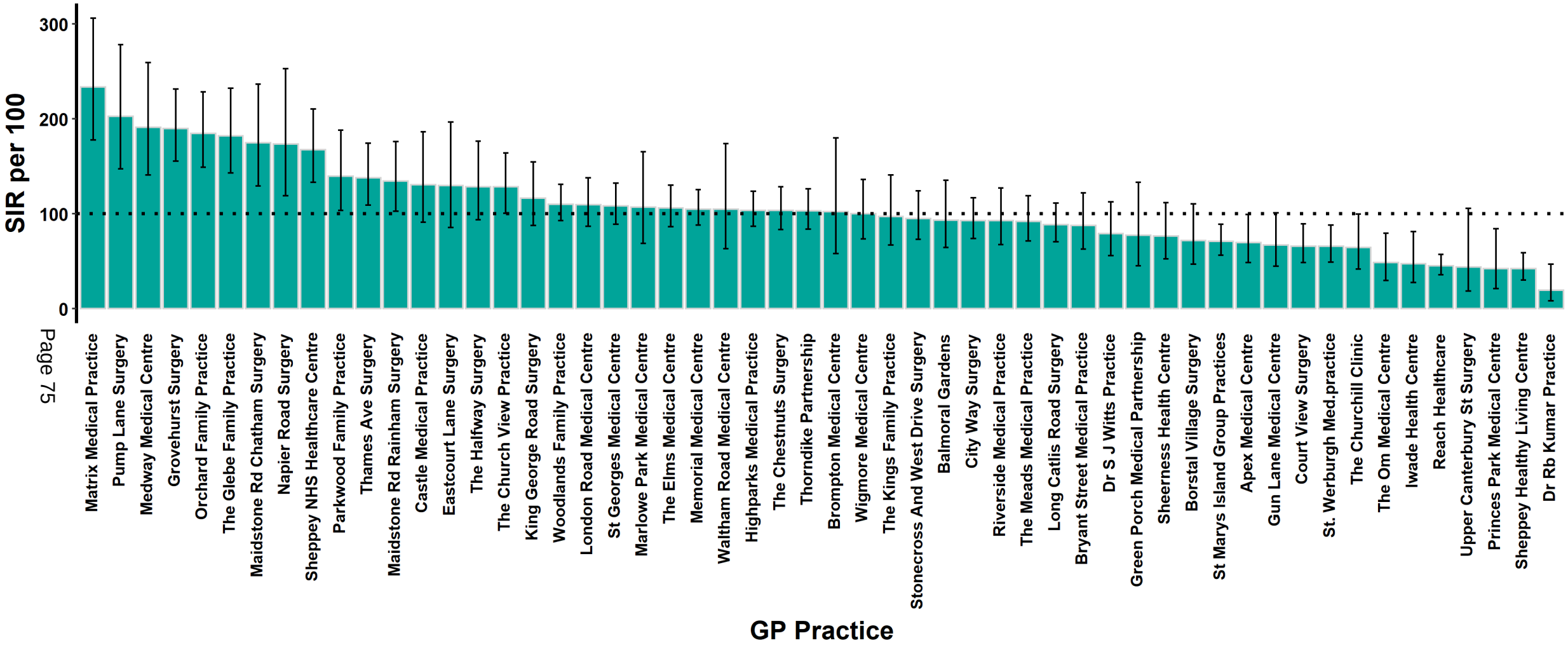
Integrated Care Partnership

DEXA: age-standardised activity rates by GP Practice in Medway and Swale; M&S average = 100 (- - -)

Examinations performed between April 2019 and March 2020



Source (data): Medway NHS Foundation Trust, 2019/20
Source (population): Patients Registered at a GP Practice, NHS Digital, April 2020
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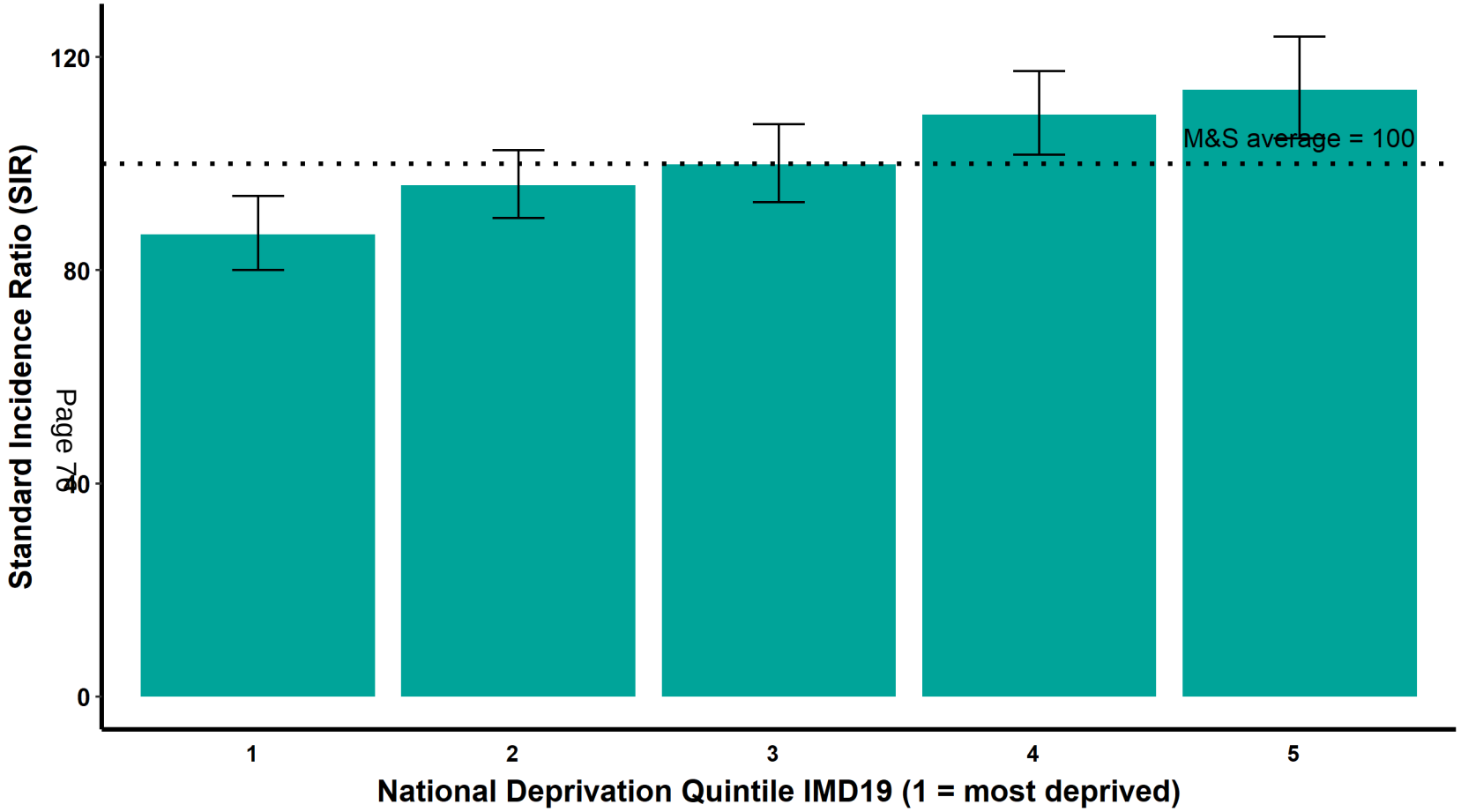
Medway and Swale Integrated Care Partnership

DEXA

SIR by national deprivation quintile in Medway and Swale
Examinations performed between April 2019 and March 2020



Source (activity data): Medway NHS Foundation Trust
Source (deprivation data): Indices of Deprivation 2019, MHCLG
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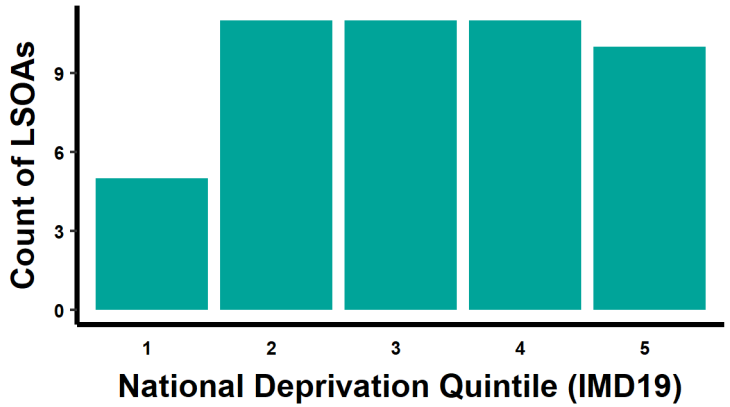
Top 20% of LSOAs with highest activity

Count of LSOAs by deprivation quintile



Top 15 LSOAs ordered by SIR			
LSOA	PCN	SIR	Dep Quintile
E01016092	Medway Rainham	192.7	5
E01016093	Medway Rainham	189.4	4
E01024721	Medway South	182.5	4
E01016060	Medway South	171.1	4
E01016131	Rochester	166.2	4
E01024577	Sittingbourne	162.5	2
E01016142	Medway Peninsula	158.2	3
E01016091	Medway Rainham	158.1	5
E01024338	Medway South	156.4	5
E01024612	Sheppey	155.0	1
E01024598	Sheppey	153.8	3
E01016043	Gillingham South	153.4	2
E01016134	Strood	152.8	3
E01016054	Medway Rainham	150.1	5
E01016160	Gillingham South	148.9	1

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Medway and Swale Integrated Care Partnership

Echocardiography

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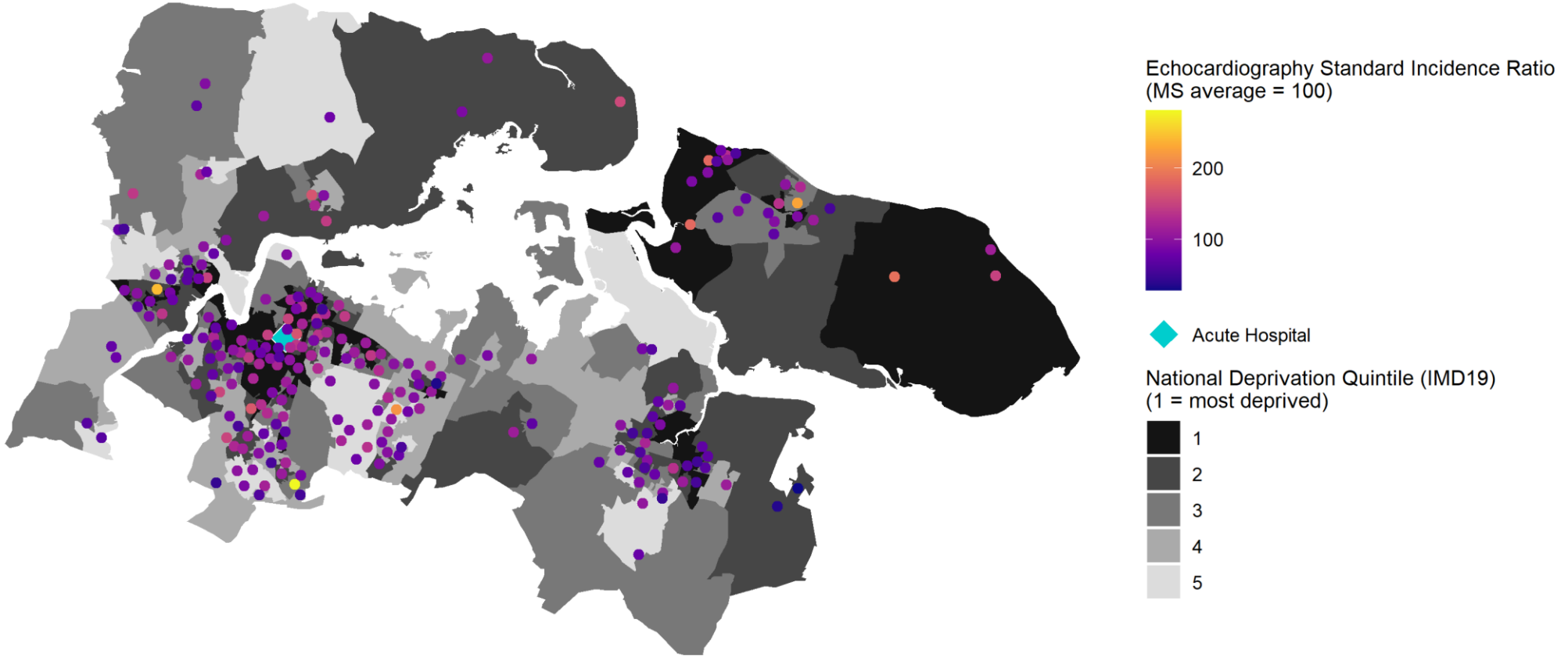
Medway and Swale
Integrated Care Partnership

Echocardiography: age-standardised activity rates by Lower Super Output Area in Medway and Swale

Examinations performed between April 2019 and March 2020
Dots represent population weighted centroids for LSOAs



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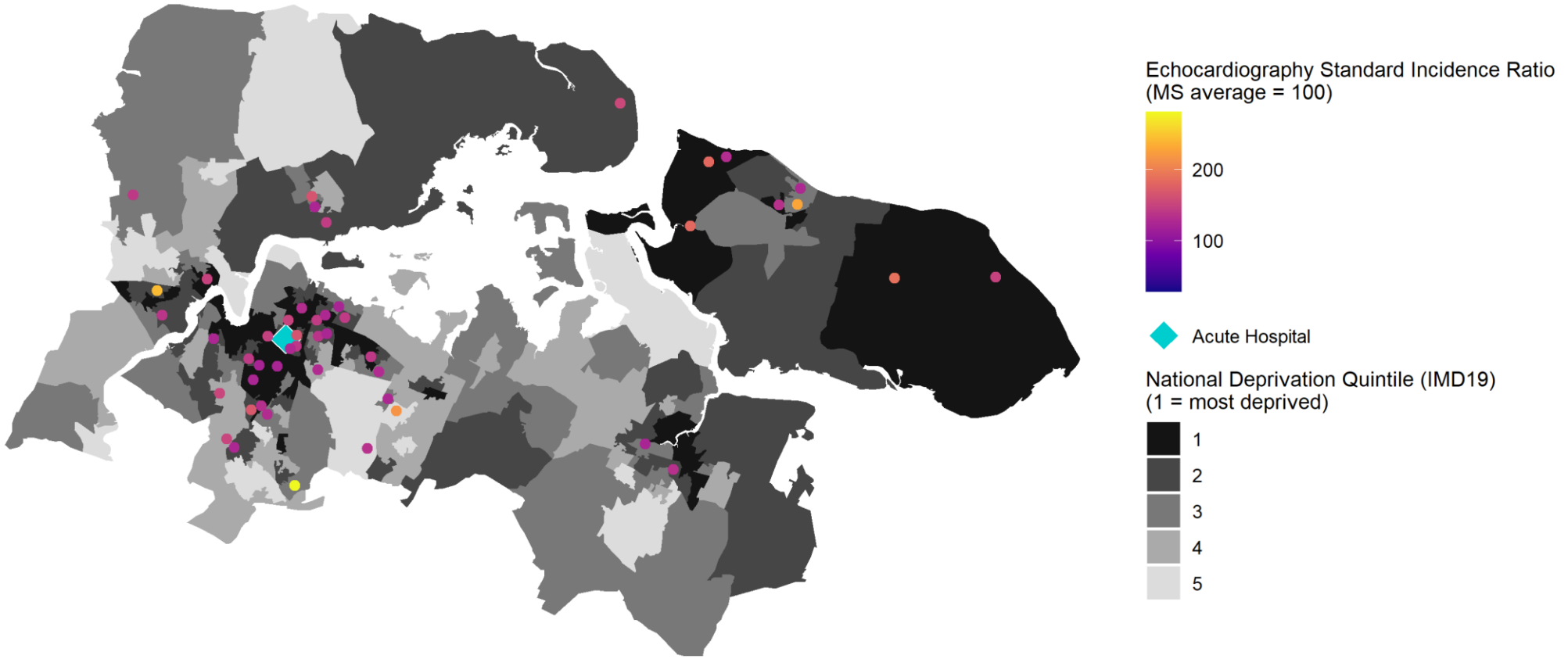
Integrated Care Partnership

Echocardiography: top fifth (20%) of LSOAs in M&S with highest age-standarised activity rates

Examinations performed between April 2019 and March 2020
Dots represent population weighted centroids for LSOAs



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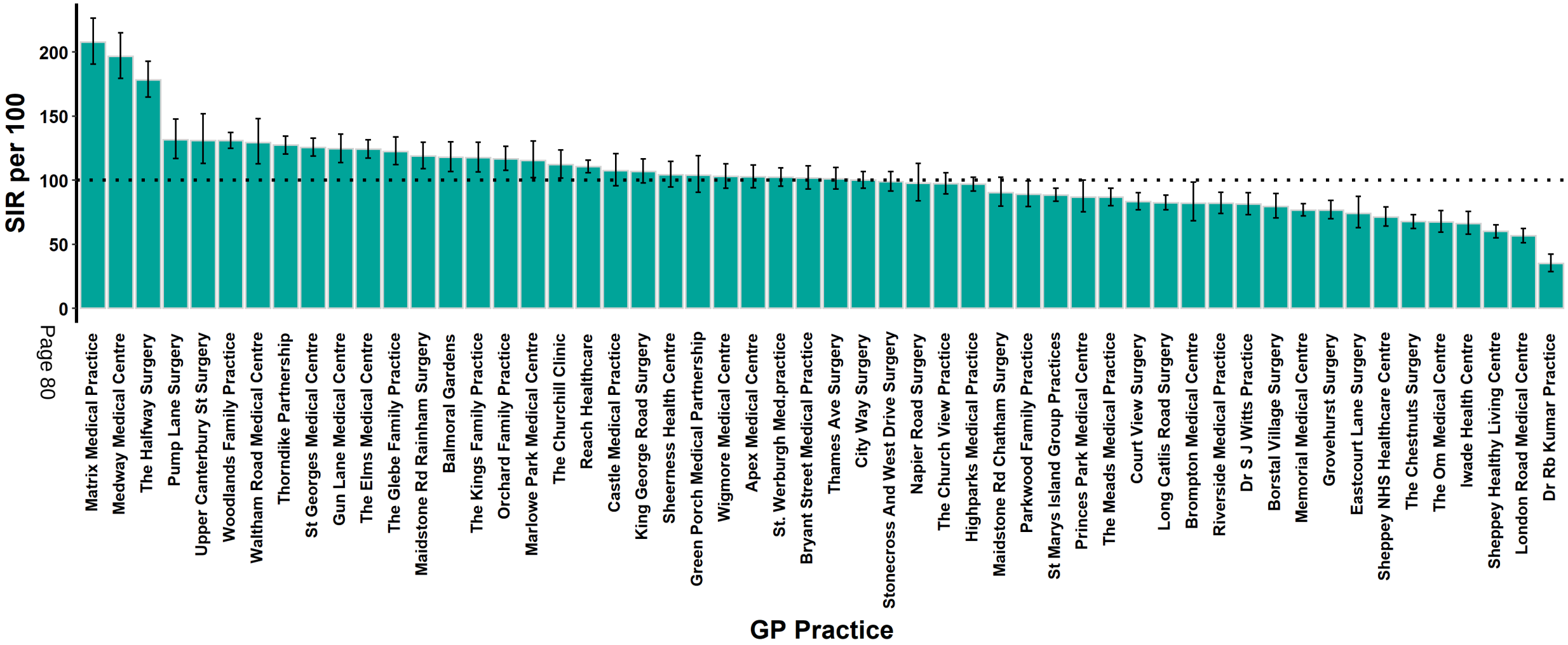
Integrated Care Partnership

Echocardiography: age-standardised activity rates by GP Practice in Medway and Swale; M&S average = 100 (- - -)

Examinations performed between April 2019 and March 2020



Source (data): Medway NHS Foundation Trust, 2019/20
Source (population): Patients Registered at a GP Practice, NHS Digital, April 2020
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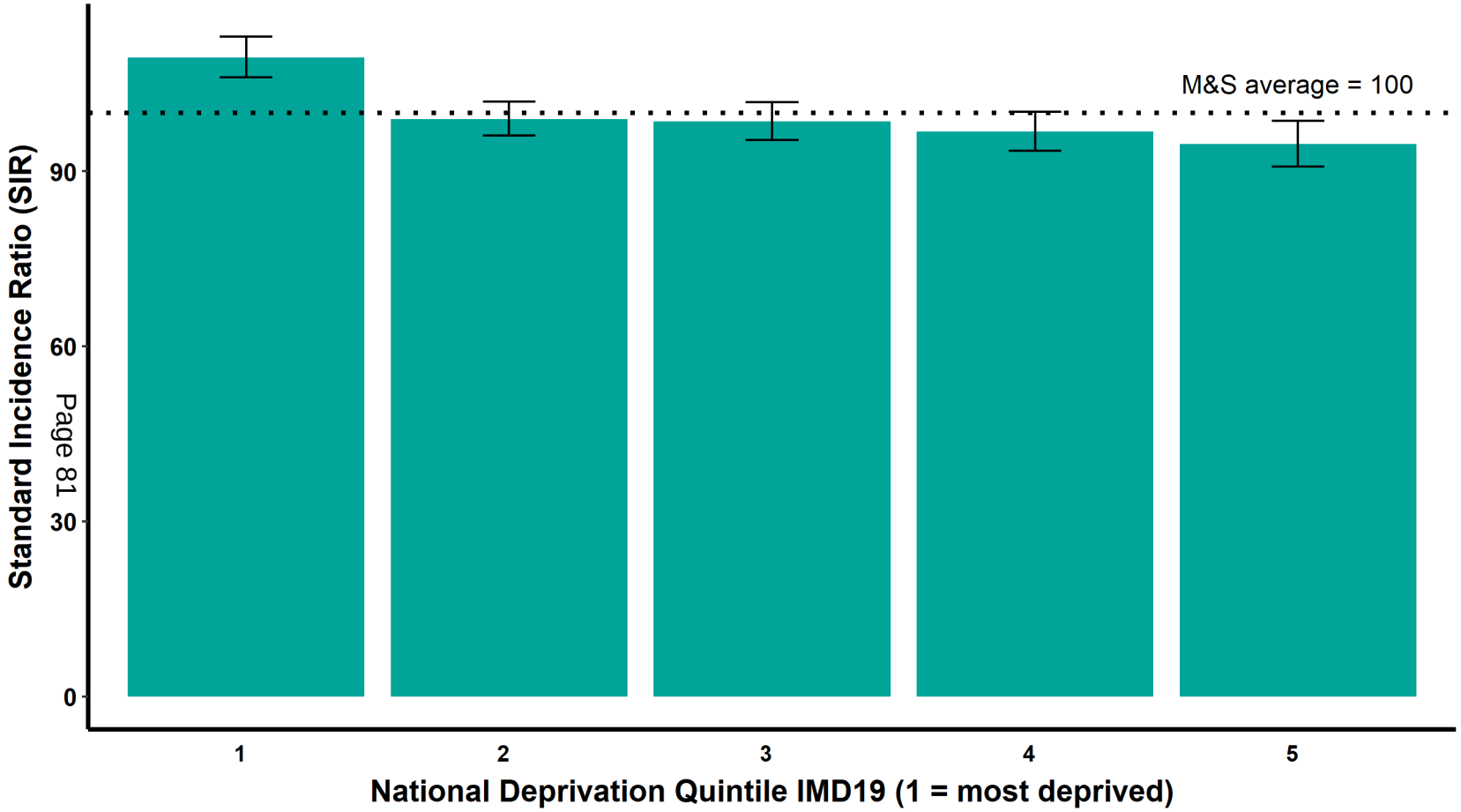
Echocardiography

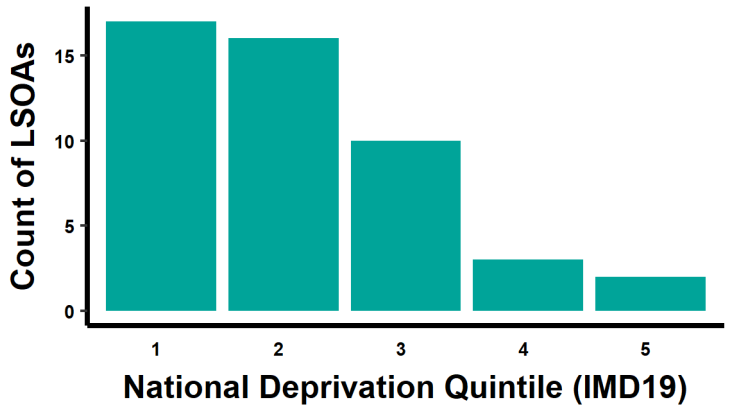
SIR by national deprivation quintile in Medway and Swale
Examinations performed between April 2019 and March 2020



Source (activity data): Medway NHS Foundation Trust
Source (deprivation data): Indices of Deprivation 2019, MHCLG
Medway Public Health Intelligence Team, Medway Council 2021-09-17

Top 20% of LSOAs with highest activity

Count of LSOAs by deprivation quintile



Top 15 LSOAs ordered by SIR			
LSOA	PCN	SIR	Dep Quintile
E01016057	Medway South	280.3	3
E01016151	Strood	243.2	2
E01024589	Sheppey	229.2	3
E01016090	Medway Rainham	215.8	5
E01024618	Sheppey	189.2	1
E01024614	Sheppey	183.2	1
E01024596	Sheppey	183.1	1
E01016067	Medway South	169.6	2
E01016044	Gillingham South	165.8	2
E01016075	Medway Peninsula	165.7	3
E01016071	Medway Peninsula	154.6	2
E01016119	Rochester	152.0	4
E01016121	Medway South	151.3	4
E01016049	Medway Central	150.2	1
E01016136	Medway Central	148.5	1

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Medway and Swale
Integrated Care Partnership

Computed Tomography (CT)

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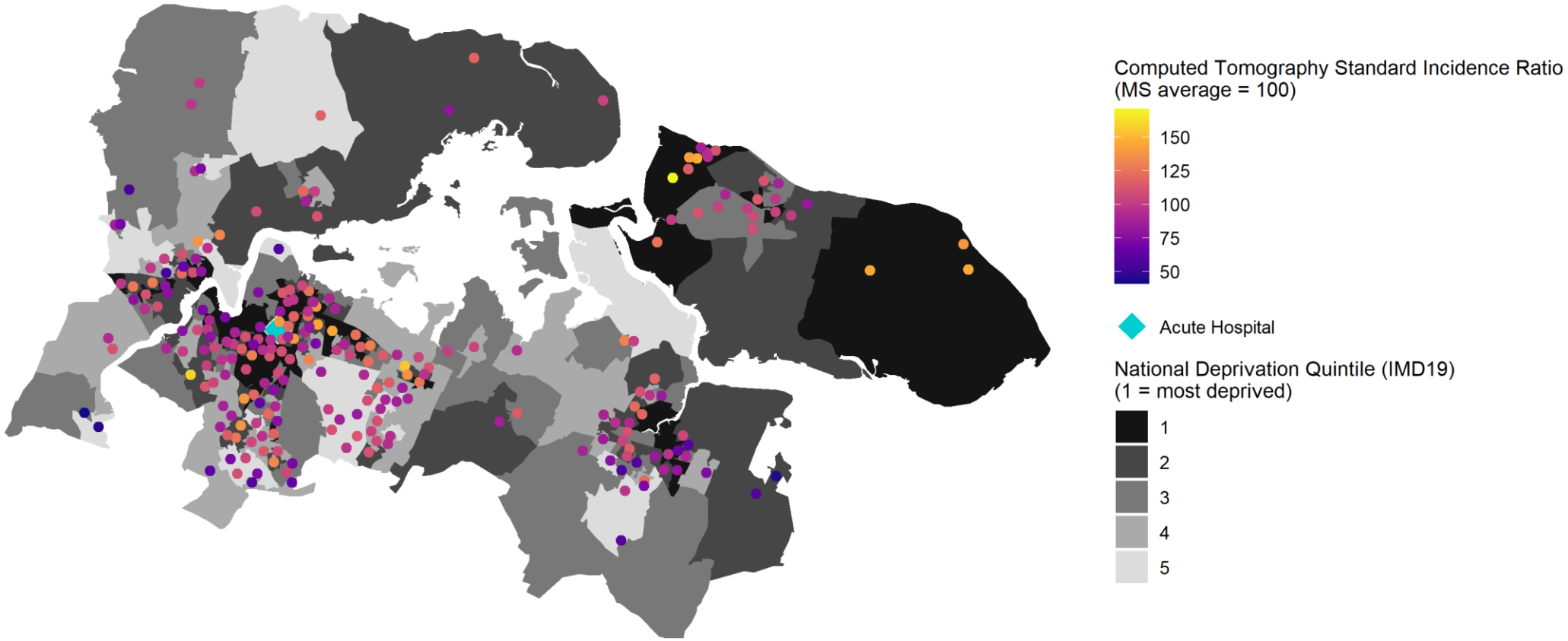
Medway and Swale
Integrated Care Partnership

Computed Tomography: age-standardised activity rates by Lower Super Output Area in Medway and Swale

Examinations performed between April 2019 and March 2020
Dots represent population weighted centroids for LSOAs



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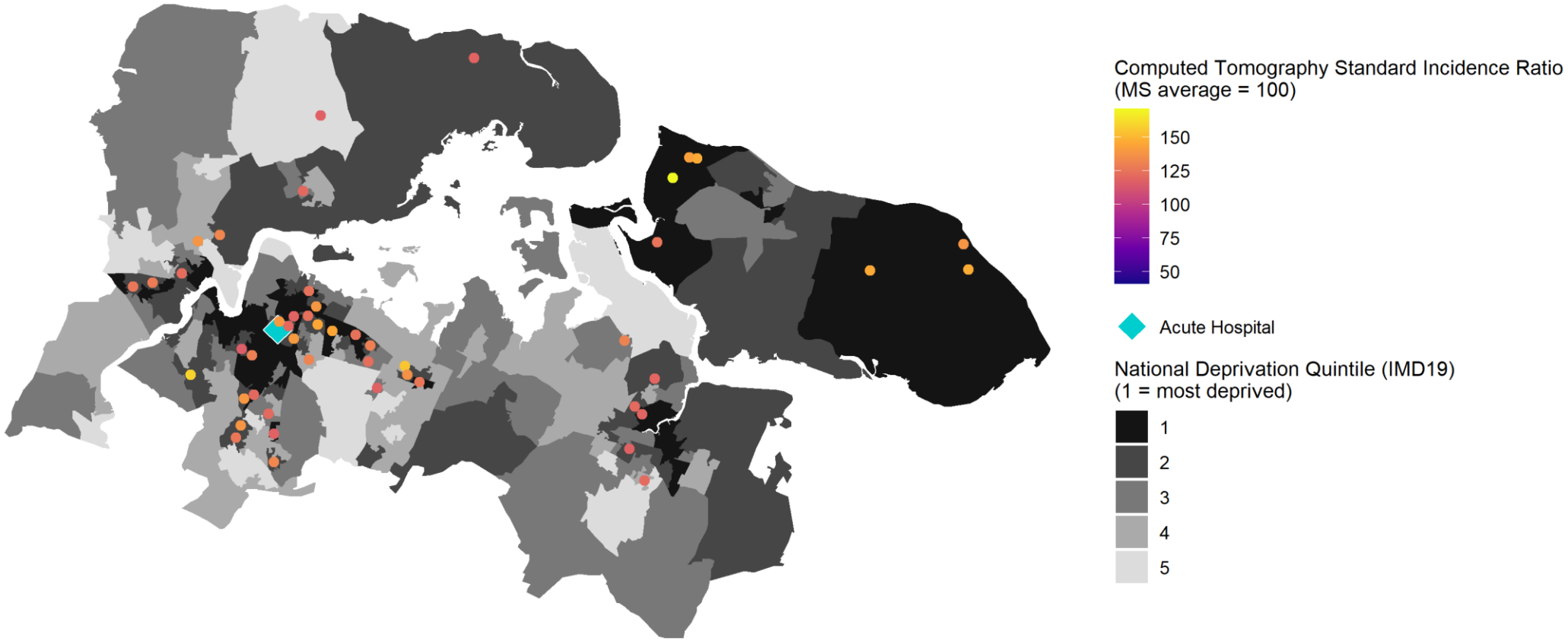
Integrated Care Partnership

Computed Tomography: top fifth (20%) of LSOAs in M&S with highest age-standarised activity rates

Examinations performed between April 2019 and March 2020
Dots represent population weighted centroids for LSOAs



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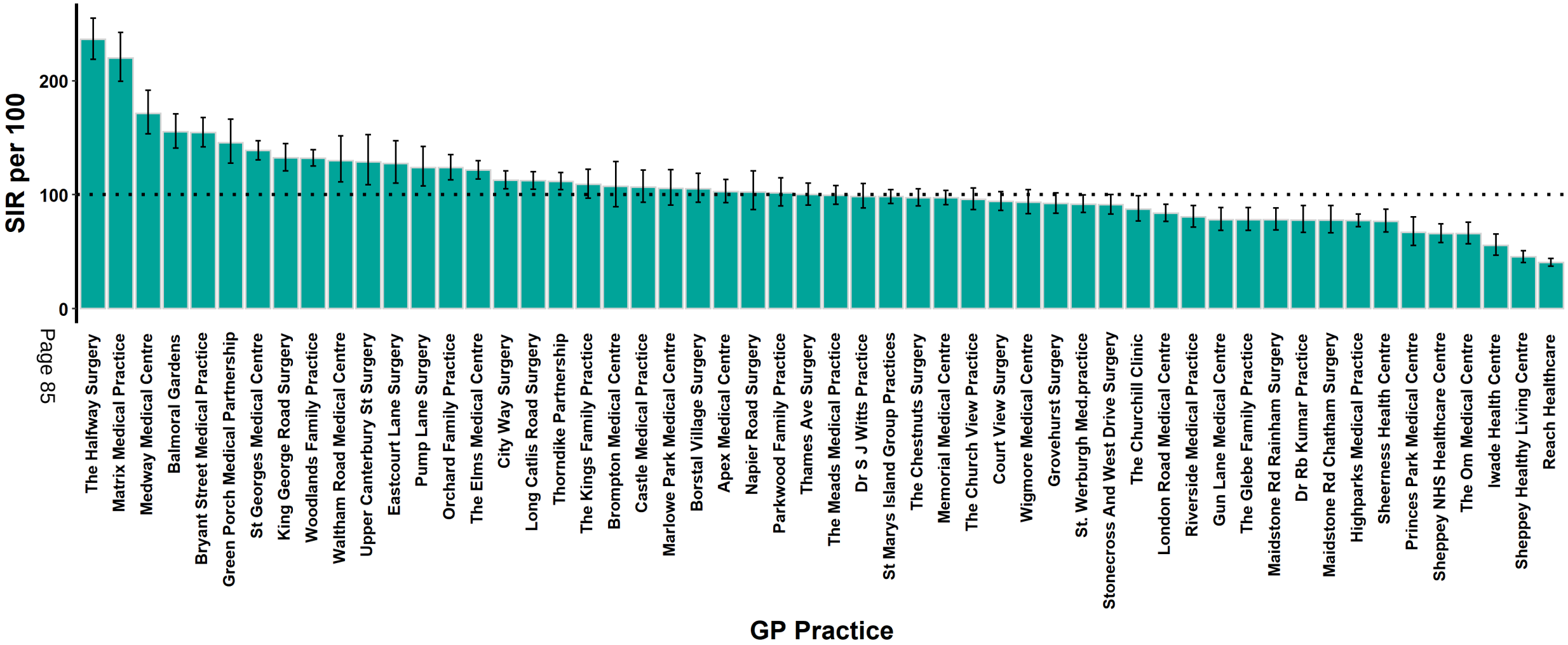
Medway and Swale
Integrated Care Partnership

Computed Tomography: age-standardised activity rates by GP Practice in Medway and Swale; M&S average = 100 (- - -)

