Medway Council
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Health and Adult Social Care Oversight and Scrutiny Committee

19 August 2026

Medway NHS Foundation Trust – Update on Urgent and Emergency Care

Report from: Siobhan Callanan, Interim Chief Executive, Medway NHS Foundation Trust

Summary

This report provides an update on the work underway to improve timely access to high quality urgent and emergency care at Medway Maritime Hospital, including updates on the system-wide efforts to eliminate corridor care at Medway Maritime Hospital, and the implementation of the Trust's Virtual Hospital to support safe and timely care at home. The paper also outlines early signs of impact and the strengthened system-wide approach now in place.

1. Recommendation

1.1. The Committee is asked to note the report.

2. Budget and policy framework

2.1. Under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 the Council may review and scrutinise any matter relating to the planning, provision, and operation of the health service in Medway. In carrying out health scrutiny a local authority must invite interested parties to comment and take account of any relevant information available to it, and, in particular, relevant information provided to it by a local Healthwatch. The Council has delegated responsibility for discharging this function to this Committee and to the Children and Young People Overview and Scrutiny Committee as set out in the Council's Constitution.

3. Background

3.1 Urgent and emergency care services provided by the Trust include the Emergency Department (ED) at Medway Maritime Hospital, and since July 2025, Minor Injury Units in Sittingbourne and Sheppey.

3.2. These services routinely see between 15,000 and 18,000 attendances each month, of which between 13,000 and 15,000 are ED attendances, equating to between 433 and 500 patients per day.

3.3. Demand for urgent and emergency care has risen across all age groups, with more people arriving at ED by ambulance and a growing number presenting with multiple long-term conditions, frailty, or severe illness. As a result, patients often need longer assessments, more investigations, and more intensive treatment, placing additional pressure on available clinical space and staff capacity.

3.4. The Trust last updated the Committee in June 2025 following the inspection of Urgent and Emergency Care services by the Care Quality Commission (CQC) in April 2025. The inspection report, published in November 2025, rated the service Requires Improvement. Of the five areas rated, well-led was Good, and ratings for safe, caring, effective and responsive Requires Improvement.

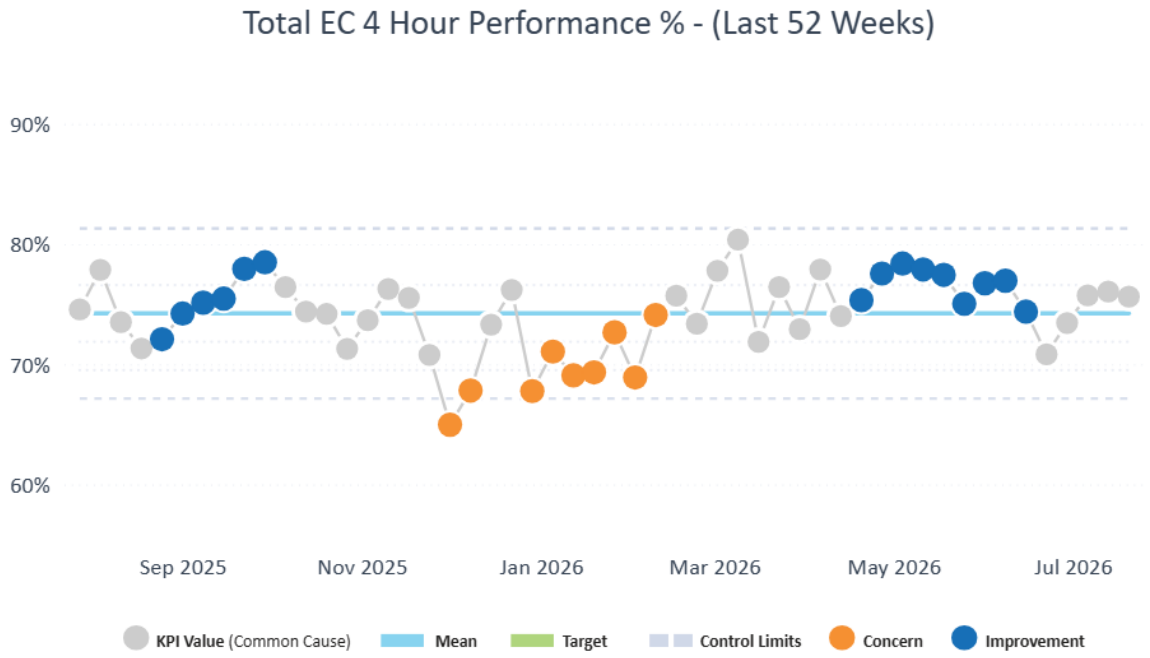
3.5. Inspectors found improvements to patient care and staff culture in the Emergency Department (ED) since the previous inspection in February 2024, and the requirements of a warning notice, issued in April 2024, had been met. It also set out further areas for improvement.

