HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Tuesday, 15th July, 2025

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Tuesday, 15th July, 2025, at 10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Gaetano Romagnuolo**

Telephone: **03000 416624**

Membership

Reform UK (9):	Mr O Bradshaw, Mr J Baker, Mr S Dixon, Ms I Kemp, Mr R Mayall, Mr T Mole, Mrs B Porter, Mrs S Roots and Dr G Sturley
Liberal Democrat (2):	Mr M Brice and Mr A Ricketts
Conservative (1):	Ms C Russell
Green (1):	Mr S Jeffery
District/Borough Representatives (4):	Councillor K Tanner, Councillor H Keen, Councillor K Moses and vacancy

UNRESTRICTED ITEMS

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

Item

1. Election of Chair

2. Election of Vice-Chair

3. Apologies and Substitutes

4. Declarations of Interests by Members in Items on the Agenda for this Meeting

5. Minutes of the meeting held on 12 March 2025 (Pages 1 - 10)

6. Carr-Hill Formula (Pages 11 - 18)

7. Winter Plan Review 2024/25 (Pages 19 - 26)

8. Wellbeing Support for NHS Staff during and after Covid (Pages 27 - 30)

9. Urgent Treatment Centre Review Update (Pages 31 - 36)

10. Community Services Procurement and Engagement Update (Pages 37 - 44)

11. Work Programme (Pages 45 - 48)

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)

Benjamin Watts
General Counsel
03000 416814

7 July 2025

KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Wednesday, 12 March 2025.

PRESENT: Mr P Bartlett (Chair), Mr P V Barrington-King, Sir P Carter, CBE, Mr P Cole, Cllr K Moses, Ms L Parfitt and Mr R G Streatfeild, MBE.

PRESENT VIRTUALLY: Ms K Constantine.

ALSO PRESENT: Dr J Jacobs (Kent Local Medical Committee), Mr G Romagnuolo (Committee Clerk)

UNRESTRICTED ITEMS

214. Apologies and Substitutes
(Item 1)

1. Apologies were received from Mr S Campkin, Mr N Chard, Ms S Hamilton, Cllr S Jeffery, Cllr H Keen and Mr J Meade. Ms K Constantine gave her apologies but joined the meeting virtually.

2. The Chair thanked Ms K Goldsmith for her support of HOSC over the last few years ad welcomed Mr G Romagnuolo as the new Clerk of HOSC.

215. Declarations of Interests by Members in items on the Agenda for this meeting.
(Item 2)

3. The Chair declared that he was a representative of East Kent Councils on the Integrated Care Partnership.

4. Mr Cole declared that he had responsibility for the Housing and Health portfolio at Sevenoaks District Council and sat on numerous Health and Wellbeing Boards in West Kent.

216. Minutes of the meeting held on 28 January 2025
(Item 3)

1. A Member suggested that, particularly with regard to Stroke Services in East Kent, there had been a good debate with constructive comments that should have been captured more comprehensively in the minutes.

RESOLVED that the minutes of the meeting held on 28 January 2025 were a correct record and that they be signed by the Chair.

217. Mental Health Transformation Across Kent and Medway - Update Report
(Item 4)

Dr Adrian Richardson, Director of Transformation and Partnerships, Kent and Medway NHS and Social Care Partnership Trust (KMPT), Dr Rakesh Koria, Ageing and Dying Well Clinical Lead, Mrs Rachel Parris, Deputy Director Out of Hospital Care (Community Services), Ms Louise Clack, Deputy Director, Adult Mental Health and Victoria Stevens, Deputy Chief Operating Officer, NHS Kent and Medway were in attendance for this item.

1. The report provided an update on changes within the mental health landscape. It focused on key programmes which were aimed at improving the provision of responsive and comprehensive mental health services for Kent and Medway residents.

2. In reply to a question, Dr R Koria (Ageing and Dying Well Clinical Lead, NHS Kent and Medway) said that the number of out-of-area beds had increased over the last two to three months. This was due to some significant flow issues across the system. Patient experience was monitored, and patient experience levels and the number of complaints had remained stable throughout the last few months.

3. The Chair asked a question about the level of security in Crisis and Recovery Houses, in particularly the one in Ashford, as there had been an incident of a patient removing themselves from the premises.

    a. Louise Clack (Deputy Director, Adult Mental Health, NHS Kent and Medway) explained that, while the House was a 24-7 staffed environment, individuals used the Crisis Recovery House voluntarily and were allowed to take their own leave from the premises.

    b. Anybody who was accepted into Crisis and Recovery houses had to have an assessment by the mental health provider trust, where a clear assessment of risk was made. This included whether the individual required clinical mental health interventions within a clinical inpatient setting which provided an enhanced level of security or non-clinical interventions with a 24-hour accessible support in a Crisis Recovery House.

c. Crisis Recovery Houses had very close links with the mental health provider trust and local crisis resolution home treatment teams. If, in a Crisis Recovery House, an individual's mental state deteriorated to the extent that the provider believed that a clinical assessment was required, then they would contact the local crisis resolution home treatment team who would conduct an assessment.

4. A Member asked whether there was a budget to support local charities that had a good track record of helping and supporting people with mental health issues.

a. Louise Clack said that there was a budget to support third sector organisations. In terms of dementia support in the community, there were 52 Dementia Coordinators. These posts were provided by the voluntary sector and were linked to Primary Care Networks.

b. The majority of urgent and emergency care transformation and community crisis alternatives were provided by the voluntary sector.

c. There were also 10 Safe Havens and a 24-7 mental health helpline which were all delivered by charities.

5. A Member asked a question about how the initiative of GPs with enhanced roles worked in practice.

a. Dr Koria explained that, traditionally, in many different clinical areas there had been a specialism, and one of them was in dementia.

b. One of the aims for the nine GPs with extended roles was to make sure that they were supported by existing wider mental health teams - including psychologists and carers - working together.

c. These GPs were very versatile because they were able, not just to manage dementia, but to provide support with other conditions that co-existed with dementia.

6. In reply to a question about the main reasons for co-locating threes Safe Havens within busy acute hospitals, Louise Clack explained that hospital settings were open 24/7 and that individuals could easily walk in to access those services. Also, Liaison Psychiatry staff were always present in emergency departments.

7. In terms of consent to access Safe Haven services, Louise Clack clarified these were only available to those aged 18 and above.

8. The Committee requested an update, at an appropriate time, on Mental Health Services and Dementia Services in particular.

9. The Chair thanked the guests and requested an update, at an appropriate time, on Mental Health Services and Dementia Services in particular.

RESOLVED that the Committee consider and note the report.

218. Adult Autism and ADHD Pathway Development and Procurement
(Item 5)

Marie Hackshall, System Programme Lead Kent and Medway – Learning Disability, Autism and ADHD was in attendance for this item.

1. The Chair welcomed Marie Hackshall, System Programme Lead Kent and Medway – Learning Disability, Autism and ADHD, to the meeting and invited questions from the Committee.

2. Marie Hackshall shared a report on the progress made on the health commissioned care pathway for adult Autism and ADHD services in Kent, the revised commissioning processes that had being undertaken, the governance arrangements for this, engagement with people with lived experience and future actions planned to address challenges within this clinical area. This report followed a previous briefing to the Committee in October 2024.

3. The Chairman commented that he was impressed with the work carried out so far in engaging with the community and that he attended one event in Ashford which was very well run. He asked for feedback from this event.

    a Marie Hackshall said that, between November 2024 and the end of February 2025, her service ran a number of engagement sessions, as well as an online survey. for people who were waiting for an ADHD assessment or who had a diagnosis of ADHD. The online survey received over 1,500 responses. The responses were used to inform the engagement sessions - two were online and two in person - which were attended by 42 people.

    b The responses highlighted significant challenges in accessing assessments and treatment, as well as support before and after diagnosis. Respondents said that they needed tailored support such as coaching, therapy, crisis services, financial and employment guidance. Other suggestions to help improve services included awareness and training for healthcare staff and GPs, better communication during the process, self-referral options, crisis escalation pathways, and a central directory for ADHD-friendly services.

4. In reply to a question about the reasons for the increase in demand for autism and ADHD services, Marie Hackshall explained that the reasons were multifaceted and complex. There was a comprehensive workstream at national level aimed at understanding why the demand had risen, and about how best to address it.

5. In Kent that demand had followed the national trend and was strongly influenced by increasing public awareness of ADHD along with social and environmental changes that had impacted on people's lives following the pandemic. Demand for ADHD assessments had risen at such pace that current service models, and the ability to keep pace with demand, had been recognised by NHS England as a significant challenge for all ICBs.

6. The Committee requested a report providing more detail about national-level work aimed at understanding the reasons for the increase in demand for autism and ADHD services, and about the commissioning and contractual arrangements of the ICB for the assessment and treatment of these conditions.