Examinations performed between April 2019 and March 2020



Source (data): Medway NHS Foundation Trust, 2019/20
Source (population): Patients Registered at a GP Practice, NHS Digital, April 2020
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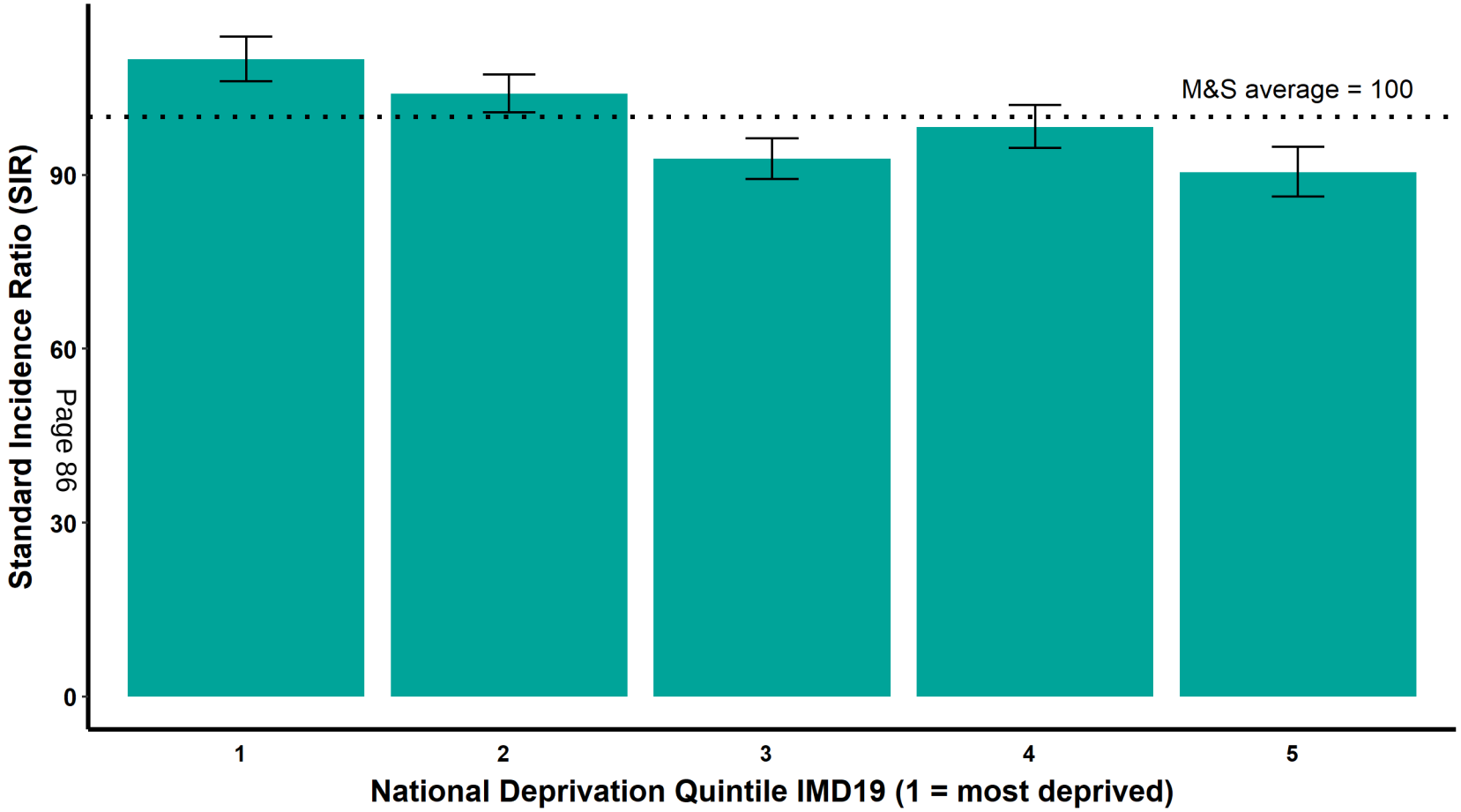
Medway and Swale Integrated Care Partnership

Computed Tomography

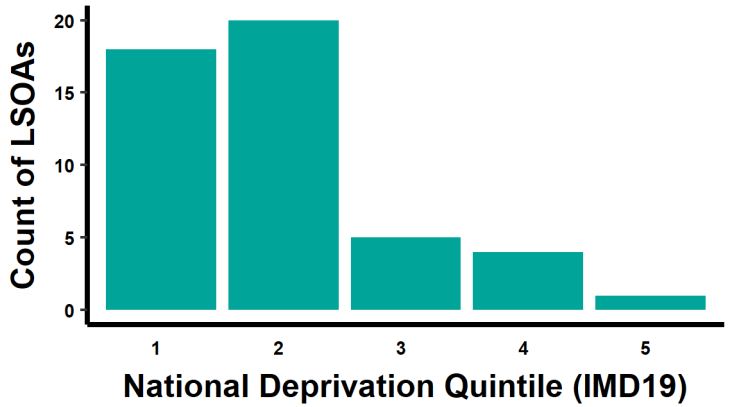
SIR by national deprivation quintile in Medway and Swale
Examinations performed between April 2019 and March 2020



Source (activity data): Medway NHS Foundation Trust
Source (deprivation data): Indices of Deprivation 2019, MHCLG
Medway Public Health Intelligence Team, Medway Council 2021-09-17

Top 20% of LSOAs with highest activity

Count of LSOAs by deprivation quintile



Top 15 LSOAs ordered by SIR

LSOA	PCN	SIR	Dep Quintile
E01024615	Sheppey	170.7	1
E01016128	Rochester	159.2	2
E01016096	Medway Rainham	154.6	4
E01024580	Sheppey	146.5	1
E01024613	Sheppey	146.2	1
E01024618	Sheppey	145.5	1
E01016043	Gillingham South	145.1	2
E01016159	Gillingham South	144.6	1
E01024614	Sheppey	143.0	1
E01016046	Gillingham South	140.6	1
E01016067	Medway South	139.7	2
E01016045	Gillingham South	139.7	2
E01016032	Gillingham South	139.2	1
E01024581	Sheppey	138.5	1
E01016173	Medway South	138.2	2

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Medway and Swale
Integrated Care Partnership

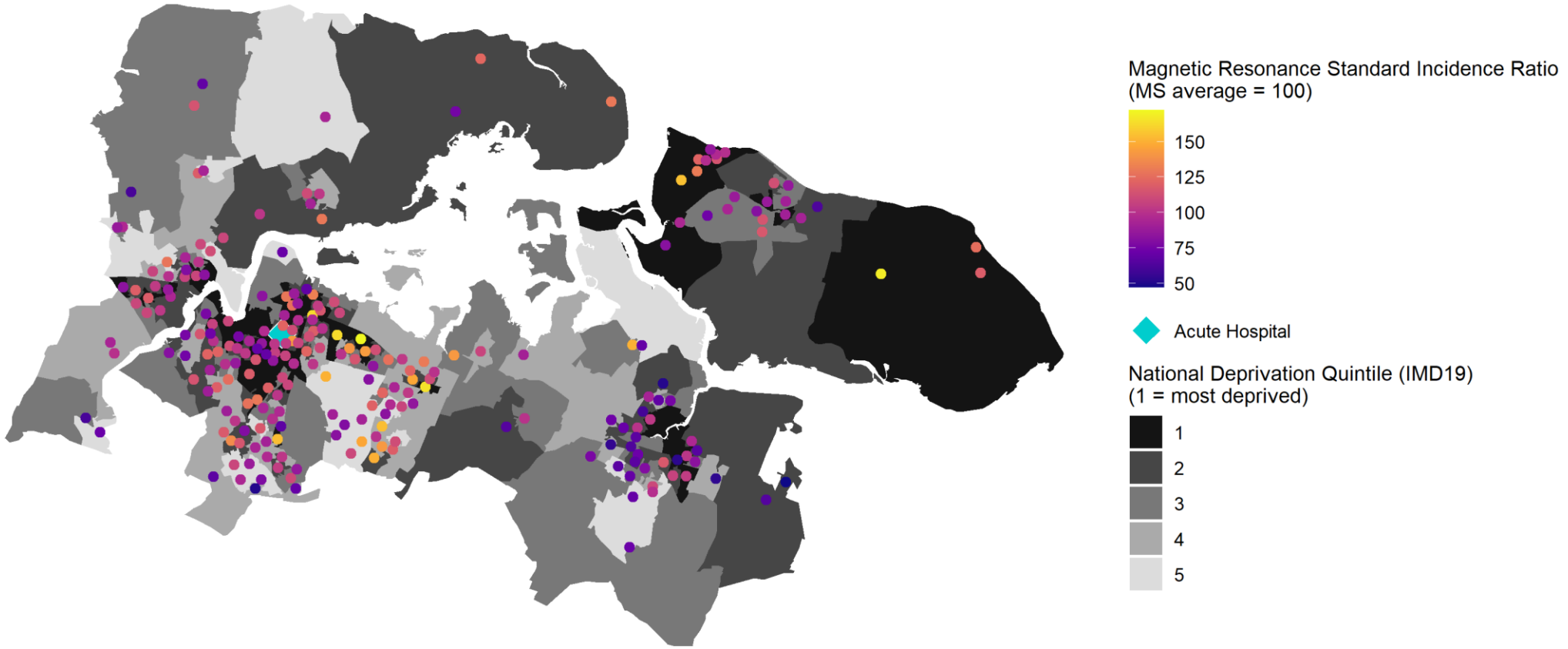
Magnetic Resonance Imaging (MRI)

DRAFT

Medway and Swale
Integrated Care Partnership

Magnetic Resonance: age-standardised activity rates by Lower Super Output Area in Medway and Swale

Examinations performed between April 2019 and March 2020
Dots represent population weighted centroids for LSOAs



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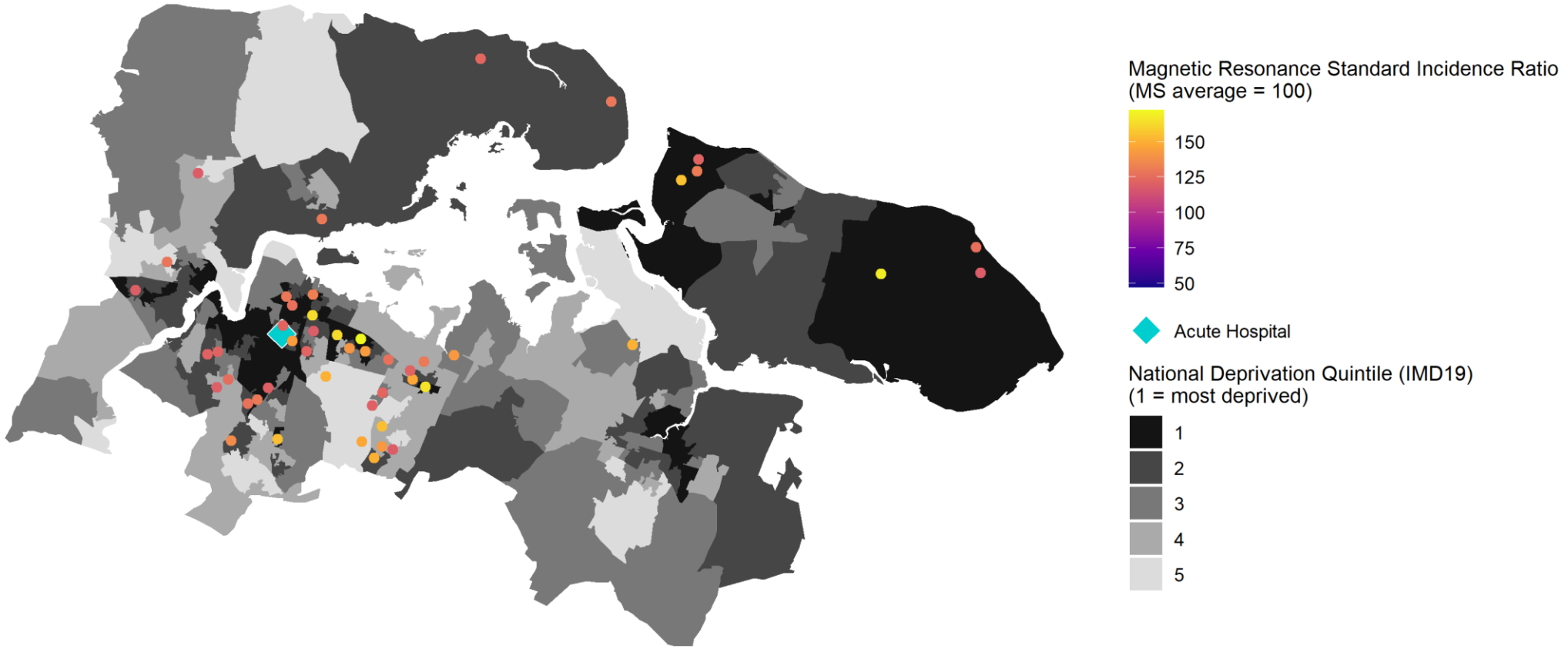
Magnetic Resonance: top fifth (20%) of LSOAs in M&S with highest age-standarised activity rates

Examinations performed between April 2019 and March 2020
Dots represent population weighted centroids for LSOAs



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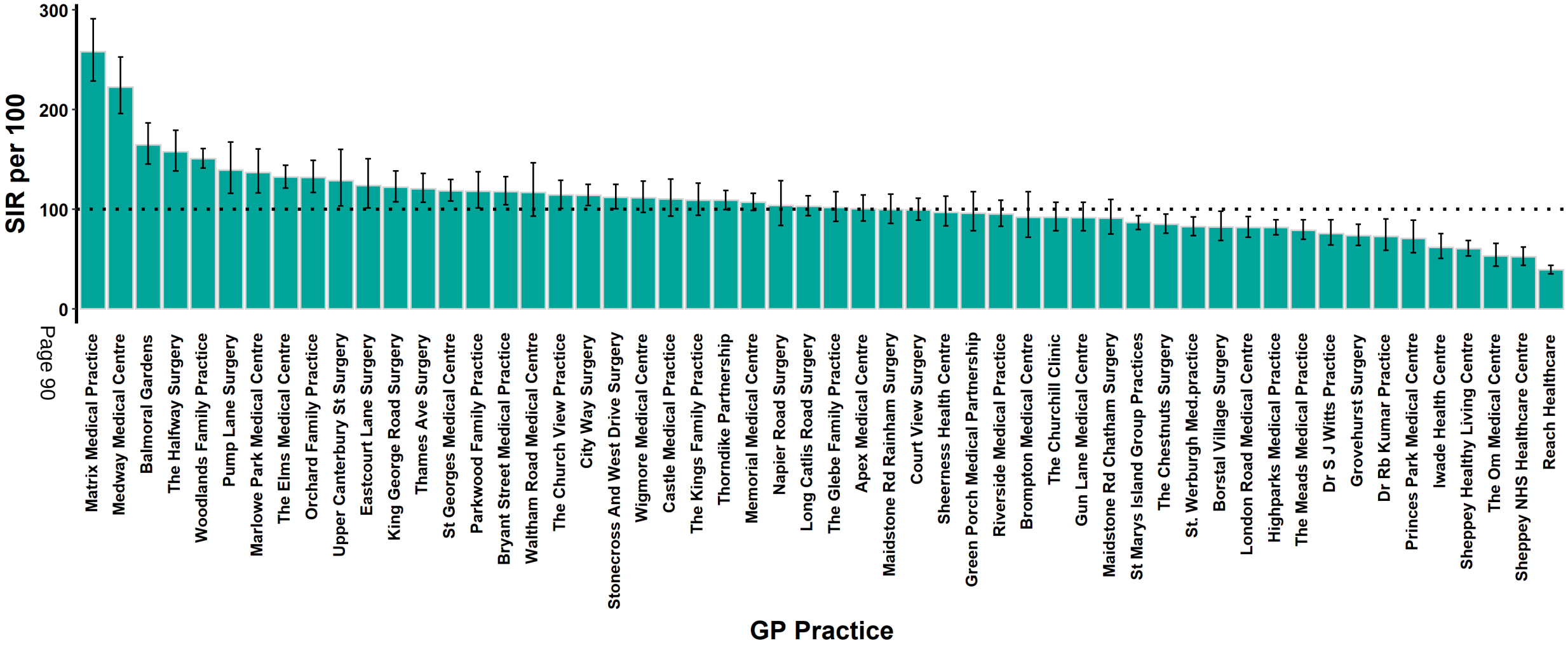
Magnetic Resonance: age-standardised activity rates by GP Practice in Medway and Swale; M&S average = 100 (- - -)

Examinations performed between April 2019 and March 2020



Source (data): Medway NHS Foundation Trust, 2019/20
Source (population): Patients Registered at a GP Practice, NHS Digital, April 2020
Medway Public Health Intelligence Team, Medway Council 2021-09-17

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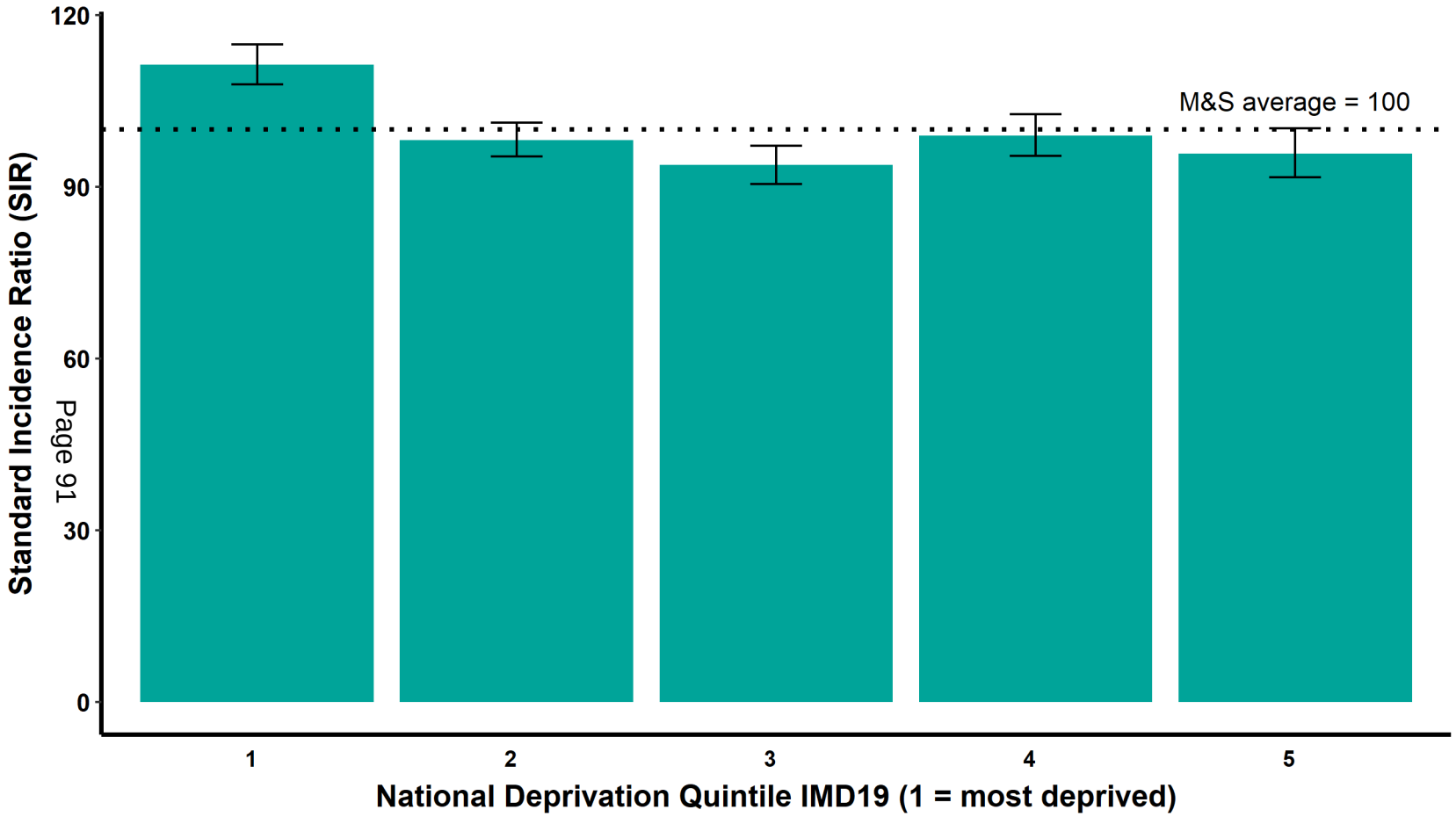
Medway and Swale Integrated Care Partnership

Magnetic Resonance

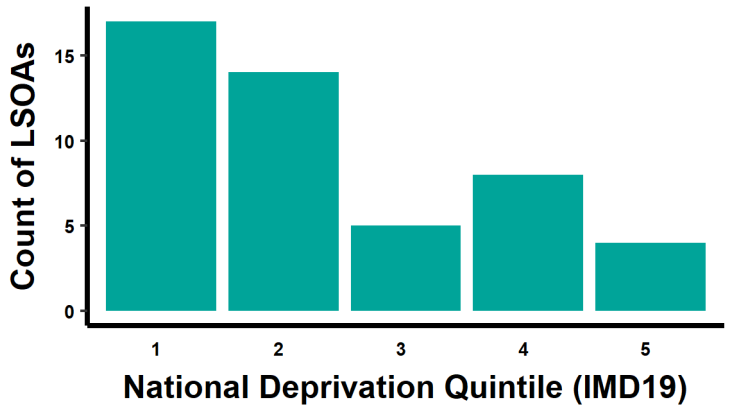
SIR by national deprivation quintile in Medway and Swale
Examinations performed between April 2019 and March 2020



Source (activity data): Medway NHS Foundation Trust
Source (deprivation data): Indices of Deprivation 2019, MHCLG
Medway Public Health Intelligence Team, Medway Council 2021-09-17

Top 20% of LSOAs with highest activity

Count of LSOAs by deprivation quintile



Top 15 LSOAs ordered by SIR			
LSOA	PCN	SIR	Dep Quintile
E01016160	Gillingham South	171.7	1
E01024618	Sheppey	168.2	1
E01016102	Medway Rainham	164.9	1
E01016040	Gillingham South	163.1	1
E01016159	Gillingham South	162.8	1
E01024615	Sheppey	154.9	1
E01016105	Medway Rainham	153.9	4
E01016059	Medway South	153.7	1
E01016176	Gillingham South	150.3	5
E01032656	Sittingbourne	150.1	3
E01016100	Medway Rainham	149.7	2
E01016098	Medway Rainham	147.2	2
E01016053	Medway Rainham	147.1	5
E01016161	Medway Rainham	143.2	1
E01016047	Gillingham South	143.2	2

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Medway and Swale
Integrated Care Partnership

Summary

DRAFT V1

Medway and Swale
Integrated Care Partnership

Data Summary: Activity

Pathway	Diagnostics	Data	Findings
Rheumatology	X-Ray	MFT and community hospitals	Activity is highest in most deprived quintiles. LSOAs with the highest activity are in Sheppey.
	DEXA	MFT only	Activity is highest in least deprived quintiles. LSOAs with the highest activity are in Medway Rainham and Medway South.
Cardiology	Echo	MFT only	Activity is highest in the most deprived quintile. LSOAs with the highest activity are in Medway South, Strood and Sheppey.
	ECG	TBC	No data yet.
Other	CT	MFT only	Activity is highest in most deprived quintiles (1 and 2). LSOAs with the highest activity in are in Sheppey, Rochester and Medway Rainham.
	MRI	MFT only	Activity highest in most deprived quintiles. LSOAs with the highest activity are in Gillingham South, Sheppey and Medway Rainham.
	Doppler	MFT and community settings	No community data (not presented).
	NOUS	MFT and AQP	No AQP data (not presented).

Medway and Swale Integrated Care Partnership

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Forecasting

Modality	Diagnostic test	Baseline demand pre-COVID (2019/20	Baseline capacity pre-COVID (2019/20)	Forecast demand (2026/27)	% forecast demand that is elective	Forecast required capacity (2026/27)
Imaging	CT					
	MRI					
	Ultrasound					
	Plain X-Ray					
Physiological measurement	Echocardiography (ECHO)					
	Electrocardiogram (ECG) including Holter monitoring					
	Oximetry					

Which data are needed

- **Demand** (we are looking into getting this by LSOA and age band to complement the activity data)
- **Capacity** (need to identify data and expertise to calculate this)

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Medway and Swale

Health and Care Partnership profile

Created by Medway Council Public Health Intelligence Team and Kent Public Health Observatory

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NHS

Summary part 1: Medway and Swale

Indicator	Compared to England
Life expectancy at birth (Male)	Similar
Life expectancy at birth (Female)	Similar
Smoking Prevalence in adults (18+) - current smokers (APS)	Similar
Percentage of adults (aged 18+) classified as overweight or obese	Worse
Children with excess weight Year 6, three year average	Worse
Percentage of physically inactive adults	Worse
Admission episodes for alcohol-specific conditions	Better
Air pollution: fine particulate matter (historic indicator)	Not compared
Total number of prescribed antibiotic items per STAR-PU	Higher
Breast cancer screening coverage (females aged 50-70)	Better
Cervical cancer screening coverage (females aged 25-49)	Better
Bowel cancer screening coverage (persons aged 60-74)	Similar
Infant mortality rate	Similar
Low birth weight of term babies	Similar
Stillbirth rate	Similar
Smoking status at time of delivery	Worse
AE attendances (0-4 years)	Worse
Percentage of 5 year olds with experience of visually obvious dental decay	Similar

Summary part 2: Medway and Swale

Indicator	Compared to England
Under 18s conception rate / 1,000	Worse
Emergency hospital admissions for asthma (< 19 yrs)	Similar
Emergency hospital admissions for epilepsy (< 19 yrs)	Worse
Emergency hospital admissions for diabetes (< 19 yrs)	Worse
Hospital admissions for mental health conditions (0-17 years)	Better
Hospital admissions as a result of self-harm (10-24 years)	Worse
Hospital admissions due to substance misuse (15-24 years)	Similar
Hypertension: QOF prevalence (all ages)	Higher
Diabetes: QOF prevalence (17+)	Higher
CHD: QOF prevalence (all ages)	Lower
CKD: QOF prevalence (18+)	Similar
Stroke: QOF prevalence (all ages)	Lower
Deaths from circulatory disease, under 75 years	Similar
Deaths from all cancer, under 75 years	Worse
Cancer diagnosed at early stage (experimental statistics)	Not compared
Unplanned hospitalisation for chronic ACSC	Worse
Depression: Recorded prevalence (aged 18+)	Higher
Serious Mental Illness: QOF prevalence (all ages)	Lower

Summary part 3: Medway and Swale

Indicator	Compared to England
Suicide rate (Persons)	Better
Suicide rate (Male)	Better
Estimated dementia diagnosis rate (aged 65 and over)	Not compared
Emergency hospital admissions due to falls (persons aged 65 and over)	Better
Emergency hospital admissions for hip fracture (persons aged 65 and over)	Worse
Osteoporosis: QOF prevalence (50+)	Lower

Contact details

If you have any questions or would like further information about these profiles, please contact either:

Dr Natalie Goldring

Senior Public Health Intelligence Manager

Public Health

Medway Council

natalie.goldring@medway.gov.uk

01634 337271

Mark Chambers

Head of Health Intelligence

Kent Public Health Observatory

Kent County Council

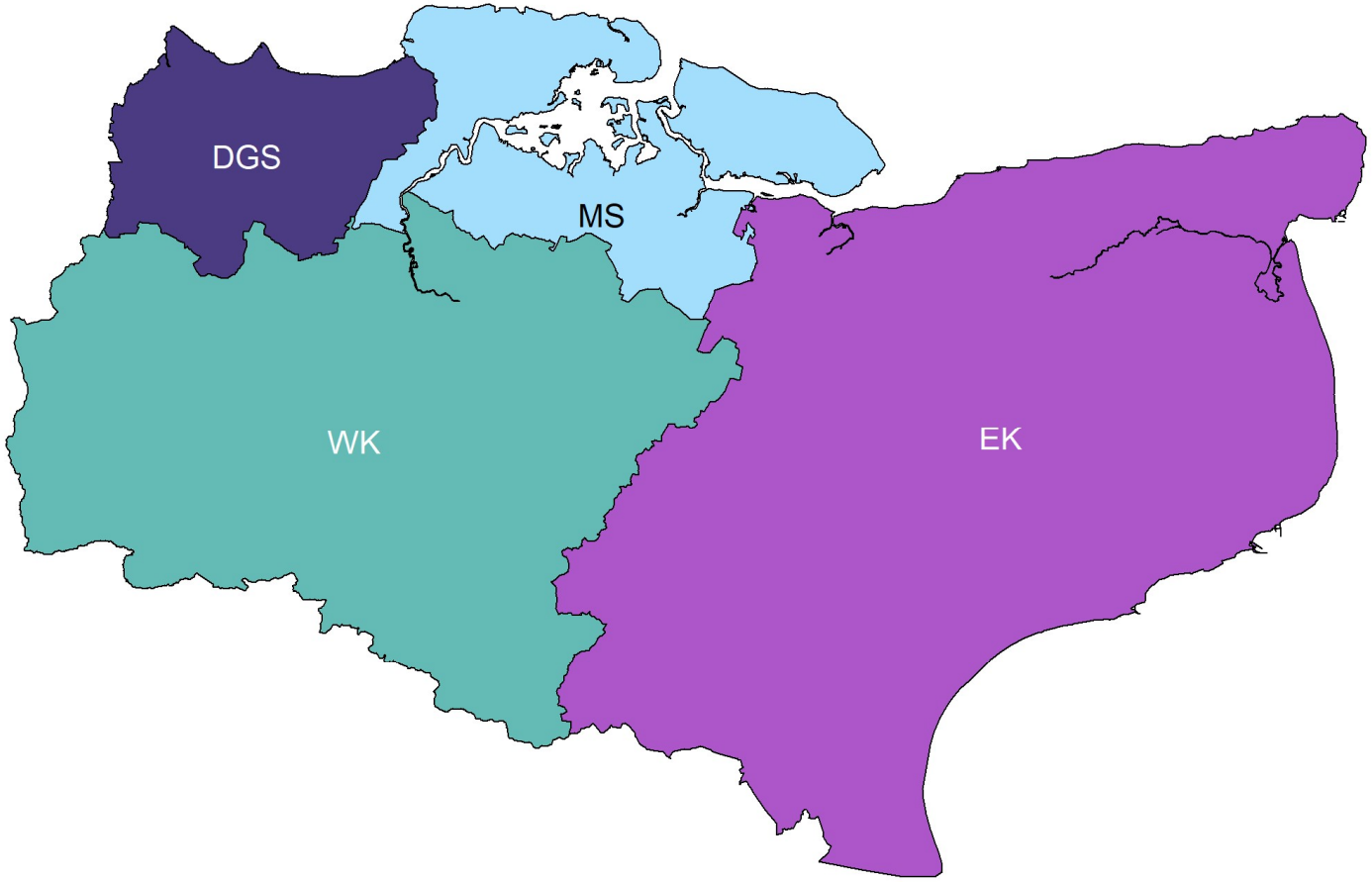
mark.chambers@kent.gov.uk

03000 422 794

Purpose

- Profiles have been created for each of the Health and Care Partnerships (HCPs) in the Kent and Medway Integrated Care System (ICS).
- 1) Dartford, Gravesham and Swanley; 2) East Kent; 3) Medway and Swale; 4) West Kent.
- The aim of the profiles is to allow comparison between each of the HCPs and identify priority areas to focus work.

Kent and Medway HCPs



Health and Care Partnerships

Dartford, Gravesham and Swanley HCP | East Kent HCP | Medway and Swale HCP | West Kent HCP

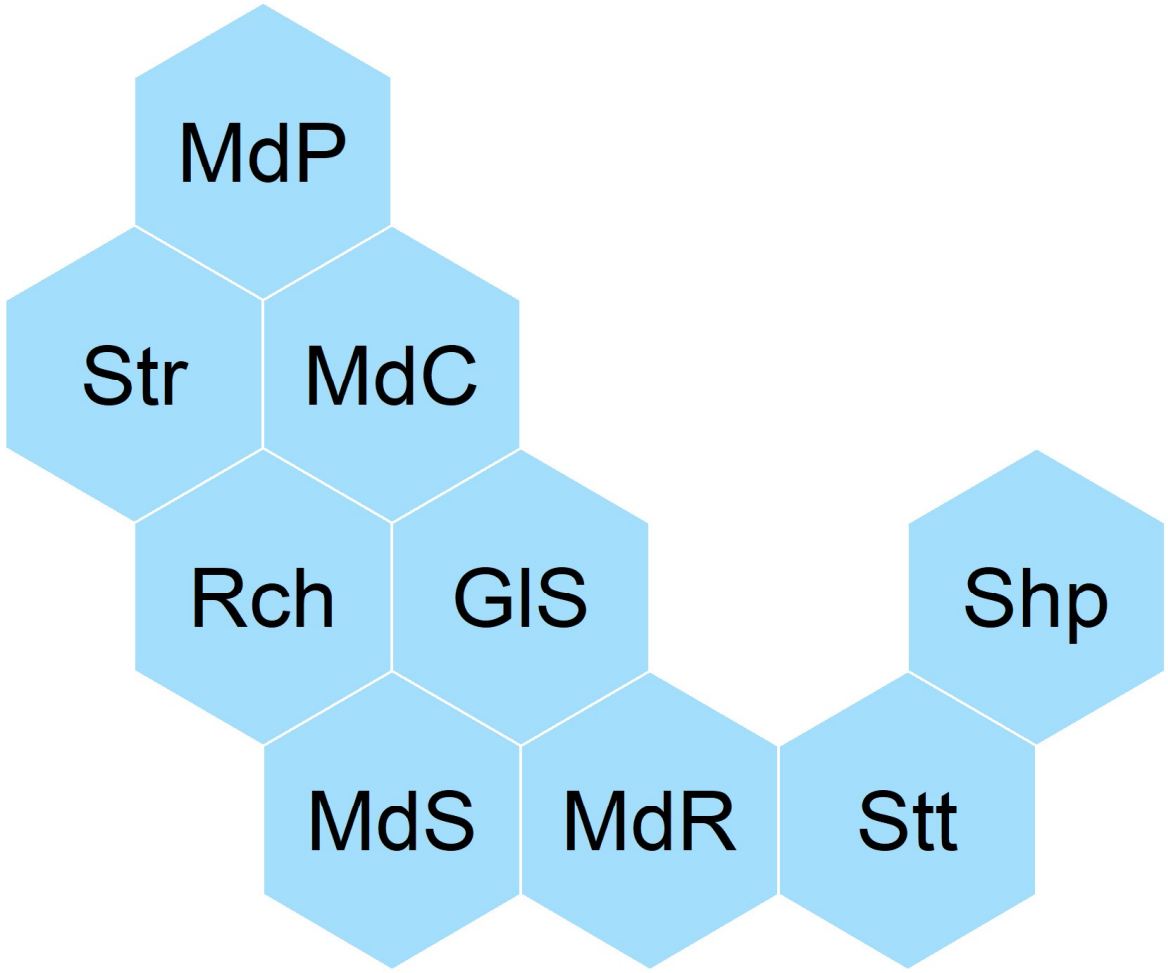
Produced by Medway Public Health Intelligence Team, Medway Council 2022-05-24

Rationale

- The profiles contain five sections, which are based on key themes identified in the NHS Long Term Plan.
- 1) Demographics; 2) Prevention and Health Inequalities; 3) Best Start in Life; 4) Major Health Conditions; 5) Ageing Well.
- Key stakeholders were consulted to identify the indicators that should be included.
- Due to limitations in the available data, some indicators could not be included for all the priorities identified at this time.

PCN hex map explained

- Some slides contain a hex map, which displays the indicator value at PCN level.
- Each hexagon represents a PCN, arranged according to its relative geography within the HCP.

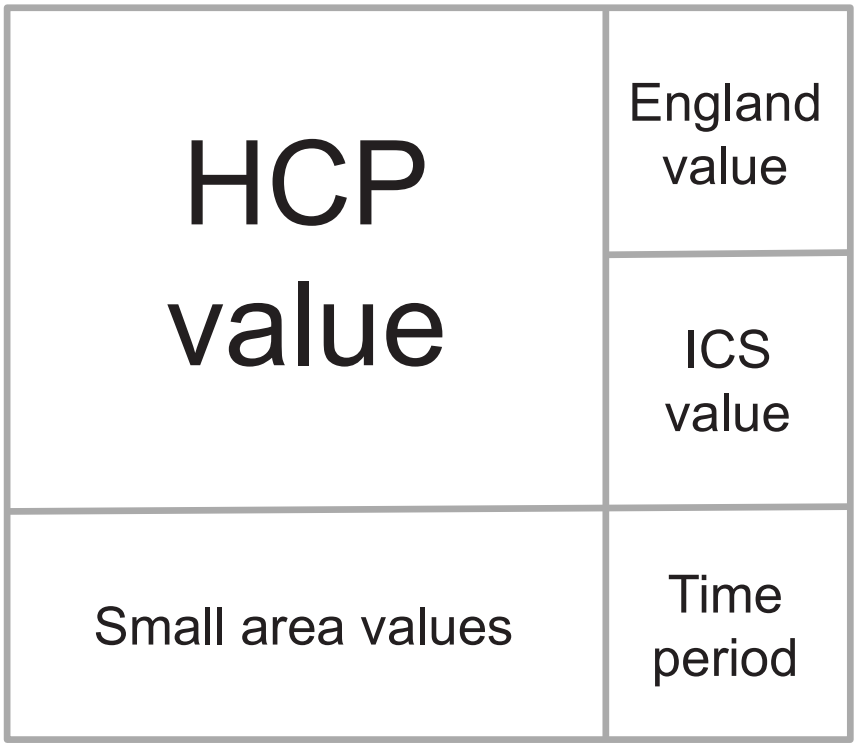


PCN abbreviations

- Shp: Sheppey
- Stt: Sittingbourne
- MdR: Medway Rainham
- GIS: Gillingham South
- MdC: Medway Central
- MdS: Medway South
- MdP: Medway Peninsula
- Rch: Rochester
- Str: Strood

Number grid explained

- Some slides contain a number grid, which displays the indicator value at different levels of geography.
- England, Kent and Medway ICS, HCP, and small area.
- The small area type displayed depends on the data available for the indicator.



