HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Thursday, 2nd April, 2026

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Thursday, 2nd April, 2026, at 10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Gaetano Romagnuolo**

Telephone: **03000 416624**

Membership

Reform UK (8):	Mr R Mayall (Chair), Mr T Mole (Vice-Chair), Mr J Baker, Mr A Kibble, Mrs B Porter, Mrs S Roots, Mr T L Shonk and Dr G Sturley
Liberal Democrat (2):	Mr M Brice and Mr A Ricketts
Conservative (1):	Ms C Russell
Green (1):	Mr S Jeffery
Restore Britain Kent (1):	Mr O Bradshaw
District/Borough Representatives (4):	Councillor K Tanner, Councillor H Keen and Councillor K Moses.

UNRESTRICTED ITEMS

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

Item

1. Apologies and Substitutes

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

3. Minutes of the meeting held on 4 February 2026 (Pages 1 - 6)

4. Children's Cancer Principal Treatment Centre Relocation (Pages 7 - 22)

5. Establishment of a Group between Medway NHS Foundation Trust and Dartford & Gravesham NHS Trust (Pages 23 - 30)

6. Reconfiguration of Stroke Services in East Kent (Pages 31 - 40)

7. Kent and Medway Community Services Transformation and Neighbourhood Health (Pages 41 - 52)

8. Work Programme (Pages 53 - 56)

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

**Timings are approximate*

Benjamin Watts
General Counsel
03000 416814

25 March 2026

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, 4 February 2026.

PRESENT: Mr R Mayall (Chair), Mr T Mole (Vice-Chair), Mr J Baker, Mr O Bradshaw, Mr M Brice, Cllr H Keen, Mr T Mallon, Mrs B Porter, Mr H Rayner, Mr A Ricketts, Mrs S Roots, Mr D Sian and Cllr K Tanner.

IN ATTENDANCE: Mr D Devlia (Strategic Partnerships Manager, South East Coast Ambulance Service), Mr D Ruiz-Celada (Chief Strategy Officer, South East Coast Ambulance Service), Dr A Richardson (Director of Partnerships and Transformation, Kent and Medway Mental Health NHS Trust), Dr A Qazi (Chief Medical Officer, Kent and Medway Mental Health NHS Trust), Mr M Riley (Managing Director, Medway Community Healthcare), Mr G Flack (Chief Finance Officer, Kent Community Health NHS Foundation Trust), Dr J Jacobs (Medical Director, Kent Local Medical Committee) and Mr G Romagnuolo (Research Officer, Overview and Scrutiny, KCC).

UNRESTRICTED ITEMS

11. Apologies and Substitutes

(Item 1)

1. Apologies were received from Mrs C Russell, who was substituted by Mr H Rayner, Mr T Shonk, who was substituted by Mr T Mallon, and by Dr G Sturley, who was substituted by Mr D Sian.

2. The Clerk, Mr Romagnuolo, informed the Committee that there had been a change in the Committee's membership, with Mr Adrian Kibble and Mr Thomas Mallon leaving the Committee, and Miss Isabella Kemp and Mr Oliver Bradshaw joining the Committee.

3. The Chair thanked Mr Kibble and Mr Mallon for their contribution, and welcomed Miss Kemp and Mr Bradshaw to the Committee.

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

(Item 2)

1. Mr Ricketts declared that he was a Public Governor of the East Kent Hospitals University NHS Foundation Trust.

13. Minutes of the meeting held on 4 December 2025
(Item 3)

RESOLVED that the minutes of the meeting held on 4 December 2025 were an accurate record and that they be signed by the Chair.

14. South East Coast Ambulance Service NHS Foundation Trust - Update on Group Model Collaboration
(Item 4)

1. Mr D Devlia (Strategic Partnerships Manager, South East Coast Ambulance Service) referred to the information on the paper which stated that, in November 2024, the boards of South East Coast Ambulance Service NHS Foundation Trust (SECAmb) and South Central Ambulance Service NHS Foundation Trust (SCAS) started exploring options for closer collaboration.
2. At a Joint Board meeting in October 2025, the two Trusts agreed to progress to a formal collaboration through the creation of a group model. A public announcement confirming the intention to form the South Central and South East Ambulance Group was made shortly afterwards - the first of its kind in England. The transition to the South Central and South East Ambulance Group was scheduled to take place in phases from late 2025 through to 2027.
3. Mr Devlia highlighted three key points to reassure the Committee.
4. Firstly, the work that had been undertaken until then had been preparatory, with the aim of exploring options and opportunities for SECAmb moving forward.
5. Secondly, there had been substantial stakeholder engagement, with internal and external partner services and organisations being invited to contribute to the development of the new Group model.
6. Finally, a key aim of this Group model was to improve service provision for all Kent residents. The model was aligned with the NHS 10-year plan and the neighbourhood model. This collaborative model was not an attempt at centralising service provision but to enhance it.
7. A Member asked how this proposal had been greeted by SECAmb staff.
    a. Mr D Ruiz-Celada (Chief Strategy Officer, South East Coast Ambulance Service) said that there was some anxiety over the way in which some of the efficiencies would be generated, although no plan had been finalised yet.
    b. He also said that the new model offered a clinically-led case for change that aimed at offering a consistent, fit for purpose and

sustainable ambulance service to patients across the Southeast, while recognising the local needs.

8. In answer to a question about the savings that the organisation expected to accrue, Mr Ruiz-Celada said that there were two sources of efficiencies that the Group model was expected to deliver. That first one was about generating efficiencies through a joint procurement and working together with a single commissioner. This process would generate savings of about £10 million. The second source was the improvement of communication with all partner agencies to avoid the deployment of ambulances when not needed.

9. In reply to a question on whether Local Government Reorganisation (LGR) would impact on the quality of Kent's ambulance service provision, Mr Ruiz-Celada said that his expectation was that there would no impact on how the service would configure its operations and clinical priorities.