7. In answer to a question about how to improve the provision of medication for ADHD in a timely way, Marie Hackshall said that the main aim was to offer 'hub and spoke models' involving more localised services to improve access to treatment. The plan was, over the course of the next 12 months, to offer those services through more localised infrastructure primary care and community care rather than through more expensive specialist settings.

8. Dr Jack Jacobs (Kent Local Medical Committee) commented that the medications that were used for some patients with ADHD were not part of the normal, core prescribing of GPs. A voluntary 'Shared Care Agreement' was necessary for GPs to do so. The visit involved a comprehensive assessment and not all practices had the resources to do so. This was one of the main reasons why this service was not offered by all GP practises.

RESOLVED that the Committee note the report.

219. Kent and Medway GP Attraction Project
(Item 6)

Dr Mayur Vibhuti, Deputy Dean of the Kent and Medway Primary Care Training Hub was in attendance for this item.

1. The Chairman welcomed Dr Vibhuti and asked him whether there were any plans to replicate this project in other parts of the country.

2. Dr Mayur Vibhuti (Deputy Dean of the Kent and Medway Primary Care Training Hub) replied that there were no current plans to replicate the project because there was not sufficient evidence to demonstrate the full impact of the initiative to encourage the local recruitment of GPs.

3. In reply to a question about how best to promote the recruitment of GPs in Kent, Dr Vibhuti said that the evidence had shown that there was an increasing number of GP trainees who wished to work part-time and that it was important to widen the type of placements on offer because more GPs had an interest in a clinical speciality, such as dermatology or ENT. It was therefore important to develop a recruitment package that moved away from the traditional GP model and instead catered for the changing demands of the workforce.

4. A key lesson learned from the project was that the level of support requested from GPs had increased in the last 15 years. Feedback indicated that additional help through mentoring and peer group assistance would contribute to the retention of GP trainees in Kent.

5. A Member asked whether there were any local GP networks. Dr Vibhuti explained that there were a number of networks, such as the one run by the Kent Local Medical Committee.

6. In reply to a question, Dr Vibhuti said that matching the local population health needs with the workforce was not simply a matter of recruiting an suitable number of professionals but to ensure that the skills they had were appropriate to meet the specific needs of local communities. For example, GPs with expertise in frailty were best placed to meet the needs of ageing coastal communities.

7. Dr Jack Jacobs (Kent Local Medical Committee) indicated that the resources injected in general practices in the last 15 years had relatively declined, and that the national contract was an important element to explain the shortage of GPs. GPs were available but there were insufficient resources to employ them. The planned national contract review might improve this situation.

8. At local level, the implementation of the Safe Working Limit to 25 patients per day, that was recommended by the British Medical Association, would lead to greater GP retention.

RESOLVED that the Committee consider and note the update.

220. Podiatry Services Move
(Item 7)

1. There were no representatives available to present this item. Having considered the information provided, the Committee decided to note the update report.

2. RESOLVED that the Committee note the update.

221. Thanet Integrated Health Hub
(Item 8)

Julia Rogers, Director of Communications and Engagement, Kent Community Health NHS Foundation Trust, Philip Griffiths, Director of Estates Optimisation, Kent Community Health NHS Foundation Trust, and Karen Sharp, Director, East Kent Health and Care Partnership were in attendance for this item.

1. The Chairman reminded Committee members that they had previously resolved that this item was a substantial variation of service; this was therefore an update on the latest developments to establish an integrated health hub at the Carey Building, in Broadstairs, Thanet.

2. A Member asked about the services that the Hub would deliver. Karen Sharp (Director, East Kent Health and Care Partnership) said that the Hub was planned to include the following:

   • An NHS community diagnostic centre (CDC), to include an MRI in phase one, expanding to respiratory, cardiology and phlebotomy services in phase two.
   • A range of community NHS services - including community nursing, podiatry, cardiac and respiratory services.
   • The relocation of St Peter's GP surgery to support growth in the patient list of up to 7,000 people.
   • Capacity to support development of a new model of care, including same day access to a GP when appropriate.
   • Signposting and support to access health and care services provided by voluntary sector organisations, such as Age UK.

3. The plans included 10 consultation or examination rooms, 2 counselling rooms, 2 treatment rooms, 8 rooms for community services and 6 for the community diagnostic centres. The second floor would be used for administrative services. There was additional space on the first floor that could potentially be used for clinical services in phase two.

4. In answer to a question about the solutions that had been planned and put in place to deal with the potential additional traffic that the Hub could cause on already busy local roads, Philip Griffiths **(**Director of Estates Optimisation, Kent Community Health NHS Foundation Trust) said that his service was working intensively with a number of partner organisations, as well as consultants, to ensure a timely and flexible solution that would involve offsite car parking as well as accessible non-emergency patient transport.

5. In reply to a question, Karen Sharp confirmed that the Hub would offer dental service provision as part of phase two of the plan.

6. Making reference to Item 6 (Kent and Medway GP Attraction Project), Dr Jack Jacobs commented that, in his view, the establishment of the Thanet Integrated Health Hub would contribute to the attraction and recruitment of GPs in the area.

7. The Committee requested an update on the latest developments and outcomes with regard to the Hub in 12-18 months' time.

RESOLVED that the Committee consider and note the report.

222. Healthwatch Kent Annual Report 2023-24
(Item 9)

Robbie Goatham, Manager, Healthwatch Kent was in attendance (virtual) for this item.

1. Robbie Goatham (Manager, Healthwatch Kent) introduced the report, provided some background information about the organisation and offered some clarity on the finance section. Finally, he paid tribute to all the volunteers for their invaluable work at Healthwatch.

2. The Committee were satisfied with the information provided in the update and had no further questions.

RESOLVED that the Committee note the report and invite Healthwatch Kent to present their 2024-25 report in due course.

223. Work Programme
(Item 10)

1. Members requested the following:

    a. An update on local Mental Health Services and Dementia Services in particular.

b. An update on the Adult Autism and ADHD Pathway Development and Procurement within a year, including information about the national-level work aimed at understanding the reasons for the increase in demand for autism and ADHD services, and about the commissioning and contractual arrangements of the local ICB for the assessment and treatment of these conditions.
c. That the paper on the Carr-Hill Formula (to be presented at the next meeting on 4 June 2025) includes a discussion of/information on the national context, in addition to the local one.

RESOLVED that the Committee consider and note the work programme.

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Item 6: Carr-Hill Formula

By: Gaetano Romagnuolo, Research Officer - Overview and Scrutiny

To: Health Overview and Scrutiny Committee, 15 July 2025

Subject: Carr-Hill Formula

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information offered by the Kent Local Medical Committee.

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1) Introduction

a) This item was requested at the HOSC meeting on 17 December 2024.

b) This paper is intended to explain the complexity of funding in General Practice, specifically the Carr-Hill Formula. The Global Sum is one of the main sources of income for the majority of General Practices. The Carr-Hill Formula – which was introduced in 2004 - directly influences how the Global Sum is calculated for practices delivering NHS General Medical Services.

2) Recommendation

a) RECOMMENDED that the Committee consider and note the report.

Background Documents

None

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Health Overview and Scrutiny Committee 15th July 2025
General Practice Funding – the Carr-Hill Formula

This paper is intended to support HOSC to understand the complexity of funding in General Practice, specifically the Carr-Hill Formula. The Global Sum is one of the main sources of income for the majority of General Practices, the Carr-Hill Formula directly influences how this is calculated for practices delivering NHS General Medical Services. The Carr-Hill Formula was implemented in 2004, at the time this represented a major shift in how funding was allocated to practices as the new formula calculated an amount of funding per practice. The introduction resulted in some practices receiving less funding than under the previous contract and to mitigate this a Minimum Practice Income Guarantee (MPIG) was negotiated to ensure no practice was left with less funding. Over time, as the core GP contract increased, the correction factor reduced from 2014 and since 2021 has been completely phased out. Practices have had to make internal adjustments to offset the loss in funding as in the same time period core funding has not kept up with inflationary cost pressures.