- Either District & Unitary Authority (UA) or Clinical Commissioning Group (CCG).

Small areas

- District & UA and former CCG data have been mapped to the HCP boundaries as per the table below.
- Caveat: District & UA data does not align with the HCP areas exactly.
- For the purpose of this profile, data for whole District & UAs have been assigned to the HCP where the majority of residents reside.

Health and Care Partnership	District & Unitary Authority	Former Clinical Commissioning Group
Dartford, Gravesham and Swanley	Dartford; Gravesham	Dartford, Gravesham and Swanley CCG
East Kent	Ashford; Canterbury; Dover; Folkestone and Hythe; Thanet	Ashford CCG; Canterbury and Coastal CCG; South Kent Coast CCG; Thanet CCG
Medway and Swale	Medway; Swale	Medway CCG; Swale CCG
West Kent	Maidstone; Sevenoaks; Tonbridge and Malling; Tunbridge Wells	West Kent CCG

Small areas continued

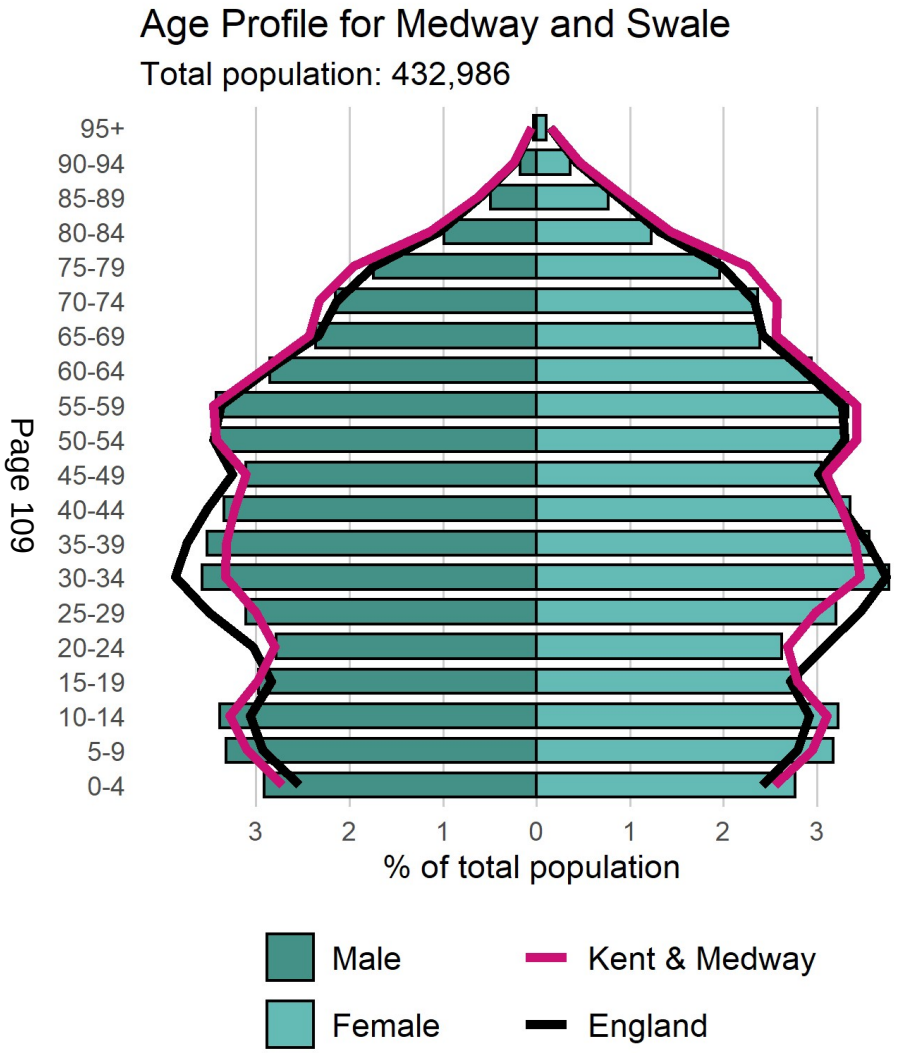
- Data at several small area levels has been used as building blocks to calculate the PCN values: Lower Super Output Area (LSOA), ward, general practice and school.
- LSOAs have a defined geographical boundary. On average the population is about 1,700 people so they can be thought of as representing a neighbourhood. There are 1,065 LSOAs within Kent and Medway.
- LSOAs and wards were assigned to PCNs on a first passed the post basis, e.g. LSOAs or wards were mapped to PCNs based on which PCN has the highest count of registered patients living in that LSOA/ward.
- School level data was assigned to PCNs based on the ward the school was located in. Only primary and nursery school data was used as this more likely reflects the child profile of the local area due to the larger catchment areas of secondary schools.

HCP value and comparison

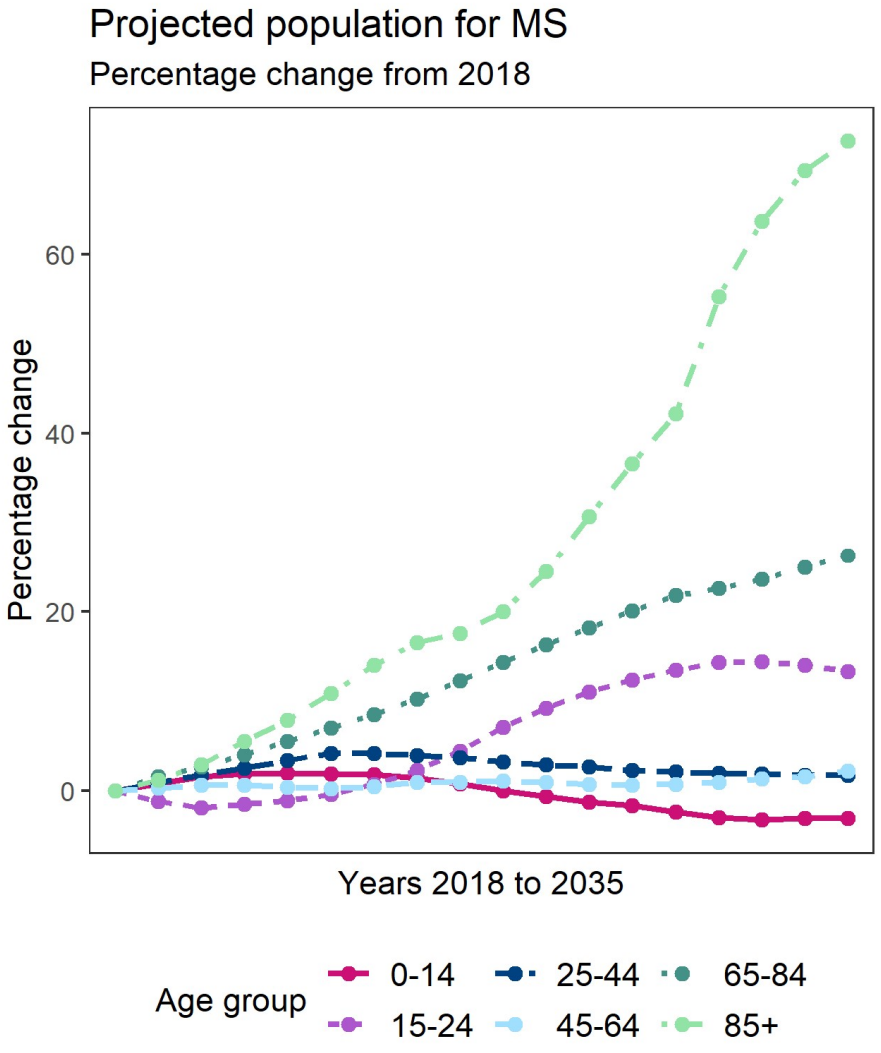
- The HCP values have been calculated from either LSOA, ward, general practice, school, District & UA or CCG level data using one of two methods:
- 1) Aggregated data: HCP values are created from aggregated counts and denominators, where data is available.
- 2) Small areas averaged: Where count and/or denominator data is not available, the HCP value is the median of the small area values.
- A RAG rating (red, amber, green) has been applied to the majority of indicators to show how well an area is performing compared to a benchmark (England). The RAG rating is assigned by comparing an area's value to a reference range, which was created using either confidence intervals (CIs) or a range around the England average (usually 5%). Green corresponds to a value that is better than England, red to a value that is worse, and amber indicates that there is no difference.
- Where it is inappropriate to label high or low values as 'better' or 'worse', for example osteoporosis prevalence, the terms 'higher' and 'lower' have been used with neutral colouring: shades of blue from light to dark. Such labelling does not imply that high values of these indicators, for example, are 'worse'.
- An indicator is shaded grey where it is inappropriate to apply a RAG rating due to the methods used in the calculation or the count is less than 10.

DEMOGRAPHICS

Population



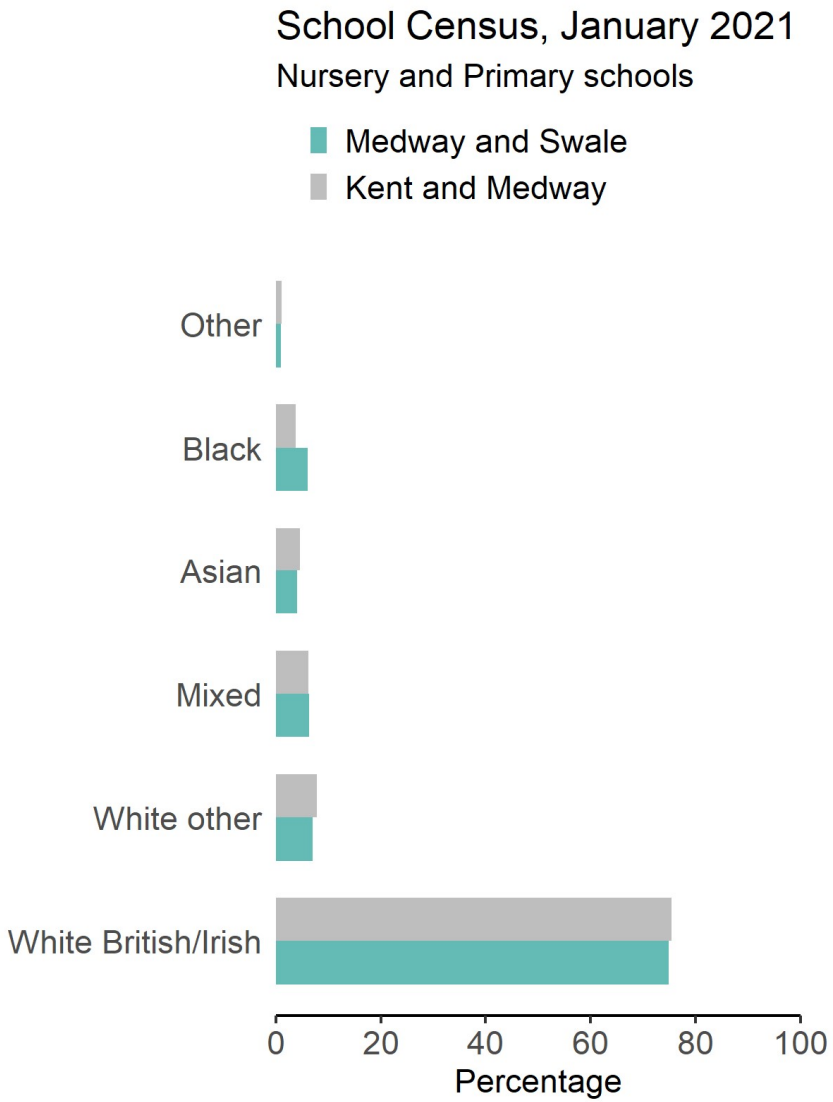
Source: NHS Digital. Patients Registered at a GP Practice. 01May2022

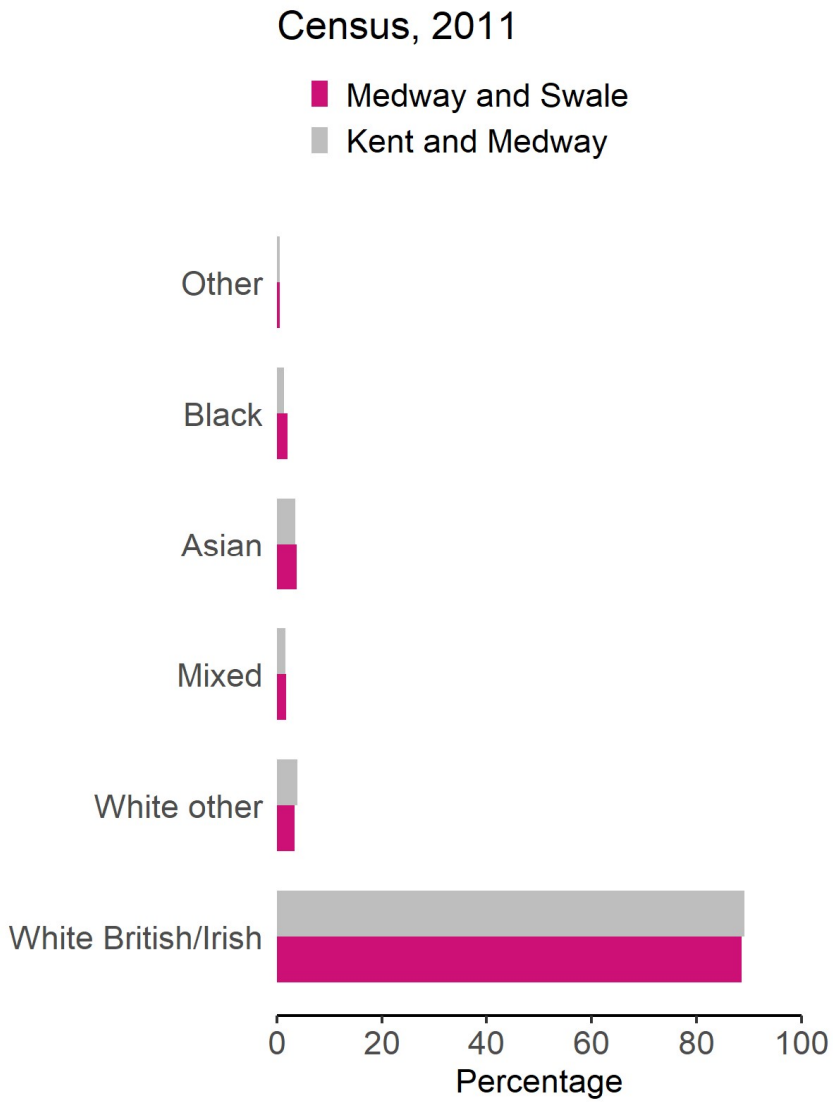


Source: ONS. Population projections for local authorities. 2018 based.

Note: Population projections have been calculated by aggregating the local authority districts assigned to the HCP.

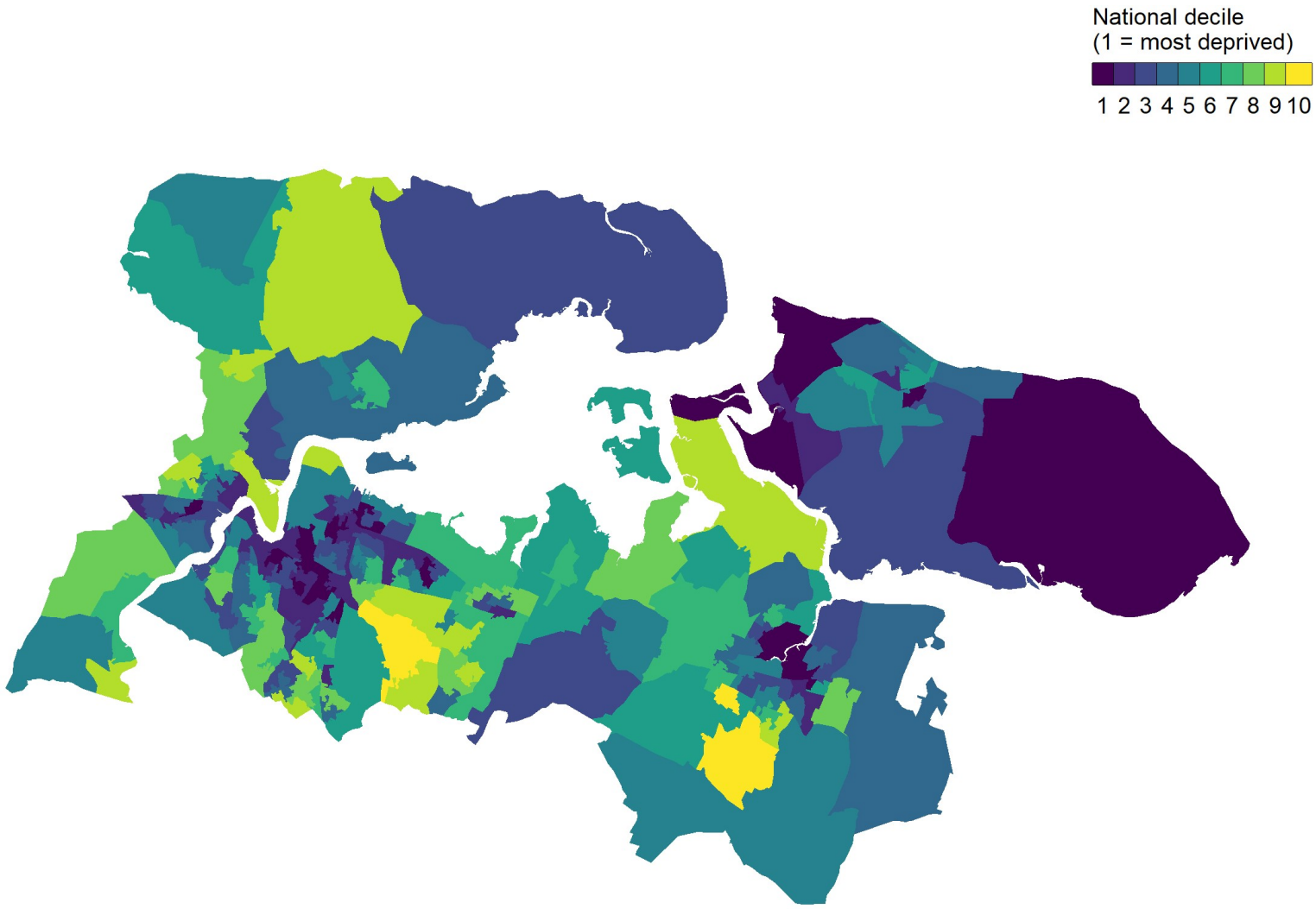
Ethnicity





Census source: NOMIS. 2011 Census. KS201EW - Ethnic group.
School Census source: GOV.UK. Department for Education. Schools, pupils and their characteristics: January 2021.

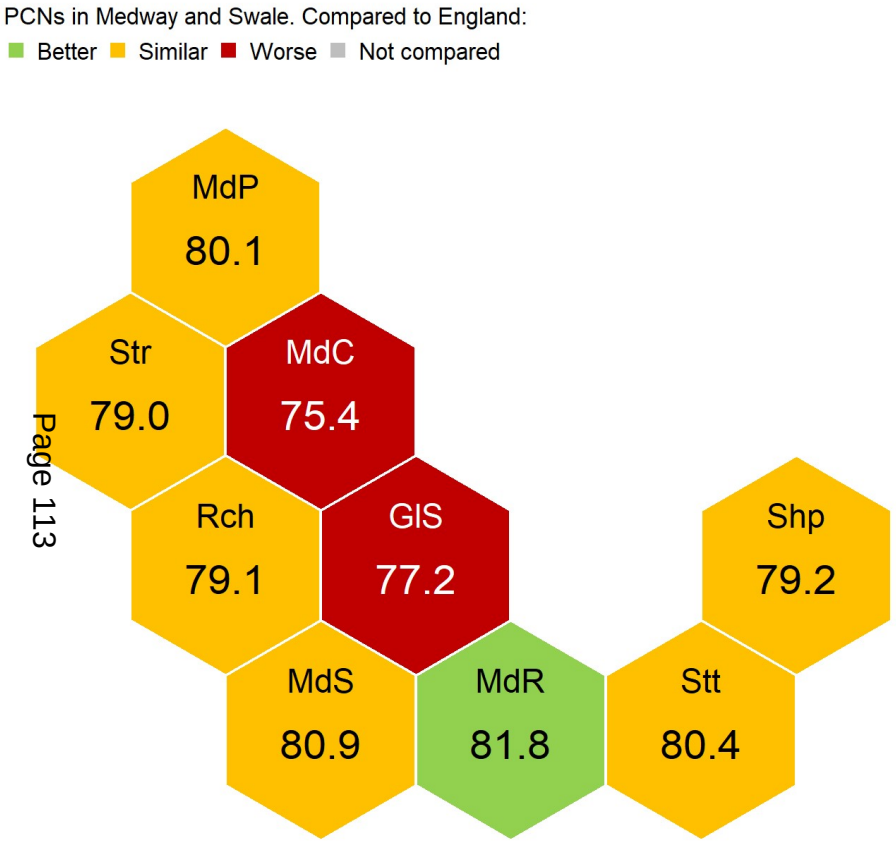
Deprivation



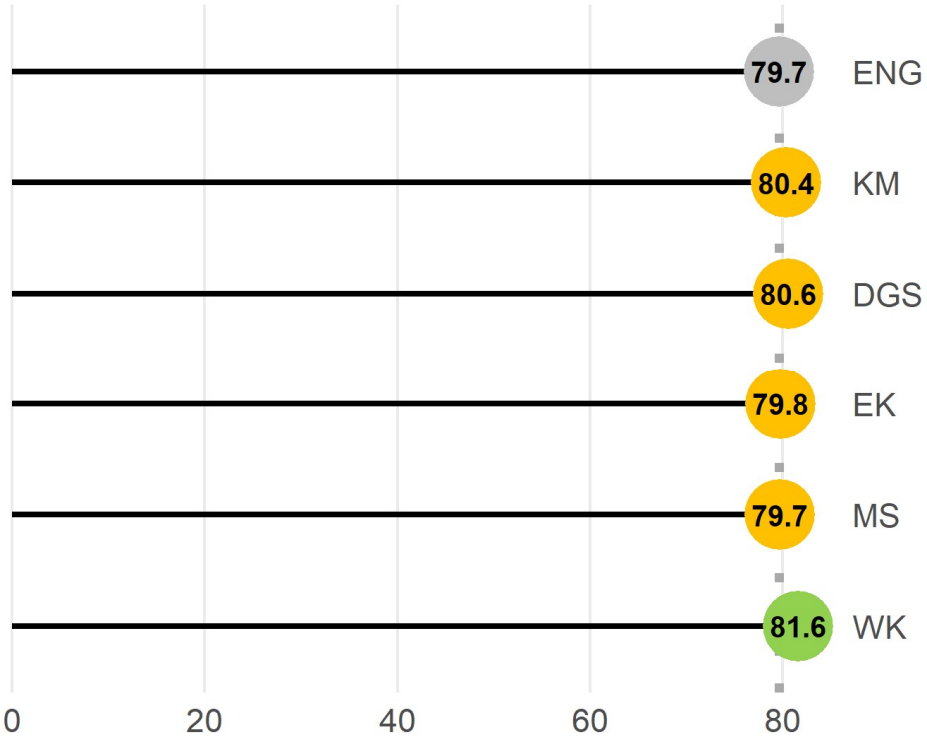
Produced by Medway Public Health Intelligence Team, Medway Council 2022-05-24

PREVENTION AND HEALTH INEQUALITIES

Life expectancy at birth (Male)



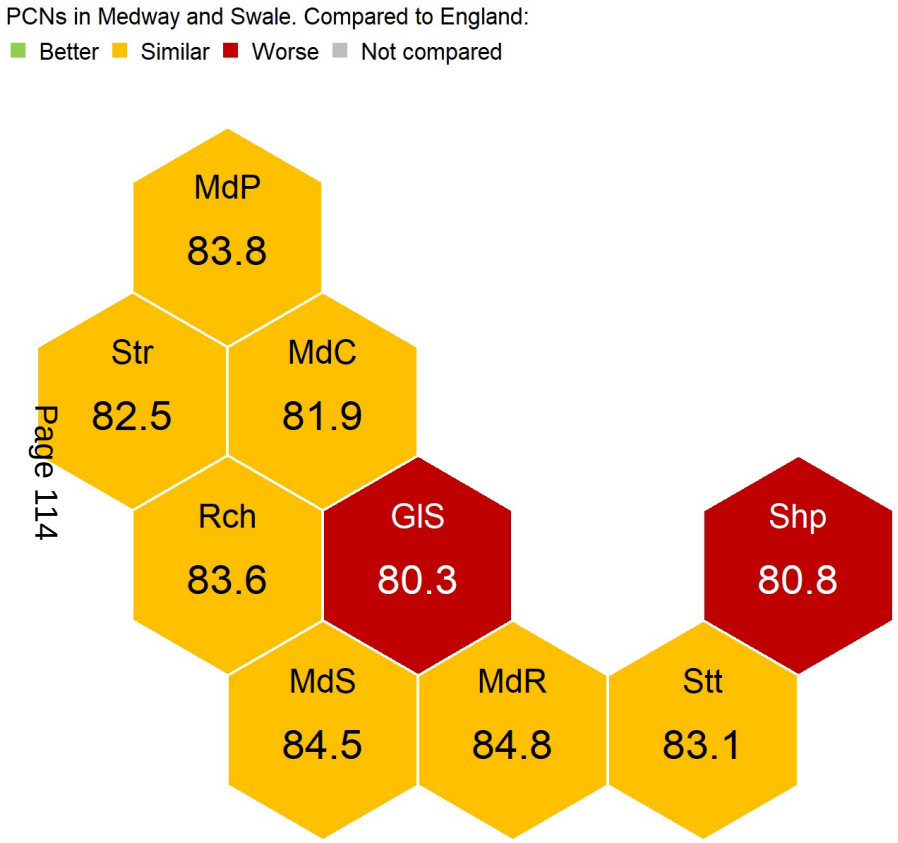
Trend data not available.



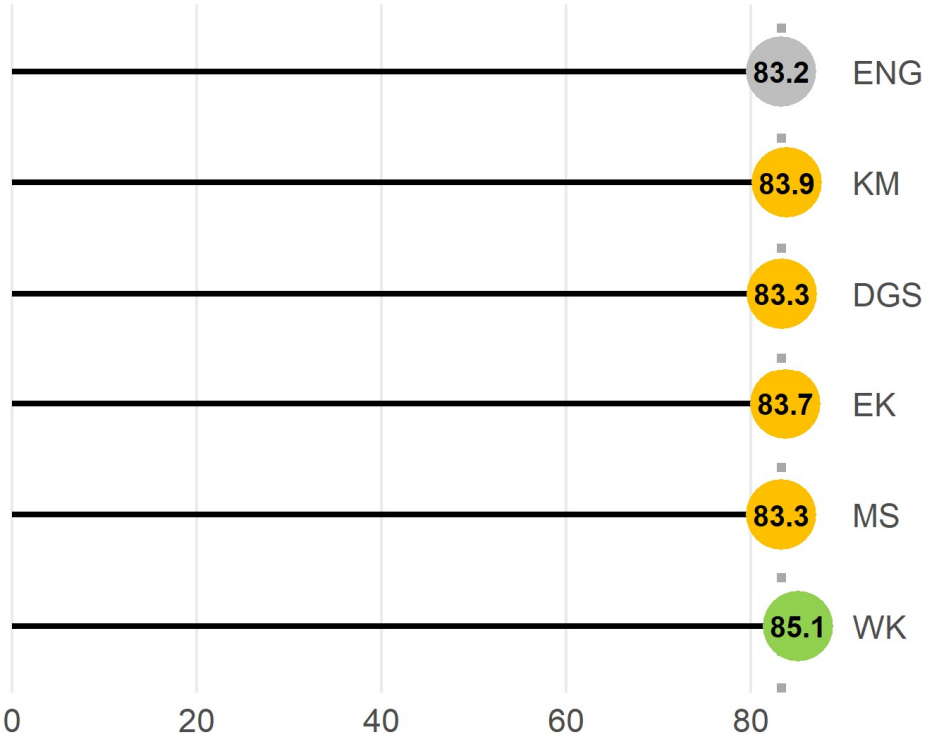
The rate in Medway and Swale is similar to England.

Value type: Years.
Latest time period: 2015 - 19.
Source: PHE, Fingertips, Indicator ID: 93283.
Value calculation: Small areas averaged.
Small area type: Ward to PCN.
RAG method: England plus/minus 2%.

Life expectancy at birth (Female)



Trend data not available.

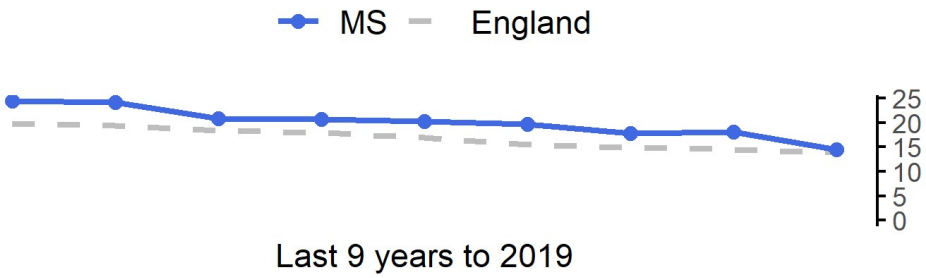


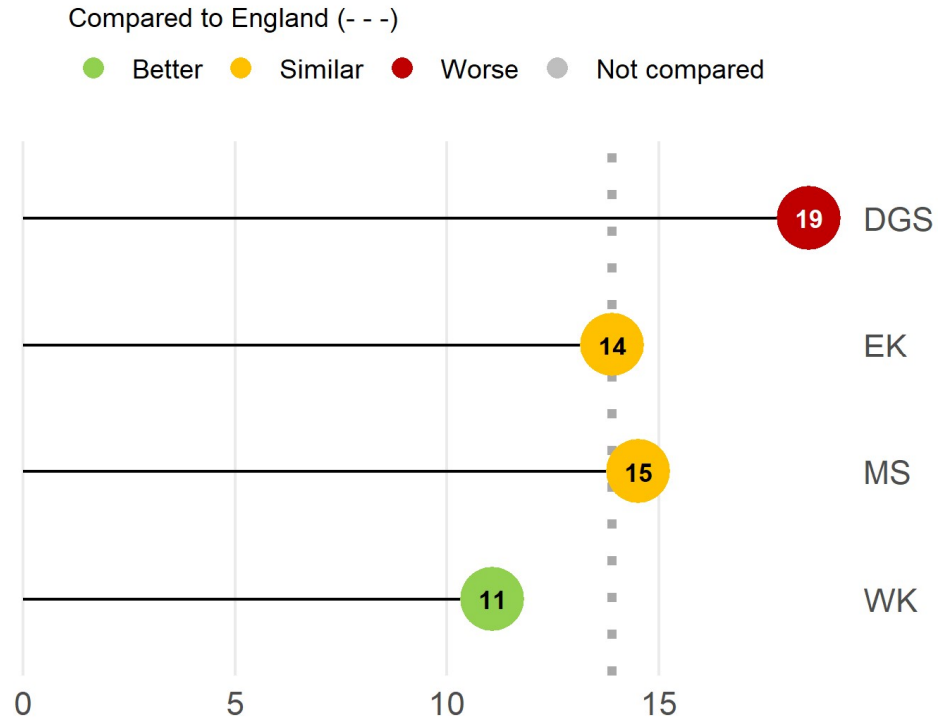
The rate in Medway and Swale is similar to England.

Value type: Years.
Latest time period: 2015 - 19.
Source: PHE, Fingertips, Indicator ID: 93283.
Value calculation: Small areas averaged.
Small area type: Ward to PCN.
RAG method: England plus/minus 2%.

Smoking Prevalence in adults (18+) - current smokers (APS)

15		14
HCP: Medway and Swale		England
		14
		Kent and Medway
14	15	2019
Medway	Swale	





The rate in Medway and Swale is similar to England.

Value type: Proportion - %.
Latest time period: 2019.
Source: PHE, Fingertips, Indicator ID: 92443.
Value calculation: Small areas averaged.
Small area type: Districts & UAs (from Apr 2021).
RAG method: England plus/minus 5%.

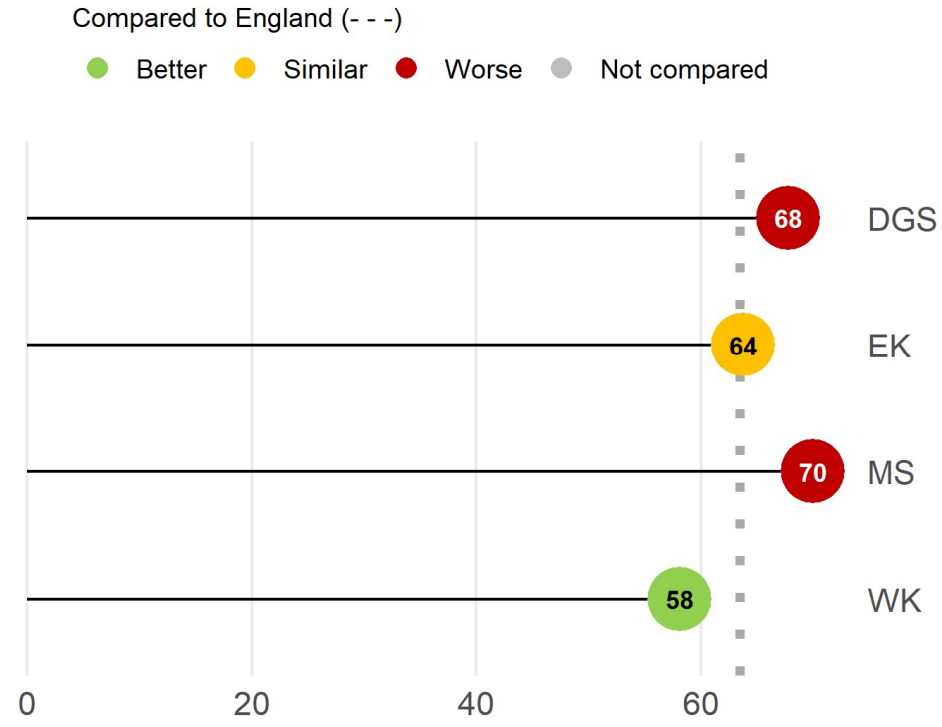
There are data quality concerns with the figure for Dartford LA (see notes on the next slide).

Smoking Prevalence in adults (18+) - Notes

- Smoking prevalence is an estimate based on a sample of the population questioned in the Annual Population Survey run by the Office for National Statistics.
- The figure for Dartford LA in 2019 was high (26.4%) but with a very wide degree of uncertainty.
- This is most likely due to a small sample of people.
- Therefore the aggregate figure for DGS HCP should be interpreted with caution.