10. A Member asked whether the Group model had taken into account the potential impact from the imminent local NHS Integrated Care Board's (ICB) restructure.

    a. Mr Ruiz-Celada replied that there was an overarching strategic commissioning group that comprised representatives of NHS England and NHS organisations in Kent and neighbouring counties whose key objective was to plan the provision of a consistent health service while meeting local need.

11. In answer to a question on whether there were any planned redundancies, Mr Ruiz-Celada said that there were no proposals for job terminations.

12. A Member asked whether there were any plans to remove ambulance infrastructure or services.

    a. Mr Ruiz-Celada said that there no such plans.

13. A Member asked whether the collaborative model involved a merger.

14. Mr Ruiz-Celada explained that this group model did not entail a merger into a single organisation but consisted of two organisations collaborating closely and producing single contracts with commissioners.

RESOLVED that the Committee note and comment on the update.

15. Kent and Medway Mental Health NHS Trust CQC Response Update
(Item 5)

1. Dr A Richardson (Director of Partnerships and Transformation, Kent and Medway Mental Health NHS Trust) referred to the information in the report and explained that the purpose of the paper was to provide a further update on the work that was underway in response to the Care Quality Commission (CQC) review and the Healthwatch report which was issued in October 2025.

2. There was a robust plan in place to address the findings from both the CQC and Healthwatch. The plan was structured around four domains:

    - Safety and Risk
    - Access and waiting times
    - Environment, experience and equity and
    - Leadership, culture and governance

3. With regard to safety and risk, a key focus had been the implementation of a new nationally mandated risk assessment approach for patients. Its objective was to provide a formulative approach to risk assessment that was co-produced with patients, and to manage risk more effectively for those who were waiting for interventions

4. In relation to access and waiting times, community mental health services in Kent and Medway had been undergoing the largest transformation in the last 30 years. This had involved the implementation of a new model of care, Mental Health Together. This model proposed the development of a Partnership Delivery Model which would more clearly define the role of provider partner agencies to enable service delivery as close to local communities as possible.

5. In terms of environment, experience and equity, the main aim was to ensure that the estates strategy was continually refreshed and reflected the needs of patients and staff. The Trust had several community buildings that were no longer fit for purpose and had clear plans for addressing this issue. The Trust also planned to undertake an accessibility audit from January to June 2026 of all its buildings.

6. In terms of leadership, culture and governance, the CQC highlighted in its report 30 mandatory training programmes where compliance was below statutory requirements. A number of actions had been taken to improve mandatory training compliance. However, the Trust was still below the 90% compliance target for 3 training programmes.

7. A Member asked for some clarification about the implementation of the National Risk Assessment Model.

    a Dr A Qazi (Chief Medical Officer, Kent and Medway Mental Health NHS Trust) clarified that this framework was nationally mandated for all mental health organisations and not just for the Kent and Medway Mental Health NHS Trust.

8. In answer to a question about the number of people on the waiting list, Dr Richardson said that the overall waiting list for Mental Health Together in Kent averaged 6,000 patients. This had to be balanced against receiving

an average of about 3,800 referrals per month. In March 2025, the waiting list was about 7,000 people, therefore there had been a reduction of 1,000 patients who were waiting to be treated in the past nine months.

9. In answer to a question on whether there were collaborative links between the Kent and Medway Mental Health NHS Trust and Healtwatch, Dr Richardson confirmed that there was a healthy, collaborative relationship between the two organisations. In April, the Trust was going to launch its new strategy which was centred around patient experience.

RESOLVED that the Committee note and comment on the update and the response to the report.

16. Proposed Integration between the Kent Community Health NHS Foundation Trust and Medway Community Healthcare
(Item 6)

10. Mr G Flack (Chief Finance Officer, Kent Community Health NHS Foundation Trust) explained that the paper provided an update on the proposal for Kent Community Health NHS Foundation Trust (KCHFT) and Medway Community Healthcare CIC (MCH) to integrate as one organisation. In July 2025, the two organisations announced they were at an early stage of developing a strategic case to explore the potential benefits and implications of working more closely. The strategic outline case was submitted to NHS England - with the preferred option of coming together as one organisation and with MCH's staff and services transferring to KCHFT. After receiving feedback from NHS England in November 2025, KCHFT and MCH were now progressing with a full business case which they planned to submit in April 2026. If agreed, integration was expected to be completed on 1 October 2026.

11. A Member asked for clarification on the claim in the paper that the integration would help with recruitment and retention.

    a Mr M Riley (Managing Director, Medway Community Healthcare) said that across both organisations, and across community services nationally, there were particular services – such as Community Nurses – where recruitment was particularly challenging and very competitive. In this case, a merger would aid recruitment as there would be less local competition. Also, working in larger teams would increase career opportunities.

12. In answer to a question about how the merger would materialise into one organisation, Mr Flack said that the existing foundation trust - the Kent Community Health NHS Foundation Trust – would remain, while the Medway Community Health Interest Company would be closed.

13. A Member asked whether there were any plans to centralise or move any services.

    a Mr Flack explained that the provision of services was dictated by the commissioners in terms of location, and that there were no plans to move any of the clinical services.

RESOLVED: that the Committee note and comment on the proposal.

17. Work Programme
(Item 7)

1. Members of the Committee requested the following:

    a. An update on the structural changes to the NHS Kent and Medway Integrated Care Board.

RESOLVED that the Committee consider and note the work programme.

END

Item 4: Children's Cancer Principal Treatment Centre Relocation

By: Gaetano Romagnuolo, Research Officer - Overview and Scrutiny

To: Health Overview and Scrutiny Committee, 2 April 2026

Subject: Children's Cancer Principal Treatment Centre Relocation

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Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by representatives of Guy's and St Thomas' NHS Foundation Trust/Evelina London Children's Hospital.

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1) Introduction

a) This report provides an update on the 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). This is where children with cancer who live in the catchment area of South London, Kent, Medway, and most of Surrey and Sussex, receive therapy.

b) The move brings the service location in line with national service specification that mandates that the Centre must be co-located with a paediatric intensive care unit.