How the global sum allocation (Carr-Hill) formula is calculated:

The global sum includes various components. The main payment is based on the GP registered patient list size (the headcount) and adjusted, using the Carr-Hill Formula, to reflect differences in the age and sex composition of the practice population, together with a range of factors which take into account the additional pressures generated by differential rates of patient turnover, morbidity, mortality and the impact of geographical location. These elements are outlined in the table below:

Drivers of workload accounted for in the formula	Description
Patient age and sex	Patients of different ages and sexes attract a different level of payment under the Carr-Hill formula based on a cost curve
Additional needs of patients	Using health survey for England 1998-2000 data, the formula takes into account standardised limited long standing illness and the standardised mortality ratio for patients under 65
List turnover	Patients in their first year of registration in a practice tend to have more consultations than others, so require extra funding

Unavoidable costs	Description
Staff market forces factor	The geographical variation in staff costs
Rurality	The impact of rurality was modelled using HMRC information on GP expenses aggregated to practice level. The impact of population density and dispersion was modelled against GP expenses, controlling for other factors

Each adjustment within the formula generates a separate practice index comparing the practice score on the adjustment to the national average. The indices are then applied to the practice list to produce a **practice weighted population.** The payment mechanism means that where patients are registered, seen and then leave the patient list within a financial quarter the practice does not receive any funding for these episodes of care. It also means that practices are not reimbursed according the actual number of patients registered, they are reimbursed according to the practice weighted population. The payment

is calculated quarterly based on the 'Capitation statement' which reflects the number of patients registered at that point in time. The current England average global sum payment is £121.79 per patient for delivery of all GP services for 12 months[1].

At the point of inception there were limited ways of measuring workload for individual practices and so the formula was derived from a sample of practice data taken from the General Practice Research Database (GPRD) between 1999 and 2002. Since this time GP records have been digitalised, we have robust coding of conditions, the ability to audit consultation numbers, durations, staff skill mix, mode of consultation and conditions being managed. We also have a greater understanding of population health and the impact of deprivation. It is widely acknowledged that the formula does not account for this and so practices in the most deprived areas receive on average 9.8% less funding per needs adjusted patient across all income streams than those in the most affluent quintile [2]. It is now widely acknowledged that the funding formula is in need of revision and reform.

What does the Global Sum Payment (Carr-Hill formula) fund practices to do?

It provides funding for practices operational costs and the costs of delivering essential GP services within core hours (0800-1830) – providing services for registered and temporary residents living within the practice area who are ill, or believe themselves to be ill, delivered in the manner determined by the practice. This includes identification and management of illnesses, providing health advice and referral to other services as required.

The number of consultations a patient can have is not limited and is determined by the patients assessed need. Some patients will need more appointments in a year and some may need less. As inflationary pressures have increased it is worth noting that the reality for practices is that the Global Sum Payment now predominantly only funds overheads such energy and staffing costs.

Other sources of funding:

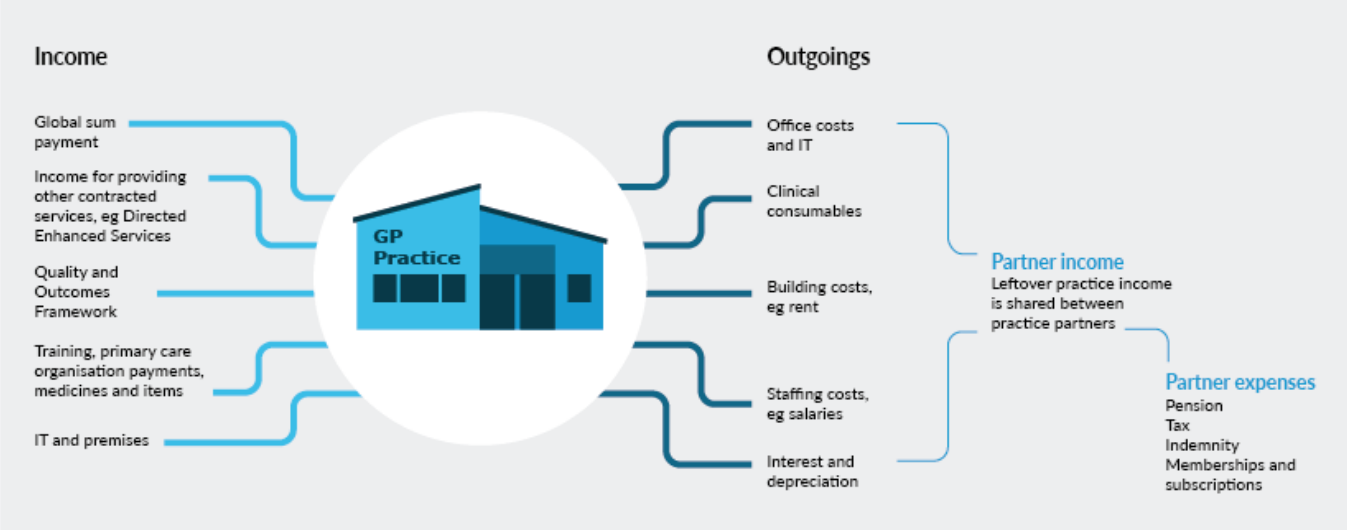
Practices claim funding for additional services, this includes:

1. **Quality Outcome Framework** (QOF) – provides an opportunity for practices to meet specific quality targets and funding is paid to practices monthly based the previous years achievement with a balancing payment the following year calculated according to actual achievement. The QOF year runs April to March. Components are renegotiated annually nationally. This year has seen many indicators moved into the Global Sum payment and a focus in the contract for 2025/26 on Cardiovascular Disease prevention.

2. **Enhanced Services** – local enhanced services are defined and commissioned by individual ICBs to meet the needs of our local population – including delivery of wound dressings, medication injections, phlebotomy, ECG, ambulatory BP monitoring, minor surgery. Directed Enhanced Services are nationally defined and includes the Primary Care Network Directed Enhanced Service (PCN DES).

3. **Primary Care Network funding** – where practices have signed up to the PCN DES they receive funding for the delivery of the services defined by the DES, responsibility is shared between the practices in the PCN and co-ordinated by the PCN Clinical Director. The Additional Roles Reimbursement Scheme (ARRS) provides funding for additional roles as determined nationally (such as PCN pharmacists, and as of this year nurses and newly qualified GPs) to deliver services.

4. As you can see in the diagram[2] below there are other sources of reimbursement such as premises, and funding for training GP registrars and medical students.

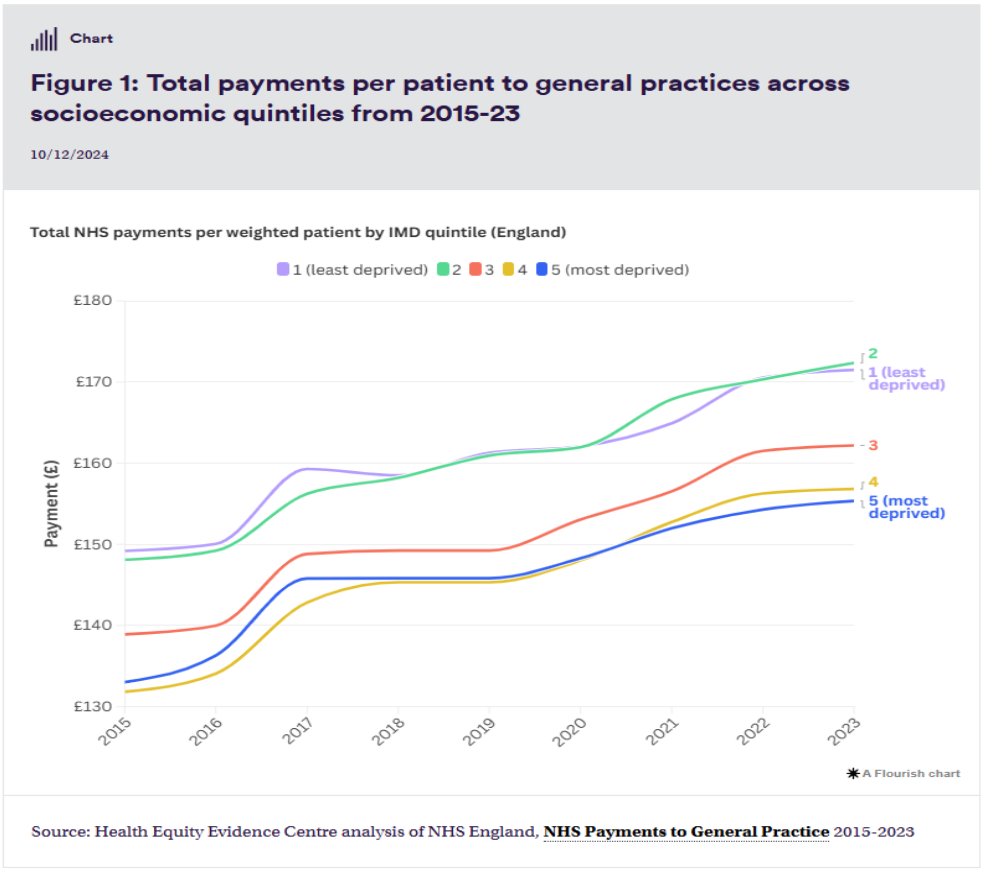


Why are GP practices struggling?

The current pressures on general practice reflect increasing population health needs and the funding provided by successive governments not keeping up with inflation, the expansion in ARRS has also added pressure to the General Practice estates.