4. Performance overview

4.1. Key indicators for **June 2026** include:

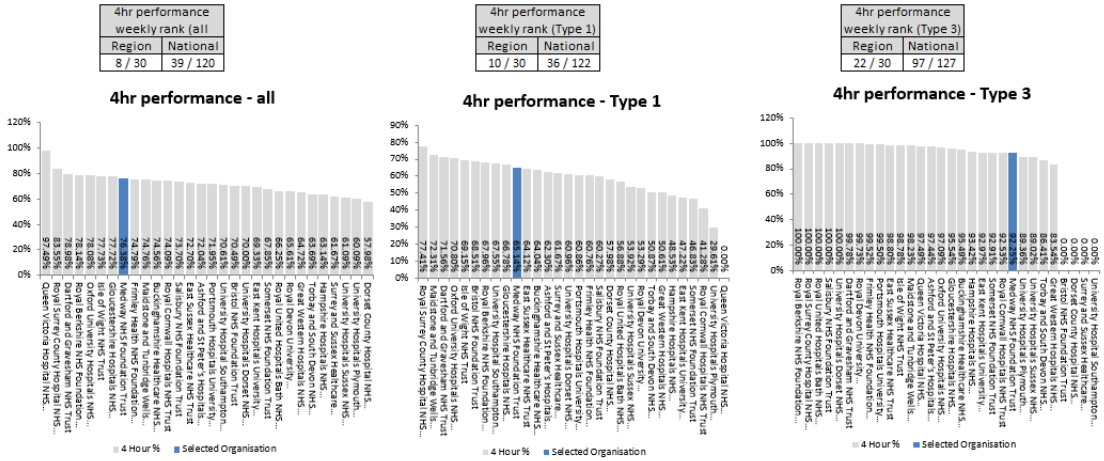
- **Patient experience** - 75 per cent of patients completing the NHS Friends and Family Test reported a positive experience of care, consistent with the trend for the last year.
- **Ambulance handovers** - 3,143 patients were conveyed to ED by ambulance, with an average handover time of 13 minutes, which remains among the quickest in the country.
- **Four-hour standard** - 74.3 per cent of patients were seen, treated, discharged or had a decision to admit within four hours of an attendance, for which the Trust was ranked 64 out of 118 trusts in England.
- **12 hour waits** – Some 822 patients waited longer than 12 hours after a decision to admit had been made to be moved to their next place of care, such as a ward bed.
- **Medically-fit patients** - On average, 112 patients were medically-fit to leave hospital each day, awaiting out of hospital care, of which 45 per cent had a length of stay of longer than 21 days.

4.2. The graph below shows the trend against the four-hour urgent and emergency care standard over the last year.



4.3. The Trust is routinely one of the higher performing trusts in the south east region against the four-hour standard for all attendances and type 1 attendances (Emergency Department only). Type 3 includes patients attending the MedOCC urgent care service, provided by Medway Community Healthcare at Medway Maritime Hospital, streamed by ED.

4.4. The graphs below show the relative positions of NHS acute trusts in the south east for the week ending 29 July (the most recently published data prior to paper submission).