2) Recommendation

a) RECOMMENDED that the Committee note the report.

Background Documents

None.

Contact Details

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Evelina London

NHS
Guy's and St Thomas'
NHS Foundation Trust

26 January 2026

Children's Cancer Principal Treatment Centre: Briefing from Evelina London Children's Hospital on progress

This document provides an update on progress towards the transfer of the Children's Cancer Principal Treatment Centre (PTC), including:

Overview and roles and responsibilities

This very specialist children's cancer service is currently provided across two sites (The Royal Marsden NHS Foundation Trust in Sutton and St George's University Hospitals NHS Foundation Trust in Tooting). Following a decision made by NHS England leaders in March 2024, planning is now underway for the service to move to Evelina London Children's Hospital (part of Guy's and St Thomas' NHS Foundation Trust), with conventional radiotherapy at University College Hospital (part of University College London Hospitals NHS Foundation Trust). The move brings the service location in line with the national service specification that mandates that the PTC must be co-located with a paediatric intensive care unit. You can read more about the reasons for the service change in the appendix which gives the background to this service change.

As of 1 April 2025, Integrated Care Boards (ICBs) and NHS England are working together, with the ICBs as responsible commissioners and NHS England as the accountable organisation. They are jointly overseeing implementation of the reconfiguration. This includes the delivery of recommendations agreed at the decision-making meeting and advice from the Mayor of London to ensure that, in line with the objectives for the service change, the future centre:

- **complies** with the national service specification with all the benefits that will bring
- **builds** on the many strengths of the existing children's cancer service
- **gives best quality care** to achieve **world-class outcomes** for children with cancer for decades to come.

Work is also ongoing with the Children's Cancer Operational Delivery Network to improve the range of care provided by the paediatric oncology shared care units (POSCUs) across the catchment area. This is in line with the POSCU national service specification for these units and will enable more care to be provided closer to home where it is clinically appropriate, reducing the amount of travel needed to Principal Treatment Centres. We know from the public consultation in 2023 how important this is for children and their families.

A pan-London working group, led by NHS England, is being established for the North Thames and South Thames Principal Treatment Centres to bring together their providers and interdependent services to work collaboratively across the region. This will ensure equity in access for patients as well as education, training and governance arrangements. Evelina London will continue to work with NHS England and relevant colleagues to ensure there are clear patient pathways developed for delivery of care closer to home.

Evelina London's role as the future provider, is to deliver the safe transfer of care, successfully integrating very specialist children's cancer services and clinical trials into its existing outstanding-rated children's services. It is working closely with partners, patients and families, staff and other key stakeholders to ensure that the future centre delivers the service change objectives[1]. This will include addressing any potential issues or risks, such as those raised through the public consultation and other engagement[2].Governance is in place between GSTT, Evelina London and partner organisations to manage the programme between The Royal Marsden NHS Foundation Trust, St George's University

[1] You can read more about Evelina London's approach, including how it is involving children, families and the public, on the Evelina London website.

[2] Potential issues raised to date include travel to the future centre and for radiotherapy, impacts on the children's cancer workforce, and on research. Read about how NHS England has responded to feedback.

Hospitals NHS Foundation Trust, ICB commissioners of specialised services, NHS England and other partner organisations. Importantly, the patient voice is represented throughout the programme and at every level of the governance structure. The Royal Marsden and St George's leadership are also integral to key decision-making boards and groups.

The team are very grateful to everyone who is contributing to this work. Families, staff and charities are sharing their experience and expertise to help ensure the change happens as smoothly as possible. They remain committed to ensuring their voices, alongside those of other partners, guide the programme to create the best possible services for children.

If you have any questions or would like to discuss this further:

- please contact Evelina London at gstt.ChildrensCancer@nhs.net
- please contact the commissioning team at england.PTCChildrensCancer@nhs.net.

Progress update from August 2025 to December 2025

Business case development

In November, a significant milestone was reached in the completion of the final Full Business Case (FBC), marking the last stage of the business case process for the PTC transfer. The case provides a fully costed, detailed proposal for service transfer and implementation and has been formally approved by the Guy's and St Thomas' NHS Foundation Trust (GSTT) Board.

Construction works must follow a sequence to ensure they are carried out as efficiently as possible. As a result, there has been a phased approach to the FBC. Following approval of the first instalment of the FBC, the GSTT Board allowed early release of funding for the first phase of building works.

A crucial update is the inclusion of a detailed timeline created with dates provided by our building contractor, John Sisk & Son. Dates for the construction works have been worked out based on the approved plans and technical drawings for the specially designed cancer outpatient and inpatient areas. The timeline indicates that construction will be completed in March 2027 and the works are mapped out to deliver a carefully planned and safe transfer from then.

The transfer date is still subject to essential building safety approvals which have been factored into the timeline but are outside of the programme team's control. Relevant approvals have been identified and incorporated using anticipated timescales provided by the Building Safety Regulator.

This programme of work is complex, planning the move of such an important service involves many different workstreams. All partner organisations worked collaboratively towards a transfer in late 2026 but the construction timeline has shown when construction can be completed. The updated timeline has been communicated to all key stakeholders.

The commitment of partner organisations in sharing expertise and guiding the programme has been outstanding. Delivering a safe transfer for children and their families continues to be the most important

factor so that the excellence of the current service can be upheld and developed further as part of a comprehensive children's hospital.

Design and construction of the cancer care spaces

Construction is progressing well on the new dedicated day care unit which will be within Evelina London's Children's Day Treatment Centre and where children will receive any treatment that doesn't require them to stay overnight. Internal walls have been built, the majority of pipework has been completed and electrical services have been installed in the ceilings. Similar works are now taking place on the floors below.

Images showing hoardings at Evelina London (above) and the crane lift (below)

Externally, a plant area has been created, a crane was used to lift a 5 tonne Air Handling Unit and other plant up on the roof. Installation and other works will continue on the roof and west elevation of the building.

