KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Thursday, 2 April 2026.

PRESENT: Mr R Mayall (Chair), Mr T Mole (Vice-Chair), Mr O Bradshaw, Mr M Brice, Mr S Jeffery, Cllr H Keen, Mr A Kibble, Mrs B Porter, Mr A Ricketts, Mrs S Roots, Mr T L Shonk, Dr G Sturley and Cllr K Tanner

ALSO PRESENT: Dr J Jacobs (Local Medical Committee) and Mr M Mulvihill

IN ATTENDANCE: Mr G Romagnuolo (Research Officer - Overview and Scrutiny), Dr Kate Langford (Chief Medical Officer, NHS Kent and Medway), Prof Avey Bhatia (Chief Nurse, Guy's and St Thomas' NHS Foundation Trust), Dr Sara Hanna (Medical Director), Trish Gray (Programme Manager), Dr Steve Fenlon / Jonathan Wade (Deputy Chief Executive, Dartford & Gravesham NHS Trust), John Goulston (Chair, Medway NHS Foundation Trust), Sukh Singh (Director of Primary and Community Care), Dr Ash Bhushan (Deputy Chief Medical Officer)

UNRESTRICTED ITEMS

259. Apologies and Substitutes
(Item 1)

1. Apologies were received from Councillor Moses, Mrs Russell (substituted by Mr Kennedy), and Mr Baker (substituted by Mr Palmer).

RESOLVED that the apologies and substitutes be noted.

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

1. Mr Ricketts declared that he may still hold a position as a Council Governor, subject to confirmation.

2. Mr Palmer declared that his spouse was an active Governor of Medway NHS Trust.

RESOLVED that the declarations of interest be noted.

261. Minutes of the meeting held on 4 February 2026
(Item 3)

RESOLVED that the minutes of the meeting held on 4 February 2026 were a correct record and that they be signed by the Chairman.

262. Children's Cancer Principal Treatment Centre Relocation
(Item 4)

Professor Avey Bhatia (Chief Nurse, Guys and St Thomas NHS Foundation Trust), Dr Sara Hanna (Medical Director and Clinical Lead for the Children's Cancer Principal Treatment Centre Programme, Evelina London) and Trish Gray (Programme Manager and Lead for Patient and Public, Evelina London) presented the following item:

1) The Committee received a report outlining the planned relocation of the Children's Cancer Principal Treatment Centre to Evelina London Children's Hospital.

2) The report provided an update on the proposed relocation of the Specialist Children's Cancer Principal Treatment Centre from the Royal Marsden NHS Foundation Trust in Sutton and St George's University Hospitals NHS Foundation Trust in Tooting to the Evelina London Children's Hospital, part of Guy's and St Thomas' NHS Foundation Trust.

3) It was noted that the service had supported child cancer patients from across South London, Kent, Medway and areas of Sussex. Members were advised that the proposed move would align the service with national specifications requiring co-location with a paediatric intensive care unit.

4) In response to questions and comments from Members, the following points were addressed:

   a) Concerns were raised about travel times to London to access radiography and the potential negative impact on families. Officers highlighted that radiotherapy provided at UCLH was in the best interests of patients. This reflected existing patient pathways for therapy and the limited availability of specialist paediatric radiotherapy staff, which would not be sustainable to replicate at Guy's and St Thomas.

   b) Further reflecting on travel times, officers discussed that the service would look to work more closely with regional hospitals, particularly shared care centres. There would be continued support for increasing local deliveries of care.

   c) Discussions would take place with the Transport for London (TfL) and the Greater London Authority (GLA), both of which had been supportive and would assist further in developing a range of travel options for families.

   d) Members were informed that all families accessing the children's cancer service at Evelina London would be offered patient transport which included provisions of suitable vehicles to take them to and from appointments. The national cancer plan, published on 4 February, had included a £10 million commitment to ensuring that children with cancer and their families would not incur travel costs.

   e) Officers discussed the ongoing programmes available to support children and families with additional aspects such as patient transport, dedicated parking, accommodation and how the function can best deliver these support arrangement aspects to the child and family.

   f) Members suggested travel option details be captured in future reports to the committee.

   g) Members sought assurance about workforce sustainability. Officers confirmed there was ongoing engagement with staff and that contingency recruitment plans were in place, as well as plan for a robust recruitment model.

5) Members welcomed the focus on improved patient outcomes and national standards, and the concise contents of the report presented.

RESOLVED to note the report.

263. Establishment of a Group between Medway NHS Foundation Trust and Dartford & Gravesham NHS Trust
(Item 5)

Dr Steve Falton (Deputy Chief Executive, Dartford and Gravesham NHS Trust) and John Goulston (Chair, Medway NHS Foundation Trust) presented the following item:

1) The Committee received a report outlining proposals to establish a collaborative group model between Medway NHS Foundation Trust and Dartford and Gravesham NHS Trust.