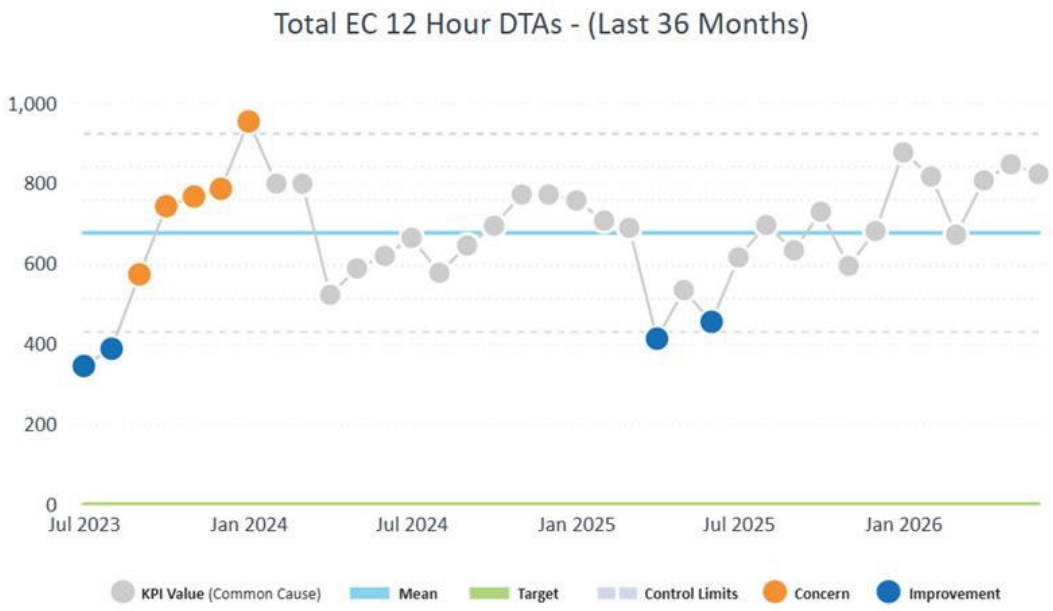


Extended waits and flow constraints

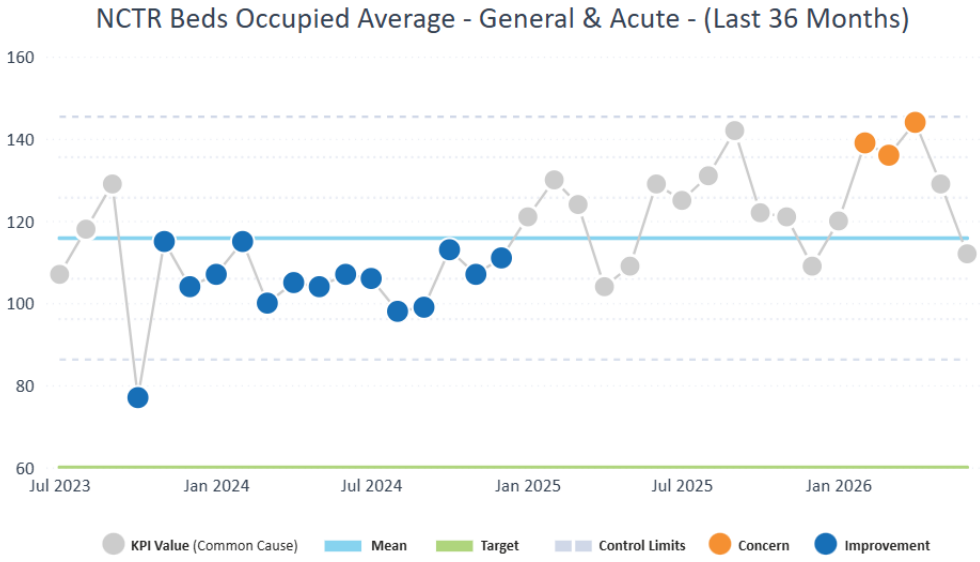
4.5. Extended waits of over 12 hours in ED have a direct impact on the quality and experience of patient care. When medically-fit patients experience discharge delays, ward beds remain occupied, and impact the ability to admit patients promptly from ED.

4.6. This contributes to sustained congestion in ED, where patients who require admission wait for prolonged periods, often in unsuitable environments, including corridor areas within the department, which is always a last resort and falls short of the standard we aim to provide every patient in our care.