All these works require careful planning and sensitive handling as they are taking place within and nearby a live day surgery unit. Drainage connection was required on lower levels to pick up the drainage coming from the new floors above. These works involved co-ordination with the day surgery team to minimise disruption, carrying out works out-of-hours where possible, as the ceilings needed to be dismantled and re-built to facilitate access.

Pre-construction works are underway for builds within Evelina London Children's Hospital and South Wing of St Thomas' Hospital.

As a reminder, all of Evelina London's children's services are located on the St Thomas' Hospital site with interlinked spaces in the Evelina London Children's Hospital building, St Thomas' Hospital and the Children's Day Treatment Centre. The core spaces of the new Children's Cancer Principal Treatment centre are in the following locations:

- an inpatient ward with 23 beds and dedicated holistic care spaces located on the 3rd floor of the children's hospital building

- a dedicated day care unit and procedure room, for day case Systemic Anti-Cancer Treatment (SACT) which includes chemotherapy, and minor procedures, on the 2nd and 3rd floors of the Children's Day Treatment Centre
- a children's cancer outpatient department in the South Wing of St Thomas' Hospital.

Engagement with families

From the start of this programme, patients and families have been at the heart of every decision. Guided by the principle that a healing environment must be clinically excellent and emotionally supportive, the team have created spaces that will provide comfort and promote independence.

Thanks to the patients and families who have been involved, there are practical features like accessible storage and entertainment systems as well as engaging artwork and flexible shared areas.

Recent engagement sessions have resulted in:

- curtains alongside glazed screens for privacy and comfort, bedside lockers for personal items, and movable TVs with gaming shelves.
- extra power sockets and cable management for parents and clinical needs.
- play areas with accessible storage, clear wheelchair spaces, and bins for tidiness.
- bedrooms with lockers, shelves in the ensuite and centralised nurse call points which are easily accessible from either side of the bed.
- access to a hob and microwave for parents and carers, individual food lockers, and bathroom and shower areas with a less clinical feel.

To date, there have been more than 160 engagements (totalling more than 240 hours over the course of 16 months) across the full spectrum of people invested in this programme.

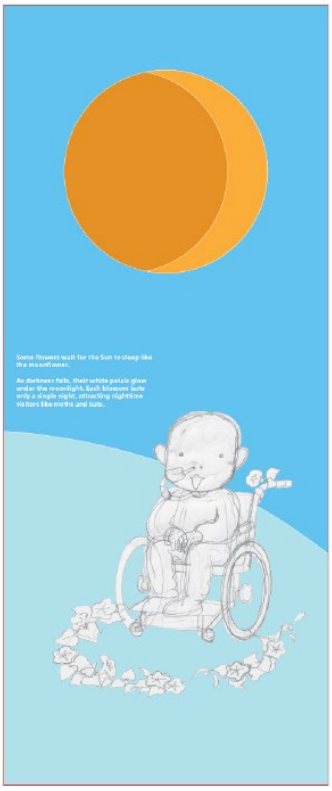
Artwork

Alongside finalising the important practical elements of the spaces, work has been undertaken with patients, families, and clinical staff at the current PTC to develop artwork for the future areas. This work is particularly important in reassuring children and young people and providing comfort on their journey. The team have heard and understand the importance of striking a balance to create spaces that are not too overwhelming or overstimulating but are fun and engaging. The spaces will be used by children aged 1 to

16, and the artwork needs to recognise the vast differences in what is comforting or exciting depending how old the child or young person is.

Recent focus has been on the artwork for the day care unit with patients and families. This has resulted in a space garden theme, in keeping with the existing space theme of the Children's Day Treatment Centre. A repeated message from children and young people using the current service has been that the connection to the outside world and nature is incredibly important. This led to the development of the theme that combines space and nature.

This area will include engaging images and interesting facts. The group of existing Evelina London characters used throughout the children's hospital have been expanded and developed to recognise the importance of resonating with this new patient population. Many of the children depicted in the new images have no hair, are wearing a hat, or have a nasogastric tube to foster a sense of community and shared experience among patients. Families and staff in the current service expressed that this is particularly important.



Examples of wall panels showing new characters desgined to resonate with children undergoing cancer treatment.

Example panel for the procedure room showing an image shown alongside references to classical Japanese poetry where cherry blossoms are likened to the scattered stars of spring.

Final designs shared with permission from Art in Site.

You can read more about the engagement work, including design workshops with young people on the Evelina London website in a story thanking families for their involvement.

In line with The Royal Institute of British Architects (RIBA) Plan of Work which outlines 8 stages to guide the design and construction of buildings, RIBA Stage 4 is underway. A report detailing how patients and families have shaped this stage is in progress and will be published online.

Travel and patient support

A Travel and Clinical Advisory Group including young people and family members continues to inform decisions about travel, family support services, treatment and care. A key priority is ensuring that travel and access to the hospital is as smooth as possible.

- **Parking** – work is underway to provide dedicated parking spaces in the St Thomas' Hospital car park, alongside a new system that will allow families to book spaces in advance, aligned with their appointment schedules. This will help reduce stress for families and ensure they have reliable access when attending appointments or staying for treatment.

- **Accommodation** – policies and booking procedures are being updated to make them clear and easy to navigate.

- **Catering** – a comprehensive summary of all available options for food and drink is being developed so patients and families can plan and feel confident about what is available during their stay.

- **Wayfinding** – work is underway to review signage and guidance across the site to make it easier for families to find their way around, particularly those visiting for the first time.

These improvements are part of a wider effort to create a welcoming and supportive environment for families, ensuring that practical needs are addressed alongside clinical care.

Planning for the future team

The Workforce Oversight Group has driven a number of initiatives to ensure existing staff are supported to transfer and that the service has the right staff for a safe go live.

- **Recruitment and training plans** – key milestones have been identified and a RAG rated planner for each individual role has been developed to ensure a robust recruitment and training plan.

- **Data driven planning** – a dedicated workstream collated staff data to inform the final FBC. This includes the roles that are in scope to transfer under TUPE regulations, and any new roles that the service will need to recruit into before or during the transition.