As the demographics and population health needs of our society have changed, the weaknesses in the funding formula have been increasingly exposed and funding is inequitable and insufficient. Other limited funding streams have been added over successive years to address local needs and this has created a complex patchwork of funding streams which practices claim for monthly or quarterly. Despite greater health and social needs in poorer areas, general practices in the most deprived areas of England receive less funding than more affluent areas.

As seen in the graph below from the briefing undertaken by Nuffield Health[3]. Practices in more deprived areas have less funding to employ staff and consequently have fewer GPs.



GP partners are not just clinicians they are also small business owners and employers the majority of whom operate in a partnership model. This comes with a number of challenges such as managing complicated income streams and holding personal liability for financial risks. Most recently GP practices have been included in the governments National Insurance increases, this will cost the average practice in Kent and Medway over £38,000. The advantages of the partnership model are partners have a strong vested interest in maintaining and developing their practice, representing the most financially efficient part of the NHS, a lot of additional work is undertaken by GP partners to maintain practice services and regulatory compliance.

The BMAs General Practitioners Committee England released their vision for General Practice in the future, 'Patients First – Why general practice is broken and how we can fix it[4].' This sets out the national context and the desire of the profession to bring back the family doctor. There is strong evidence that patients who have continuity of care have better health outcomes, reduced need for frequent visits, reduced admissions to hospital and improved patient satisfaction. Guidance to practices from the BMA aims to support safe working and increase continuity of care by reducing the number of patient contacts GPs undertake in a day, this recognises the increased burden of disease and complexity that patients now present with.

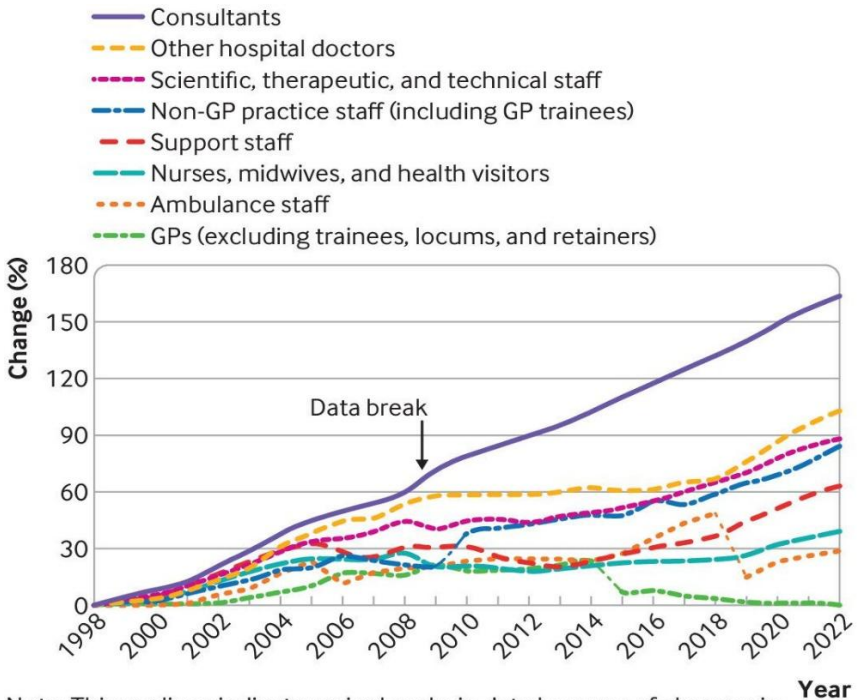
Many practices are being forced to freeze recruitment due to increasing cost pressures and financial uncertainty, without sustained guaranteed increases in practice funding continuity of care will continue to be compromised. For the first time we are now seeing underutilised or unemployed GPs in some areas while at the same time other areas have found it hard to recruit. Our current government hope to improve this situation by including GPs within 2 years of qualification in the PCN ARRS. In practice many PCNs have already recruited other roles using this budget and so have been unable to utilise the offer. GPs employed in this scheme work across a number of practices and so these posts can be less attractive and have the potential to further stifle continuity of care for patients.

Locally the Primary Care Training Hub have developed GP Fellowship Schemes which have been popular and enable GPs to continue to develop their skills while working in practices, recent funding cuts have reduced the opportunities available. The LMC continue our support offer for practices and recently have added a regular Mid Career Peer Network and Coaching offers to GPs across Kent and Medway.

Due to the national lack of investment into the Global Sum one in five independent NHS GP practices across England has been lost since 2013. Practices are closing and their patients are being either taken over by neighbouring practices or an incumbent provider takes over the service from the existing practice.

As the body of evidence increases to support investment in primary and community care in terms of improved health outcomes the newly elected government have worked with GPC England and this led to agreement of the 2025/26 contract and a commitment from the Rt Hon Wes Streeting, Secretary of State for Health and Social Care, to work with GPC England to secure a new substantive GP contract within this parliament. It is widely agreed that a transfer of resources from acute services to enable an NHS focus towards proactive and preventative care in the community should occur and following the NHS public consultation and the more recent dissolution of NHS England, at the time of writing we await the publication of the NHS Ten Year Plan.

Locally our Full Time Equivalent (FTE) GP numbers remain approximately 142 below the national average, currently each FTE GP cares for 2702 patients (this number varies across our region, in Medway and Swale 1 FTE GP has 3833 patients). Our GP numbers continue to struggle which reflects national trends. The table below from the British Medical Journal[5] indicates the change in staff mix between 1998 and 2022 and demonstrates the decline in GP numbers which continues today in 2025. The paper identified that trends in health staff numbers more or less match Department of Health spending trends.



Note: Thinner lines indicate major breaks in data because of changes in definition or data collection

Sources: NHS Digital[2345]

Local projections based on population size increase and demographics estimate that an increase in 1.7 million appointments per year will be needed by 2030 to meet the needs of our population. General practices in Kent and Medway deliver on average 910 777 appointments per month, 69% are delivered as in person appointments. The total population of Kent and Medway is, according to NHS digital data May 2025, 2,038,583. The data demonstrates practices are seeing more patients than ever before. Despite this the challenge of access reflected from feedback from our patients remains as demand frequently exceeds practice capacity, ability to triage and assess need, and increasing needs and demand due to increased disease burden caused by our aging population. The situation is compounded by the pressures of other parts of the NHS system leading to patients with increasingly complex conditions being managed in General Practice while waiting to be seen by specialists. The LMC have been working closely with Kent and Medway ICB to identify and address local enhanced services to support patient care closer to home, this includes introduction of the Primary Care Quality Standard and other initiatives already presented to the HOSC.

In 2024 Lord Darzi's independent investigation into NHS Performance[6] illustrated the current challenges faced by the NHS. The report made clear the value of General Practice to our Health Care System, indeed for every £1 spent on primary and community care in the NHS there is a return of up to £14 to the local economy[7]. We hope this paper illustrates to the HOSC the essential role General Practice plays in supporting our patients and explains the complex funding arrangements. General Practice and GPs can truly be valued and invested in, with this investment practices will be able to spend more time with patients, focus on preventative care, chronic disease management and increasing continuity of care.

Report Author: Dr Caroline Rickard, Medical Director, Kent Local Medical Committee

References

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7. **NHS Confederation** (2023) The Influence of NHS Spending on Economic Growth (online). Available at: https://www.nhsconfed.org/system/files/2023-08/The-influence-of-NHS-spending-on-economic-growth.pdf.

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Item 7: Winter Plan Review 2024/25

By: Gaetano Romagnuolo, Research Officer - Overview and Scrutiny

To: Health Overview and Scrutiny Committee, 15 July 2025

Subject: Winter Plan Review 2024/25

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

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1) Introduction

a) The creation of a Winter Plan is a statutory requirement for Integrated Care Boards. At the HOSC meeting on 17 December 2024, NHS Kent and Medway (the Integrated Care Board) provided the Committee with an overview report of the preparations for 2024/25 winter period. The Committee noted the report and requested that NHS Kent and Medway provide feedback on the performance of the winter plans at the HOSC meeting in mid-2025.

2) Recommendation

a) RECOMMENDED that the Committee note the report.

Background Documents

Kent County Council (2024) *'Health Overview and Scrutiny Committee (17/12/2024) https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=9544&Ver=4*

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NHS Kent and Medway Winter Plan

Background

The creation of a winter plan is a statutory requirement for integrated care boards. The ICB produced a comprehensive plan, linking to national priorities, while incorporating lessons learned from previous year This paper explains the process that was undertaken in formulating the plan, and headlines contained within it.

We received local guidance from the NHS England South East regional team in August 2024 followed by a letter published nationally by NHSE on 16 September 2024 which outlined the requirements to maintain our bedded capacity across all areas, to support people to stay well, and ensure that we maintain patient safety and experience across all our services.