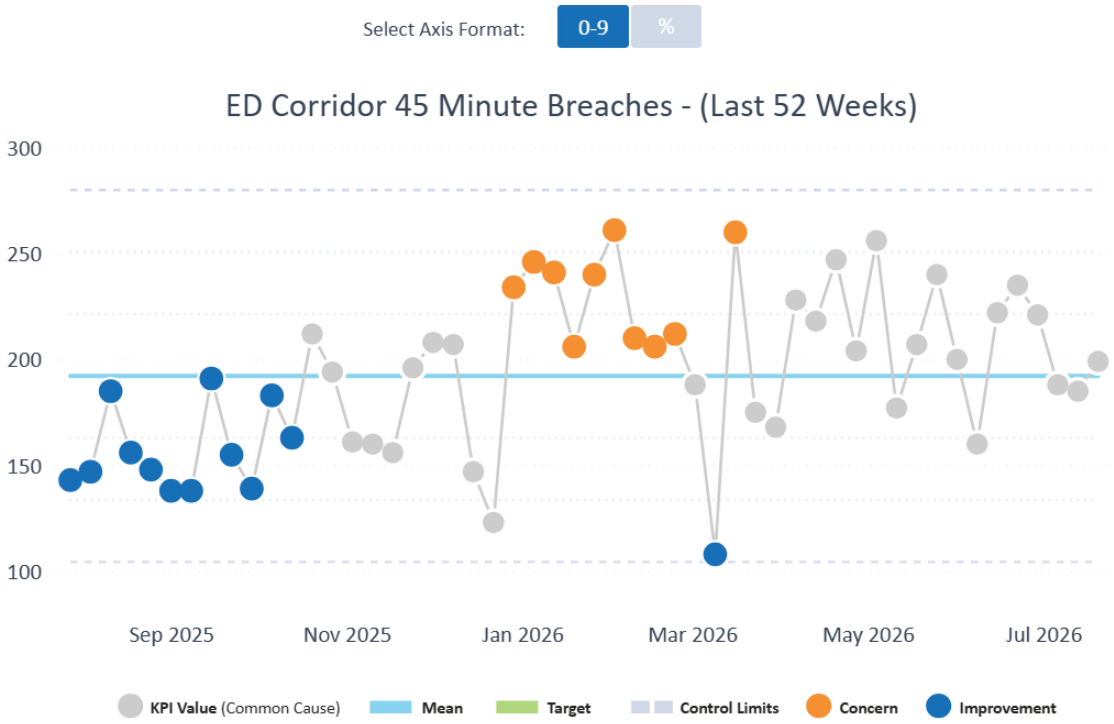
4.7. The graph below shows the trend in the number of patients waiting longer than 12 hours from the decision to admit (DTA) to hospital has been made to their transfer to the next place of care, such as a ward bed.



4.8. The graph below shows the weekly trend in the number of patients who are medically fit to leave hospital wards awaiting out-of-hospital care. These delays limit bed availability and impacts flow through the hospital, contributing to extended ED waits.



4.9. The graph below shows the use of corridor care at the Trust over the last year. In June, 896 patients spent longer than 45 minutes being cared for in a corridor in ED, compared to 963 in the May 2026.



5. Eliminating corridor care

5.1. Corridor care is a significant patient safety and experience issue, which impacts staff morale. As defined by NHS England, corridor care refers to any patient being cared for in an area not designed for treatment, including corridors within ED and spaces around nurse stations within the department.

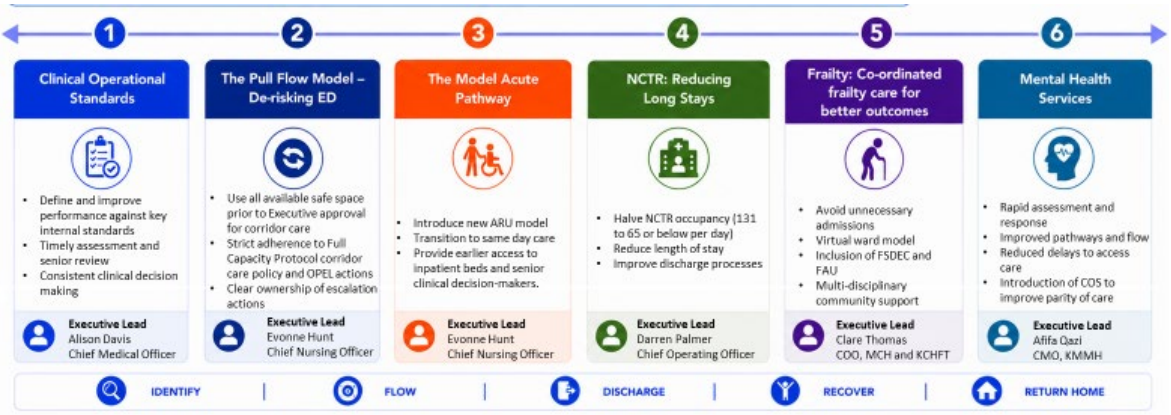
5.2. The Trust is fully committed to eliminating corridor care in line with national guidance. Achieving this requires a whole-system response, addressing barriers across the patient journey, both within the hospital and in community, mental health and social care pathways.