- **Staff engagement** – many existing PTC staff have taken up an open invitation to visit Evelina London. Focus groups for different staff groups have been held at The Royal Marsden in Sutton and St George's Hospital to provide professional support and give an opportunity to discuss concerns (for example, access to flexible working). Evaluation has shown these sessions were well received and is guiding future work. There is a continued focus on sourcing information about travel expenses/reimbursement and flexible working to support staff in making their decision to transfer. Meetings for all PTC staff are held quarterly with the agenda developed in response to staff queries, these meetings are an important opportunity to share information encourage an open discussion.

- **Organisation development** – work has been commissioned with the organisational development team at GSTT to support bringing together the teams and 3 distinct organisational cultures to develop a shared culture and vision.

- **Recruitment and retention** – a detailed recruitment plan and timeframe will ensure the right staff with the right skills are in post when the service transfers. This is crucial to providing a safe service. Clinical leads have been tasked to RAG rate roles and quantify the time taken to recruit to each role as well as detail training and education requirements to inform recruitment timelines.

- **Learning and development** – an education workstream has been established to develop a sustainable training programme. The programme will map continued training required to support staff (considering specific oncology training needs) and outline an education plan and timeline to support Evelina London staff to care for children with cancer as well as any other training needs of transferring staff.

Treatment and care planning

The Clinical Oversight Group has increased its representation to include new workstream leads to ensure oversight for the whole clinical programme. Workstreams cover wide-ranging topics, divided to allow a focus on resource with subject matter. Milestones are being tracked through the board with a focus in most workstreams on fully mapping clinical pathways in each area. Progress includes:

- **Diagnostic Imaging and Molecular Radiotherapy** – Evelina London visits are being arranged for the current PTC nursing team responsible for nurse-led sedation. Following this, operational planning will begin to implement the service. The molecular radiotherapy working group has started to map their clinical pathways, Thyroid and MIBG (a type of radioiodine therapy).

- **Diagnostic Pathology** – A histopathology group met and considered the operational delivery work plan, clinical expectations, rapid turnaround times and the need to validate and optimise immunohistochemistry antibodies for paediatric solid tumours as well as discussing capacity to meet clinical demands.

  An overview of the Specialist Integrated Haematological Malignancy Diagnostic Service (SIHMDS) working group's progress was presented at the pathology board. It showed plans for fortnightly meetings and operational steps such as integrating ordering and labelling in EPIC (the electronic health record system), sample pathways, the development of Stand Operating Procedures (SOPs) for handling cerebro spinal fluid (CSF) samples onsite, and maintaining rapid turnaround for specific tests.

- **Bone Marrow Transplant (BMT)** – Collaboration with University College London Hospitals and Great Ormond Street Hospital NHS Foundation Trust is ongoing to refine the total body irradiation (TBI) pathway and associated SOPs. The team is reviewing SOPs, documentation and booking forms to ensure alignment with local processes and patient safety requirements.

- **Surgery and Interventional Radiology (IR**) – A theatre timetable identifying and allocating provision for the oncology services across IR, main theatres and the new procedure room has been completed.

- **Neuro Oncology** – The workstream group established the core multidisciplinary team attendance for neuro oncology to ensure the correct clinicians are involved with decision making. There has been a focus on plans for time-critical neuro-transfer leading to agreement that the Evelina London time-critical transfer policy will be reviewed and modified to accommodate patients from both King's College Hospital and St George's Hospital.

- **Leukaemia and Lymphoma** – A clinical pathway has been finalised, with agreement on the management of high and low risk patients. There has been a focus on the outpatient provision for the service, feeding into the outpatient clinic model in the new department.

- **Palliative care** – Current focus is on developing an integration plan for The Royal Marsden and Evelina London teams.

- **Solid Tumour and Sarcoma** – Pathways are being mapped for the tumour groups, agreeing the referral process, imaging requirements and multidisciplinary process for each one. The working group will begin to work jointly with the surgical and IR workstream to ensure the correct surgical and theatre input is included in pathway developments.

- **Late Effects (health problems that appear months or years after cancer)** – Integration of the paediatric and adult endocrine teams is ongoing to ensure continuity across acute and long-term follow-up services. The working group also focused on the proposed outpatient timetable for the new unit. Feedback was provided and the group identified key services to develop joint clinics with.

- **Inpatients, day case and outpatient care** – Admission, discharge and transfer pathways have been created for review.

- **Pharmacy** –The working group continue to focus on setting up drugs on the patient record system with the majority of the main chemotherapy drugs completed. The group are ensuring all treatments used in the paediatric cancer service are made available at Evelina London. They are also working closely with interlinked projects to provide the required aseptic pharmacy capacity (for manufacture of chemotherapy and other drugs) and to automate the existing children's pharmacy to expand capacity for non-aseptic drugs. Pathways are being set up for management of paediatric cancer clinical trials.

- **Digital** – A data migration strategy and agreement have been completed to ensure a smooth transfer of patient information at the point of transfer. The strategy includes critical decisions about how data can be safely and efficiently shared and proposals for how best to do this to the benefit of patients and clinical staff managing ongoing care.

Radiotherapy

University College London Hospitals (UCLH) continues to work closely with partners to plan the safe transfer of children's radiotherapy services from The Royal Marsden to University College Hospital.

There has been good progress in the programme to replace UCLH Linear Accelerators (Linacs), the first of which will be ready to start treating patients in Summer 2026. Planning is now underway for the next Linac replacement to take place in Winter 2026 prior to the transfer of services, including the development of the clinical guidelines and standard operating procedures for patients. Development work has also begun to improve the digital interface with GSTT and The Royal Marsden, to allow clinicians at other organisations to easily view clinical information and maintain continuity of care as much as possible.

In order to adequately provide accommodation in close proximity to UCLH for children's radiotherapy patients and their families or carers, a tender process jointly with their Proton Beam Therapy (PBT) service will begin in early 2026 to increase the accommodation provision. In additional, a fundraising campaign with UCLH Charity to improve the play area in the radiotherapy department and enhance patient experience has been launched.