2) Officers discussed the Trusts' close working relationship and the desire to pursue a North Kent collaboration. A number of shared services were already in place and well established.

3) There was a desire to move beyond individual service-level collaboration towards a more focused and linked approach. This would enable a consideration of services collectively to respond to challenges and opportunities.

4) Members were advised that the proposed group model aimed to enable a more streamlined approach to collaboration and would facilitate quicker discussions between clinicians, whilst seeking to improve the use of patient and population data to inform decision-making. The approach sought to reduce procedural barriers and allow clinicians to develop optimal solutions.

5) Officers further highlighted that some specialised services across Kent were relatively fragile, often reliant on small teams, and that long-term sustainability must be a key consideration. Collaboration between organisations was seen as a means of addressing this.

6) In response to questions and comments from Members, the following points were noted:

   a) Members queried which clinical collaborations were being explored. Officers recognised the length of time it had taken for projects such as pathology to embed. Data from both organisations would be used to inform future decisions to improve the service and would look to repatriate aspects of work back into Kent.

   b) A high-level roadmap was to be shared, setting out the current service positions and identifying areas that could be targeted for potential joint working.

c) Members raised concerns regarding both Trusts' leadership continuities in light of forthcoming senior appointments. A lack of continuity and the need for robust governance arrangements were also highlighted.

d) Concerns were raised on the collaborative aspects of the scheme and a potential move towards a trust merger. Clarification was provided that the proposal did not constitute a merger and that both organisations would remain separate.

e) The Medway NHS Foundation Trust was accountable through its Board of Directors to the Council of Governors, which included publicly elected governors representing its membership. In addition, the Trust was accountable to local authority scrutiny arrangements, including both HOSC and the Medway Health and Adult Social Care Overview and Scrutiny Committee (HASC).

f) Members suggested exploring the recruitment of a chief executive to oversee both aspects of the combined joint trust. Officers responded that there would be a definitive requirement for chief executives across both trusts.

g) Officers confirmed that any significant changes to services would be subject to the appropriate public engagement and consultation in accordance with NHS requirements.

7) Members recognised the potential benefits of shared services and improved resilience.

RESOLVED to note the report.

264. Reconfiguration of Stroke Services in East Kent
(Item 6)

Dr Kate Langford (Chief Medical Officer, NHS Kent and Medway) presented the following item:

1) The committee received a report providing an update on the proposed reconfiguration of stroke services in East Kent, which would result in the creation of a Hyper-Acute Stroke Unit (HASU) at William Harvey Hospital in Ashford.

2) Dr Langford highlighted that the temporary stroke unit at Kent & Canterbury Hospital (KCH) had delivered strong patient outcomes which would inform and aid the transition to the William Harvey site. She explained that ambulance journey times from Thanet to the William Harvey for the angioplasty service had ranged between 33 to 56 minutes over the past year. She later confirmed this was in the same band as the expected times during the original stroke review which demonstrated travel times did not appear to have changed significantly since then. The comparable blue light times for the stroke service at KCH were not available.

3) Subject to planning permission (expected imminently), construction at William Harvey was expected to commence on 1 June 2026, with an anticipated opening in late 2027/ early 2028.

4) Members discussed the report and the following points were noted:

   a) Dr Langford said she expected equivalent patient outcomes at the William Harvey HASU to the KCH service.

   b) Recognising the increased travel time for Thanet residents, a Member asked how their outcomes would be monitored. Dr Langford confirmed SNNAP data would continue to be collected which would allow comparison between particular geographical areas. Whilst this data was not published, the Committee could request such information in a future paper.

   c) The call to needle times were available but had not been provided for this report.

   d) Future stroke patients requiring the thrombectomy service would be transferred to KCH (once the service was open). Such transfers were common practice, and current transfers from Kent were to London.

   e) Dr Langford explained that a target of 1 hour and 20 minutes had been set to get victims of a stroke into the unit for treatment. The current triage processes had worked well and contributed to meeting this target.

5) The Committee were concerned about the proposals, and wanted to see the stroke unit at KCH retained, for the following reasons:

   a) potential health inequalities, noting that more deprived areas may be disproportionately affected by increased travel distances to a service that was further away from them.

   b) The stroke unit at KCH was already performing very well and achieving positive patients outcomes.

   c) There were limited public funds available, and the capital money could be invested in other areas that were not performing so well.

   d) The relocation was expected to achieve equivalent, not improved, outcomes.

   e) The data and evidence was from 2018 and a lot had changed since then (such as a pandemic, the introduction of a Marmot coastal region and the Sturry Link Road) so it may no longer be reliable.

6) Dr Langford acknowledged those concerns but explained that the changes were part of a whole county service reconfiguration, and reminded the Committee that the KCH unit had always been a temporary arrangement, as it was not suitable for a long-term stroke service, which would typically be located on an acute site with co-located services. She reported that the hospital Trust's preference was to co-locate acute services on a single site to support a more efficient delivery of care.