5.3. This change cannot happen overnight but by approaching it in a series of safety-focussed phases, starting with the patients in the highest-risk areas in ED, we have a real opportunity to embed lasting improvements that will strengthen safety and improve patient care and outcomes.

New way of working

5.4. In early July, the system partners introduced new ways of working, underpinned by strengthened oversight, shared accountability and a collective focus on eliminating the use of corridor care.

5.5. This programme is being delivered through six interconnected workstreams, as set out below, each targeting a key area of improvement and designed to ensure that delays are reduced both inside and outside the hospital.



5.6. **Clinical Operational Standards** – the Trust is finalising a refreshed set of standards that set clear expectations for timely assessment, senior review and consistent clinical decision-making across all clinical and operational teams. These standards will support safer, more predictable flow. See Appendix.

5.7. **Pull Flow Model** - A new pull-based approach is being embedded to ensure teams proactively pull patients from ED and assessment areas, supported by real-time oversight and clear escalation routes.

5.8. **Model Acute Pathway** - This pathway defines the optimal patient journey from arrival to discharge, ensuring that every step is designed to minimise delay, reduce unwarranted variation and support timely movement through the hospital.

5.9. **Reducing Long Stays** - Focused work is underway to halve the number of patients who have 'No Criteria to Reside' and stays over seven, 14 and 21 days, with targeted reviews, earlier senior decision-making and closer collaboration with community partners to unblock delays.

5.10. **Coordinated Frailty Care** - Strengthened frailty care will support earlier identification of needs, rapid assessment and alternatives to admission, helping frail patients access the right care in the right place.

5.11. **Mental Health** - Work is underway to improve access to timely mental health assessment, reducing delays in ED and ensuring patients receive specialist support sooner.

Strengthened oversight

5.12. Recognising that eliminating corridor care is a whole-system challenge, a new fortnightly oversight forum, jointly chaired by NHS Kent and Medway and NHS England South East, brings together system partners to drive delivery, remove barriers and maintain accountability across organisations.

5.13. A new rhythm of system-wide meetings designed to accelerate progress towards eliminating corridor care is now established, with all system partners engaged in a more disciplined and coordinated effort that strengthens daily oversight, speeds up decision-making and ensures delays are unblocked in real time.

5.14. Twice-daily ‘No Criteria to Reside’ calls with system partners have been introduced to expedite flow, resolve issues early and maintain a shared understanding of risk. Alongside this, a daily executive huddle with system leaders provides a clear escalation route, enabling rapid action where delays occur.

5.15. These changes are already helping the system to work differently, with a clear focus on disciplined daily flow management, clearer escalation routes and stronger cross-organisational accountability.

Early progress

5.16. Daily cross-system huddles are supporting earlier discharges, strengthening out-of-hospital care, and reducing unnecessary attendances for frail or elderly patients. Targeted work is also underway to ensure patients with mental health needs access care more quickly and that medically-fit patients return home sooner.

5.17. Early signs of progress are evident. Transport is being arranged earlier, the Discharge Lounge is being used more consistently, and decisions for patients with the least complex discharge needs are being made more quickly. As a result, more patients are returning home, or to their next place of care, sooner.

5.18. Although the overall number of patients with no criteria to reside has remained broadly stable in recent weeks, the time they spend in hospital has reduced. Notably, length of stay has fallen by 13 days for patients who are medically-fit to leave hospital but cannot return home safely, requiring 24-hour care in a residential care or nursing home.