Percentage of adults (aged 18+) classified as overweight or obese

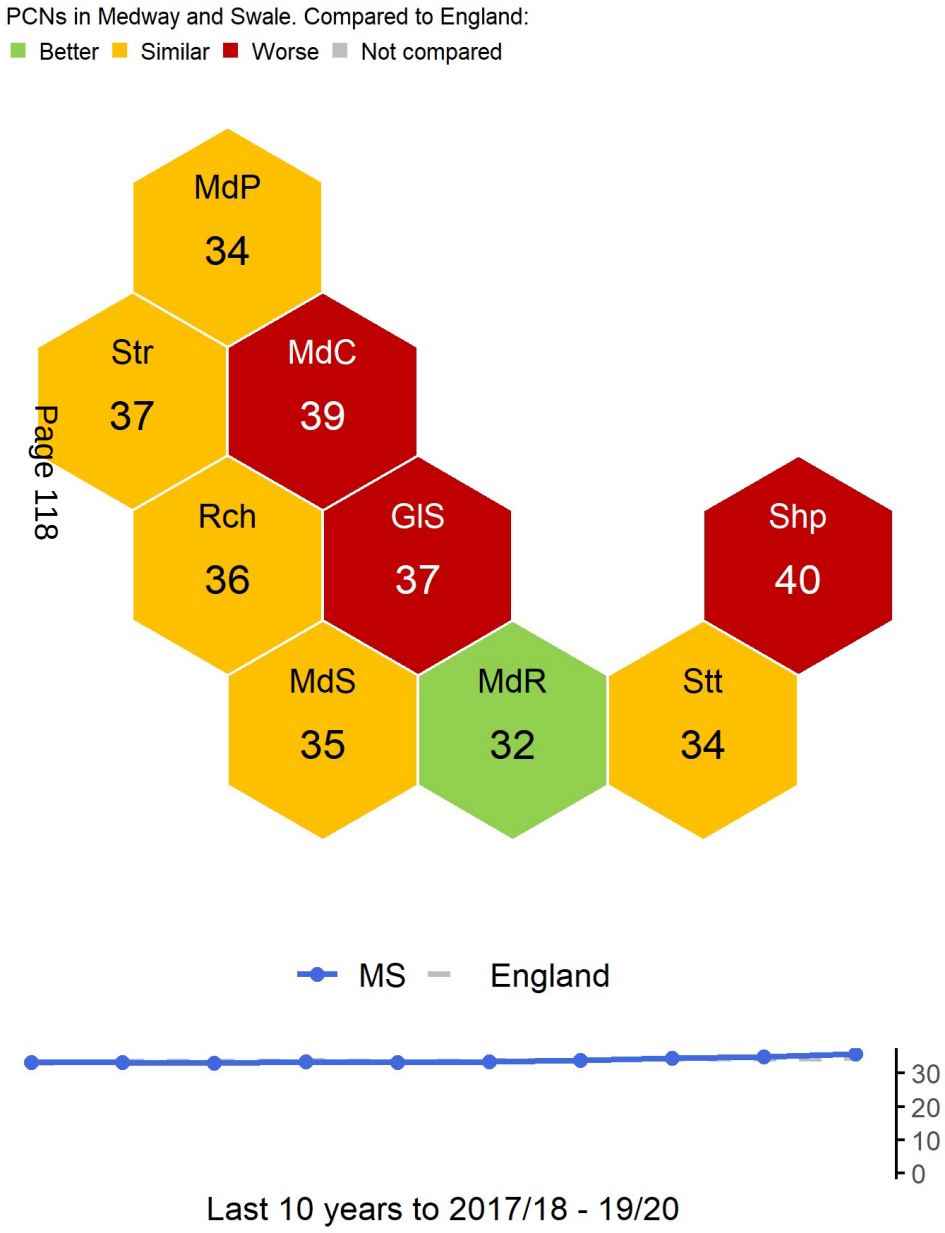
70		63
HCP: Medway and Swale		England
		64
		Kent and Medway
69	71	2020/21
Medway	Swale	

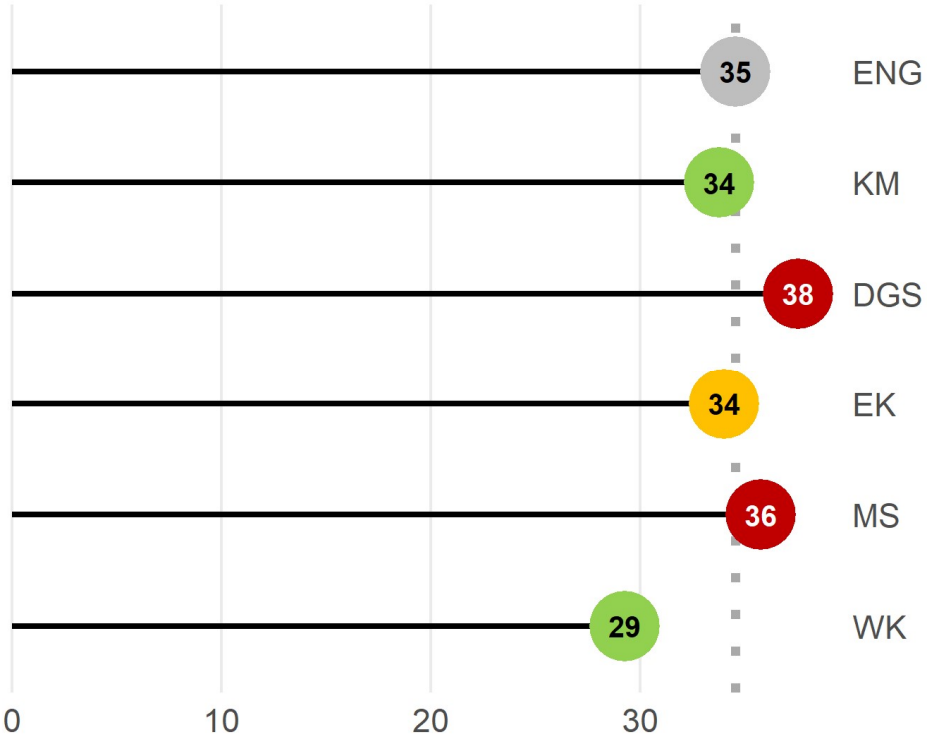


The rate in Medway and Swale is worse than England.

Value type: Proportion - %.
Latest time period: 2020/21.
Source: PHE, Fingertips, Indicator ID: 93088.
Value calculation: Small areas averaged.
Small area type: Districts & UAs (from Apr 2021).
RAG method: England plus/minus 5%.

Children with excess weight Year 6, three year average



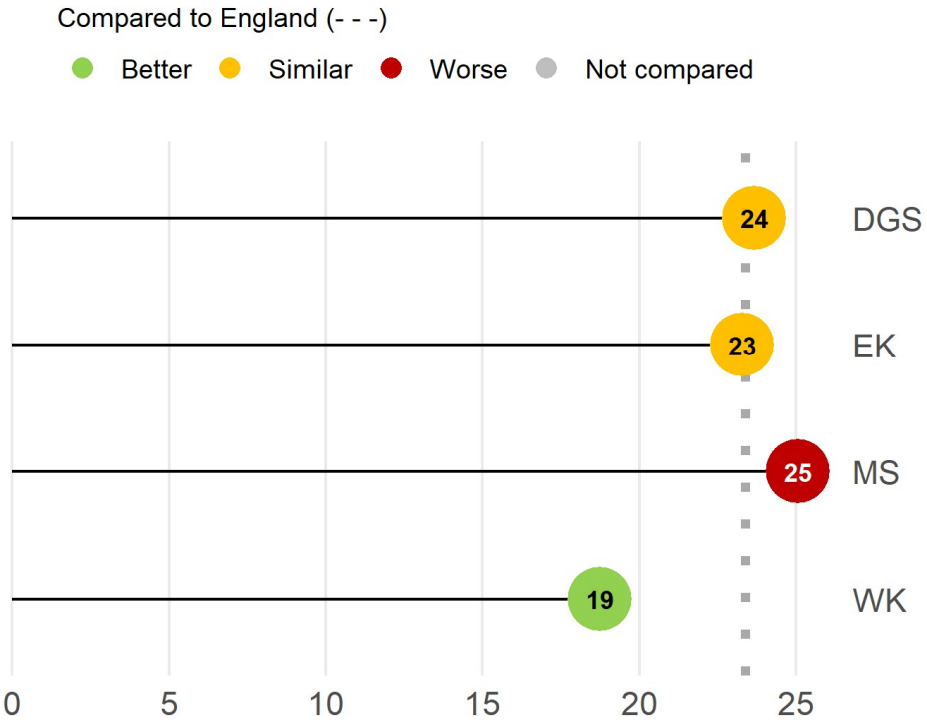


The rate in Medway and Swale is worse than England.

Value type: Proportion - %.
Latest time period: 2017/18 - 19/20.
Source: PHE, Fingertips, Indicator ID: 93108.
Value calculation: Aggregated data.
Small area type: Ward to PCN.
RAG method: Confidence interval (95%) - Wilson Score method.

Percentage of physically inactive adults

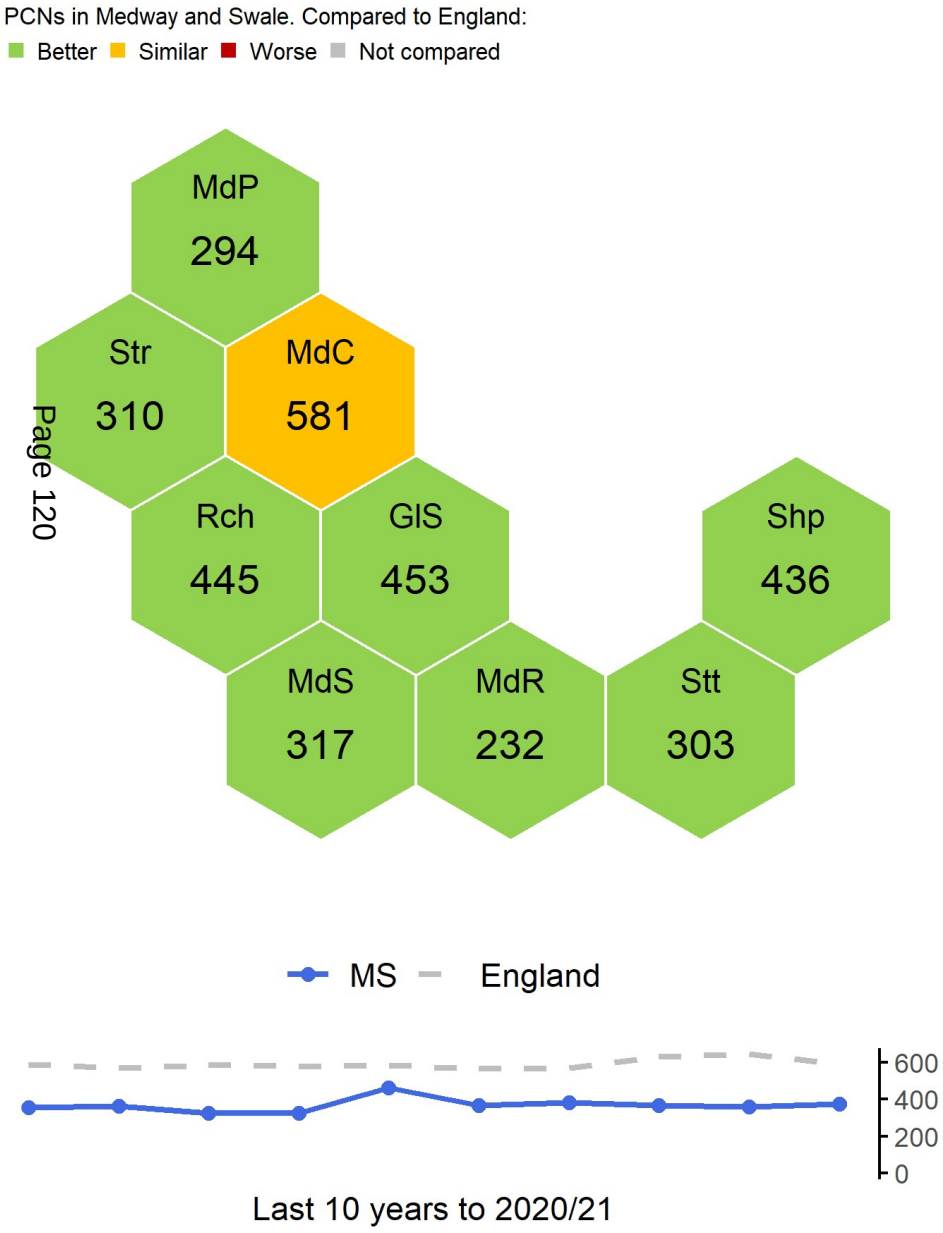
25		23
HCP: Medway and Swale		England
		22
		Kent and Medway
24	26	2020/21
Medway	Swale	

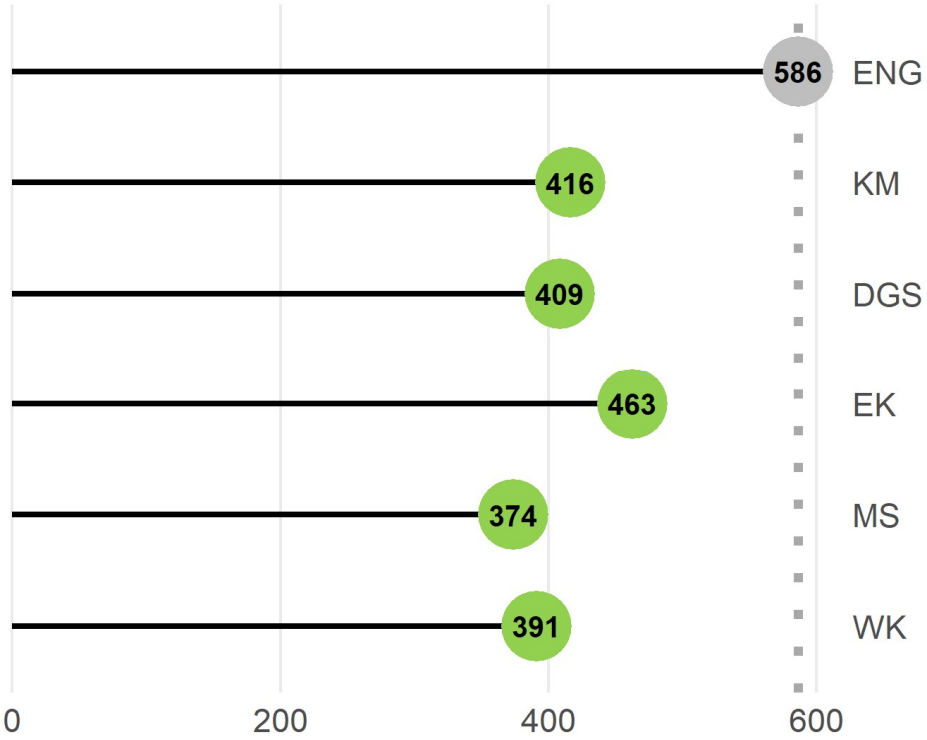


The rate in Medway and Swale is worse than England.

Value type: Proportion - %.
Latest time period: 2020/21.
Source: PHE, Fingertips, Indicator ID: 93015.
Value calculation: Small areas averaged.
Small area type: Districts & UAs (from Apr 2021).
RAG method: England plus/minus 5%.

Admission episodes for alcohol-specific conditions



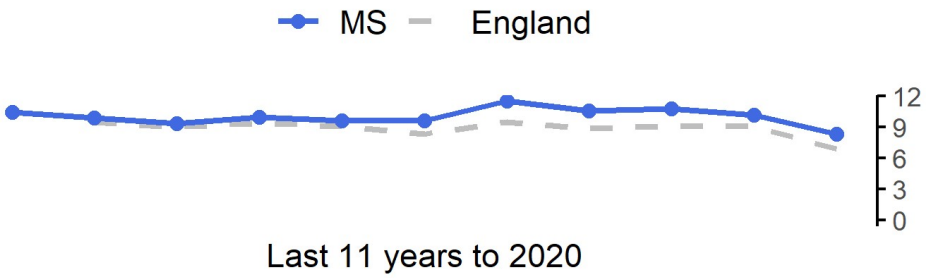


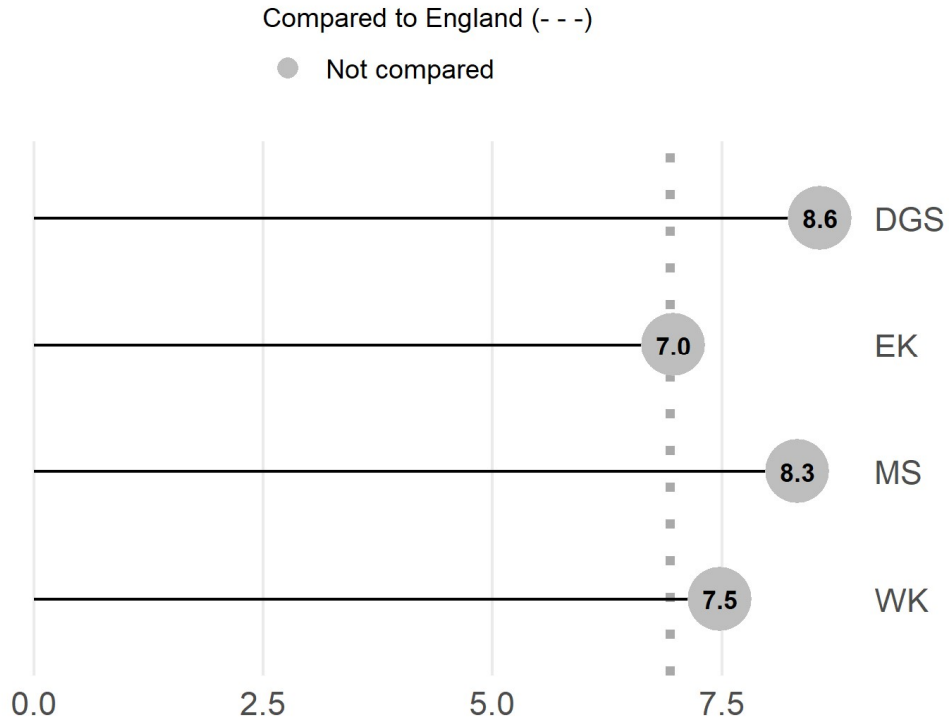
The rate in Medway and Swale is better than England.

Value type: Directly standardised rate per 100,000.
Latest time period: 2020/21.
Source: Hospital Episode Statistics (HES), NHS Digital.
Value calculation: Aggregated data.
Small area type: LSOA to PCN.
RAG method: Confidence interval (95%) - Dobson's method.

Air pollution: fine particulate matter (historic indicator)

8.3		6.9
HCP: Medway and Swale		England
		7.6
		Kent and Medway
8.9	7.7	2020
Medway	Swale	

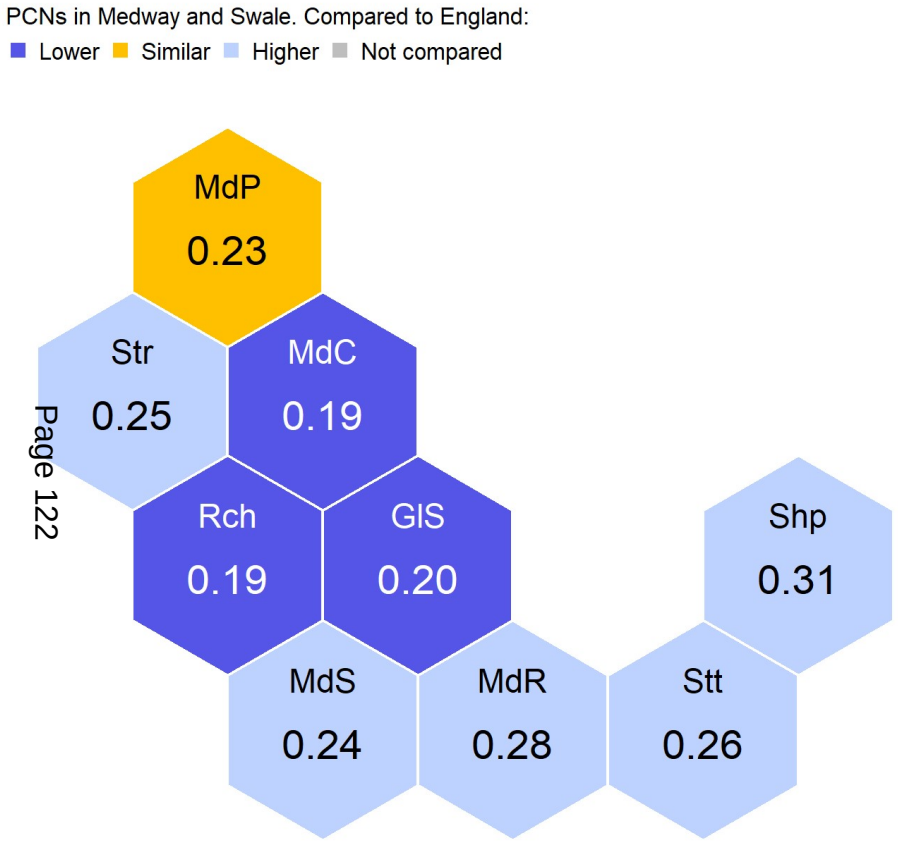


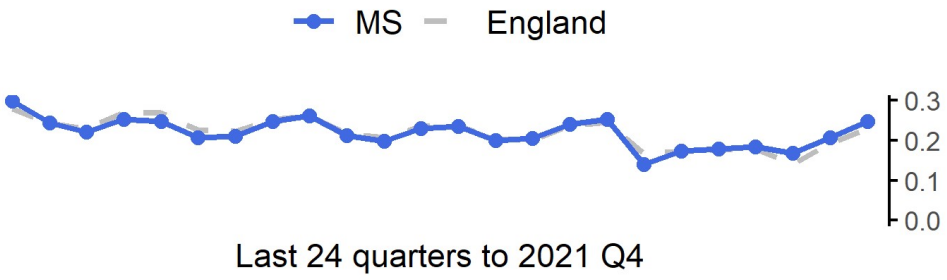


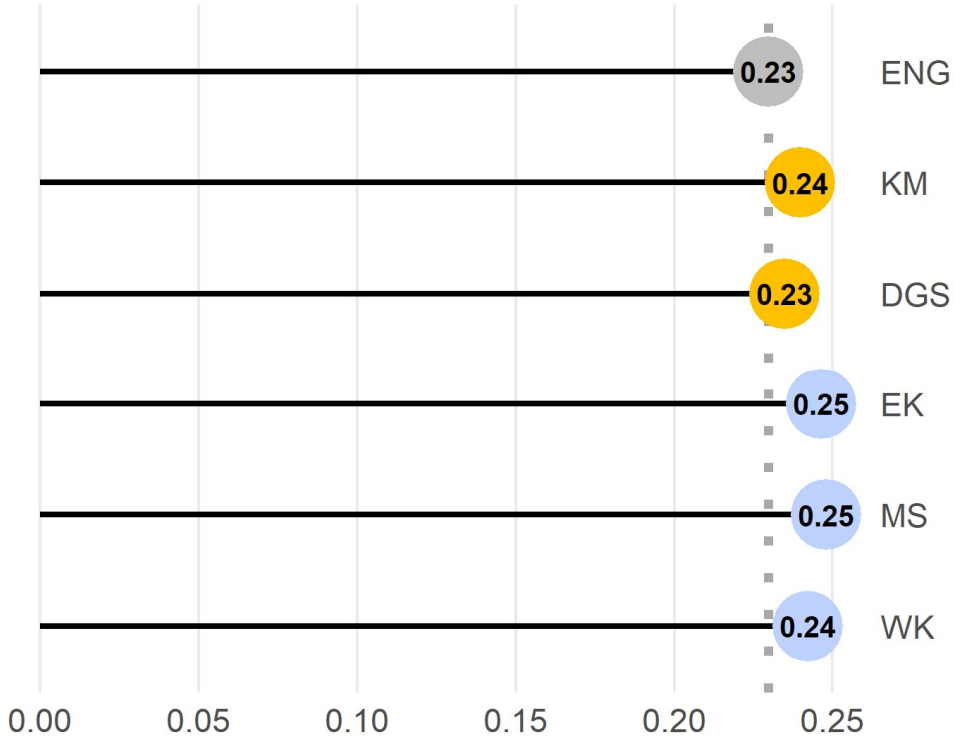
Medway and Swale cannot be compared to England statistically.

Value type: Mean - µg/m3.
Latest time period: 2020.
Source: PHE, Fingertips, Indicator ID: 92924.
Value calculation: Small areas averaged.
Small area type: Districts & UAs (from Apr 2021).
RAG method: None applied.

Total number of prescribed antibiotic items per STAR-PU





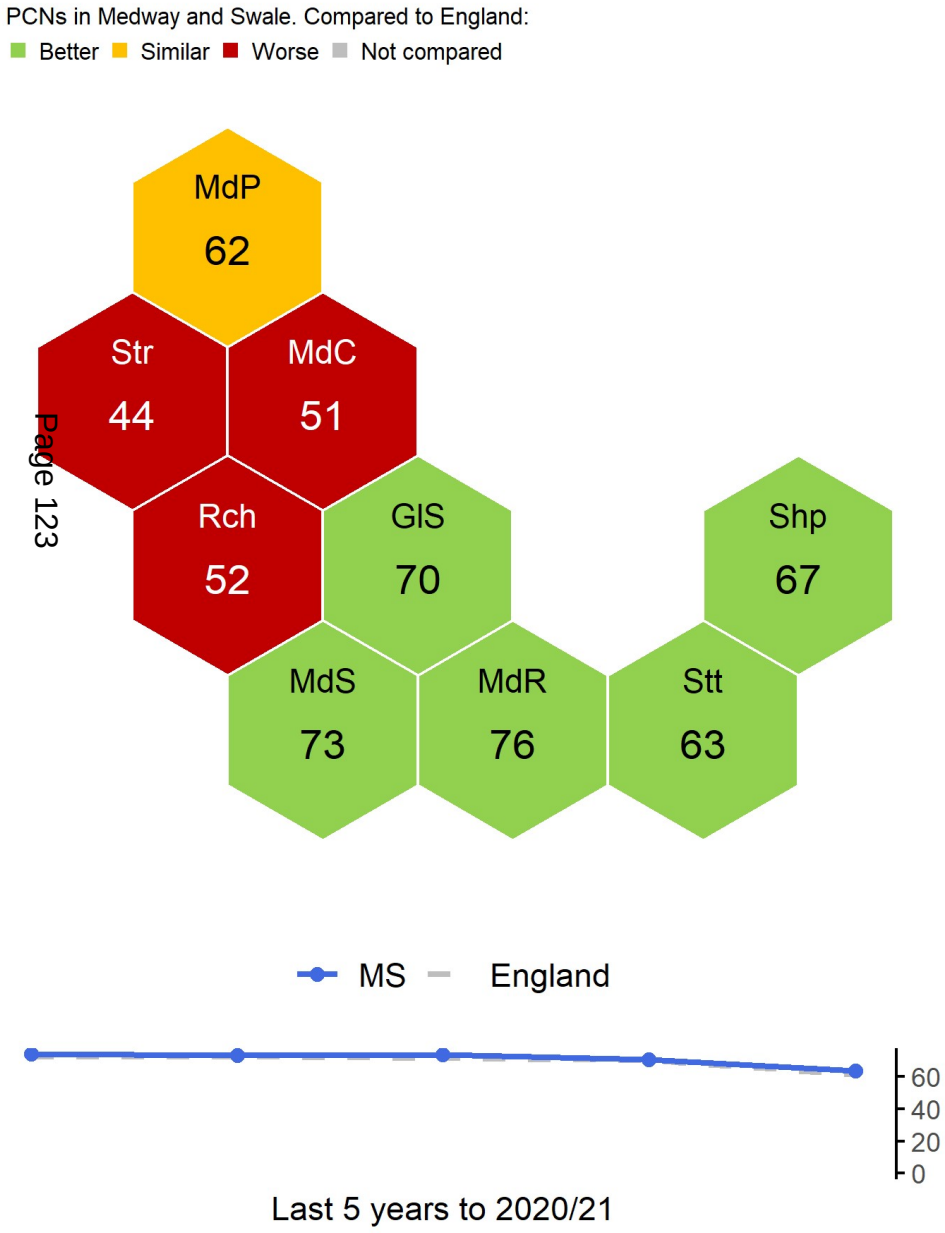


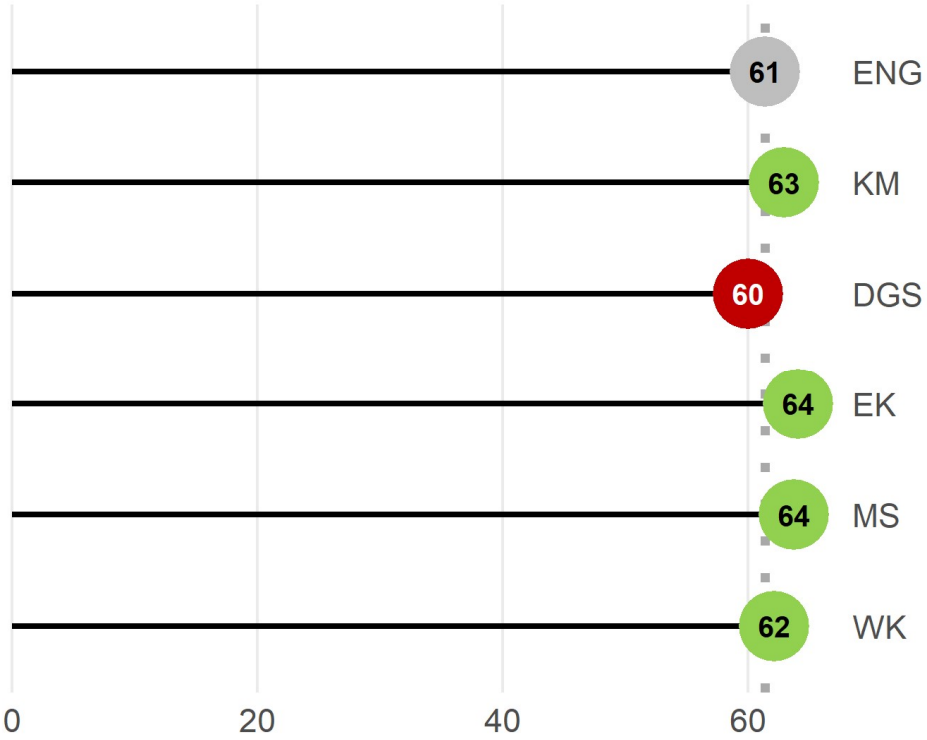
STAR-PU: Specific Therapeutic group Age-sex weightings Related Prescribing Unit

The rate in Medway and Swale is higher than England.

Value type: Indirectly standardised ratio - per STAR-PU.
Latest time period: 2021 Q4.
Source: PHE, Fingertips, Indicator ID: 91900.
Value calculation: Small areas averaged.
Small area type: Practice to PCN.
RAG method: England plus/minus 5%.

Breast cancer screening coverage (females aged 50-70)

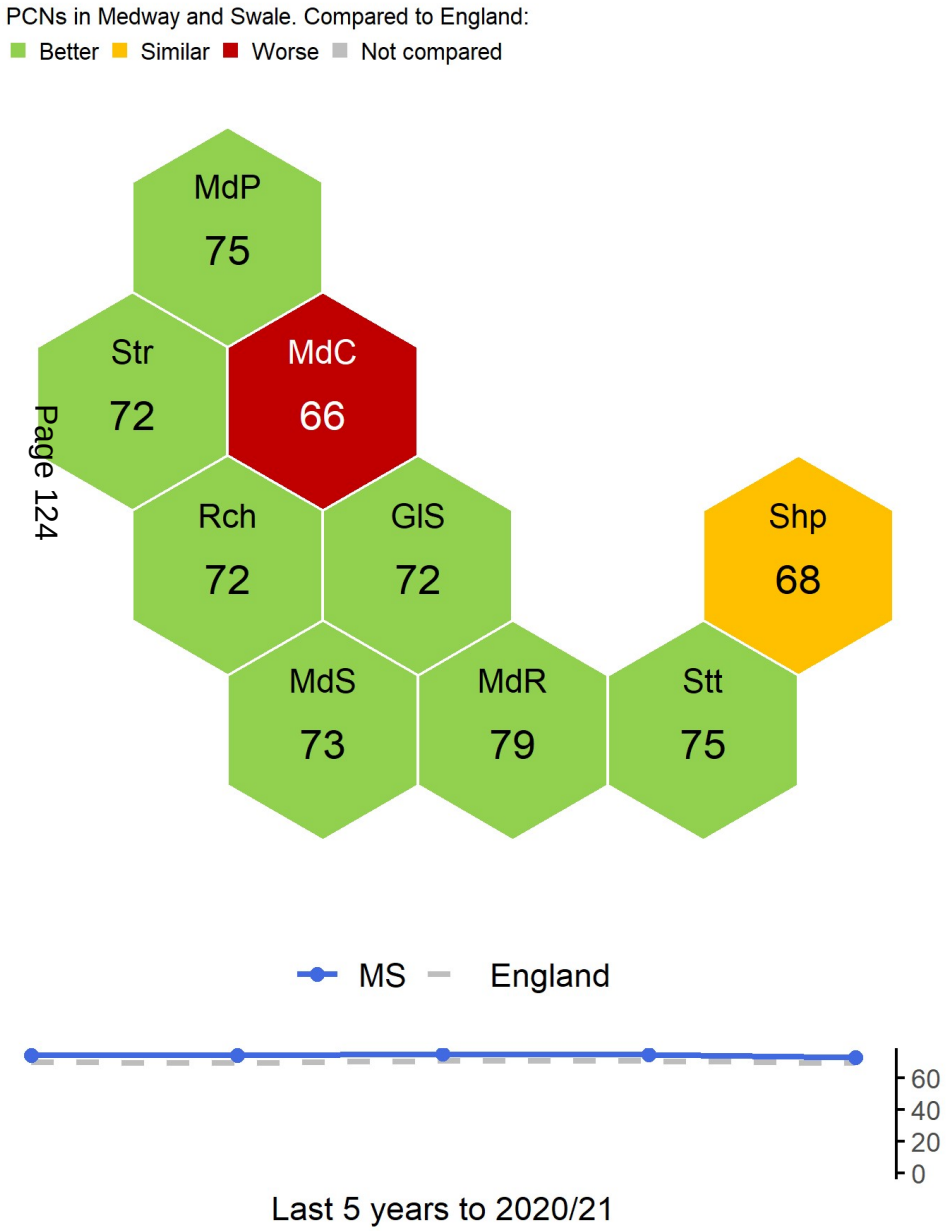


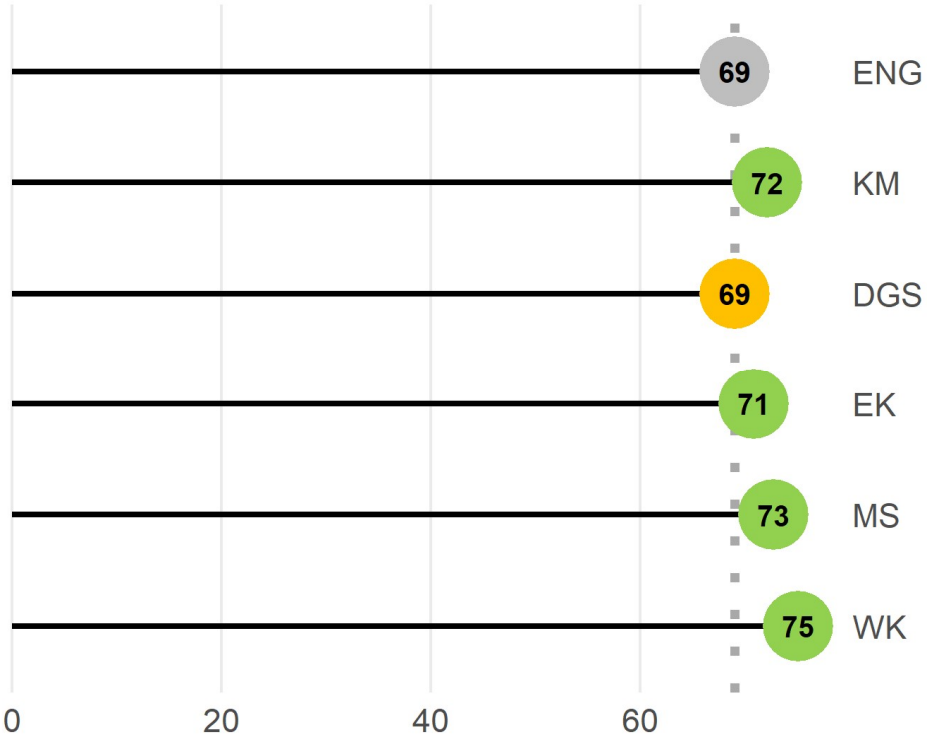


The rate in Medway and Swale is better than England.

Value type: Proportion - %.
Latest time period: 2020/21.
Source: PHE, Fingertips, Indicator ID: 91339.
Value calculation: Aggregated data.
Small area type: Practice to PCN.
RAG method: Confidence interval (99.8%) - Wilson Score method.