The national areas of focus are:

- Same day emergency care (SDEC)
- Single point of access (SPOA)
- Virtual wards
- Urgent and emergency care (UEC) high impact changes
- Maintain elective activity.

An additional letter was received from NHSE on 12 November 2024 providing four additional key components for delivery over winter, these are:

1. Vaccination and immunisation of eligible patients and staff.

2. Segmentation of the population and wrap around support for the most vulnerable patients to keep them well and avoid admission in a crisis.

3. ICB assurance that sufficient capacity exists within SPOAs to ensure appropriate plans can be put in place and that outcomes from SPOAs are regularly reviewed.

4. Work is in place to reduce the average length of stay for non-elective patients who can be discharged to their usual place of residence (pathway 0) by an average of one day at system level and to reduce variation across clinical specialties.

A whole-system plan was developed which combined various elements across the continuum of care - primary, community, acute, mental health and social care.

Using public health information and data analysis to review previous assumptions and to predict demand, modelling has been carried out to predict particularly busy periods during winter and where the toughest areas will be.

The plan included surge plans, capacity and demand predictions, improvements to mitigate demand, urgent emergency care assurance and localised Health and Care Partnership (HCP) plans.

This pack was submitted to NHSE on 29 November 2024 and was previously shared at a HOSC meeting in early 2025.

Creating the Plan and the Priorities

A number of winter events were held to bring together subject matter experts from across the system. These included: two system-wide events, one focused on primary care, and HCP-led events, to bring together subject matter experts from across the system.

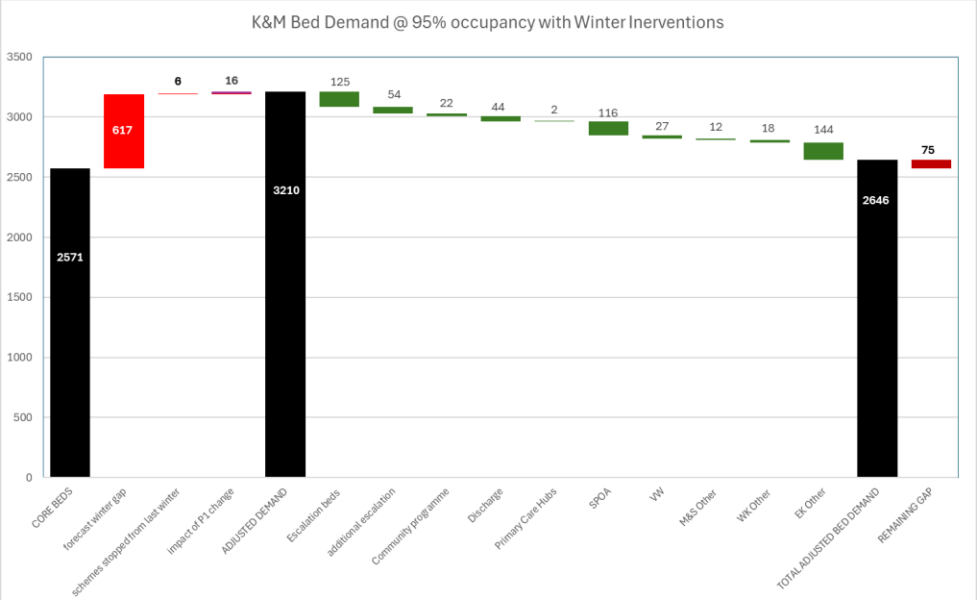
From the first event, in July 2024, a list of 13 priority projects were identified as needing to be in place to support the system over winter. They were:

- proactive management of adult and paediatric respiratory patients
- identifying the top one per cent of people who need support, including frailty
- further development of the primary care hubs
- roll out of the better use of beds programme to ensure the patients are cared for in the facility that best meets their needs, implementing at speed to increase capacity
- VCSEF engagement
- re-activation of a discharge taskforce to support patients being discharged to their usual place of residence
- support for nursing and care homes to avoid unnecessary admissions to A&E
- targeted support for patients who present at health services multiple times
- development single point of access (SPOA) models
- ensure and maintain capacity of same day emergency care (SDEC) units
- development of two-hour response/urgent community response (UCR)
- ongoing work to utilise virtual ward capacity as an alternative to beds in the acute hospitals

Each of these projects were facilitated by the ICB with key system partners to create or use existing steering groups to continually monitor progress over the winter months in preparation an expected winter peak around mid-December 2024.

As with previous years, the planning cycle was data driven, based on forecast data to identify potential gaps in access to care defining and implementing mitigations and risk management.

One of the key components of the winter plan was the modelling of expected requirement for beds and capacity of the system. A waterfall graph is produced to show how all the schemes focused on creating more capacity are factored in and the gap that remains. For winter 24/25 we modelled on various occupancy levels but present here 95% as this around the level we peak at each year.



In addition, primary care services across Kent and Medway planned to offer circa 57,000 extra appointments over the winter period.

How Winter Went

The winter period was managed well across the system through the ICB Operational Command Centre (OCC) and with the appointment of a Winter Director the 2024-2025.. Metrics were collected and analysed regularly to identify trends early and the weekly touchpoint meetings were introduced to allow for early escalation of any issues from system partners.

Liaising directly with NHSE, the ICB were able to maintain a good level of services across the system during a difficult period which saw higher use of many services across primary, secondary and community care settings.

The 13 High Impact Projects were monitored through bi-weekly updates at the ICB with many of the key functions being put in place before the start of December 2024 but with monitoring and assurance processes continuing into early 2025.

Some highlights from the projects include:

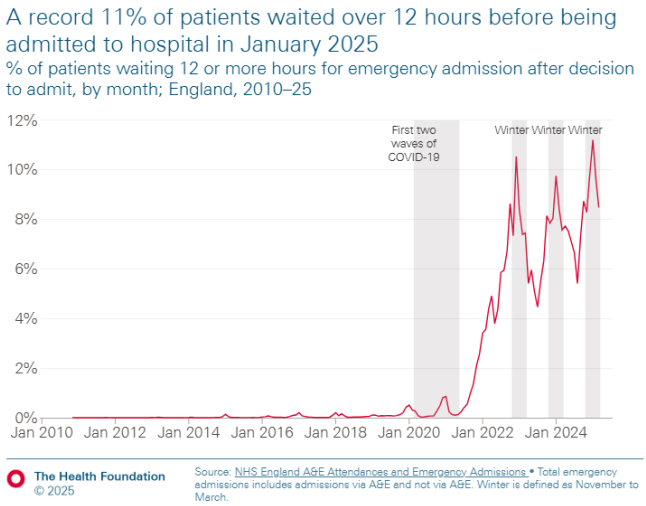
- Health Care Partnership (HCP) webinars completed in December focusing on identifying the 1% of patients who need support around issues linked to frailty.
- Johns Hopkins Risk Stratification model live across all HCP areas
- Transfer of Care Hubs developed across all HCP areas
- Primary Care Networks mobilised Same Day Winter Access Hubs (SDWAH) from 1 November, with the aim to provide a minimum of 57,142 additional appointments between November 2024 and March 2025.
- Multi-Agency Discharge Events (MADE) put in place to focus on discharges for pathway 0 patients

- Best practice forums held with Clinical Lead and providers through January & February 2025 to review progress and share learnings of care home support programme
- Single Points of Access (SPOA) set up in East, West and North Kent with ongoing continuous improvement work established to review and improve all
- Increase in use of Virtual Wards over Winter.

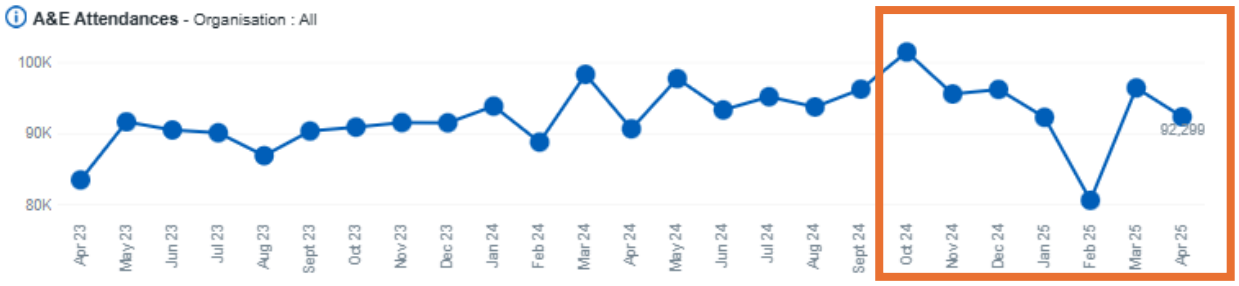
National Winter Position:

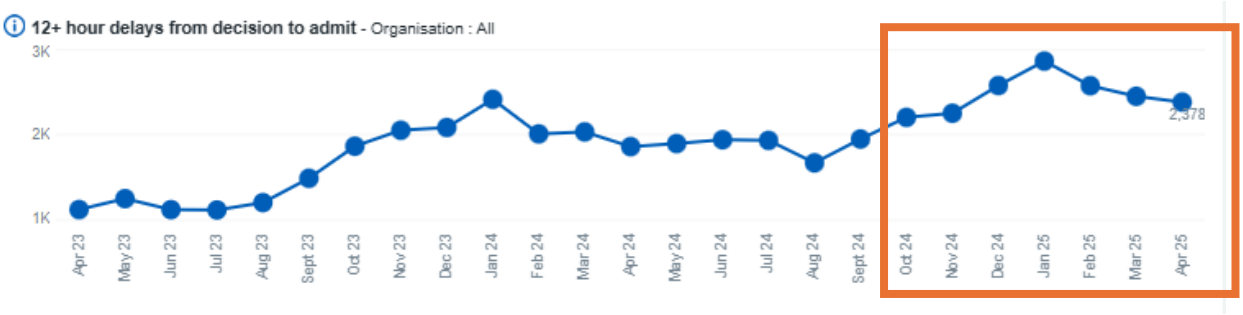
(The Health Foundation 2025, "*Did the NHS experience record pressures this winter?*" Did the NHS experience record pressures this winter? - The Health Foundation Accessed: 22/05/25)

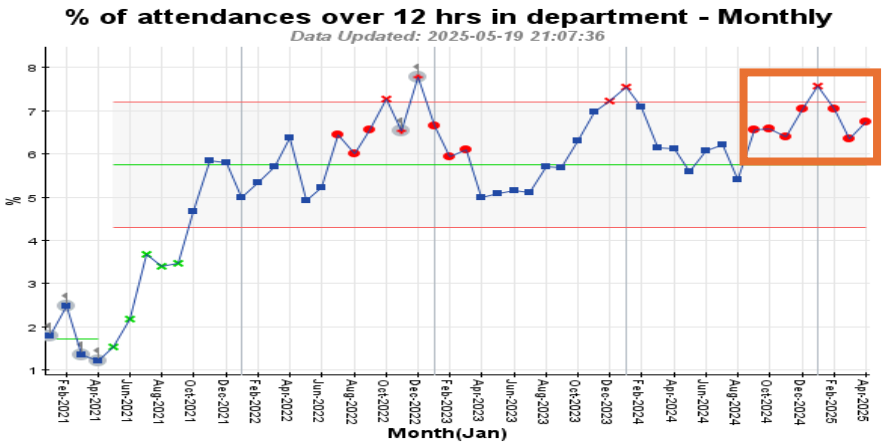
- This winter saw the NHS in distress. Only 73% of A&E patients were treated within 4 hours, similar to the last two winters, and far below the 95% constitutional standard. The number of people experiencing 12-hour waits before admission reached a new record high. Numbers of A&E diverts and ambulance handover delays were worse than over previous winters.
- Looking at operational performance, winter pressures and other factors, the analysis explores the extent to which disruptions to urgent and emergency care were caused by higher than usual levels of winter illnesses and/or systemic weaknesses within the NHS.
- Levels of flu and diarrhoea and vomiting were higher than usual. Hospital admissions for flu reached a similar peak to winter 2022/23 but took longer to fall, leading to a 50% higher total number of flu bed days. However, hospital admissions for RSV were similar to previous winters, while admissions for COVID-19 remained low.
- Winter A&E attendances have risen steadily each year. However, slightly fewer patients attended major A&E departments in winter 2024/25 than in 2023/24, and emergency hospital admissions fell slightly. This suggests the NHS struggled to cope with a small increase in demand from patients needing emergency hospitalisation, while also expanding elective activity in line with government commitments to improve elective performance.
- Bed occupancy during winter has been rising for the last 15 years, exceeding the NHS 92% threshold for the first time in winter 2017/18, highlighting a system at its limits. Since COVID-19, a substantial increase in delayed discharges is likely to have obstructed the flow of patients out of hospitals, worsening bottlenecks upstream in the care pathway from A&E into wards and from ambulances into A&E.
- Overall, the conditions this winter, while severe, were similar to those in recent years and not far above what the NHS can normally expect. Attributing operational problems to external factors such as winter illnesses and higher demand risks offering false comfort about the resilience of the health service.



Kent & Medway Winter 24/25 Data







K&M is currently consistently meeting or exceeding the <10% target for 12 hrs in department .

Data comparisons - Organisation : All

	April 2024	March 2025	April 2025
Performance	81.6%	81.8%	81.1%
Attendances	90,615	96,378	92,299
Breaches	16,668	17,585	17,432
4+ hour delays from decision to admit	4,603	4,476	4,630
12+ hour delays from decision to admit	1,857	2,446	2,378
Emergency admissions	18,138	16,214	15,648
Emergency admissions via A&E	14,461	13,735	13,265

The Winter period was a difficult time across our healthcare providers which was also mirrored by difficulties faced in adult social care and community settings with high levels of demand and constraints to capacity. Peaks in pressures were seen following the bank holiday at Christmas and Easter but this as expected. Overall the winter period in Kent & Medway as with the national position was not anymore or less harsh than previous years with the plans put in place to deal with the increased demand facilitating a prepared response to the winter period.

Item 8 - Wellbeing Support for NHS Staff during and after Covid

By: Gaetano Romagnuolo, Research Officer - Overview and Scrutiny

To: Health Overview and Scrutiny Committee, 15 July 2025

Subject: Wellbeing Support for NHS Staff during and after Covid

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

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

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1) Introduction

a) This item was requested by a Member of the Committee. It is an overview of the support offered to NHS Staff during and after Covid.

2) Recommendation

a) RECOMMENDED that the Committee note the report.

Background Documents

None

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NHS
Kent and Medway

Wellbeing support for colleagues during Covid

- Safety of colleagues was prioritised with PPE, staff vaccinations, and accommodation for working colleagues. Colleagues were also redeployed to support front line colleagues.
- National health and wellbeing support included national wellbeing apps, communities of practice and up to 176 wellbeing interventions for local consideration and use.
- In Kent and Medway all organisations had a range of wellbeing support including Employee Assistance Programmes and access to counselling, trained Trauma Risk Management Practitioners, leadership support circles (equipping leaders with evidence base wellbeing interventions), coaching and mentoring and wellbeing conversation training rolled out and embedded.
- Wobble rooms were in place away from clinical environments as decompression areas and Project Wingman roaming bus provided wellbeing promotion and support.
- Talking Wellness service provided by KMPT offered therapeutic support for mental health challenges including a Mental Wellbeing Information Hub and 24-hour helpline provided resources and urgent support available to all colleagues in health and care.
- Long Covid clinics developed for staff and public.

NHS
Kent and Medway

Support for staff post pandemic

- Long Covid clinics remain in place in Kent and Medway
- National wellbeing apps and wellbeing support in place continued until December 25.
- South-East and Kent and Medway Health and Wellbeing group remains in place including TRIM practitioners to support networking, development and continued support
- All Kent and Medway colleagues continue to be able to access therapeutic support through EAPs or counselling services
- Kent and Medway health and wellbeing shared website for all colleagues in NHS, LAs and social care to access
- Health and wellbeing conversations are now standard practice
- Leadership support circles remain in some organisations as needed.
- Formal wellbeing groups in organisations and work with staff side organisations as needed.

Item 9: Urgent Treatment Centre Review Update

By: Gaetano Romagnuolo, Research Officer - Overview and Scrutiny

To: Health Overview and Scrutiny Committee, 15 July 2025

Subject: Urgent Treatment Centre Review Update

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

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1) Introduction

a) This paper provides an update on the review of urgent treatment centres (UTCs) in Kent and Medway. The main aim of the review is to provide a consistent urgent treatment offering to: reduce variation in access and outcomes; support the reduction of emergency department attendances for minor conditions and; deliver effective services to drive value for money.

2) Recommendation

a) RECOMMENDED that the Committee note the report.

Background Documents

Kent County Council (2024) *'Health Overview and Scrutiny Committee (17/12/2024) https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=9544&Ver=4*

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Kent County Council
Health Overview and Scrutiny Committee

15 July 2025

Kent and Medway Urgent Treatment Centre Review Update

Report from: Ed Waller, Chief Transformation and Partnerships Officer and Interim Chief Delivery Officer
Tamsin Flint, Head of Urgent and Emergency Care Commissioning

1. Summary

1.1 The purpose of this report is to provide an update on the review of urgent treatment centres in Kent and Medway. Our aim is to provide a consistent urgent treatment offering to reduce variation in access and outcomes, support the reduction of emergency department attendances for minor conditions, and deliver effective services to drive value for money.