5.19. This reduction represents a substantial improvement in patient flow and a clear reduction in avoidable delays. This progress reflects stronger day-to-day collaboration across all providers in the local health and care system, with teams working together to resolve issues quickly and develop new pathways at pace.

5.20. As a result, patients are experiencing earlier discharge, more appropriate care settings, and fewer unnecessary admissions – demonstrating that the improvement work is translating into tangible benefits for patients.

5.21. Taken together, these actions represent welcome progress to provide consistently safe, timely and dignified care. The strengthened oversight, shared accountability and disciplined daily management now in place provide

a strong foundation for sustained improvement and support the system commitment to eliminating corridor care.

6. Virtual Hospital

Expanding the virtual ward service

6.1. In November 2025 the Trust expanded its well-established virtual ward service from 80 to 120 beds and made them available 24/7.

6.2. Previously this service was only available from 8am and 8pm, with no overnight monitoring, limiting the range of conditions and acuity of patients that could be admitted under this service.

6.3. Thanks to significant investment in staff and systems, the expanded service now admits more patients and of higher acuity.

6.4. This is helping to relieve pressure at Medway Maritime Hospital, by freeing up inpatient beds for those who need them most, which in turn helps to reduce delays and overcrowding in ED.

6.5. Further discussions are ongoing with Medway Council about the interaction between Hospital at Home and social care.

How the virtual ward works

6.6. Enabled by technology, patients' vital signs (such as pulse, blood pressure and oxygen levels) are remotely monitored, and treatments given (such as intravenous antibiotics, and breathing support), with close oversight, and regular contact, from the hospital's Surgical, Medical and Acute Recovery Team (SMART).

6.7. The SMART Team comprises doctors, nurses and Allied Healthcare Professionals (AHPs). All our virtual ward inpatients remain under the care of hospital consultant, which is the same as inpatients within the hospital.

6.8. Should a patient's condition deteriorate while under the virtual ward, clinicians can quickly undertake further assessment of the patient on screen or over the phone.

6.9. At any time of day or night, a member of the Virtual Hospital team can visit the patient at home, and if needed, arrange for them to be brought into hospital for further tests or treatment.

6.10. On average, only four per cent of virtual ward patients require this level of escalation, with more than 95 per cent remaining at home for the duration of their care.

Impact of the expanded service

6.11. Expanding this service is already helping patients who need acute care to leave hospital sooner (step down patients) and means that some people do not need to come into hospital at all (admission avoidance).

6.12. In the first eight months of the expanded service (November 2025 to June 2026), the team cared for 2,193 patients, 37 per cent more than in the same eight-month period in 2023/24, before the expansion. These are patients who would otherwise have needed a bed within the hospital.

6.13. This growth has been greatest in the medical virtual ward, the focus of the expansion, which cared for more than three times as many patients as in the same period in 2023/24 (1,037 compared with 302).

6.14. Step down patients continue to account for the majority of admissions but the proportion of patients admitted to avoid a hospital stay altogether has risen from around a third before the expansion to nearly half of all admissions by June 2026 (43 per cent).

6.15. Together, these patients would otherwise have needed almost 16,000 hospital bed days. This is equivalent to freeing up around 65 hospital beds, more than two additional wards, every day, rising to more than 70 beds a day by June 2026 as the service continues to grow.

6.16. This additional capacity is being delivered safely and effectively. Almost 96 per cent of patients completed their treatment at home with no re-escalation or readmission back to hospital, up from 91.5 per cent before the expansion, and fewer than three in 100 needed to return to hospital.

6.17. The shorter length of stay achieved at the start of the expansion has also been sustained, with medical patients spending a median of eight days under the virtual hospital.

6.18. The dedicated multi-disciplinary team working directly with clinicians in ED to identify which patients can be admitted under the expanded service continues to have an impact. By June 2026, around one in five patients admitted to the virtual ward were referred directly from ED, compared with around two per cent before the expansion. This helps reduce waiting times and flow through ED.

6.19. Feedback from patients and staff demonstrates widespread support for this way of caring for acute patients. Additionally, the service received national recognition when in June it was awarded the NHS Excellence Award for Delivering Value.

Next steps

6.20. Building upon the robust performance of the service, we will continue to scale capacity and will be introducing an integrated pathway with primary care and social care partners so that we can support direct admissions from those

services when patients require acute care and their place of residence is the best place for them to receive it.