Cervical cancer screening coverage (females aged 25-49)

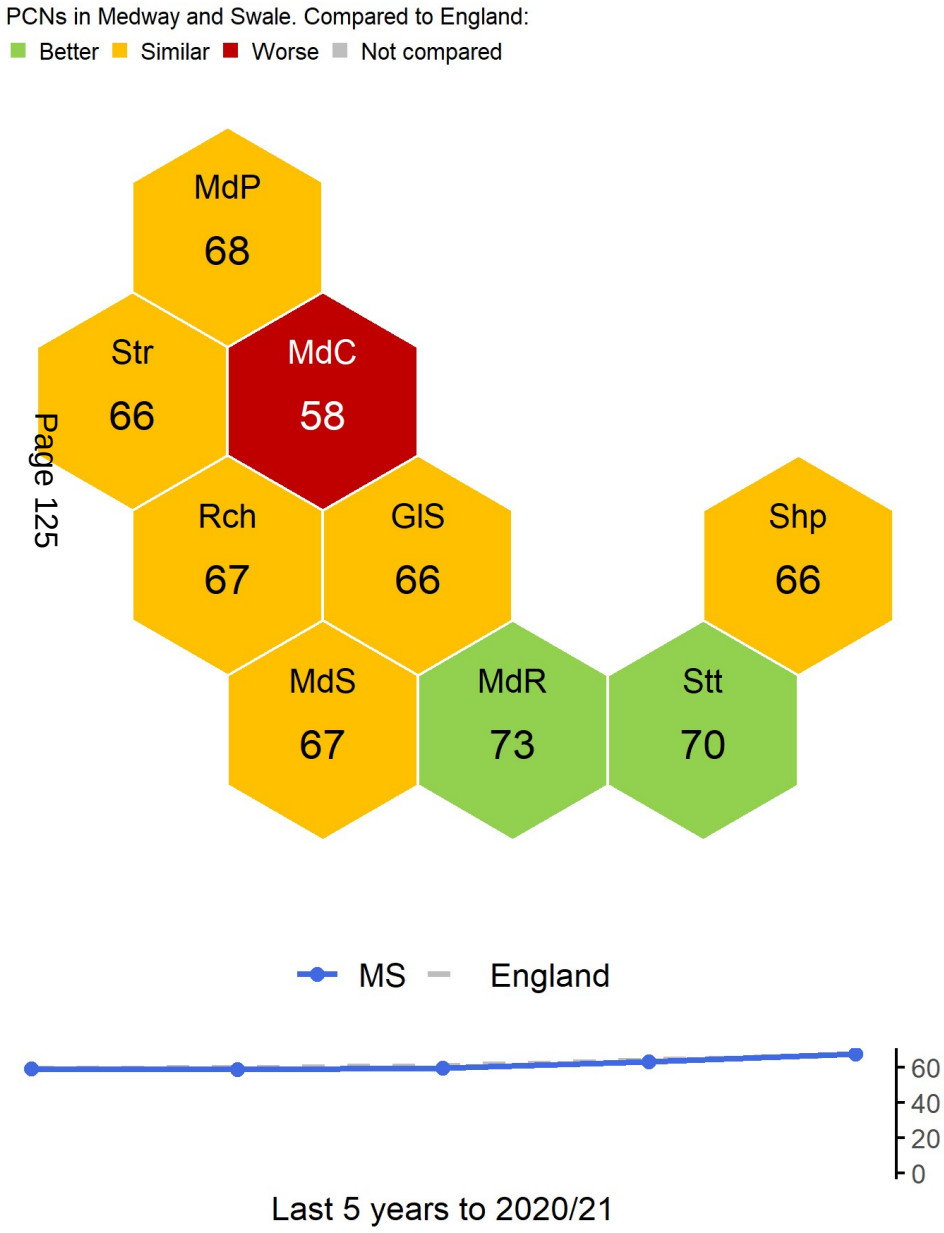


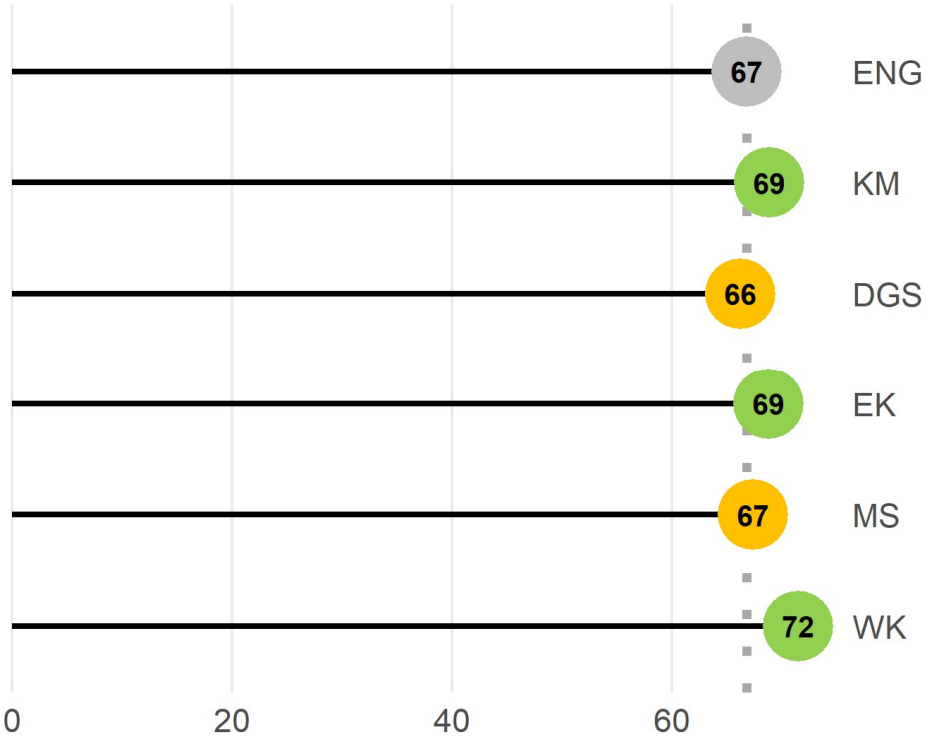


The rate in Medway and Swale is better than England.

Value type: Proportion - %.
Latest time period: 2020/21.
Source: PHE, Fingertips, Indicator ID: 93725.
Value calculation: Aggregated data.
Small area type: Practice to PCN.
RAG method: Confidence interval (99.8%) - Wilson Score method.

Bowel cancer screening coverage (persons aged 60-74)





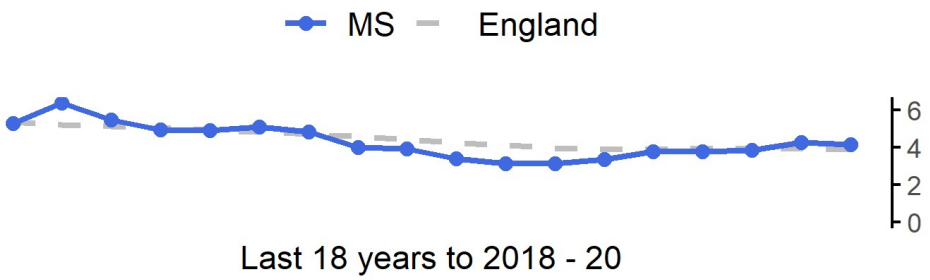
The rate in Medway and Swale is similar to England.

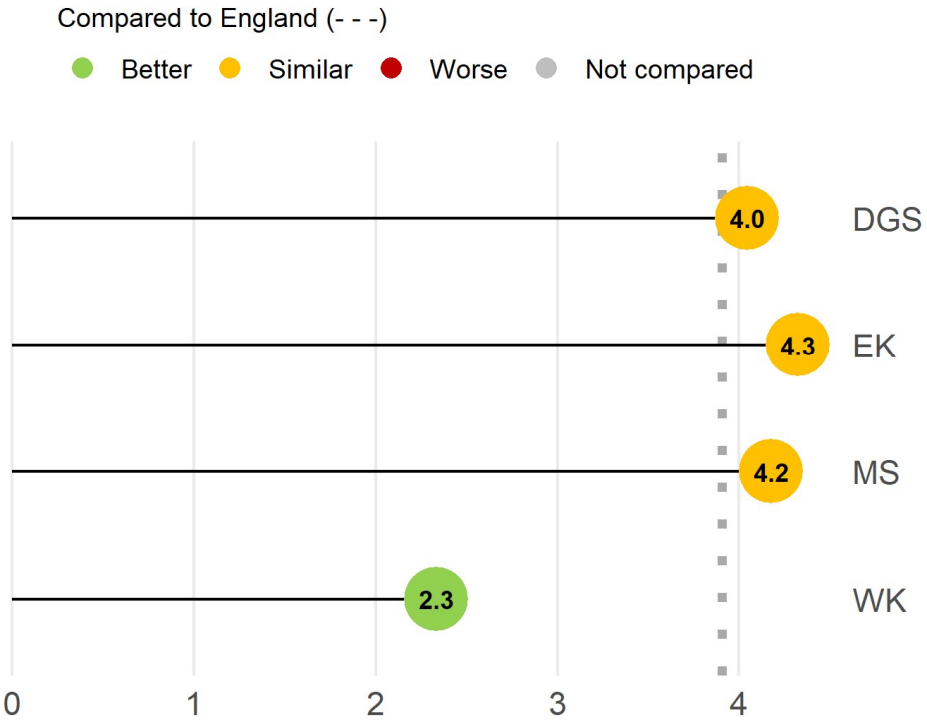
Value type: Proportion - %.
Latest time period: 2020/21.
Source: PHE, Fingertips, Indicator ID: 92600.
Value calculation: Aggregated data.
Small area type: Practice to PCN.
RAG method: Confidence interval (99.8%) - Wilson Score method.

BEST START IN LIFE

Infant mortality rate

4.2 HCP: Medway and Swale		3.9 England
		3.7 Kent and Medway
3.8 Medway	5.0 Swale	2018 - 20



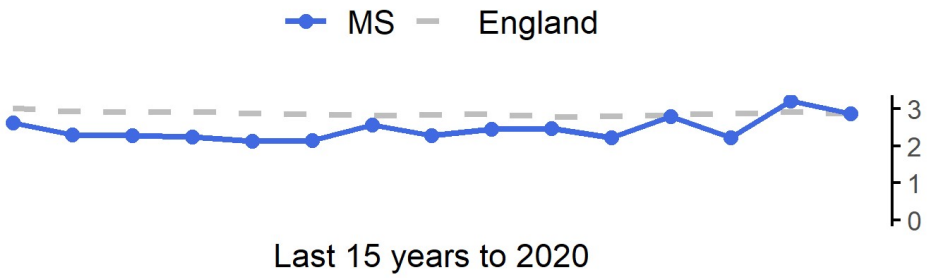


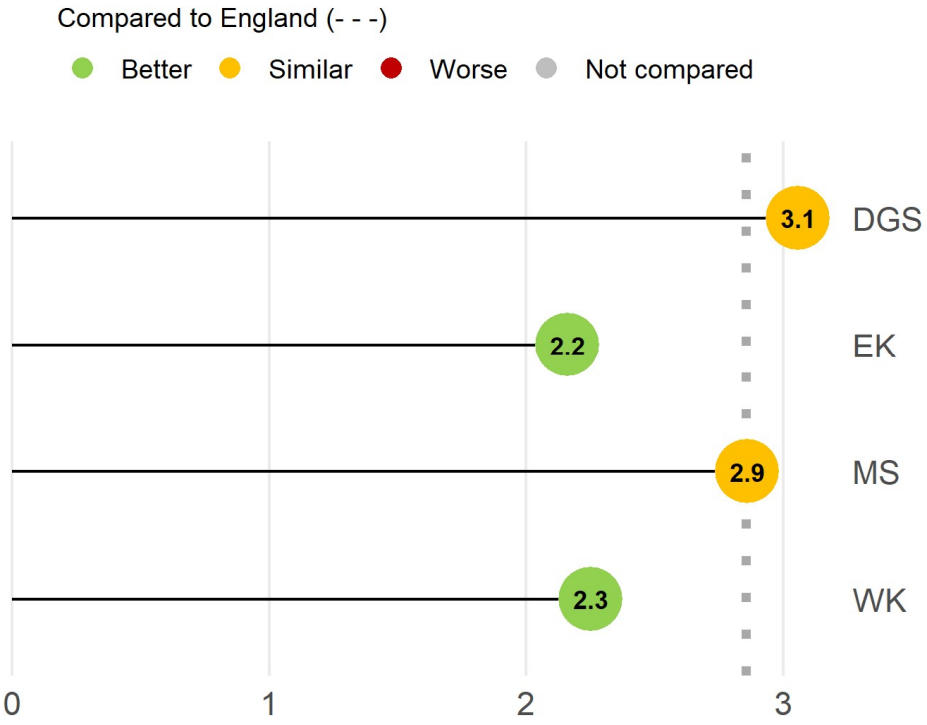
The rate in Medway and Swale is similar to England.

Value type: Crude rate - per 1,000.
Latest time period: 2018 - 20.
Source: PHE, Fingertips, Indicator ID: 92196.
Value calculation: Aggregated data.
Small area type: Districts & UAs (from Apr 2021).
RAG method: Confidence interval (95%) - Byar's method.

Low birth weight of term babies

2.9 HCP: Medway and Swale		2.9 England
		2.5 Kent and Medway
2.8 Medway	3.0 Swale	2020



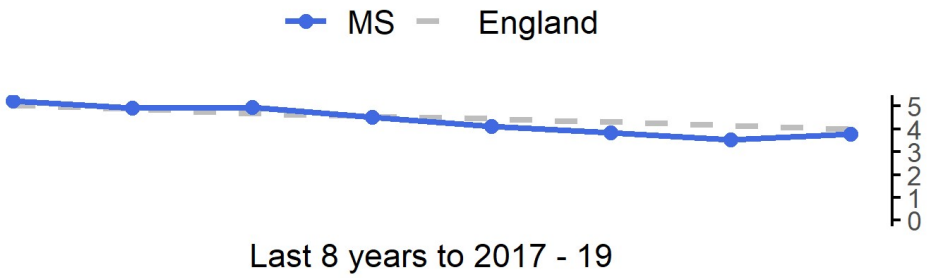


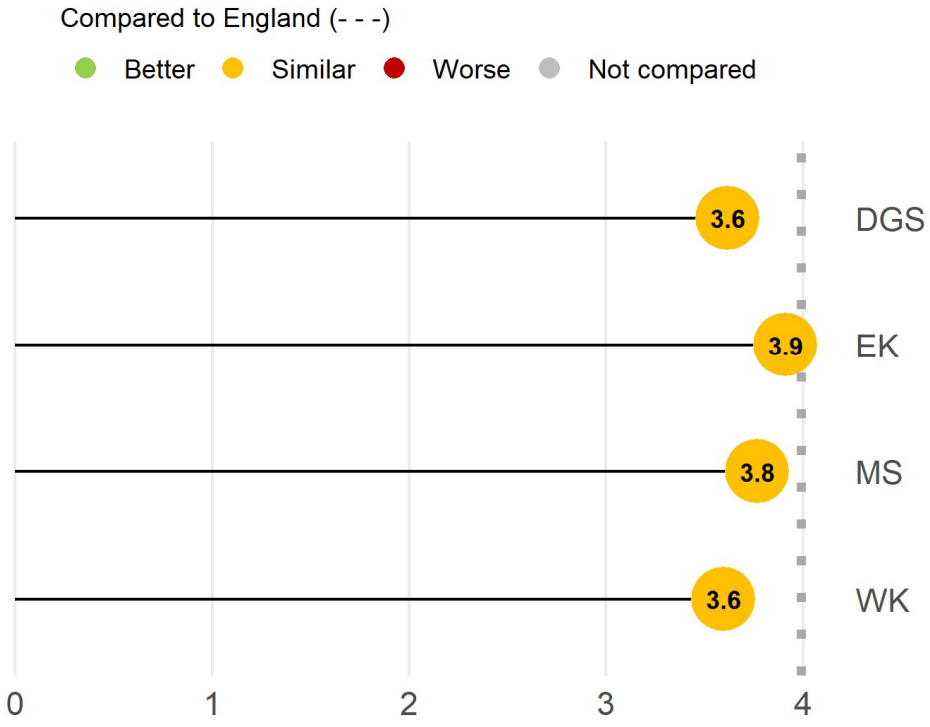
The rate in Medway and Swale is similar to England.

Value type: Proportion - %.
Latest time period: 2020.
Source: PHE, Fingertips, Indicator ID: 20101.
Value calculation: Aggregated data.
Small area type: Districts & UAs (from Apr 2021).
RAG method: Confidence interval (95%) - Wilson Score method.

Stillbirth rate

3.8		4.0
HCP: Medway and Swale		England
		3.7
		Kent and Medway
4.5	2.0	2017 - 19
Medway	Swale	



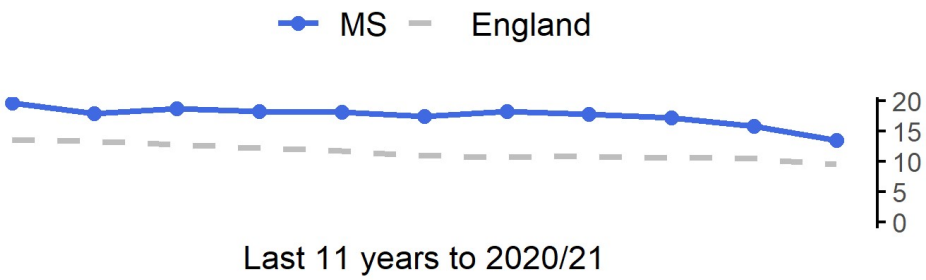


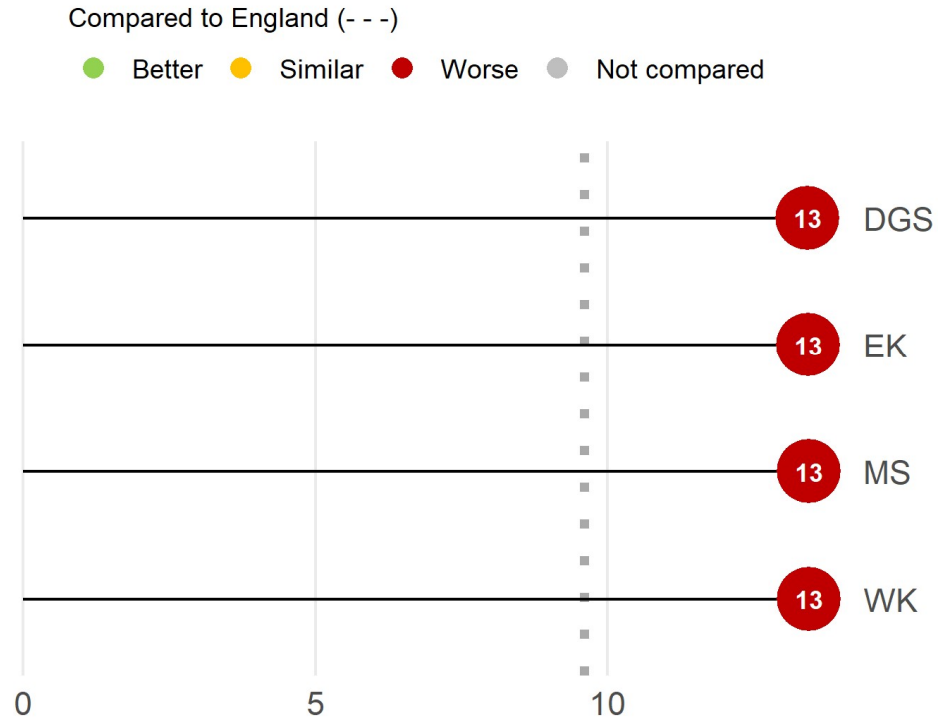
The rate in Medway and Swale is similar to England.

Value type: Crude rate - per 1,000.
Latest time period: 2017 - 19.
Source: PHE, Fingertips, Indicator ID: 92530.
Value calculation: Aggregated data.
Small area type: CCGs (2018/19).
RAG method: Confidence interval (95%) - Byar's method.

Smoking status at time of delivery

13		10
HCP: Medway and Swale		England
		13
		Kent and Medway
13	14	2020/21
Medway	Swale	

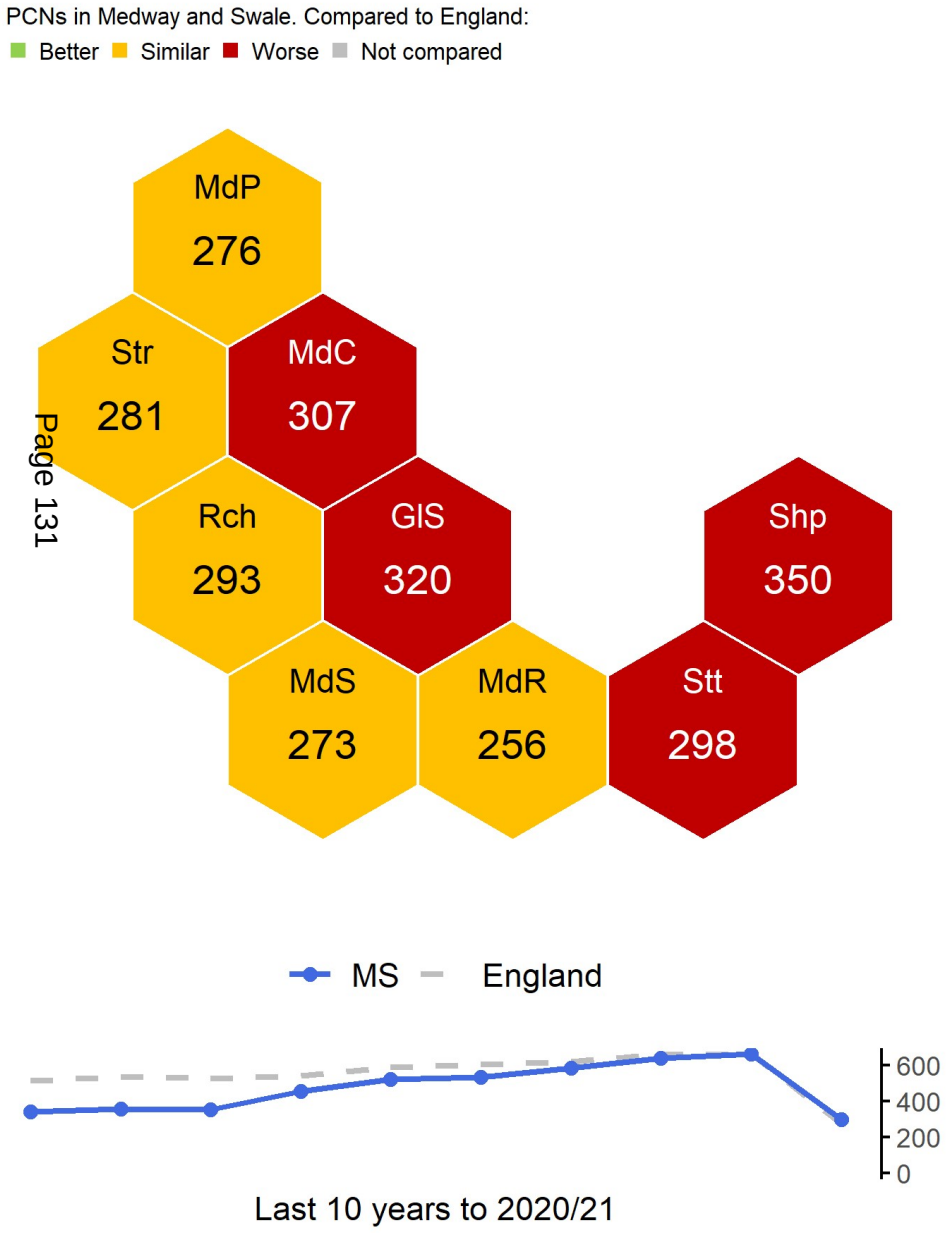


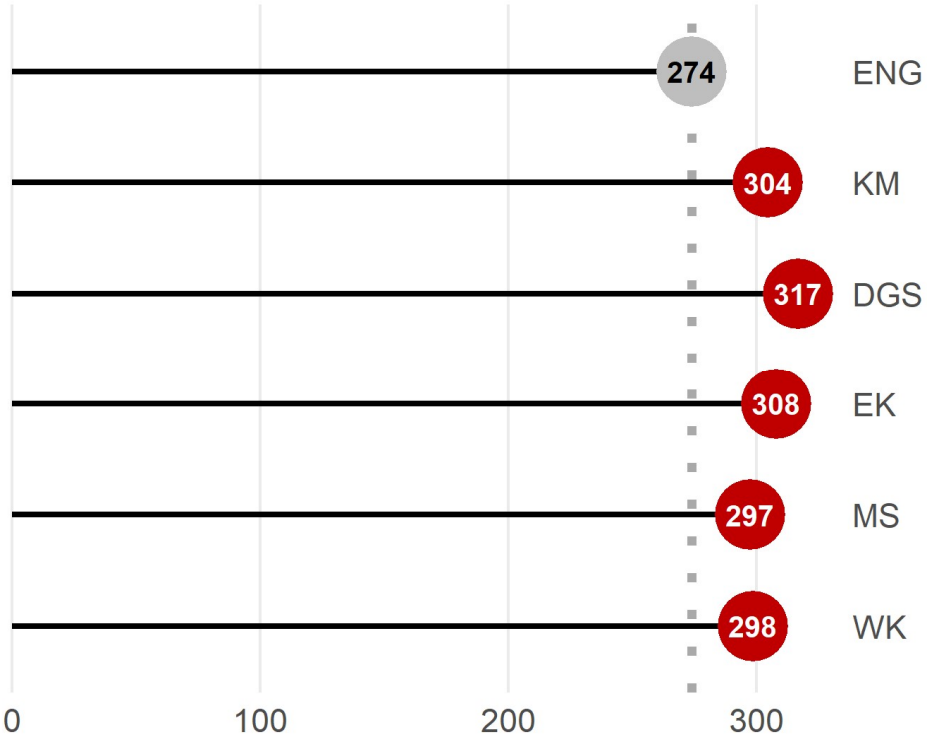


The rate in Medway and Swale is worse than England.

Value type: Proportion - %.
Latest time period: 2020/21.
Source: PHE, Fingertips, Indicator ID: 93085.
Value calculation: Aggregated data.
Small area type: Districts & UAs (from Apr 2021).
RAG method: Confidence interval (95%) - Wilson Score method.

AE attendances (0-4 years)



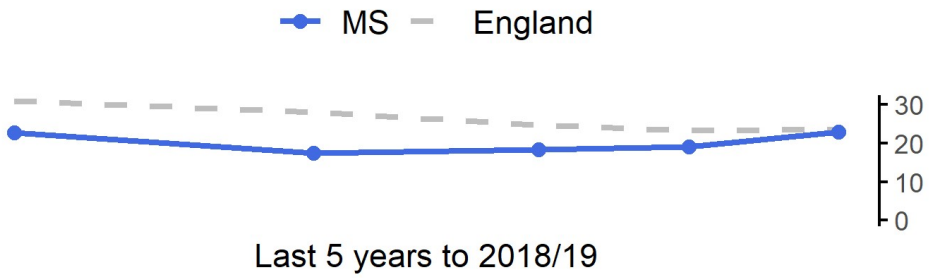


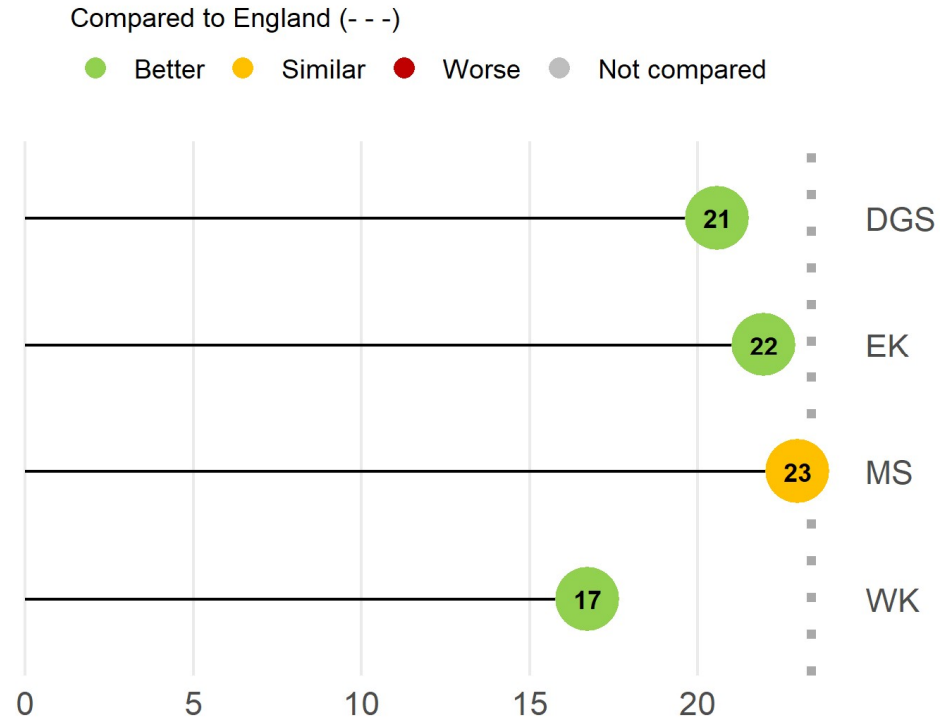
The rate in Medway and Swale is worse than England.

Value type: Crude rate per 1,000.
Latest time period: 2020/21.
Source: Hospital Episode Statistics (HES), NHS Digital.
Value calculation: Aggregated data.
Small area type: LSOA to PCN.
RAG method: Confidence interval (95%) - Byar's method.

Percentage of 5 year olds with experience of visually obvious dental decay

23 HCP: Medway and Swale		23 England
		20 Kent and Medway
25 Medway	20 Swale	2018/19



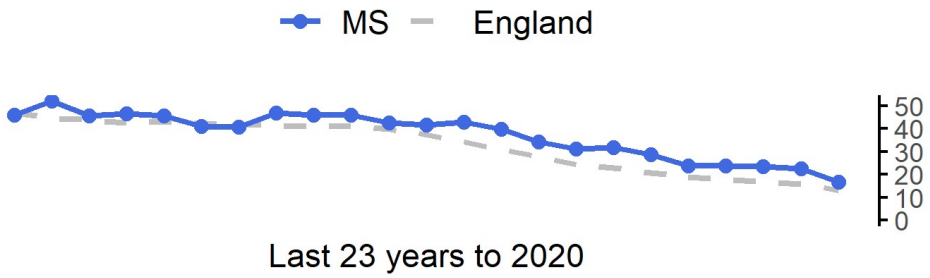


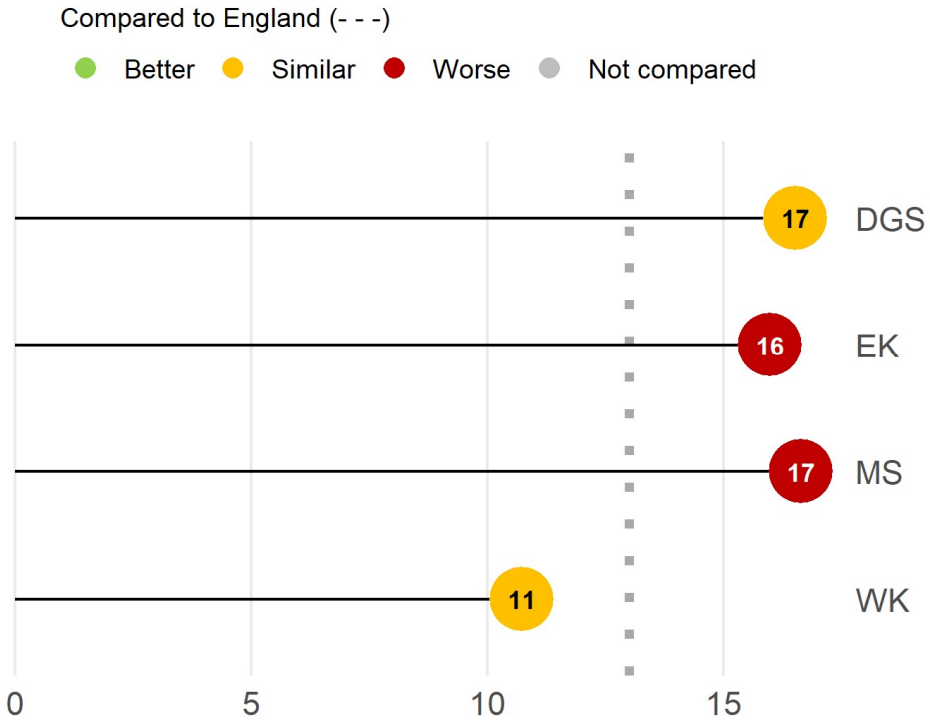
The rate in Medway and Swale is similar to England.

Value type: Proportion - %.
Latest time period: 2018/19.
Source: PHE, Fingertips, Indicator ID: 93563.
Value calculation: Small areas averaged.
Small area type: Districts & UAs (pre Apr 2019).
RAG method: England plus/minus 5%.

Under 18s conception rate / 1,000

17 HCP: Medway and Swale		13 England
		15 Kent and Medway
18 Medway	14 Swale	2020

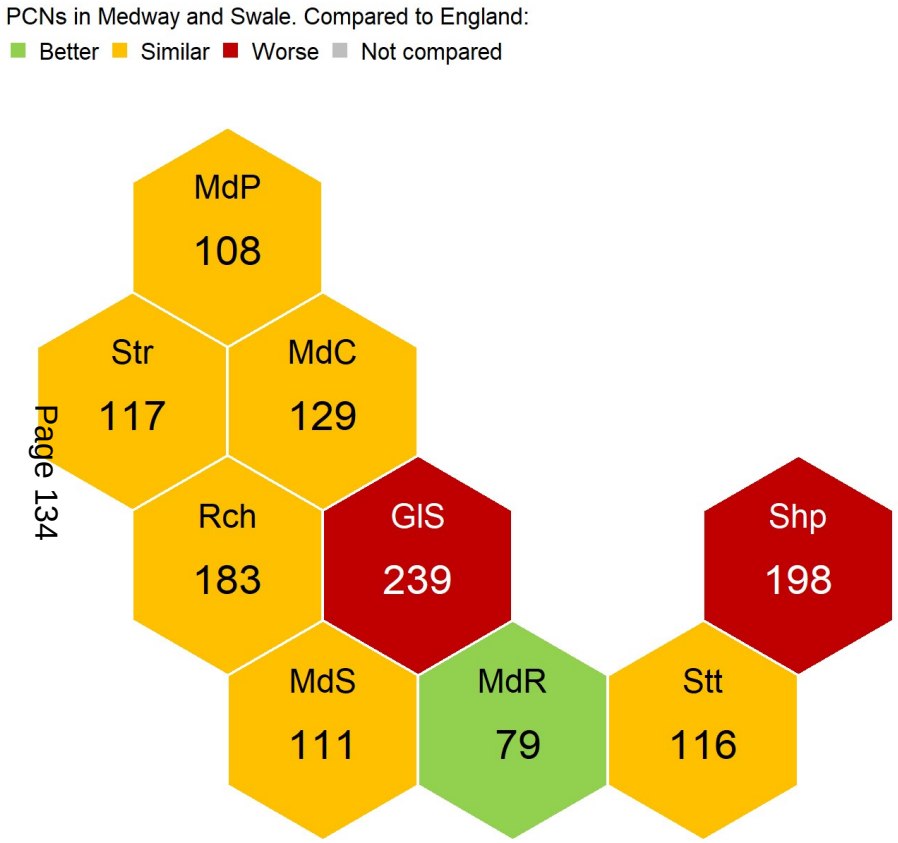


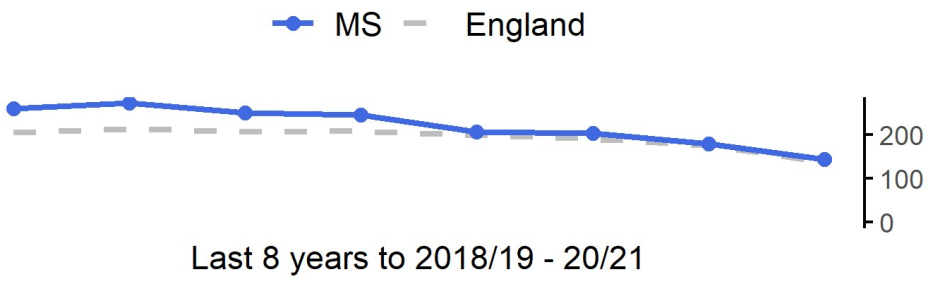


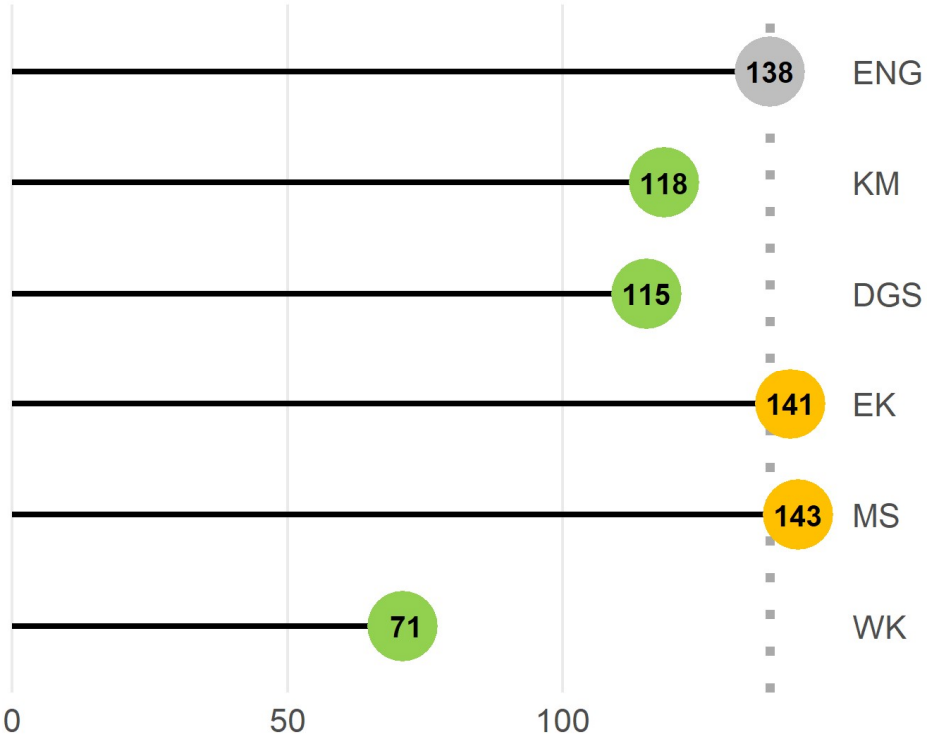
The rate in Medway and Swale is worse than England.

Value type: Crude rate - per 1,000.
Latest time period: 2020.
Source: PHE, Fingertips, Indicator ID: 20401.
Value calculation: Aggregated data.
Small area type: Districts & UAs (from Apr 2021).
RAG method: Confidence interval (95%) - Byar's method.