2. Recommendations

2.1. This paper is for the Committee to note.

3. Budget and policy framework

3.1. 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 Kent. 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.

4. Kent and Medway urgent treatment centre review update

4.1. **Summary**

The purpose of this report is to provide an update on the review of urgent treatment centres in Kent and Medway. Our aim is to provide a consistent urgent treatment offering to reduce variation in access and outcomes, support the reduction of emergency department attendances for minor conditions, and deliver effective services to drive value for money.

4.2. **Background**

Urgent treatment centres (UTCs) were developed to provide accessible and convenient services for treating non-life-threatening conditions, aiming to reduce pressure on Accident and Emergency (A&E) departments and ensure patients receive appropriate care. Our UTC strategy needs to consider the GP Out of Hours Service (OOH) and is also integral to the capacity across primary care. The ICB recognises the inconsistency in patient offering across different HCP footprints and plans to review services delivered across urgent care and OOH with the aim or improving equity of access, improving services and ensuring best value.

In Kent and Medway, several UTC services are in place, with varying providers and opening hours. National standards for UTC services include being open 7 days a week for at least 12 hours a day, seeing both booked and walk-in patients, treating minor injuries and ailments, and having a named senior clinical leader supported by a multi-disciplinary workforce. They must also have access to patient records, accept appropriate ambulance conveyance, and report daily on the Emergency Care Data Set (ECDS).

We also still have some minor injury unit (MIU) services in Kent, providing urgent care to a slightly lesser specification that urgent treatment centres. Read more about the differences between MIUs and UTCs on our website.

Current services in place across Kent and Medway are detailed in the table below:

Site	Provider	Opening
Maidstone Hospital	MTW	8-8pm
Pembury Hospital	MTW	8-8pm
Sevenoaks	MTW	8-8pm
Edenbridge MIU	KCHFT	8-6pm Monday – Friday
Darent Valley Hospital	DVH	8-8pm
Gravesham	DVH	8-8pm
Medway Hospital	MFT with MedOCC	24 hours
Sheppey Hospital MIU	KCHFT (MFT from 1st July)	8-8pm
Sittingbourne Hospital MIU	KCHFT (MFT from 1st July)	8-8pm
Kent &Canterbury Hospital	EKHUFT	24 hours
Buckland Hospital	EKHUFT	8-8pm
QEQM	EKHUFT	24 hours
WHH	EKHUFT	24 hours
Deal Hospital	KCHFT	8-8pm
Folkestone Hospital	KCHFT	8-8pm
Faversham	Faversham Medical Practice	8-8pm
Herne Bay	Herne Bay Integrated Care	8-8pm
Whitstable	Estuary View Medical Practice	8-8pm

4.3 **Update**

NHS Kent and Medway Integrated Care Board (ICB) plans to implement a consistent model across the system, incorporating a single UTC specification for providers aligned with national standards.

The model will deliver consistent patient outcomes across UTC and OOH services, and ensuring services deliver effective use of resources.

Delivery of the model will include partnership with primary care. The acute sites will implement 24hour UTCs to support patient flow, while community UTC provision will be reviewed through patient and staff engagement, analysis of patient need and demand, and quality impact.

The approach will initially be managed in four parts, which will then be brought together and blended into a single strategic plan for UTC's across K&M:

East Kent due for completion in quarter 3 2025

West Kent due for completion in quarter 3 2025

Medway & Swale due for completion in quarter 4 2025

North Kent due for completion in quarter 4 2025

This will be followed by consolidation of a Kent and Medway plan

Current position

East Kent

A review of the UTCs in east Kent is under way with a number of aspects being explored, these include:

- Engagement with stakeholders to gather feedback (including patient and UTC workforce surveys)
- Mapping of current UTC (type 3) activity and budgets to establish the urgent care needs of the local population and the capacity they require
- Undertaking a clinical audit for each co-located UTC (QEQM and WHH)
- Quality site visits to review each UTC performance against the service specification and quality metrics to understand the variation against the national core standards and clinical and operating models.
- Reviewing the clinical pathways across UEC to maximise use of UTCs where clinically appropriate
- Demand and capacity analysis
- Scope opportunities across the system
- Presenting our learnings and recommendations to the ICBs Executive Management Team

West Kent and North Kent

We plan to move the current co-located UTCs to a 24 hour seven days a week model. A full review of UTC sites in these HCPs is being planned, mirroring the approach taken in East Kent, starting with patient and staff engagement.

Medway and Swale

Sheppey and Sittingbourne Minor Injury Units (MIU) are currently provided by KCHFT. They work to a slightly lower specification that the current UTC standard. These services will transfer to Medway Foundation Trust on 1 July 2025 with the intention of transitioning these services into UTCs by Q4.

GP Out of Hours Services

To support the UTC strategy, running parallel to this work is the GP out of hours (OOH) services review. The GP OOH service operates during times when regular GP surgeries are closed, such as evenings, weekends, and bank holidays. The GP OOH services provide advice, information, and

treatment for NHS patients who become unwell during the out-of-hours period when their own GP surgery is closed. These services are for patients with an urgent need who cannot wait until their surgery's opening hours. This service includes face-to-face assessments at acute sites, home visits, and a telephone line for triage and advice.

The integration between GP OOH services and UTCs involves:

- Face to face base assessments: following triage within NHS 111 the patients needing face to face assessments before the next working day will be booked into the appropriate UTC. The face-to-face element of the OOH service is being transferred to UTCs to ensure continuous care.
- Home Visiting: following triage within NHS 111 the patients requiring an urgent assessment within their home will be cared for by an integrated team including nurses, hospices and GP.
- Telephone triage: there is an expectation that the telephone line will handle a significant portion of calls, reducing the need for face-to-face visits. The plan is to incorporate this activity into the NHS 111 services as part of the clinical assessment platform.

4.4 Next steps

Once all of the reviews have been completed, a formal paper summarising the outcome of the review, our proposals for future plans and how we intend to consult further with stakeholders will be shared.

5. Risk management

5.1. There are no significant risks to the Council arising from this report

6. Financial implications

6.1. There are no financial implications for the Council arising from this report.

7. Legal implications

7.1. There are no legal implications arising from this report.

8. Lead officer contact

Ed Waller Chief Strategy and Partnerships Officer and Interim Chief Delivery Officer NHS Kent and Medway

Item 10 - Community Services Procurement and Engagement Update

By: Gaetano Romagnuolo, Research Officer - Overview and Scrutiny

To: Health Overview and Scrutiny Committee, 15 July 2025

Subject: Community Services Procurement and Engagement Update

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

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1) Introduction

a) This report provides an update on the Kent and Medway Integrated Care Board (KMICB) Community Services procurement. It also outlines the next steps to contract sign-off and service 'go live' and describes the communication and engagement plans employed.

2) Recommendation

a) RECOMMENDED that the Committee consider and note the update.

Background Documents

Kent County Council (2023) *'Health Overview and Scrutiny Committee (19/07/2023),* Agenda for Health Overview and Scrutiny Committee on Wednesday, 19th July, 2023, 10.00 am
Kent County Council (2023) *'Health Overview and Scrutiny Committee (06/09/2023),* Agenda for Health Overview and Scrutiny Committee on Wednesday, 6th September, 2023, 1.00 pm
Kent County Council (2023) *'Health Overview and Scrutiny Committee (07/12/2023),* Choose agenda document pack - Health Overview and Scrutiny Committee 7 December 2023

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KCC Health Overview and Scrutiny Committee

15 JULY 2025

Kent and Medway Integrated Care Board Community Services Procurement and Engagement Update

Report from: Ed Waller, Chief Strategy and Partnerships Officer, NHS Kent and Medway

Natalie Davies, Chief of Staff, NHS Kent and Medway

Author: Mark Atkinson, Director of Strategic Commissioning and Operational Planning, NHS Kent and Medway

Fay Sinclair, Director of Communications and Engagement, NHS Kent and Medway

Summary

The purpose of this report is to:

- update the KCC Health Overview and Scrutiny Committee (HOSC) on the Kent and Medway Integrated Care Board (KMICB) Community Services procurement (annual value c.£237m), including completion of bid evaluation and Contract Award
- outline the next steps to contract sign-off and service 'go live'
- update on communications and engagement plans to make sure we fully engage throughout the lifetime of the contract to achieve the best for our populations.

1. Recommendations

1.1. Members are asked to consider and note the update.

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 Kent. 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 as set out in the Council's Constitution.

3. Background and timeline

3.1. The KMICB Community Services procurement followed the decision by the ICB Board in February 2023, in line with its legal obligations, to reprocure the three main Community Services provider contracts:

- HCRG Care Group (HCRG)
- Kent Community Health NHS Foundation Trust (KCHFT)
- Medway Community Healthcare

3.2. The Community Services Review (CSR) was established to take forward the procurement, to ensure the long term delivery of community health services, including our ambition to address health inequalities for people across Kent and Medway.