7) Some Members suggested that the Chair write to the NHS and the Secretary of State for Health to express the Committee's lack of confidence in the changes and that the proposed move would not improve patient outcomes for East Kent.

8) Dr Sturley proposed, and Cllr Tanner seconded, the following motion:

(a)That Canterbury should be retained as the permanent East Kent hyper-acute stroke unit.

(b) That NHS Kent and Medway and NHS England provide further clear evidence supporting the proposed model to William Harvey.

(c) That a full, updated Equality Impact Assessment be completed, with specific focus on Thanet and coastal East Kent as well as deprivation and transport access.

(d) That side-by-side modelling between the current (Canterbury) and proposed alternative arrangements, including the impact on Ashford and Thanet.

(e) That independent assessment be undertaken covering travel times, ambulance resilience, access to family support rehabilitation and discharge planning.

(f) Justification be provided from the ICB as to why the existing high-performing service cannot be retained as a permanent East Kent HASU.

9) A vote was carried out and the motion passed. Mr Jeffrey wished to be recorded as abstaining from the motion, which he felt was in breach of Section 2 of the Local Government Act 1986.

10) The Clerk advised the committee that, whilst HOSC could express comments or concerns to the NHS, they remained the ultimate decision maker in regard to proposals, and whilst the committee could request information they had limited ability to require changes. Concern was expressed that the proposed motion may not be enforceable.

RESOLVED that the Committee ask NHS Kent and Medway to address the following concerns:

(a)That Canterbury should be retained as the permanent East Kent hyper-acute stroke unit.

(b) That NHS Kent and Medway and NHS England provide further clear evidence supporting the proposed model to William Harvey.

(c) That a full, updated Equality Impact Assessment be completed, with specific focus on Thanet and coastal East Kent as well as deprivation and transport access.

(d) That side-by-side modelling between the current (Canterbury) and proposed alternative arrangements, including the impact on Ashford and Thanet.

(e) That independent assessment be undertaken covering travel times, ambulance resilience, access to family support rehabilitation and discharge planning.

(f) Justification be provided from the ICB as to why the existing high-performing service cannot be retained as a permanent East Kent HASU.

265. Kent and Medway Community Services Transformation and Neighbourhood Health
(Item 7)

Dr Sukh Singh (Director of Primary and Community Care, NHS Kent and Medway) presented the following item:

1) The Committee received a report outlining proposals for the community services transformation and the development of neighbourhood health models across Kent and Medway.

2) Benefits of the transformation were to accelerate neighbourhood health within Kent and Medway, community service partners working jointly to support multi neighbourhood services, as well as the development of 24/7 urgent community response services.

3) Members were advised that the first year of the neighbourhood health programme had focused on the top 5% in need population, a cohort that accounted for a disproportionate level of urgent and emergency care usage. The aim was to support these individuals to remain at home through targeted interventions and improved integration between primary, secondary, community and mental health services.

4) A Kent and Medway Neighbourhood Health Programme Board had been established and would bring together partners across health, social care, the voluntary sector and local authorities to develop joint neighbourhood health plans. These plans aligned with the national neighbourhood health framework published the previous month.

5) In response to questions and comments from Members, the following points were noted:

    a) Members questioned the level of ambition within the proposals and whether it represented a significant departure from existing models of care. In addition, queries were raised on the use of the Better Care Fund and what key aspects of integration with other agencies would be explored.

    b) Officers responded by describing the current model process and its impact on patients. Proposals focused on delivering treatment responses in a collaborative manner and if successful would represent a significant improvement.

    c) Changes included the development of multidisciplinary teams and proactive care planning. Officers discussed that engagement with Council colleagues would support a more focused approach, enabled by the shared clinical model. It was acknowledged that the first year focused on establishing foundations, with scope for more ambitious proposals in future years.

    d) Members raised concerns regarding patient assessment by private care sectors, the continued delivery in rural areas and the importance of robust and consistent patient assessment processes.

e) Officers outlined the development of a “trusted assessor” model to ensure coordinated and effective care delivery across services. The model was described in detail and the benefits that had already been seen throughout the county was a testament to the ongoing mitigations in place.

6) Members noted the proposals and requested that progress and outcomes be reported in due course.

RESOLVED to note the report.

266. Work Programme
(Item 8)

1) The Committee considered its work programme.

2) Members made the following requests:

(a) to consider establishing a Joint Overview and Scrutiny Committee in relation to the recent meningitis outbreak.

(b) that East Kent Hospitals University NHS Foundation Trust provide a report to the next meeting of the Committee on the handling of the meningitis outbreak, including both operational response and governance arrangements.

3) The Chair noted the requests, saying they would be reviewed and brought forward at an appropriate time.

RESOLVED to note the work programme.

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