Emergency hospital admissions for asthma (< 19 yrs)





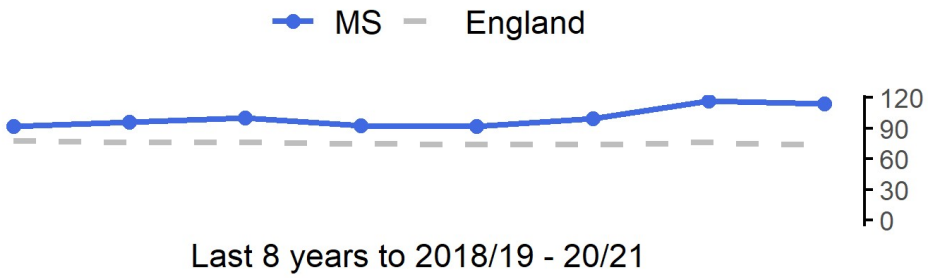


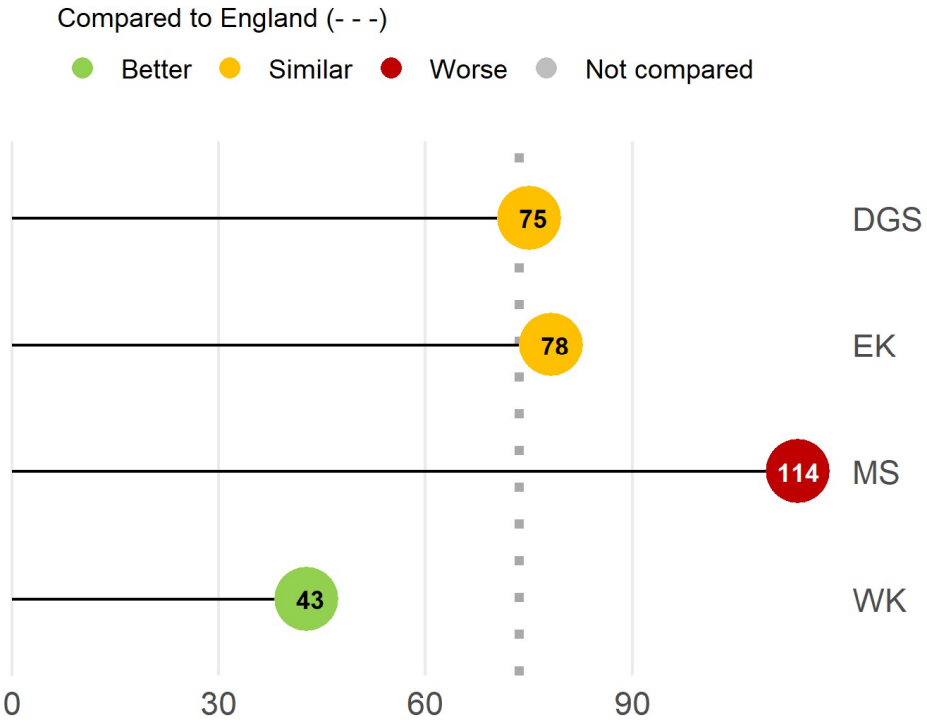
The rate in Medway and Swale is similar to England.

Value type: Crude rate - per 100,000.
Latest time period: 2018/19 - 20/21.
Source: Hospital Episode Statistics (HES), NHS Digital.
Value calculation: Aggregated data.
Small area type: LSOA to PCN.
RAG method: Confidence interval (95%) - Byar's method.

Emergency hospital admissions for epilepsy (< 19 yrs)

114 HCP: Medway and Swale		74 England
		76 Kent and Medway
117 Medway	108 Swale	2018/19 - 20/21



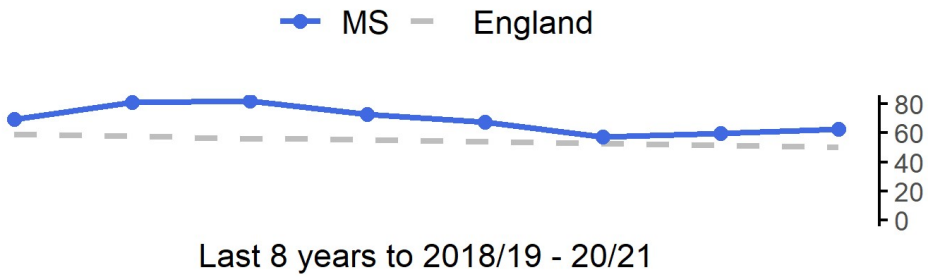


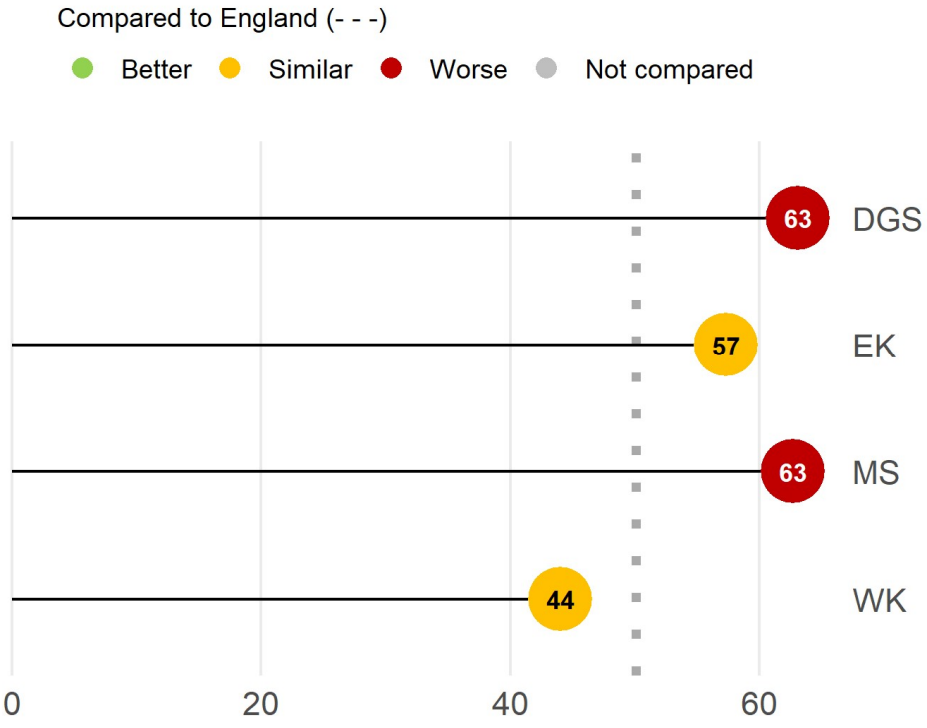
The rate in Medway and Swale is worse than England.

Value type: Crude rate - per 100,000.
Latest time period: 2018/19 - 20/21.
Source: Hospital Episode Statistics (HES), NHS Digital.
Value calculation: Aggregated data.
Small area type: District & UA.
RAG method: Confidence interval (95%) - Byar's method.

Emergency hospital admissions for diabetes (< 19 yrs)

63 HCP: Medway and Swale		50 England
		55 Kent and Medway
59 Medway	70 Swale	2018/19 - 20/21



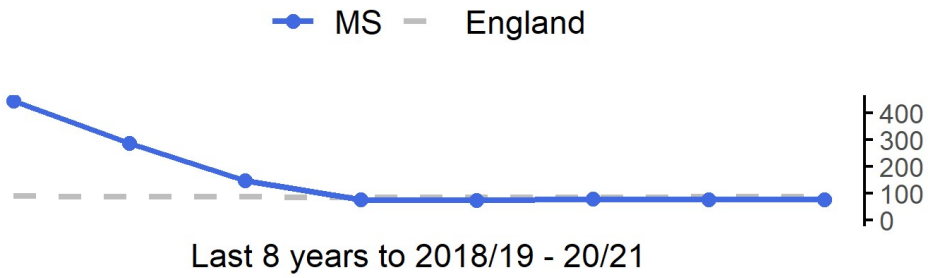


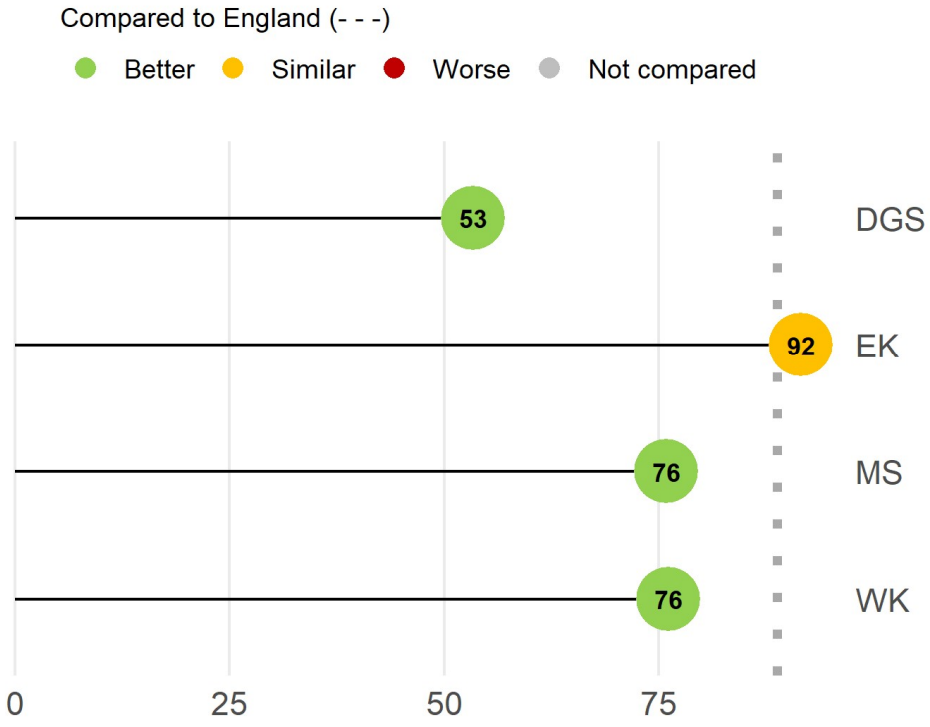
The rate in Medway and Swale is worse than England.

Value type: Crude rate - per 100,000.
Latest time period: 2018/19 - 20/21.
Source: Hospital Episode Statistics (HES), NHS Digital.
Value calculation: Aggregated data.
Small area type: District & UA.
RAG method: Confidence interval (95%) - Byar's method.

Hospital admissions for mental health conditions (0-17 years)

76		89
HCP: Medway and Swale		England
		77
		Kent and Medway
74	79	2018/19 - 20/21
Medway	Swale	

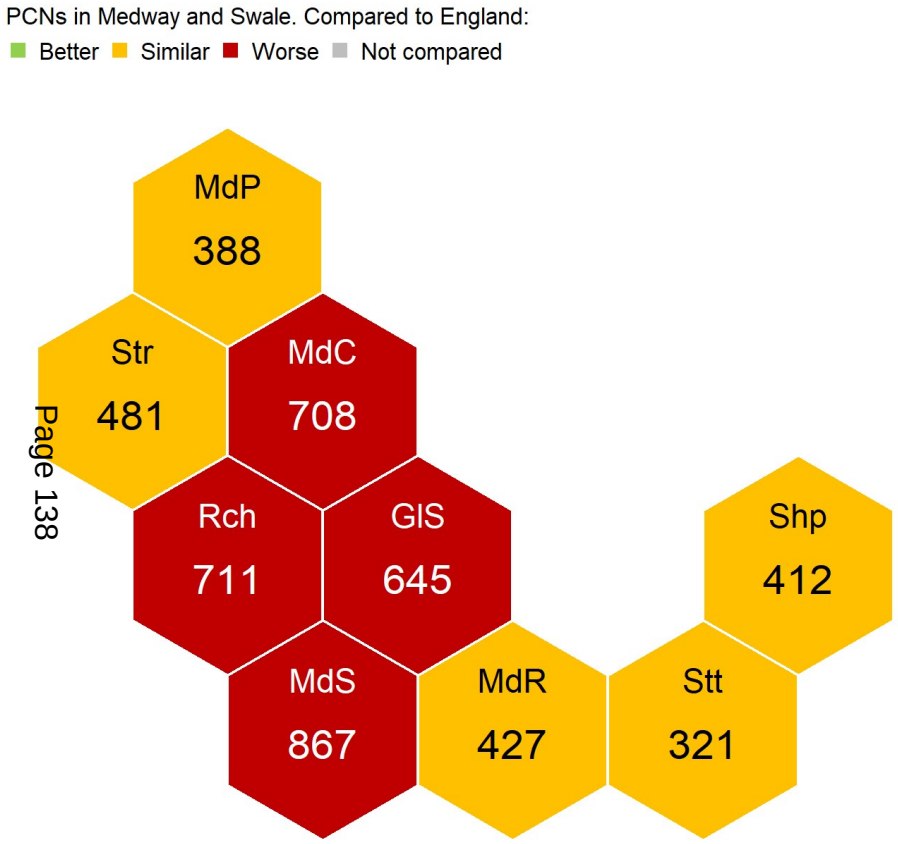


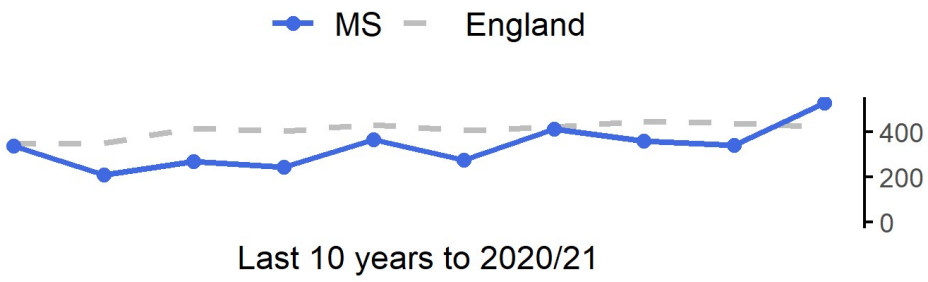


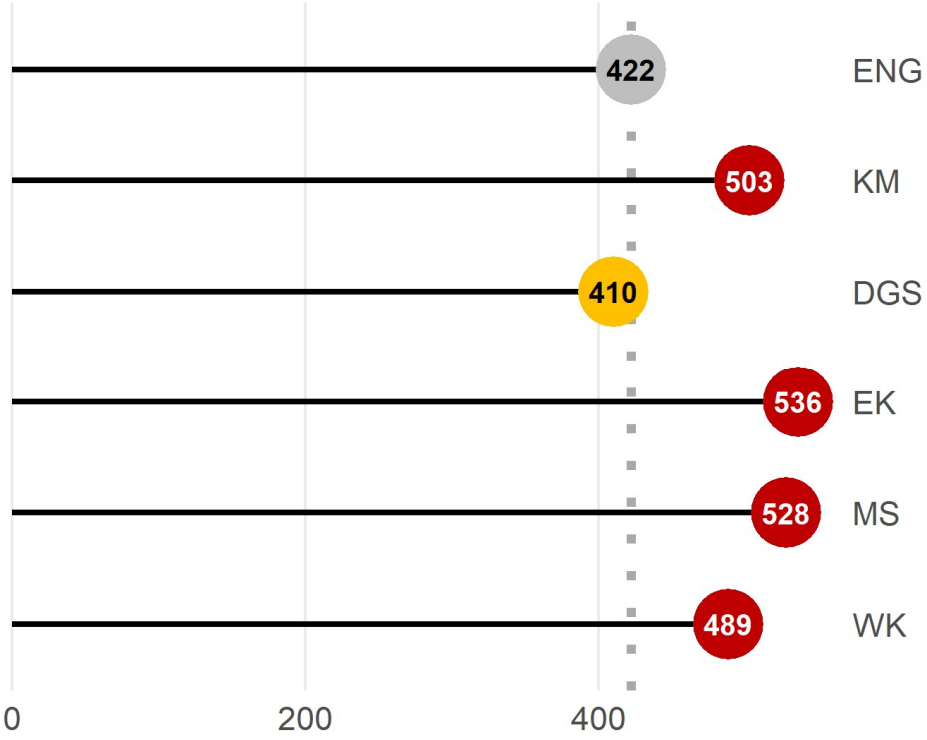
The rate in Medway and Swale is better than England.

Value type: Crude rate - per 100,000.
Latest time period: 2018/19 - 20/21.
Source: Hospital Episode Statistics (HES), NHS Digital.
Value calculation: Aggregated data.
Small area type: District & UA.
RAG method: Confidence interval (95%) - Byar's method.

Hospital admissions as a result of self-harm (10-24 years)





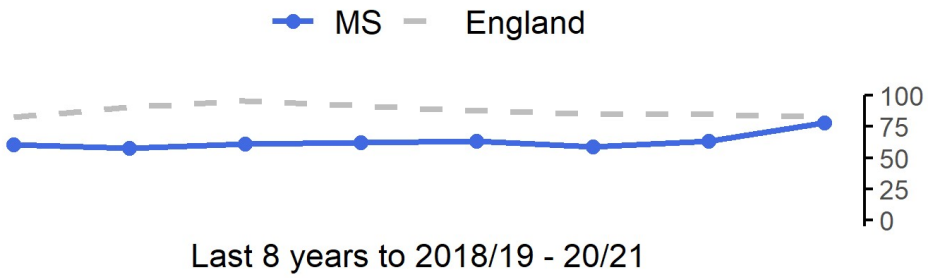


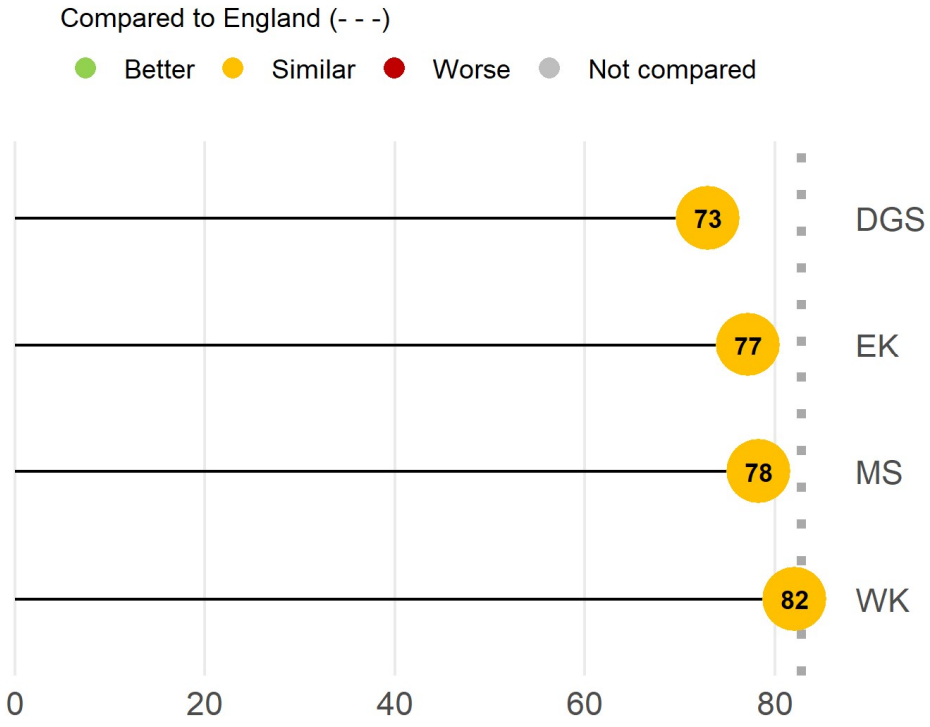
The rate in Medway and Swale is worse than England.

Value type: Directly standardised rate.
Latest time period: 2020/21.
Source: Hospital Episode Statistics (HES), NHS Digital.
Value calculation: Aggregated data.
Small area type: LSOA to PCN.
RAG method: Confidence interval (95%) - Dobson's method.

Hospital admissions due to substance misuse (15-24 years)

78		83
HCP: Medway and Swale		England
		78
		Kent and Medway
82	61	2018/19 - 20/21
Medway	Swale	



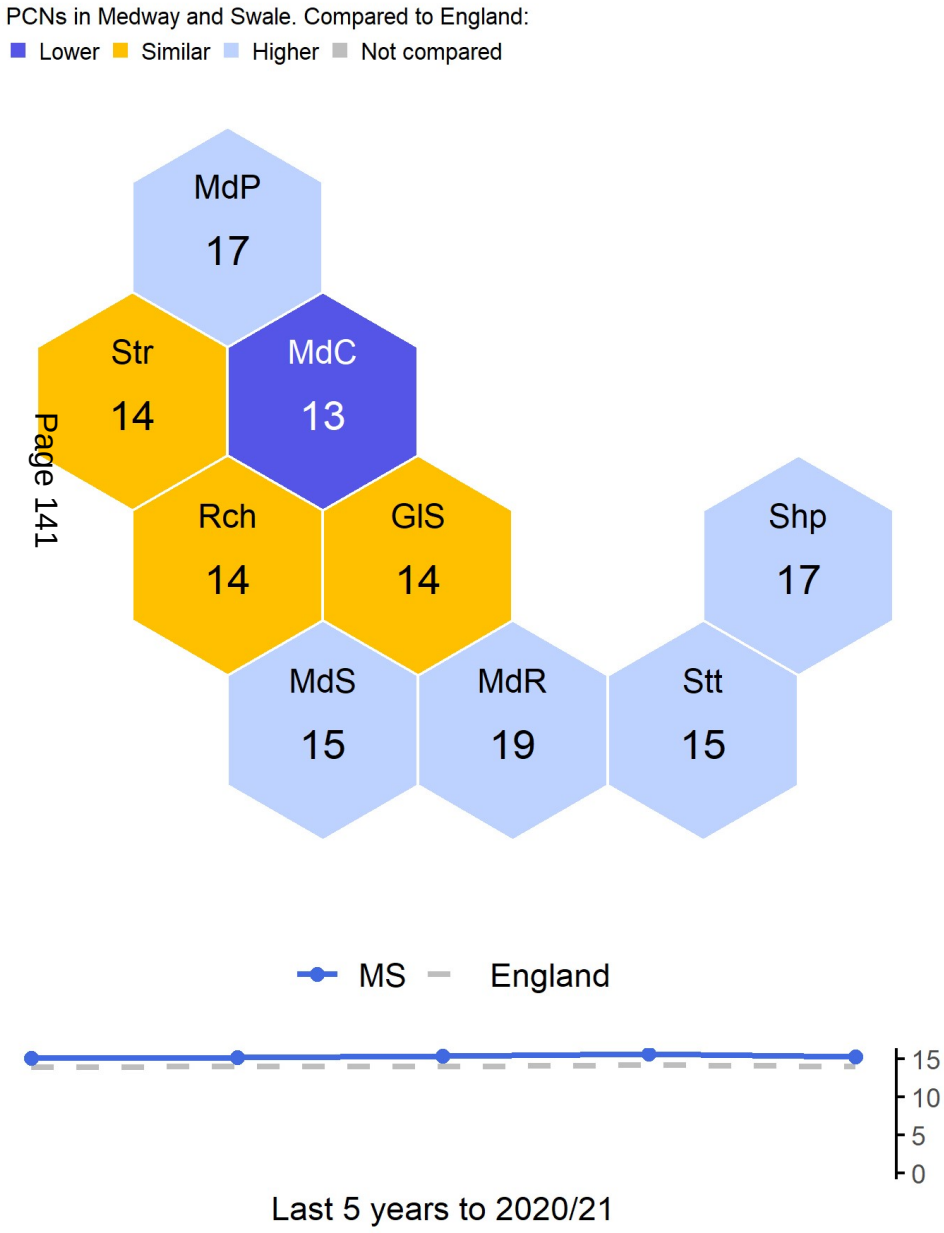


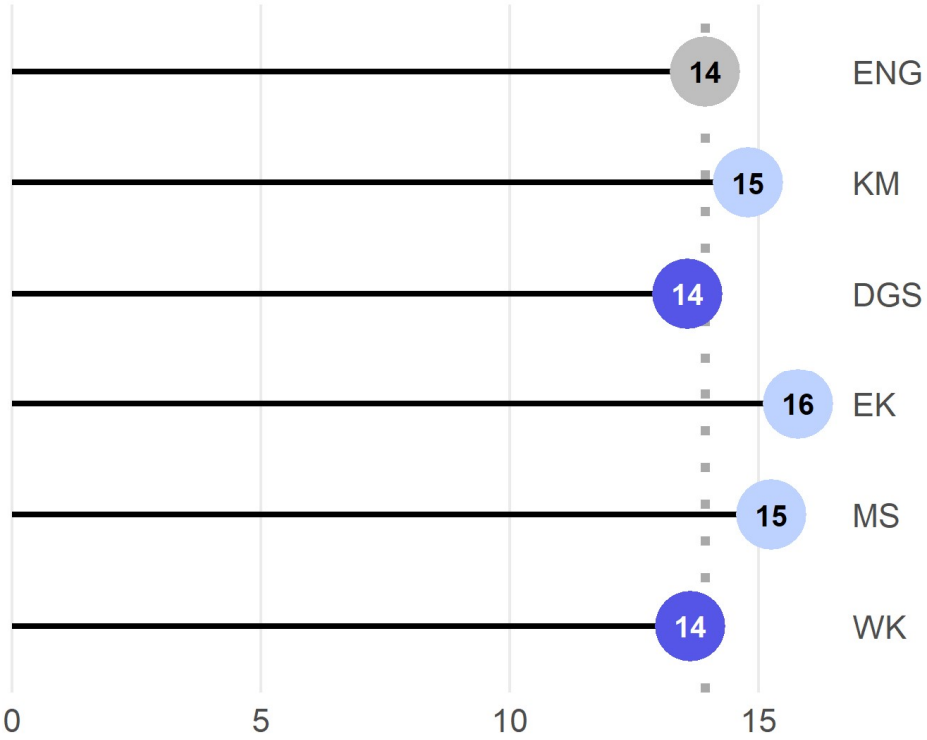
The rate in Medway and Swale is similar to England.

Value type: Crude rate - per 100,000.
Latest time period: 2018/19 - 20/21.
Source: Hospital Episode Statistics (HES), NHS Digital.
Value calculation: Aggregated data.
Small area type: District & UA.
RAG method: Confidence interval (95%) - Byar's method.

MAJOR HEALTH CONDITIONS

Hypertension: QOF prevalence (all ages)

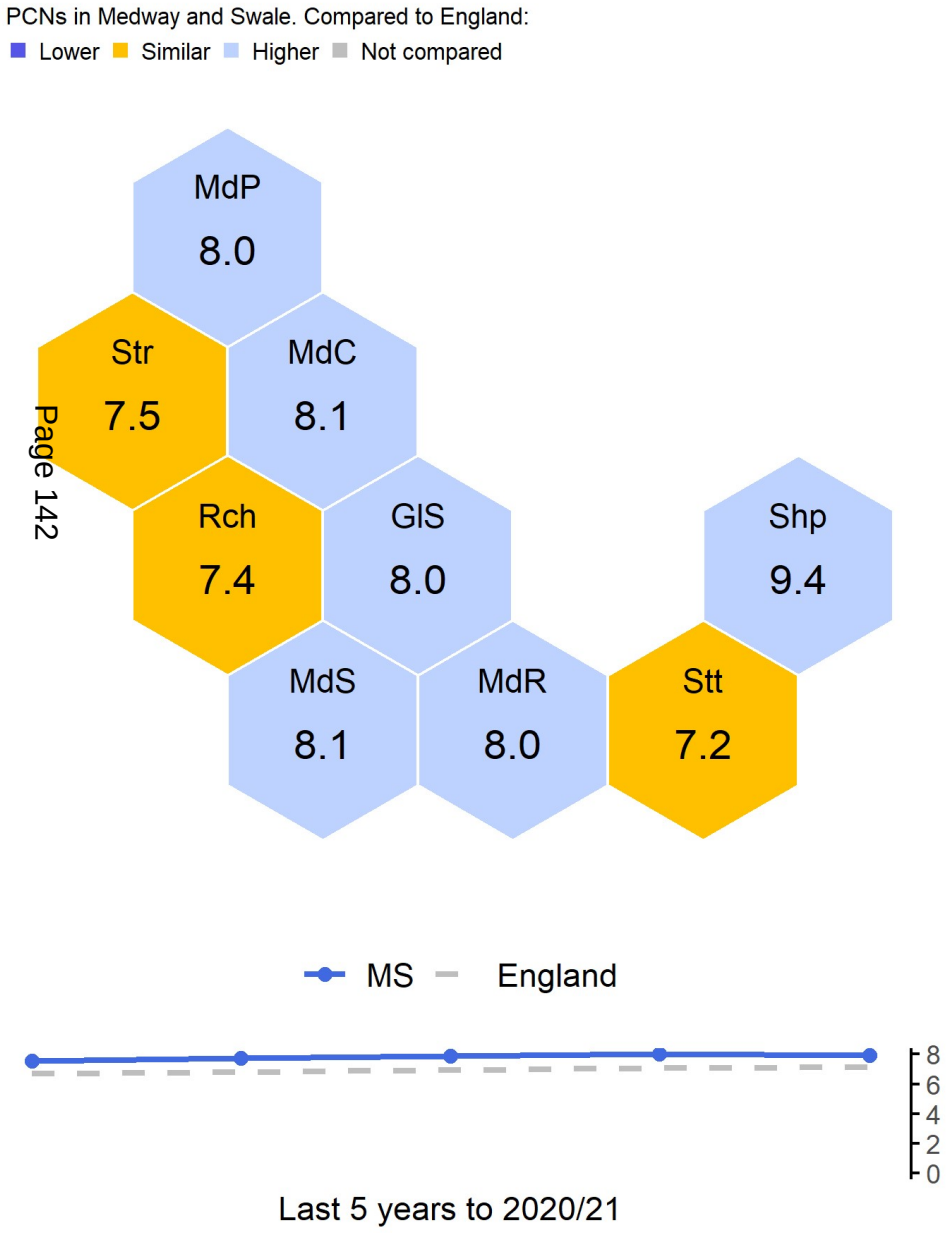


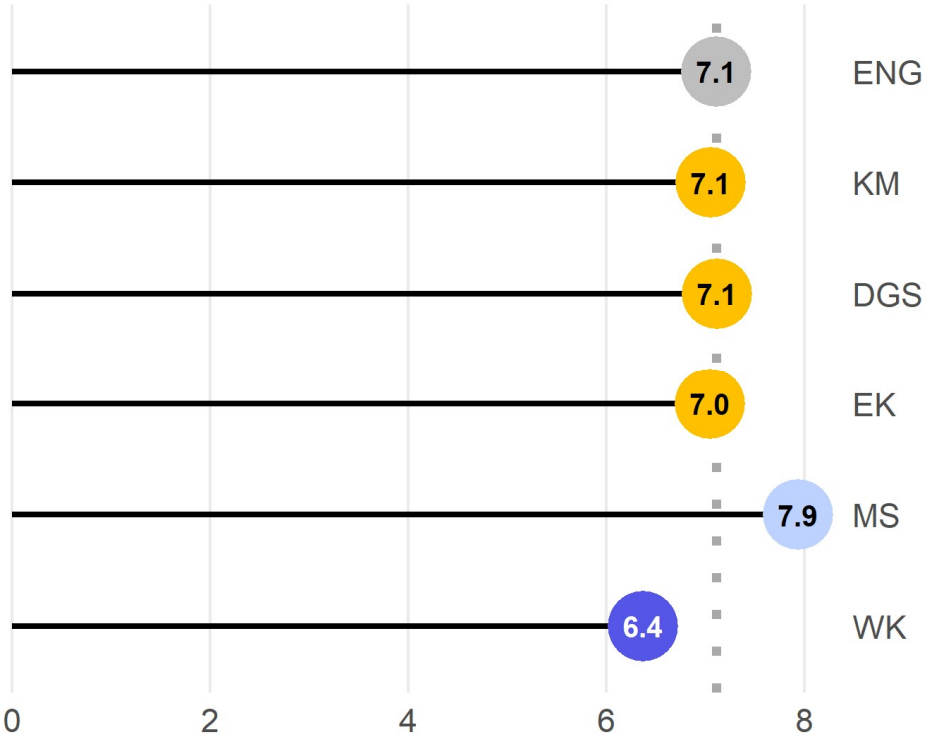


The rate in Medway and Swale is higher than England.

Value type: Proportion - %.
Latest time period: 2020/21.
Source: PHE, Fingertips, Indicator ID: 219.
Value calculation: Aggregated data.
Small area type: Practice to PCN.
RAG method: Confidence interval (99.8%) - Wilson Score method.

Diabetes: QOF prevalence (17+)

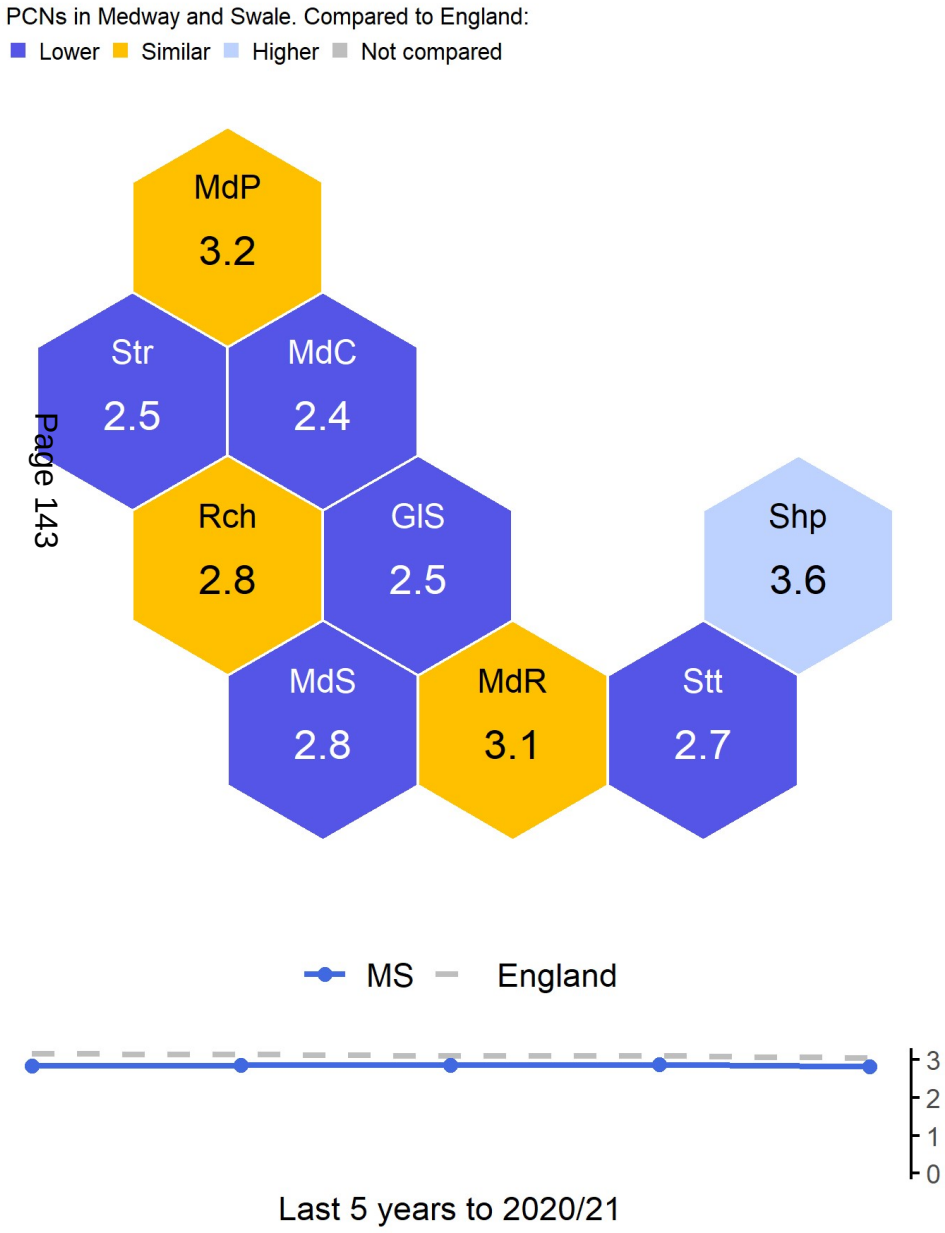


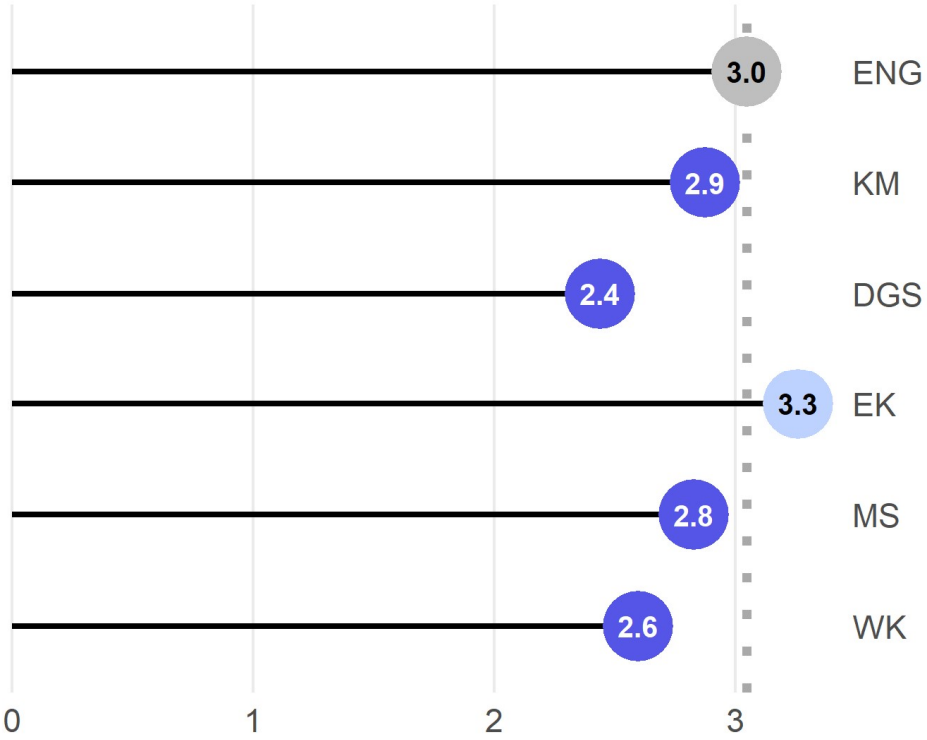


The rate in Medway and Swale is higher than England.