6.21. As the Medway Virtual Hospital continues to grow, it will continue to develop more virtual pathways that support delivery of the NHS 10 Year Health Plan, which aims to end 'hospital by default' by delivering more care locally and at home.

7. Risk Management

7.1. There are no direct risks to the Council arising from this report.

8. Climate change implications

8.1. There are no direct climate change implications arising from this report.

9. Financial implications

9.1. There are potential financial implications for Medway Council in respect of increasing numbers of persons leaving hospital and being diverted from inpatient care and residing in the community with Care Act 2014 eligibility.

10. Legal implications

10.1. There are potential legal implications for Medway Council in respect of increasing numbers of persons leaving hospital and being diverted from inpatient care and residing in the community with Care Act 2014 eligibility.

Lead officer contact

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Appendices

Appendix 1 Draft Clinical Operational Standards

Background papers

None

Appendix 1: Draft Clinical Operational Standards

ACUTE CARE — Seven days a week

After the patient is booked into Emergency Department (ED) or Urgent Treatment Centre (UTC):

1. Initial nursing triage / assessment to be completed **within 15 minutes.**
2. The relevant patients will have blood samples, ECGs and chest x-rays requested **within 60 minutes.**
3. An ED Doctor will see the patient **within 60 minutes.**
4. ED Doctors will make the decision to observe the patient in EM5 or refer to speciality **within 150 minutes.**
5. If the patient requires referral to a speciality, a ST4 Doctor or above will physically review the patient and make the referral in accordance with the acute admission guidelines.

After referral by ED:

6. Admitting specialty teams will clerk the patients **within 60 minutes from the time of referral.** A decision to either admit, transfer, discharge or observe in EM5 will still need to be made within four hours of patient attendance to ED reception.
7. If the receiving speciality require a different speciality input, a ST3 or above Doctor will refer and the second speciality will review the patient **within 60 minutes.**

RADIOLOGY — Seven days a week

8. **X-rays and CTs and completed reports to be available seven days a week for Emergency Department and inpatients within:**
   - 1 hour for critically unwell patients.
   - 4 hours for all urgent patients.
   - 24 hours for all non-urgent inpatients including MRI requests and ultrasound requests.

SPECIALTY — Seven days a week

9. **Following the specialty referral made in ED, all patients are to be reviewed by a Consultant within:**
   - 6 hours between **8am and 8pm** or
   - 14 hours between **8pm and 8am**

ACUTE MEDICAL UNIT (AMU)

Seven days a week:

10. All patients are to be reviewed daily by a senior decision maker in the Acute Medical Unit.
11. Patients who are new, sick, for discharge and those with new investigation results should be reviewed a second time.

Five days a week:

12. Sub-specialty teams to review patients **within two hours of the referral time** during the standard working hours, 8am to 5pm.

INPATIENT WARDS

13. Daily board rounds in all wards by a Consultant of the week to be conducted in line with the Trust Board Round Standard Operating Procedure (SOP). Patients who are sick, symptomatic, new and for discharge should reviewed as a priority. Estimated Discharge Date (EDD) and criteria to reside should be documented on every ward round.

Five days a week:

14. Medical outliers on surgical wards and vice versa should be reviewed daily by Consultant.

Seven days a week:

15. Electronic Discharge Notes (EDNs) to be **completed before midday on the day of discharge**, excluding golden patients which are to be completed during the previous day.

OTHER SERVICES

Seven days a week:

16. **Referral to mental health liaison officer** should be assessed and decision to transfer or discharge should be made **within one hour from referral.**
17. **Referral to front door discharge team** – patients should be assessed **within one hour** and the decision to discharge or admit should be made **within one hour from referral.**

18. All admitting patients should have Medicines reconciliation by pharmacy completed **within 24 hours of booking to ED reception.**

    Site team - patients transferring **out of critical care units** (CCU, ICU, HDU, ECU) should be **prioritised for inpatient bed allocation,** above other requests for available beds, **24/7.**

19. **Where specialties provide an admissions unit, an expert / senior decision maker should receive referrals** and provide advice to the community and hospitals every day to prevent unnecessary hospital attendance / admission and to facilitate hospital discharge.