Research

The Research Integration Oversight Group (with representatives from all partner organisations) continues to meet monthly to monitor workstream progress, identify and mitigate risks and agree priorities.

The External Advisory Board have held 3 meetings. At one meeting, Board member Prof. Dr. Michel Zwaan, Head of Trial and Data Centre – Princess Máxima Centre, shared insights from leading a similar service transition in Utrecht in the Netherlands, offering valuable perspective on managing research continuity.

Research transition managers are in post at both Evelina London and The Royal Marsden.

Work from these boards and working groups has included:

- an outline of key research milestones as a framework for a safe and well-governed transition.
- a comprehensive overview of The Royal Marsden's current research portfolio to help confirm a refined list of transitioning studies, so set-up and governance can begin.
- initial modelling of the transitioning workforce and mapping associated training, competency and induction requirements to support safe service continuity.
- mapping of Standard Operating Procedures to inform future harmonisation and alignment.
- structured tabletop exercises (in-person and virtual engagement sessions) delivered in collaboration with The Royal Marsden research team to inform the structure of the future integrated research delivery model. Sessions explored:
    - research governance and delivery models,
    - patients' pathways

    - financial models.

- meetings with key interdependent workstreams including pharmacy, digital, imaging, and biobanking to understand pathways and transition requirements.

The focus of the next quarter will be to continue the collaborative planning, with focus on continuity of care. Once mapping is complete the focus will shift to communication and engagement with staff and sponsors to support research readiness.

Appendix

Background

In March 2024, after a rigorous, clinically-led process including a public consultation, NHS England chose Evelina London Children's Hospital (part of Guy's and St Thomas' NHS Foundation Trust) to be the future provider of very specialist cancer services for children who live in south London and much of south east England[3].

As a result of this decision, the current Children's Cancer Principal Treatment Centre, which is provided across two sites (The Royal Marsden NHS Foundation Trust's hospital in Sutton and St George's University Hospitals NHS Foundation Trust's hospital in Tooting), will move to Evelina London, with conventional radiotherapy at University College Hospital. This reconfiguration will mean:

- seriously ill children with cancer undergoing chemotherapy or bone marrow transplants will be on the same site as a level 3 children's intensive care unit (the highest level of intensive care) which is able to provide life support. This is required by the national service specification which sets the clinical requirements for Principal Treatment Centres in England and is based on clear and robust clinical evidence (including NICE guidance) about what is best for children with cancer.
- children will benefit from the expertise of many other specialist services that they may need within Evelina London's specialist children's hospital
- the future centre will have the potential, like other major centres worldwide, to provide groundbreaking CAR-T treatment and other treatments expected in the future that require a children's intensive care unit onsite.

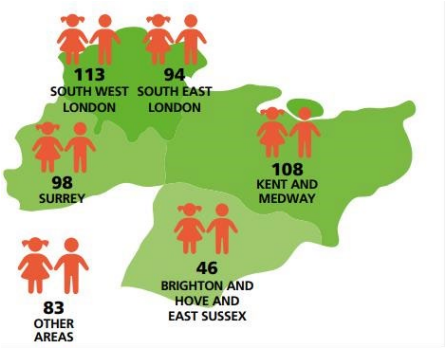
Who does this change affect?

Children's Cancer Principal Treatment Centres are responsible for making sure every child with cancer gets the expert care they need. They provide diagnosis, treatments, and coordination of very specialist care for children aged 15 and under, and there are 13 of them in England. Data from the public consultation about this change, which was undertaken by NHS England in autumn 2023, showed that:

- about 1,400 children are under the care of the Principal Treatment Centre (PTC) for south London and much of south east England at any given time
- about 190 children in the catchment area are newly diagnosed with cancer every year.

[3] You can read more about the decision-making by NHS England (London and South East Regions) on the transformation partners website.

This graphic shows the number of children from each area having inpatient care at the PTC.



Copyright: NHS England

How will this work?

All specialist children's cancer services will transfer from The Royal Marsden to Evelina London except for children's conventional radiotherapy, which will move to University College Hospital in central London[4]. This is where children with cancer who live in the catchment area of south London, Kent, Medway, most of Surrey and much of Sussex already have proton beam therapy[5]. Conventional radiotherapy for patients aged 16 and over will continue to be provided at The Royal Marsden.

Children's cancer surgery currently provided at St George's Hospital will also transfer to Evelina London. St George's children's cancer shared care unit[6], neurosurgery service[7], and children's intensive care unit will not move, and will continue to provide care for children who need it. In addition, Kings will continue to provide neurosurgery for children with brain tumours in their catchment area.

At Evelina London, there will be an inpatient ward, day case treatments area, and an outpatient department specially designed for children with cancer and their families. Many other services that children with cancer may need, including the level 3 children's intensive care unit, diagnostics (such as MRI and CT scans), and specialist children's services (heart, kidney, gastroenterology, infectious diseases services, and many others) are already provided by Evelina London and will be expanded where necessary to cope with the added demand.

Some inpatients will need to be transferred from Evelina London for treatment elsewhere, such as for radiotherapy, or specialist surgery, including neurosurgery, at centres with specific expertise. This will be carefully planned

[4] University College London Hospitals NHS Foundation Trust, which University College Hospital is part of, already provides all forms of radiotherapy for children under the care of the other Principal Treatment Centres (PTCs) in London and the south east.

[5] In coming years, more children are expected to have proton beam therapy than conventional radiotherapy. Though it is only suitable for certain types of tumours, proton beam therapy precisely targets tumours, reducing damage to healthy tissue and potentially reducing long-term side effects.

[6] This is one of 15 children's cancer shared care units in hospitals across the catchment area, which provide supportive care and, where agreed, specific chemotherapy treatments as close to home as possible, sharing care with the PTC.

[7] The majority of neurosurgery (approximately 80%) for children with cancer will continue to be at King's College Hospital, with the other 20% at St George's Hospital, as it is now.