Value type: Proportion - %.
Latest time period: 2020/21.
Source: PHE, Fingertips, Indicator ID: 241.
Value calculation: Aggregated data.
Small area type: Practice to PCN.
RAG method: Confidence interval (99.8%) - Wilson Score method.

CHD: QOF prevalence (all ages)

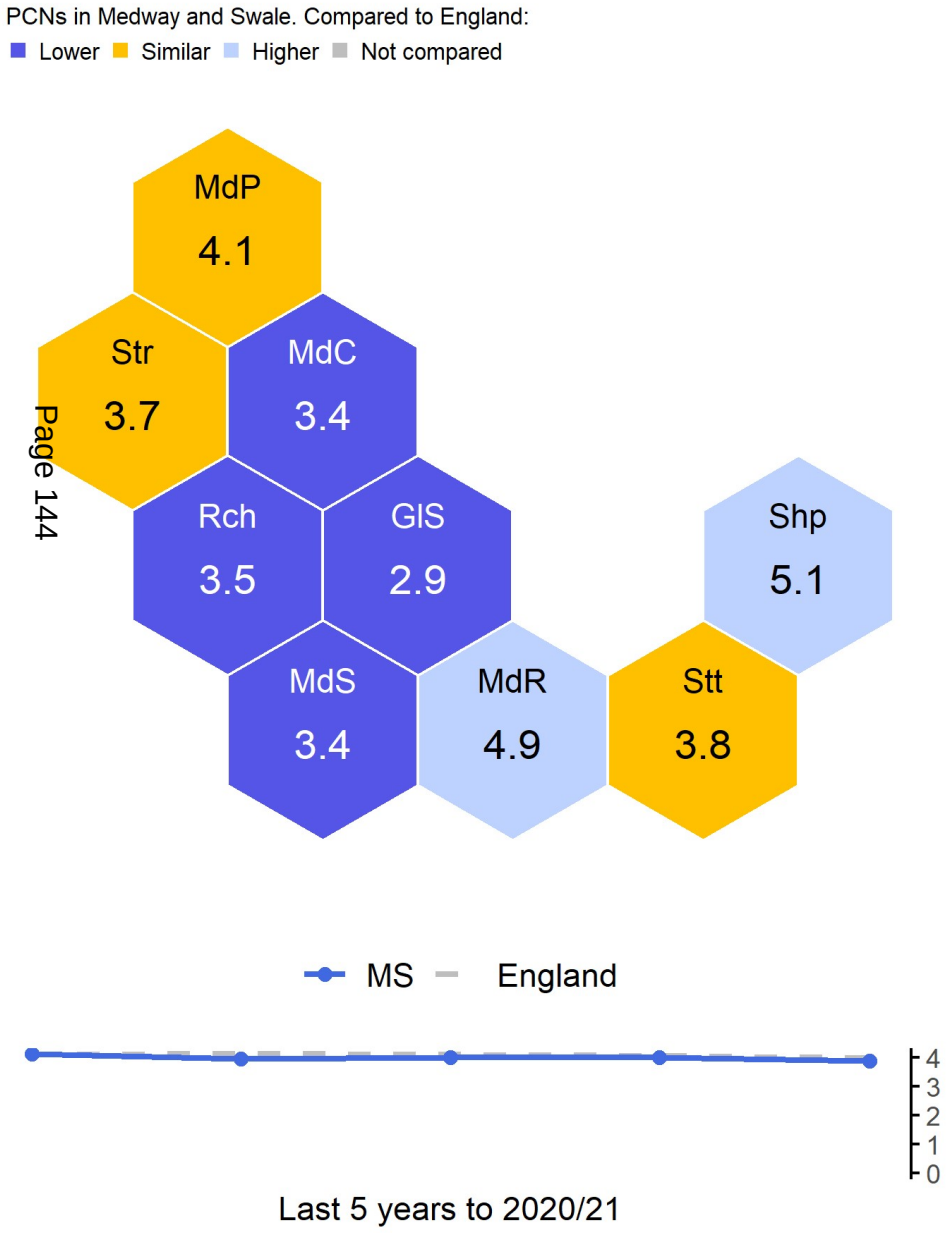


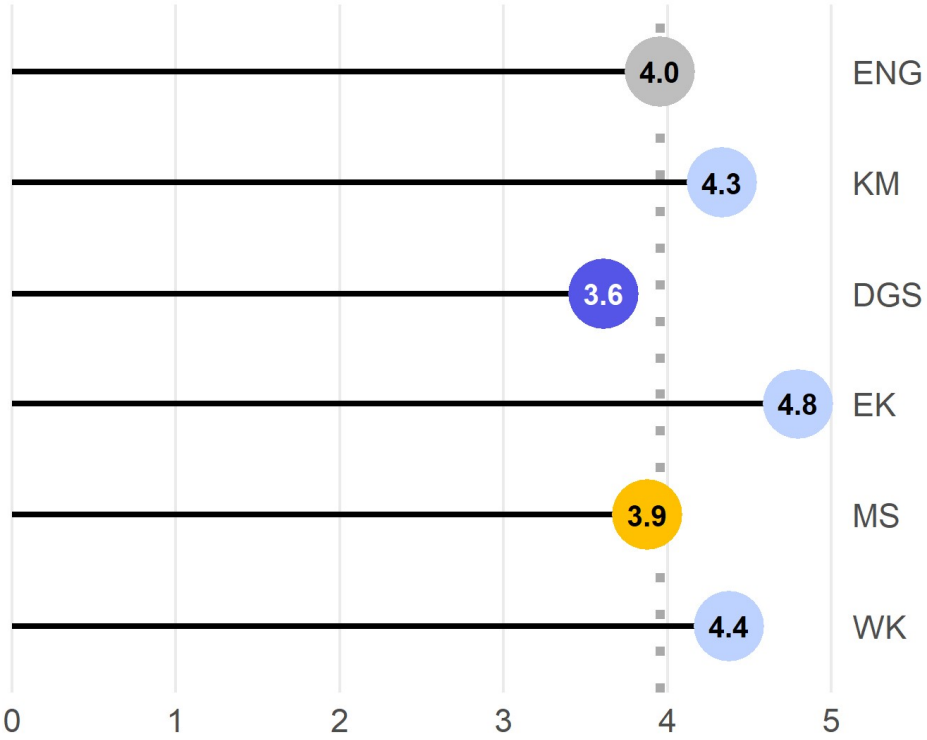


The rate in Medway and Swale is lower than England.

Value type: Proportion - %.
Latest time period: 2020/21.
Source: PHE, Fingertips, Indicator ID: 273.
Value calculation: Aggregated data.
Small area type: Practice to PCN.
RAG method: Confidence interval (99.8%) - Wilson Score method.

CKD: QOF prevalence (18+)

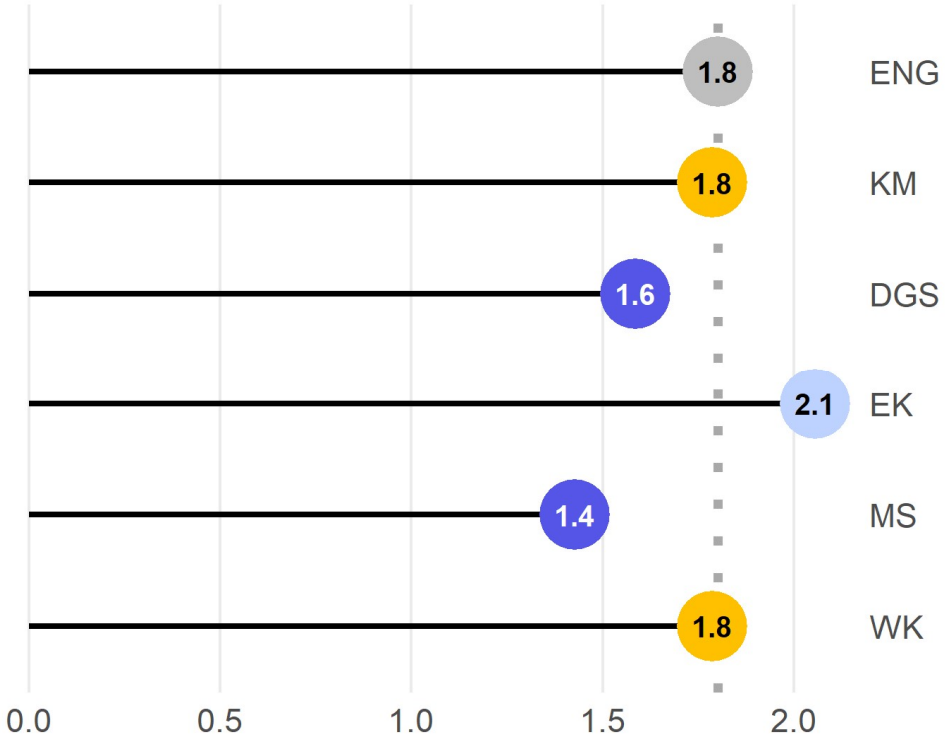




The rate in Medway and Swale is similar to England.

Value type: Proportion - %.
Latest time period: 2020/21.
Source: PHE, Fingertips, Indicator ID: 258.
Value calculation: Aggregated data.
Small area type: Practice to PCN.
RAG method: Confidence interval (99.8%) - Wilson Score method.

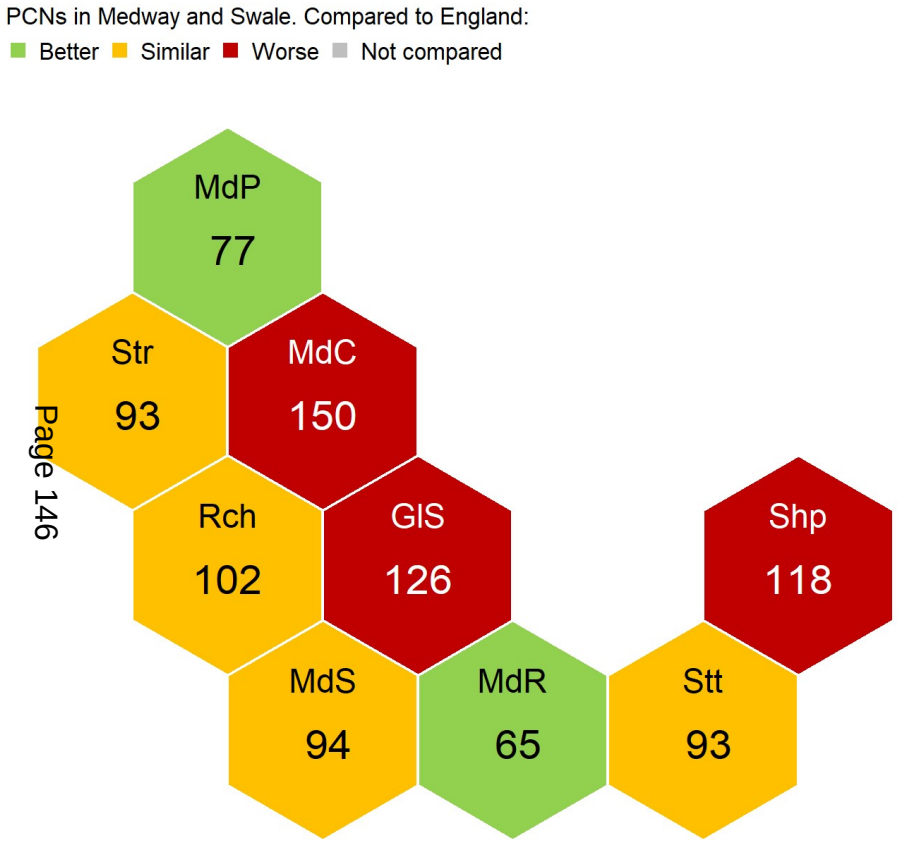
Stroke: QOF prevalence (all ages)



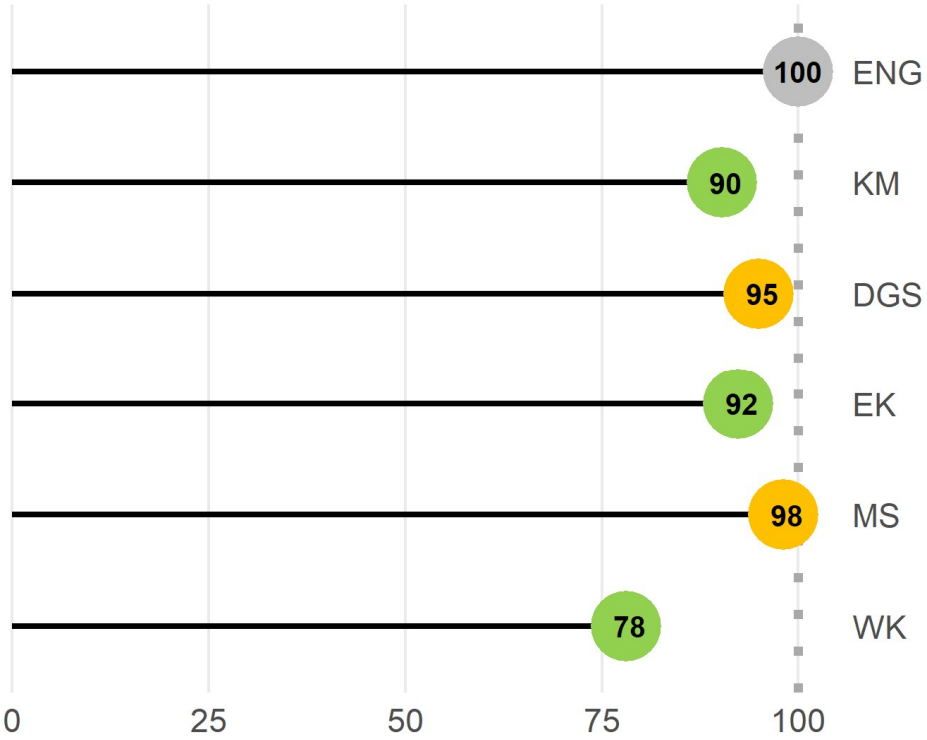
The rate in Medway and Swale is lower than England.

Value type: Proportion - %.
Latest time period: 2020/21.
Source: PHE, Fingertips, Indicator ID: 212.
Value calculation: Aggregated data.
Small area type: Practice to PCN.
RAG method: Confidence interval (99.8%) - Wilson Score method.

Deaths from circulatory disease, under 75 years



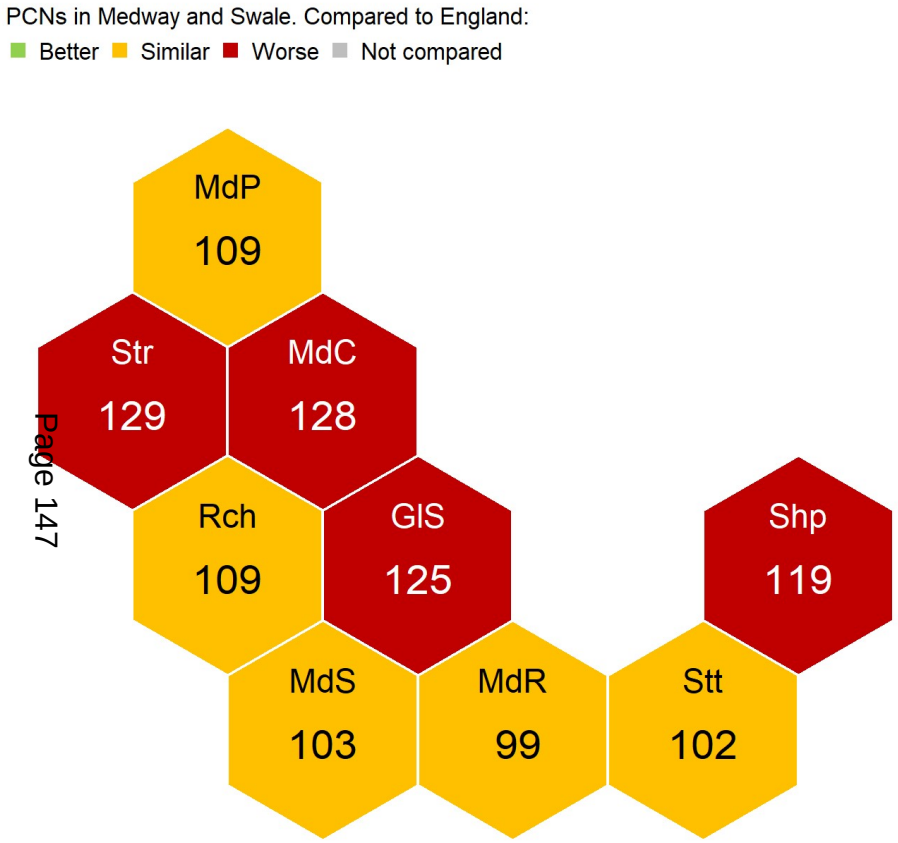
Trend data not available.



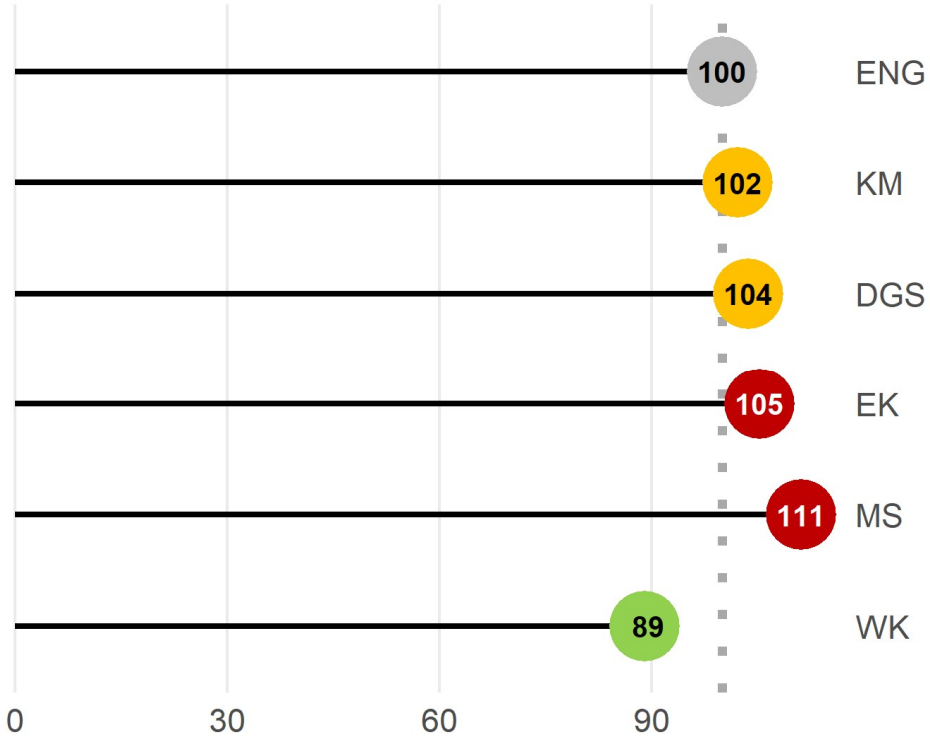
The rate in Medway and Swale is similar to England.

Value type: Indirectly standardised ratio per 100.
Latest time period: 2015 - 19.
Source: PHE, Fingertips, Indicator ID: 93256.
Value calculation: Aggregated data.
Small area type: Ward to PCN.
RAG method: Confidence interval (95%) - Byar's method.

Deaths from all cancer, under 75 years



Trend data not available.

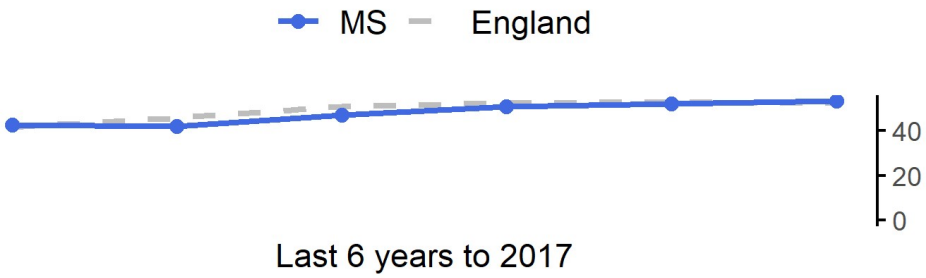


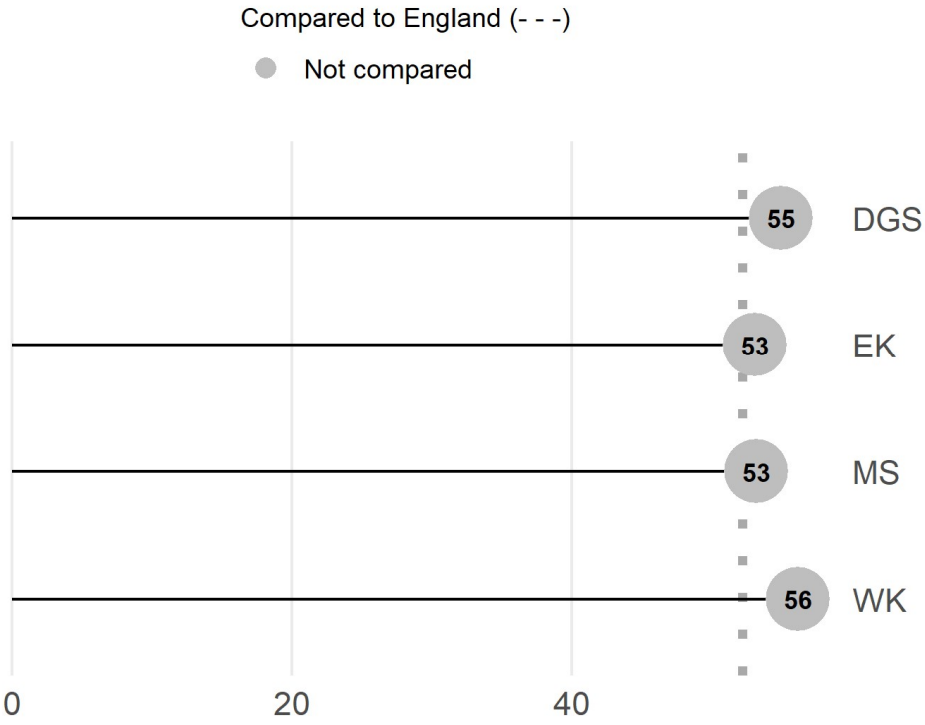
The rate in Medway and Swale is worse than England.

Value type: Indirectly standardised ratio per 100.
Latest time period: 2015 - 19.
Source: PHE, Fingertips, Indicator ID: 93254.
Value calculation: Aggregated data.
Small area type: Ward to PCN.
RAG method: Confidence interval (95%) - Byar's method.

Cancer diagnosed at early stage (experimental statistics)

53		52
HCP: Medway and Swale		England
		54
		Kent and Medway
49	59	2017
Medway	Swale	

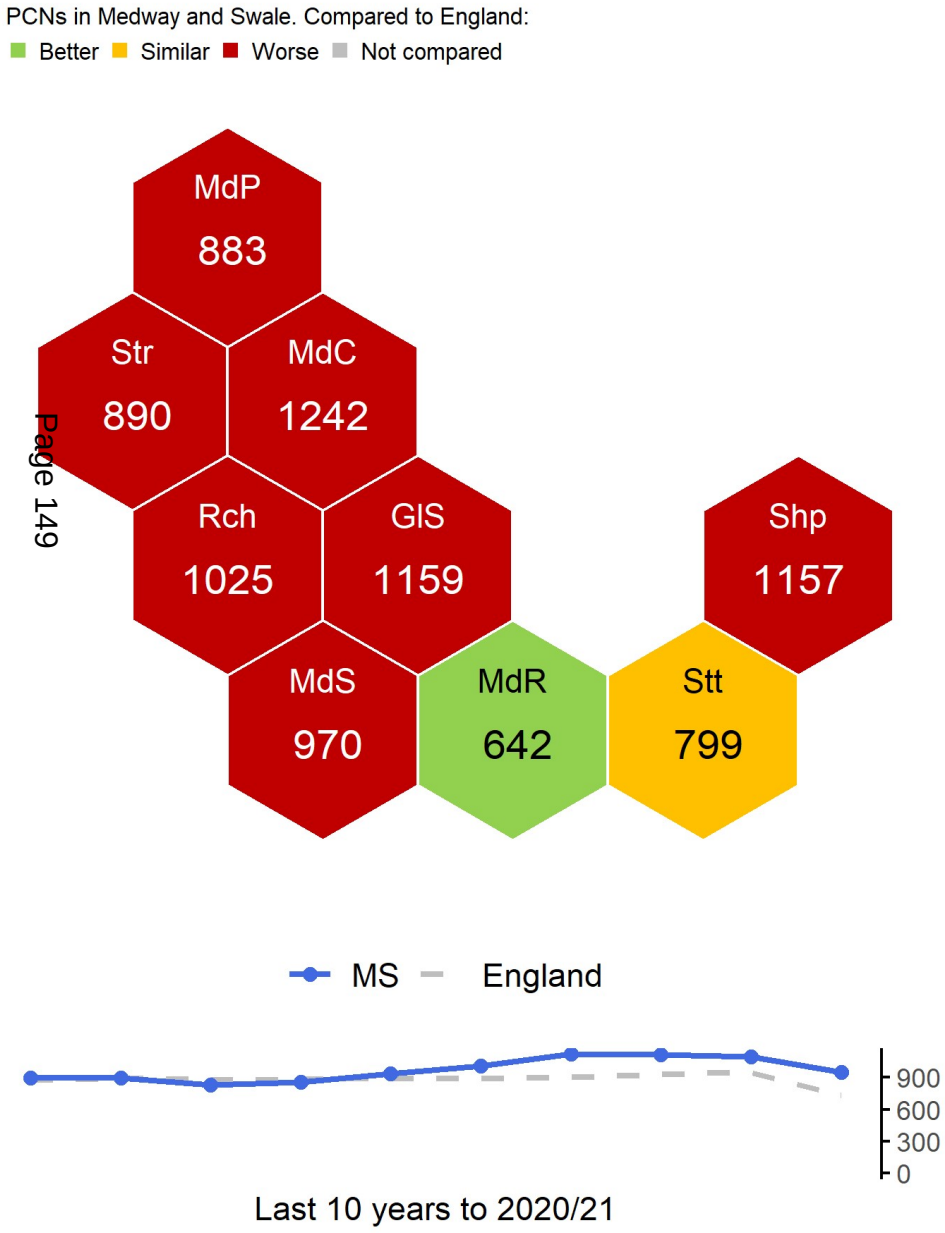


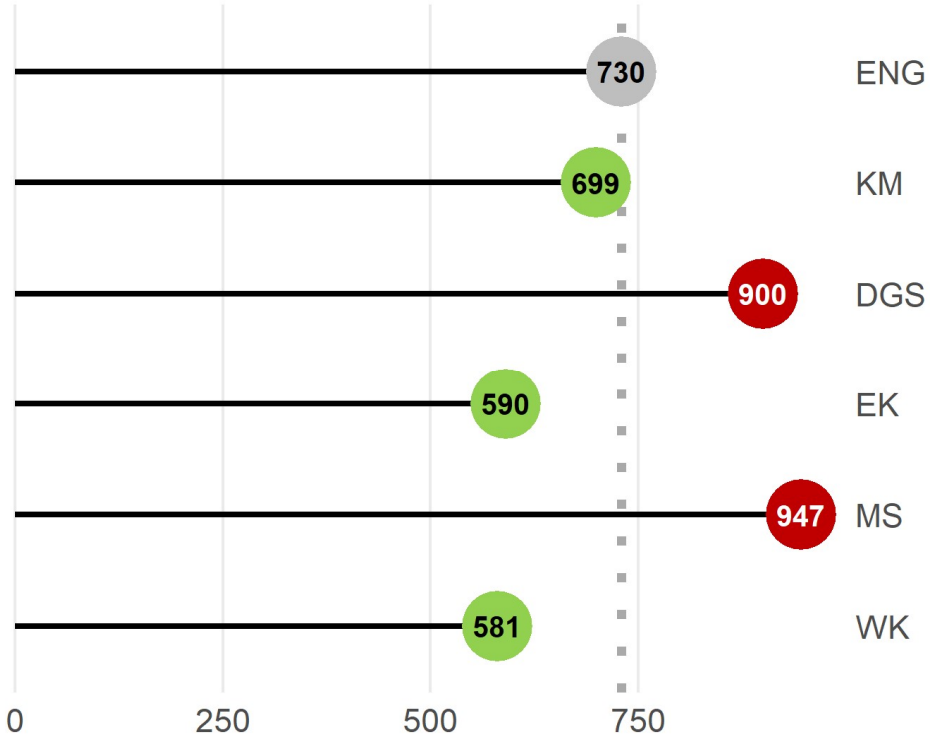


Medway and Swale cannot be compared to England statistically.

Value type: Proportion - %.
Latest time period: 2017.
Source: PHE, Fingertips, Indicator ID: 90834.
Value calculation: Aggregated data.
Small area type: Districts & UAs (2019/20).
RAG method: None applied.

Unplanned hospitalisation for chronic ACSC

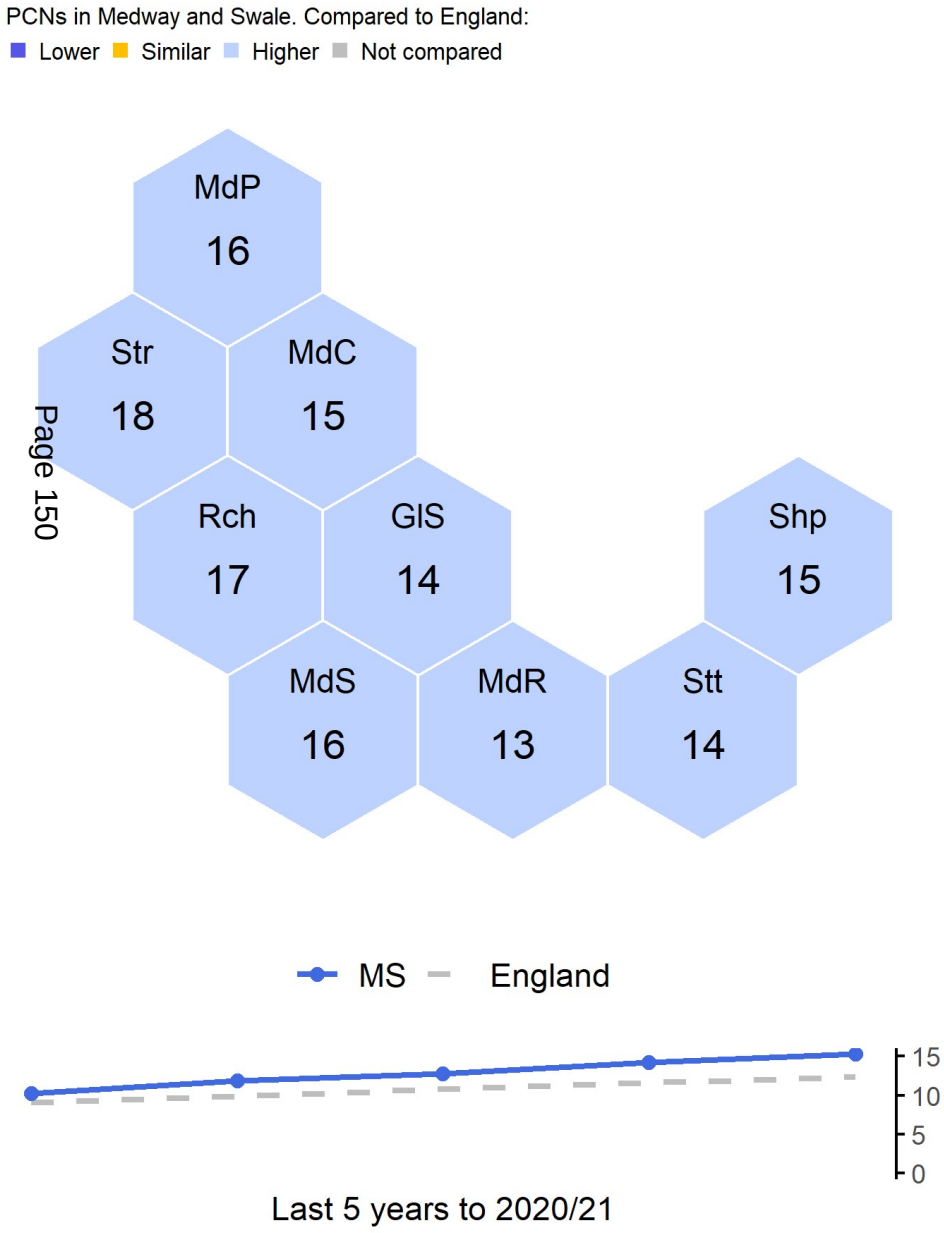


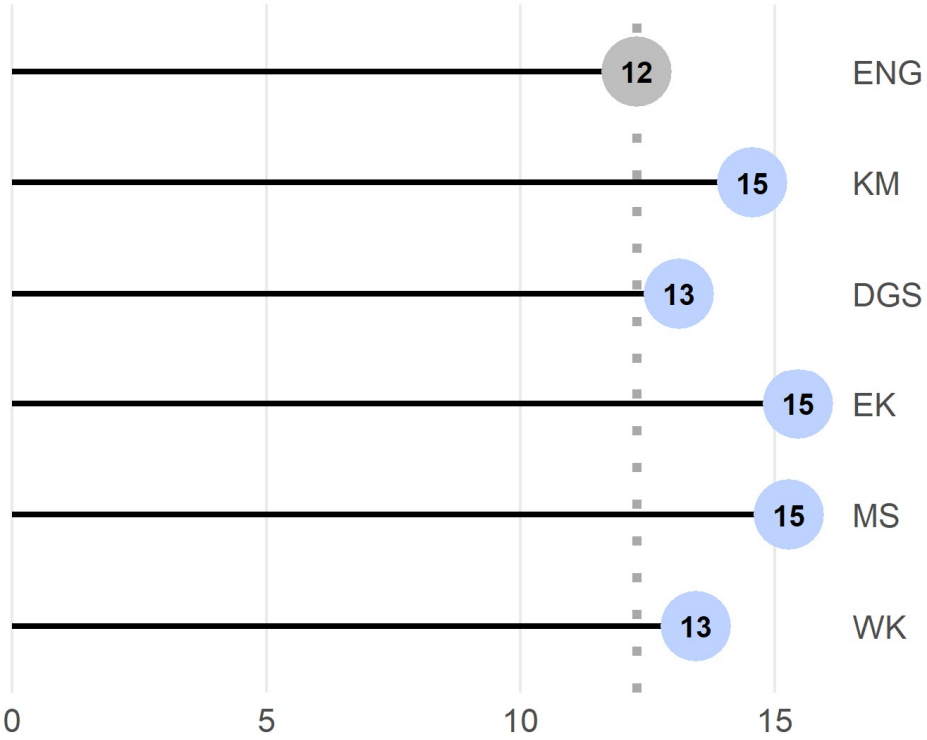


The rate in Medway and Swale is worse than England.

Value type: Directly standardised rate per 100,000.
Latest time period: 2020/21.
Source: Hospital Episode Statistics (HES), NHS Digital.
Value calculation: Aggregated data.
Small area type: LSOA to PCN.
RAG method: Confidence interval (95%) - Dobson's method.