3.3. The work to develop the Invitation to Tender (ITT) included drafting and updating service specifications for Adults and Children's Services, to ensure continuity of current services. Additionally, an Ambitions document of proposed service priorities was produced through stakeholder collaboration to inform plans for service transformation to be developed with the preferred provider/s. At approximately £1.8bn over an 8 year (5+3) contract, the procurement is the largest in Kent and Medway.

3.4. Further to Local Authority challenge in September 2023 that the proposed procurement represented 'Substantial Variation', the procurement was paused whilst the ICB worked with HASC and HOSC to clarify the position.

3.5. The CSR was relaunched in February 2024 and has progressed in line with the Programme Plan to ensure a full and transparent procurement of the services to be in place by 27 October 2025.

3.6. The CSR has been overseen by the CSR Steering Committee, involving operational leads and SMEs from the ICB, KCC and Medway Council, supported by the Director of Strategic Commissioning & Operational Planning and his team, as well as procurement and legal advisors.

3.7. The tender for four adult lots (Dartford, Gravesham and Swanley; East Kent,

Medway and Swale and West Kent), plus the two children's lots – Kent and Swale and the rest of Kent, was published in December 2024.

3.8. The deadline for bid submissions was 14 February 2025, following which the submissions were comprehensibly evaluated and moderated by 65 evaluators

to achieve agreement on final scores, as overseen by the ICB's procurement agency, Arden & Gem CSU (AGEM).

3.9. At the end of March, AGEM completed the Contract Award Recommendation Report (CARR) which was also reviewed by the ICB's legal advisors, ahead of submission to the ICB's Executive Management Team (EMT), which approved publication to the ICB Board.

4. Phase 4: Contract award, mobilisation and contract commencement

4.1. The final phase of the work programme for the reprocurement of adults and children's physical community healthcare services is summarised below:

22 April – an extraordinary ICB Board meeting was held for CARR approval, following which letters were sent to the successful and unsuccessful bidders, an intention to award notice was published to the market, and updates sent to local authority chief executives and other stakeholders.

7 May - the required eight-working day 'standstill' period was completed and no 'representations' or challenges were received.

8 May - NHS Kent and Kent formally announced the award of new contracts to Kent Community Health NHS Foundation Trust (KCHFT) as lead provider in a partnership between themselves, HCRG Care Group (HCRG) and Medway Community Healthcare (MCH). The awards were announced via ICB channels and emails to key stakeholders, including Kent Council's chief executive. Contract assurance and mobilisation planning commenced with the preferred provider.

12 June – first Contract Management Committee (CMC) meeting for the new Community Services contract to oversee contract sign-off, mobilisation and service transformation planning and delivery. (NB The six individual contracts have been amalgamated into one contract). The CMC took over from the CSR Steering Committee which held its final meeting on 26 June.

30 June – the date for contract sign-off (by KCHFT for the main contract and concurrently KCHFT's sub-contracts with HCRG and MCH) is on hold, subject to NHSE approval.

27 October – service commencement further to completion of service mobilisation, including development of Data Protection Impact Assessments (DPIAs) and Service Development Improvement Plans (SDIPs). Contracts will run for at least five years, with the potential for a three year extension.

5. Service Transformation and Stakeholder Engagement

5.1. As part of the submission process, providers were asked to set out their plans for engaging people who use their services and involving staff.

5.2. A new community services transformation and improvement group, as cited in the Ambitions document, will develop transformation plans for adults and children's services. The group, comprising stakeholders including providers, VCSEF groups, Kent's Health Advisory and Scrutiny Committee and Kent's Health Overview and Scrutiny committee, Healthwatch and other patient representatives and NHS Kent and Kent, will work together to determine how our ambitions can be best met.

5.3. Our ambitions will inform the development of a Transformation Plan to be published by KCHFT and their partners to the ICB by 31 March 2026 for approval, with agreed milestones and deliverables confirmed through costed service development improvement plans (SDIPs). In line with the contract, planning (Year 1) and delivery of agreed plans (Years 2,3 and potentially 4) will be funded to a maximum 2% of the total annual contract value.

5.4. The group's role will include regular review of service specifications, to reflect any changes from the implementation of our ambitions, making sure redesigned community services – adults and children's - are fit for the future.

5.5. Critical to this will be development of a communications and engagement subgroup, whose membership will reflect the make-up of the main group and include subject matter experts, to ensure there is adequate patient, staff and community involvement. The engagement we carried out in summer of 2024 and previous engagement carried out by partners shows what matters most to people using services and, also, what matters to staff.

5.6. Following contract sign off, the group will review the ambitions document with its focus on:

Adults: Ageing well, community nursing, community outpatients' appointments, diagnostics, elective community hubs, end of life care, frailty,

integrated specialist services, intermediate care, rehabilitation, single point of access – out of hospital urgent care.

Children's: A new model of care, which demonstrates integration, services as close to people as possible, a single clinical record, elective community care, specialist care, therapies, community nursing.

5.7. The group will look at different areas of community healthcare services, identifying how best to make sure they meet the ambitions we have already

set. We will involve people who use services and staff in these development plans – putting their voice and experience at the heart of what we do.

5.8. Some developments may be grouped together around areas of care or service use to meet the needs of the population. For example, to improve frailty care, several services may need to change. In these cases, we will engage on them together.

5.9. Each change will have its own communications and engagement plan, specific to services users, audiences and scale.

5.10. From Spring 2026, engagement and – where relevant – formal consultation on the agreed transformation plans will begin.

5.11. There will be discussion with Kent and Medway's health scrutiny committees to agree levels of engagement or formal consultation on each project, depending on the change envisioned and in line with an agreed approach to the management of major change.

5.12. Engagement will be overseen by a patient or lived experience panel – we will recruit this panel from users and from community members. Engagement will include:

- pre-engagement with service users and staff, which will usually take between three and four months, but up to six months for some areas identified as needing bigger change. There will be a series of workshops looking at each area for transformation and developing a proposed pathway of care. HOSC members will be invited to workshops

- further development through publication of pathways of care – checking with staff and patients following workshops

- oversight from the patient or lived experience panel.

5.13. Our fundamental communications and engagement principle is to make sure there is enough time built into work to ensure full engagement and

formal consultation, where necessary. We will work with the Committee to make sure we continue to carry out meaningful engagement with our population, and we will continue to engage with members at every available opportunity.

5.14. Implementation of the costed Transformation Plan, including necessary engagement and consultation, is expected to be two years although, if required, a third year has also been built into the contract.

6. Risk management

6.1. There are no significant risks to the council arising from this report.

7. Financial implications

7.1. There are no financial implications for the council arising from this report

8. Legal implications

8.1. There are no legal implications arising from this report

Item 11: Work Programme 2025

By: Gaetano Romagnuolo, Research Officer - Overview and Scrutiny

To: Health Overview and Scrutiny Committee, 15 July 2025

Subject: Work Programme 2025

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) The Health Overview and Scrutiny Committee (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) 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) HOSC is requested to 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 note the work programme.

Background Documents

None

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Work Programme - Health Overview and Scrutiny Committee

1. Items scheduled for upcoming meetings

9 October 2025		
Item	**Item background**	**Substantial Variation?**
Maidstone and Tunbridge Wells NHS Trust – outcome of review into serious incident	The Committee wishes to understand what lessons have been learnt following the review into a child death at Tunbridge Wells Hospital.	-
Maidstone and Tunbridge Wells NHS Trust – Clinical Strategy	To receive updates about the Strategy and its workstreams, when appropriate.	TBC
Maidstone and Tunbridge Wells NHS Trust – Fordcombe Hospital	Members requested to receive an update on the extent to which the purchase of the private hospital has been successful one year after opening.	-
Kent and Medway Prosthetics Service	The Committee wishes to receive an update on the move of the Service and transfer of staff.	TBC

2. Items to be scheduled

Item	**Item Background**	**Substantial Variation?**
Phlebotomy services in Deal	The Committee requested an update once a new provider has been identified.	-
Mental Health Transformation - Places of Safety	The Committee requested an update once the unit has been operational for a meaningful period of time.	-
SECAmb Volunteer Strategy	Members requested to see the Strategy once ready.	-

Edenbridge Medical Centre	The Committee requested an update including metrics, how preventative work reduces instances of acute hospital stays, and how these models of care support GP practices.	-
Community Services review	The Committee requested an update on the Community Services procurement	No
Healthwatch Annual Report 2024-25	The Committee will be presented with the Healthwatch Annual Report 2024-25	-
Mental Health services/Dementia services	The Committee requested an update on local Mental Health Services and Dementia Services in particular.	No

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

No proposals are currently under scrutiny by the Kent and Medway Joint HOSC.