Benefits of the change

The future Principal Treatment Centre at Evelina London will bring together expert staff from the current service at The Royal Marsden and St George's Hospital with Evelina London's specialist teams who already care for children with complex and rare medical conditions.

At the future centre:

- very sick children who need intensive care input will no longer be transferred to another hospital as happens now. Such transfers are currently done as safely as possible but, even in a special children's ambulance with an expert team onboard, they add avoidable risks and stress to what is already a very difficult situation
- some very sick children may be able to avoid intensive care completely thanks to face-to-face review by onsite intensive care specialists, working closely with the cancer teams
- for children who need it, the intensive care unit will be just one floor away from the cancer ward
- most other specialist children's services that children with cancer may need will also be onsite, including tertiary heart and kidney services
- Guy's and St Thomas' have pledged to create exceptional capabilities for immunological and advanced cellular research for children's cancer care, supported by a comprehensive clinical trial programme and advanced imaging research. This could have national and international benefits
- it will be easier for different specialist teams treating the same children to work closely together, improving care for children, supporting new kinds of research, and helping the future centre keep and attract new staff
- more children will be supported to access care closer to home where this is clinically appropriate, as a result of Evelina London using its experience of working closely with paediatric teams across the catchment area to improve care at children's cancer shared care units.

This is a complex programme and, as with any service move, there are risks that need to be managed. All organisations involved are committed to working closely together to ensure the best outcome for children.

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Item 5: Group between Medway and Dartford & Gravesham NHS Trusts

By: Gaetano Romagnuolo, Research Officer - Overview and Scrutiny

To: Health Overview and Scrutiny Committee, 2 April 2026

Subject: Establishment of a Group between Medway NHS Foundation Trust and Dartford and Gravesham NHS Trust.

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by representatives of Dartford & Gravesham NHS Trust and Medway NHS Foundation Trust.

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1) Introduction

a) The purpose of this paper is to update the Committee on the outcome of an independent review into the potential benefits of closer collaboration between Medway NHS Foundation Trust and Dartford and Gravesham NHS Trust. The paper also outlines the next steps for the development of the Group and leadership arrangements for both Trusts.

2) Recommendation

a) RECOMMENDED that the Committee note the report.

Background Documents

None.

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Kent County Council

Health Overview and Scrutiny Committee

Wednesday, 2 April 2026

Establishing a Group between Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust

Report from: Jonathan Wade, Chief Executive, Dartford and Gravesham NHS Trust, and John Goulston, Chair, Medway NHS Foundation Trust.

1. Summary

1.1. The purpose of this paper is to update the Committee on the outcome of an independent review into the potential benefits of closer collaboration between Medway NHS Foundation Trust and Dartford and Gravesham NHS Trust, and to outline the next steps for the development of the Group and leadership arrangements for both trusts.

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. Organisational overview

4.1. Dartford and Gravesham NHS Trust, which runs Darent Valley Hospital in Dartford, and Medway NHS Foundation Trust, which runs Medway Maritime Hospital in Gillingham, are neighbouring acute hospital trusts.

4.2. Both trusts deliver a comprehensive range of acute, elective, and emergency services, serving diverse communities with some shared patient flows and overlapping catchment areas.

4.3. The two organisations serve a combined population of approximately 800,000 people across North Kent and Medway. Together they employ approximately 10,500 staff and have a combined operating budget of just over £1 billion.

4.4. The trusts are both members of the Kent and Medway Acute Provider Collaborative and signatories of the Kent and Medway NHS Strategy.

5. Drivers for change

5.1. Both trusts have great strengths and expertise and in recent years, have demonstrated commitment to partnership working — particularly in clinical services (including Rheumatology, Urology, Ear Nose and Throat, and Pathology), shared procurement, and workforce initiatives.

5.2. However, much of this collaboration has occurred on an ad hoc basis, sometimes without sufficient formal governance or long-term strategic alignment, which has led to mixed success.

5.3. The trusts also face converging challenges which include:

- rising demand from an aging population
- long waits for treatment
- variations in clinical outcomes
- staffing pressures
- fragmented digital systems
- limited capital investment to invest in buildings and new equipment, and
- significant underlying deficits.

5.4. The two organisations also share the following interdependencies:

- patient flows across urgent, elective, and diagnostic services
- shared medical and nursing workforce pools
- common suppliers and contracting arrangements
- aligned clinical transformation priorities (elective recovery, quality improvement and digital transformation), and
- shared system objectives within the Integrated Care System (ICS) framework.

5.5. While both trusts have achieved notable service improvements in recent years, the scale of challenge demands a structural approach beyond incremental improvement.

6. Independent review and case for change

6.1. Last year, NHS Kent and Medway commissioned an independent review to assess the potential benefits of closer collaboration between the two trusts. The review examined opportunities to improve quality of care, patient outcomes, operational performance and efficiency.

6.2. The review identified clear benefits of closer collaboration to:

- improve the quality and consistency of care
- enhance patient outcomes
- strengthen operational efficiency and resilience
- expand staff development and leadership opportunities
- accelerate performance improvement across both organisations.

6.3. In evaluating the case for greater collaboration, the review considered three organisational options:

- continuing with the current arrangements
- establishing a formal Group
- merging into a single new organisation.

6.4. It concluded that establishing a governance-backed group is the preferred option. This model – already widely adopted across NHS providers – enables trusts to work under a shared leadership team while remaining separate statutory bodies.

6.5. The review also recommended that the trusts develop, in time, a shared leadership team, including a Group Chief Executive and Group Chair, supported by strong site-based leadership.

6.6. The review's recommendations have been considered and approved by both Boards, and are supported by Medway's Council of Governors, Kent and Medway Integrated Care Board, and NHS England's South East Regional Team.

7. Anticipated benefits

7.1. The vision is for a clinically-led, financially sustainable, and digitally enabled Group that delivers outstanding, integrated care to the population of North Kent and Medway, ensuring every patient receives equitable, high-quality care regardless of geography.