Depression: Recorded prevalence (aged 18+)

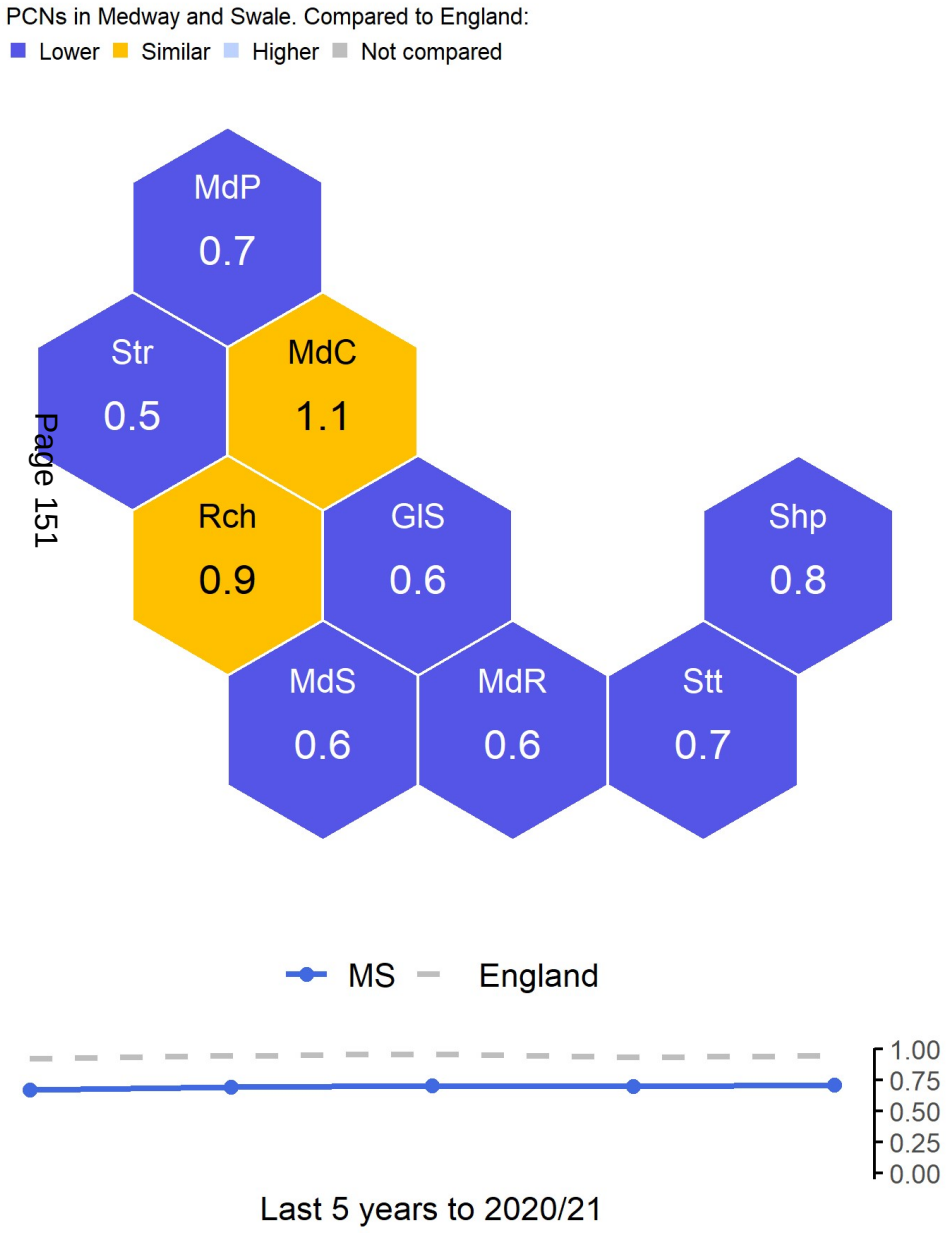


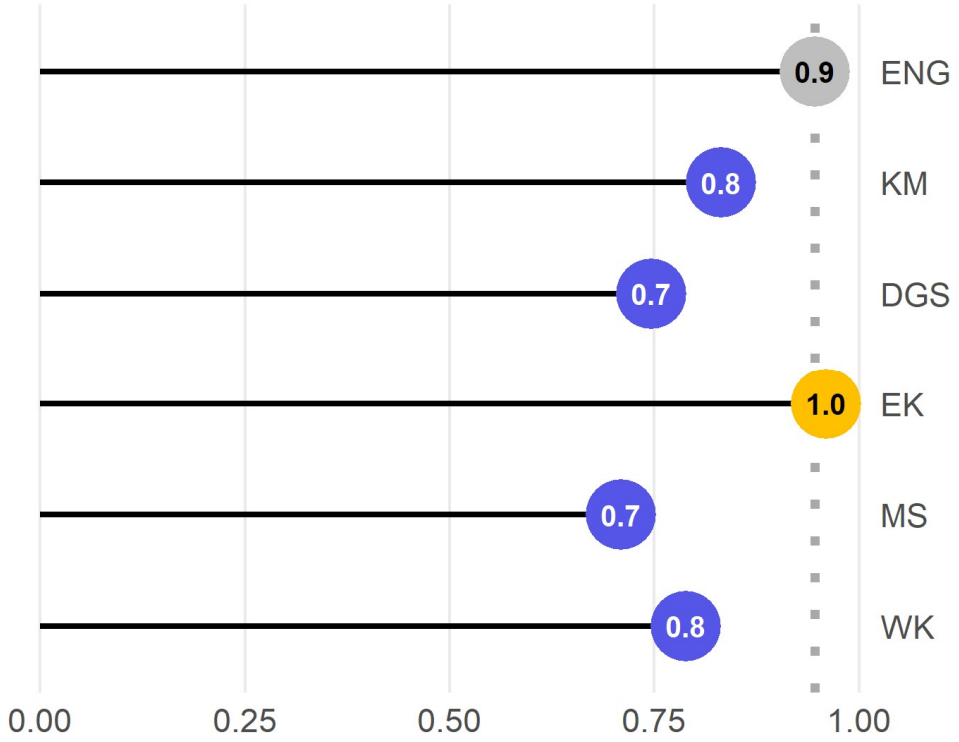


The rate in Medway and Swale is higher than England.

Value type: Proportion - %.
Latest time period: 2020/21.
Source: PHE, Fingertips, Indicator ID: 848.
Value calculation: Aggregated data.
Small area type: Practice to PCN.
RAG method: Confidence interval (99.8%) - Byar's method.

Serious Mental Illness: QOF prevalence (all ages)



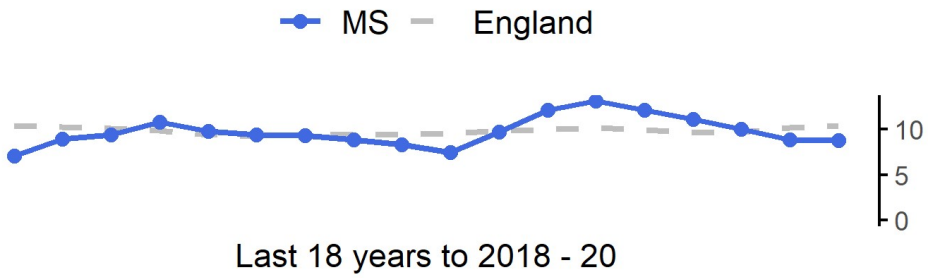


The rate in Medway and Swale is lower than England.

Value type: Proportion - %.
Latest time period: 2020/21.
Source: PHE, Fingertips, Indicator ID: 90581.
Value calculation: Aggregated data.
Small area type: Practice to PCN.
RAG method: Confidence interval (99.8%) - Wilson Score method.

Suicide rate (Persons)

9		10
HCP: Medway and Swale		England
		11
		Kent and Medway
9	9	2018 - 20
Medway	Swale	

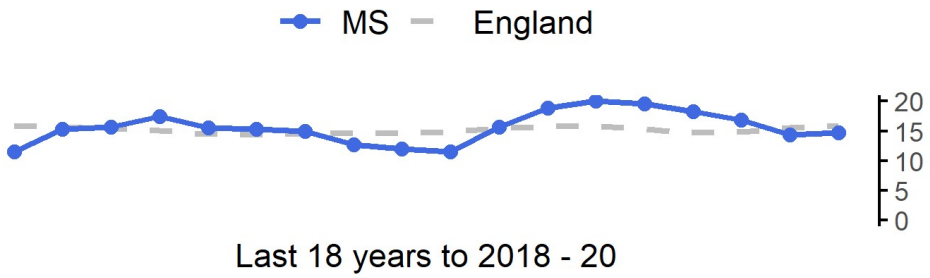


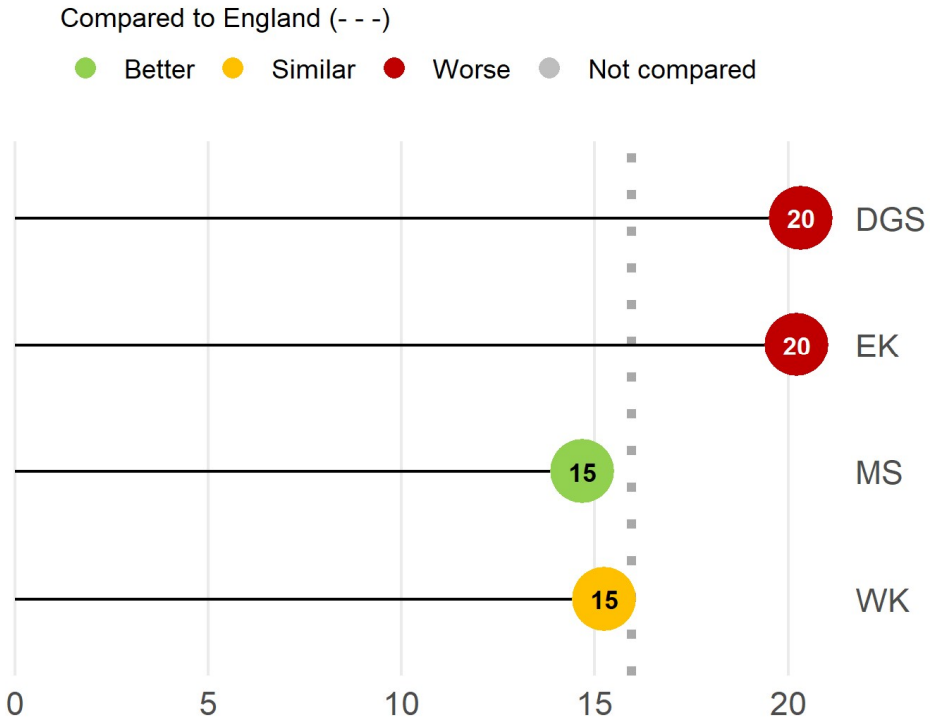
The rate in Medway and Swale is better than England.

Value type: Directly standardised rate - per 100,000.
Latest time period: 2018 - 20.
Source: PHE, Fingertips, Indicator ID: 41001.
Value calculation: Small areas averaged.
Small area type: Districts & UAs (from Apr 2021).
RAG method: England plus/minus 5%.

Suicide rate (Male)

15		16
HCP: Medway and Swale		England
		18
		Kent and Medway
14	15	2018 - 20
Medway	Swale	





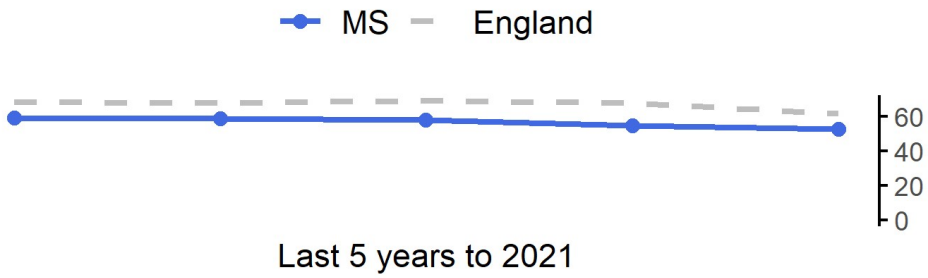
The rate in Medway and Swale is better than England.

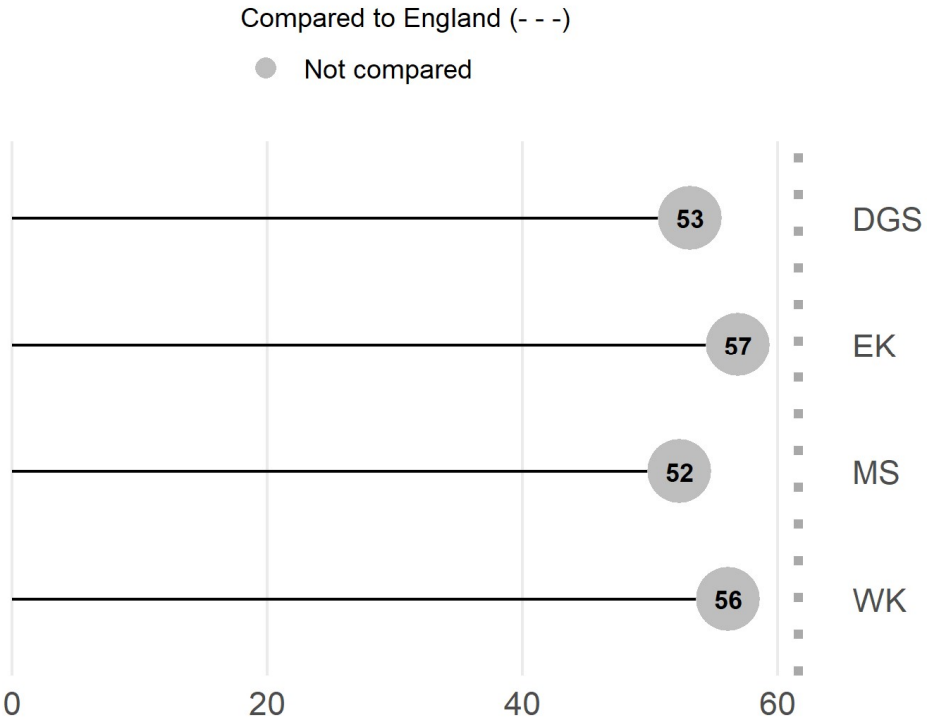
Value type: Directly standardised rate - per 100,000.
Latest time period: 2018 - 20.
Source: PHE, Fingertips, Indicator ID: 41001.
Value calculation: Small areas averaged.
Small area type: Districts & UAs (from Apr 2021).
RAG method: England plus/minus 5%.

AGEING WELL

Estimated dementia diagnosis rate (aged 65 and over)

52		62
HCP: Medway and Swale		England
		55
		Kent and Medway
51	55	2021
Medway	Swale	



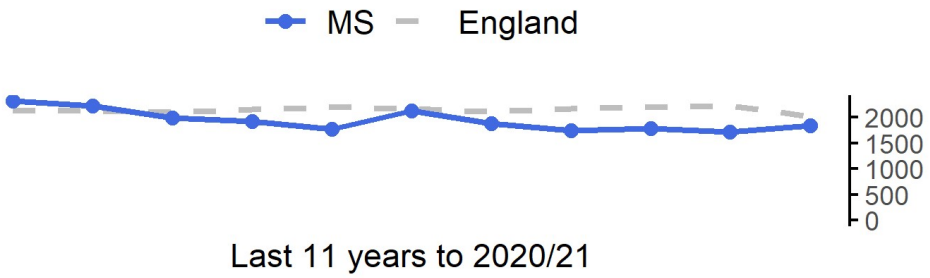


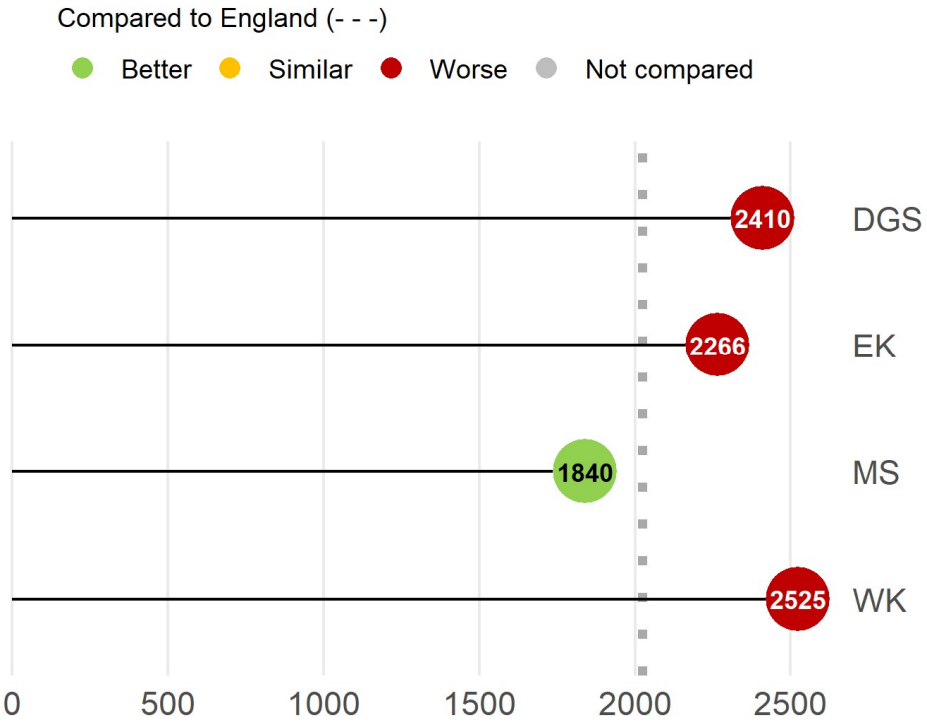
Medway and Swale cannot be compared to England statistically.

Value type: Proportion - %.
Latest time period: 2021.
Source: PHE, Fingertips, Indicator ID: 92949.
Value calculation: Aggregated data.
Small area type: Districts & UAs (from Apr 2021).
RAG method: None applied.

Emergency hospital admissions due to falls (persons aged 65 and over)

1840		2023
HCP: Medway and Swale		England
		2302
		Kent and Medway
1786	1893	2020/21
Medway	Swale	





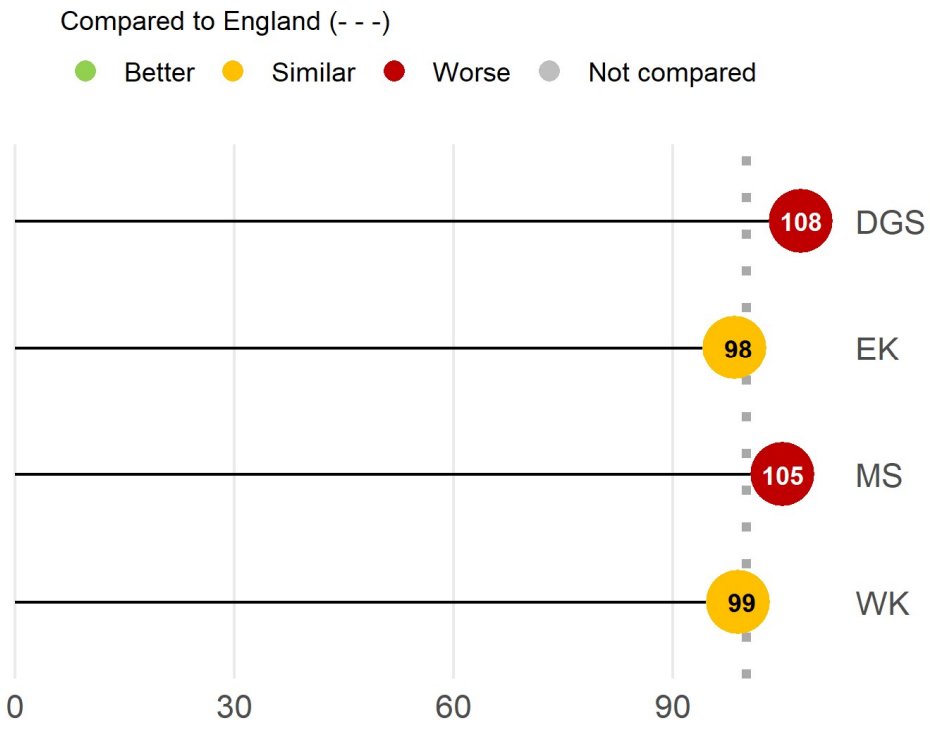
The rate in Medway and Swale is better than England.

Value type: Directly standardised rate - per 100,000.
Latest time period: 2020/21.
Source: PHE, Fingertips, Indicator ID: 22401.
Value calculation: Small areas averaged.
Small area type: Districts & UAs (from Apr 2021).
RAG method: England plus/minus 5%.

Emergency hospital admissions for hip fracture (persons aged 65 and over)

105 HCP: Medway and Swale		100 England
		101 Kent and Medway
107 Medway	103 Swale	2015/16 - 19/20

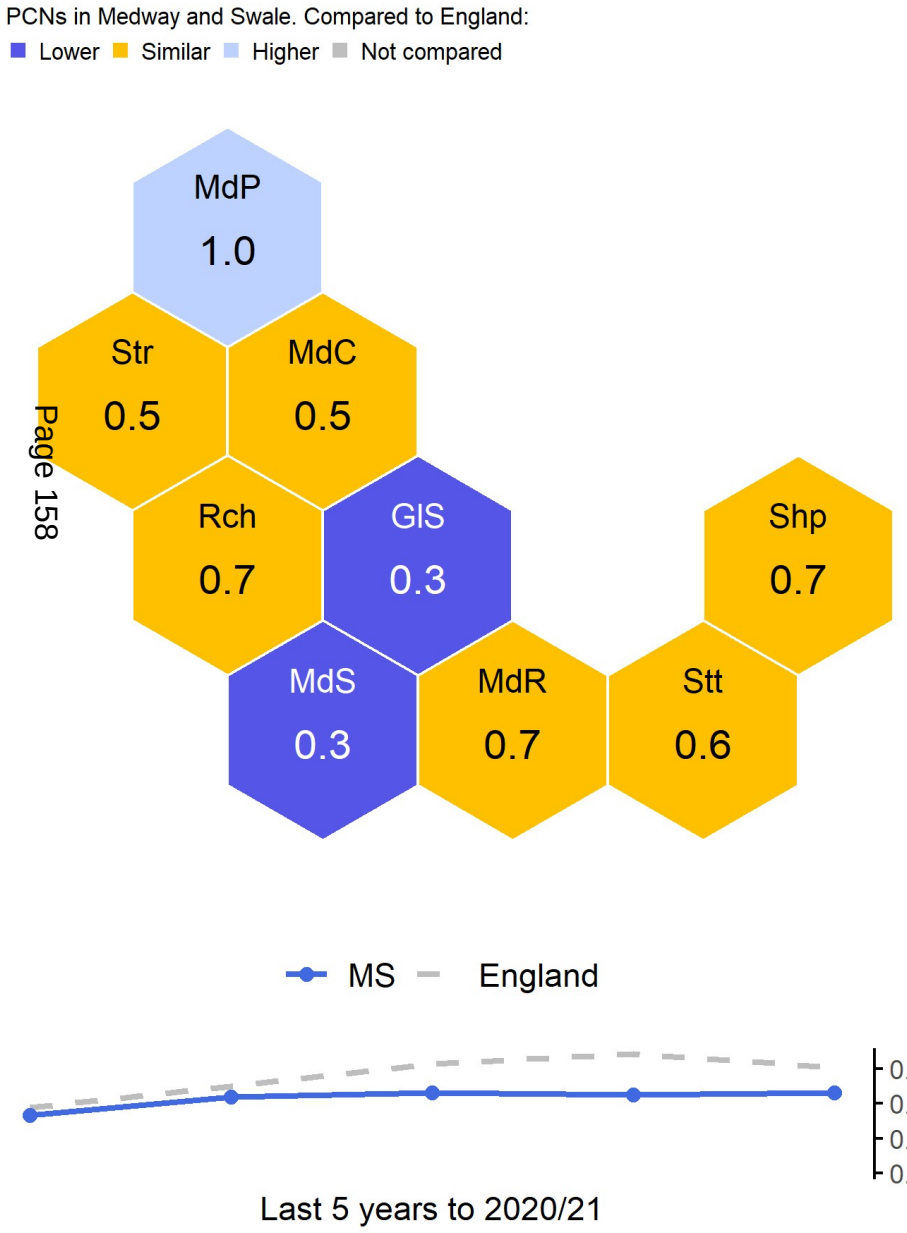
Trend data not available.

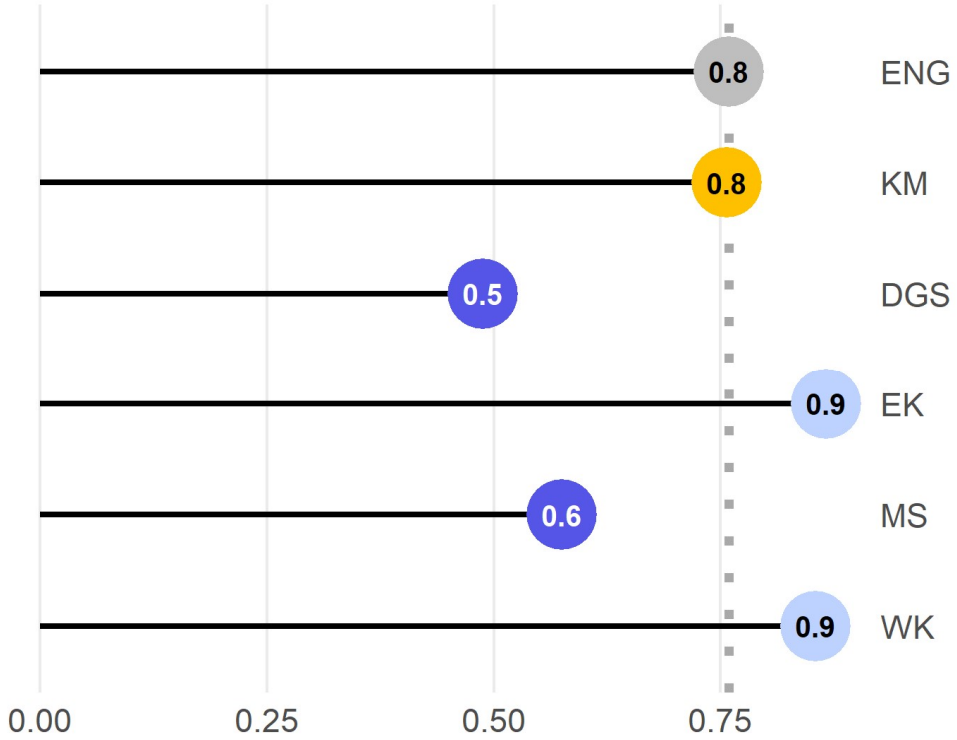


The rate in Medway and Swale is worse than England.

Value type: Indirectly standardised ratio per 100.
Latest time period: 2015/16 - 19/20.
Source: PHE, Fingertips, Indicator ID: 93241.
Value calculation: Small areas averaged.
Small area type: Districts & UAs (from Apr 2021).
RAG method: England plus/minus 5%.

Osteoporosis: QOF prevalence (50+)





The rate in Medway and Swale is lower than England.

Value type: Crude rate - %.
Latest time period: 2020/21.
Source: PHE, Fingertips, Indicator ID: 90443.
Value calculation: Aggregated data.
Small area type: Practice to PCN.
RAG method: Confidence interval (99.8%) - Wilson Score method.

Item 10: Sexual Assault Referral Centre - Kent

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 30 November 2022

Subject: Sexual Assault Referral Centre - Kent

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

It provides background information which may prove useful to Members.

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1) Introduction

a) The Chair of HOSC was contacted by NHS England South East Region in May 2022 regarding a location change for Kent's Sexual Assault Referral Centre (SARC). The service is commissioned by NHS England, the Police Force and the Office of the Police and Crime Commissioner. It serves all ages and deals with forensics and wraparound care for new patients as well as historic cases that come to light.

b) The current service is delivered from Armstrong Road, Maidstone and provided by Mountain Healthcare.

c) Due to a change in the accreditation process, the current facility is not suitable to provide the SARC service in the long term.

2) Potential Substantial variation of service

a) The Committee is asked to review whether this proposal constitutes a substantial variation of service. There are no formal criteria setting out what a substantial variation of service is, and it is down to the Committee to decide.

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

c) Where the Committee deems the proposed changes as being substantial, the NHS must consult with it prior to a final decision being made, though the NHS always remains the decision maker.

d) Once the final decision has been reported to HOSC, the Committee shall decide if it supports the decision, does not support the decision, and/or provide comment on it. Where it does not support the decision, the Committee can refer it to the Secretary of State.

3. Recommendation

If the proposals relating to the relocation of Kent's Sexual Assault Referral Centre are deemed substantial:

RECOMMENDED that:

(a) the Committee deems that the relocation of Kent's Sexual Assault Referral Centre is a substantial variation of service.

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

If the proposals relating to the relocation of Kent's Sexual Assault Referral Centre are not deemed substantial:

RECOMMENDED that:

(a) the Committee deems that the relocation of Kent's Sexual Assault Referral Centre is not a substantial variation of service.

Background Documents

None.

Contact Details

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

Health Overview and Scrutiny Committee
Substantial Change Assessment

A. Background Information
1. Name of responsible (lead) health organisation:
NHS England
2. Brief description of the proposal (please include information about timelines and whether the proposed change is temporary or permanent):
Change in location of existing Sexual Assault and Referral Center at 7, West Court South Park Business Village, West Ct, Maidstone ME15 6JD to 18 Kings Hill Ave, Kings Hill, West Malling ME19 4AE. Difference of circa 8-10 miles.
3. Why is this change being proposed? What is the rationale behind it?
New forensic standards have been introduced to these services and the premises that they operate from. Having assessed the existing premises it is deemed that they will not meet the new required standards and cannot be adapted to do so. New premised have been found to deliver these services from that can be made fit for purpose.
4. What are the main factors driving the change? Please indicate whether they are clinical factors, national policy initiatives, financial or staffing factors.
The main factors driving change is the introduction of new standards and the need for services to become accredited to be able to deliver these services.
5. How does the change fit in with the wider strategic direction of healthcare in the Health and Wellbeing Board?
These services are mandated to be commissioned by NHSE and we do this jointly with local Police Forces and the Office of the Police and Crime Commissioner.

6. Description of population affected:
These services serve the population of Kent.
7. Date by which final decision is expected to be taken:
The procurement opportunity with be presented to the market in the first quarter of 2023 with a contract start date of 1st April 2024.
8. Confirmation that HOSC have been contacted regarding change - including. date and nature of contact made:
Contact made with HOSC Contact Kay Goldsmith

B. Assessment Criteria
1. **Legal Obligations:** Have the legal obligations set out under Section 242 of the consolidated NHS Act 2004 to 'involve and consult' been fully complied with?
Yes
Comments: As the location of the service will be changing then NHSE have a duty to consult. A formal consultation process is planned for Dec 2022 – Feb 2023.
2. **Stakeholder Engagement**: Have initial responses from service users (or their advocates) and other stakeholders such as Healthwatch indicated whether the impact of the proposed change is substantial?
No
3. **Stakeholder Engagement:** Does the service to be changed receive financial or 'in kind' support from the local community?
No
4. **Stakeholder Engagement:** Is there any aspect of the proposal that is contested by the key stakeholders? If so what action has been taken to resolve this?
None to date

5. **Staff Engagement:** Have staff delivering the service been fully involved and consulted during the preparation of the proposals?
Yes
6. **Staff Engagement:** Do staff support the proposal?
Yes
7. **Patient Impact:** Does the proposed change of service has a differential impact that could widen health inequalities (geographical, social or otherwise)?
No
8. **Patient Impact:** How many people are likely to be affected?
Unknown. We have figures for previous years but only indicative.
9. **Patient Impact:** Will the proposed change affect patient access? If so how?
No
10. **Patient Impact**: How will the proposed change affect the quality and quantity of patient service?
No service change is proposed only the location of the service
11. **Patient Impact:** Does the proposal appear as one of a series of small incremental changes that when viewed cumulatively could be regarded as substantial?
No
12. **Patient Impact:** How will the change improve the health and wellbeing of the population affected?
No proposed change to the existing service

13. **Wider Impact:** Will the proposed changes affect: a) services elsewhere in the NHS b) services provided by the local authorities, c) services provided by the voluntary sector?
No
14. **Standards**: How does the proposed change relate to the National Service Framework Standards?
In line with the framework and statutory responsibility to commission and provide this service
15. **Risk:** What could the possible negative impacts of the change be? What mitigations are in place to reduce any potential negative impacts of the proposed change?
Risk register in place. No significant risks identified.

C. Outcome/Decision
1. Is this considered to be a significant change by provider?
No
2. Is this considered to be a significant change by HOSC?
Yes/No (please delete as appropriate)

Item 11: CAMHS Tier 4 provision at Cygnet Hospital, Godden Green

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 30 November 2022

Subject: Learning from the closure of Cygnet Hospital, Godden Green

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Summary: This report invites the Health Overview and Scrutiny Committee to consider the response provided by NHS England (NHSE) Direct Specialised Commissioning and the Kent and Sussex CAMHS Provider Collaborative to questions raised at the last meeting.

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

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1) Introduction

a) At its meeting on 24 November 2020, HOSC was notified that Cygnet Hospital, Godden Green, near Sevenoaks had closed following a serious incident which was under investigation by the service commissioner, NHS England.

b) In July 2022 a written report on the closure was presented to HOSC following conclusion of the investigation. Members had additional questions which were passed onto NHS England, and their response is attached to this covering report.

c) The questions were:

i. What areas were covered by the 186 CAMHS tier 4 beds in the South East region?

ii. Did the 186 include the removal of the 20 beds taken out of service at St Mary Cray?

iii. What was the breakdown of tier 4 beds by county and how many were vacant?

iv. Why were the additional 6 beds at Kent and Medway Adolescent Hospital (KMAH) still not available?

v. Was it accurate that there was an eating disorders day clinic at Haywards Heath but it was almost impossible to get there by public transport?

2. Recommendation

RECOMMENDED that the Committee consider and note the response.

Background Documents

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

Kent County Council (2022) *'Health Overview and Scrutiny Committee (7/7/22)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8969&Ver=4

Contact Details

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

30.08.22

Dear Kent Health Overview and Scrutiny Committee (HOSC) Members,

Thank you for your questions following the presentation of the Cygnet Godden Green Report presented to HOSC on 7th July. Apologies for the delay in response, we wanted to ensure a thorough and accurate response from NHS England (NHSE) Direct Specialised Commissioning and the Kent and Sussex CAMHS Provider Collaborative.

A. What areas were covered by the 186 CAMHS tier 4 beds in the South East region?

The South East Region covers Oxfordshire, Buckinghamshire, Berkshire, Hampshire, IOW, Kent, Surrey, and Sussex. Young people can be placed in services located in the South East from anywhere nationally if the referral is accepted, although every attempt is made to keep young people close to home.

B. Did the 186 include the removal of the 20 beds taken out of service at St Mary Cray?

For the purpose of this response we are assuming this relates to the recent closure of Kent House. Kent House is part of the London Provider Collaborative and therefore would not be in any figures that we have given or hold. If there are any additional questions regarding this service, the South London Partnership will need to be contacted. The South East Region did not have any young people from Kent in Kent House at the time of closure.

C. What was the breakdown of tier 4 beds by county and how many were vacant?

The beds are not broken down by county rather by the Provider Collaborative that oversees that regional area including several providers and types of service. In the South East there are 4 CAMHS Provider Collaboratives: Thames Valley, Kent and Sussex, Surrey, Hampshire, and Dorset. Please note the Dorset segment of the Wessex and Dorset Provider Collaborative overlaps into the South West NHS England Region as does the Thames Valley Provider Collaborative overlap with Gloucestershire, Bristol North and North Somerset geographical footprint. NHSE retain Commissioning responsibility for CAMHS Medium Secure Services at Bluebird House in Hampshire.

D. Why were the additional 6 beds at Kent and Medway Adolescent Hospital (KMAH) still not available?

We anticipate the additional 6 beds being operational, date to be confirmed, following the completion of the build, date to be confirmed. Recruitment campaigns are underway, and adverts remain live for all new posts. In addition, the establishment of Band 6 Children's nurses are being increased in local acute

hospitals to support the further development of the General Adolescent Unit/Eating Disorder pathway. This is expected to have a positive effect on vacancies moving forward.

E. Was it accurate that there was an eating disorders day clinic at Haywards Heath, but it was almost impossible to get there by public transport?

There is not an Eating Disorders day service at Haywards Heath. It is of note that an Eating Disorders day service is opening in Hove in Sussex.

Item 12: Work Programme 2022

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 30 November 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

Contact Details

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

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Work Programme - Health Overview and Scrutiny Committee

1. Items scheduled for upcoming meetings

31 January 2023		
Item	**Item background**	**Substantial Variation?**
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
Integrated Care Board – update on first 6 months	To receive an update on the early stages of ICB implementation.	-
Kent & Medway Integrated Care Strategy (interim)	To note the publication of the interim strategy, due to be published in December 2022.	-

2. Items yet to be scheduled

Item	Item Background	Substantial Variation?
Burns service review	To receive information about a review of burns services by NHS England Specialised Commissioning	TBC
Podiatry Services	To receive an update on the service following its relocation.	No
Maidstone and Tunbridge Wells NHS Trust - Mortuary Security	To receive the Trust's reaction to Sir Jonathan Michael's report following its publication.	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).	-
Urgent Care Review Programme - Swale	Following the meeting on 2 March 2022, the Chair invited future updates on the transformations and related public communications.	No

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: 6 December 2022		
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