7.2. Proposed clinical benefits:

- Reduced unwarranted variation through standardised clinical pathways and shared governance.
- Improved access and patient outcomes through joint service planning.
- Enhanced safety through shared learning, joint morbidity reviews, and quality improvement systems.
- Improved patient experience through listening to our patients and co-designing improvements to clinical pathways.

7.3. Proposed workforce benefits:

- Provide equity and equality for all staff through an open and transparent culture that enables staff to speak up and be empowered and engaged.
- Shared workforce planning and career development frameworks.
- Improved recruitment and retention through joint branding and training.
- Enhanced clinical leadership opportunities and cross-site collaboration.

7.4. Proposed operational benefits:

- Unified leadership and shared enabling services in key areas.
- Reduced duplication and more efficient use of resources.
- Streamlined decision-making and greater organisational agility.

7.5. Proposed financial benefits:

- Recurrent savings through economies of scale.
- Improved capital efficiency and purchasing power.
- Strengthened ability to attract external investment and transformation funding.

8. National and system alignment

8.1. In recent years national health policy has promoted greater collaboration between health and care system partners, including NHS trusts, for example through the introduction of provider collaboratives and a new legislative framework in the 2022 Health and Care Act.

8.2. Establishing the Group is directly aligned to key national NHS strategic policies and frameworks, including:

- **The NHS 10 Year Health Plan for England (2025):** supporting more sustainable care through three transformational shifts – from hospital to community, from analogue to digital and from treatment to prevention.
- **Provider Collaboration Guidance (NHS England, 2023)**: encouraging formalised partnerships that improve system performance and resilience.
- **NHS Operational Planning Guidance (2025/26)**: focusing on elective recovery, urgent and emergency care performance, workforce sustainability, and financial balance.
- **NHS People Promise**: promoting shared workforce planning, development, and compassionate leadership.
- **Net Zero and Greener NHS Framework**: mandating carbon reduction through coordinated estate and procurement strategies.

8.3. The group approach creates a structure consistent with these objectives — ensuring that both trusts act as system partners within the Kent and Medway ICS, rather than as competitors for resources and staff.

8.4. It is also aligned with key system priorities. The Kent and Medway ICS aims to deliver ‘One System, One Population, One Budget’, supporting population health improvement and system sustainability.

8.5. The Group is an enabling mechanism to deliver the ICS’s five strategic aims:

- **Improved population health**: By standardising care and strengthening preventative services across North Kent and Medway.
- **Tackling health inequalities**: By ensuring equitable access and outcomes across catchment areas.
- **Enhancing quality and productivity**: Through shared governance, data-driven improvement, and efficiency in service delivery.
- **Supporting economic sustainability**: By releasing savings and reinvesting in clinical priorities.
- **Building workforce resilience**: By sharing talent pipelines, training opportunities, and leadership capacity.

8.6. The Group will operate within and contribute to the wider system architecture, ensuring alignment with ICB objectives, provider collaboratives, and neighbourhood-level care integration.

8.7. Engagement will include Primary Care Networks, community providers, and the ICS to strengthen system collaboration and ensure that the model supports integrated care delivery.

9. Current context and leadership arrangements

9.1. The creation of the Group is a significant step forward for both trusts at a time when the NHS in Kent and Medway is undergoing significant change, alongside considerable operational and financial pressures.

9.2. As a result, since announcing the intention to form the Group last November, the trusts have kept all aspects of its development under close review, with particular attention to leadership capacity.

9.3. Having considered this, the trusts have decided that it is right, for the time being, to maintain two separate Chief Executives. This approach will ensure that each trust has the dedicated leadership focus required to address immediate priorities: reducing waiting times, improving patients' outcomes, transforming organisational culture, and strengthening financial performance.

9.4. The trusts are now recruiting substantive Chief Executives. Jonathan Wade stepped down as Interim Chief Executive of Medway NHS Foundation Trust on 31 March, and will step down as Chief Executive of Dartford and Gravesham NHS Trust this summer. Siobhan Callanan, Interim Deputy Chief Executive, will continue to provide leadership and stability at Medway NHS Foundation Trust while the recruitment process is underway.

10. Next steps

10.1. The trusts are at the beginning of a journey to establish the Group and implementation will take time and be phased, with foundational work already underway to ensure the Group can realise its intended benefits.

10.2. The Boards have agreed to establish a joint committee to determine the most appropriate approach, pace and structure for the Group's development. This will be supported by an experienced Programme Director.

10.3. Over time, this will include developing the Group operating model, setting out how the trusts will make decisions together, govern themselves, agree shared priorities, and implement the changes required.

10.4. The trusts remain confident that the Group's development presents significant opportunities for innovation and improvement that will benefit patients. They will continue to engage openly as this work progresses, listening to feedback and drawing on learning from other NHS groups to strengthen services now and for the future.

11. Climate change implications

11.1. The development of the Group is aligned to delivery of Net Zero and Greener NHS Framework which mandates carbon reduction through coordinated estate and procurement strategies.

12. Financial implications

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

12.2. Both trusts currently operate under deficit positions, with system control totals requiring substantial recovery plans.

12.3. A Group approach will enable resource optimisation, cost avoidance, and reinvestment into frontline services.

12.4. Financial oversight will be managed through a Group Finance and Performance Committee reporting to both Trust Boards.

13. Legal implications

13.1. There are no direct legal implications for the Council arising from this report.

13.2. Each Trust will retain:

- statutory accountability for CQC registration and compliance
- independent external audit and annual report, and
- separate Foundation Trust membership (for Medway NHS Foundation Trust).

13.3. The Group will operation under a Memorandum of Understanding, formalised via aligned Schemes of Reservation and Delegation (SoRD).

14. Lead officer contact

Jonathan Wade, Chief Executive, Dartford and Gravesham NHS Trust
John Goulston, Chair, Medway NHS Foundation Trust.

Item 6: Reconfiguration of Stroke Services in East Kent

By: Gaetano Romagnuolo, Research Officer - Overview and Scrutiny

To: Health Overview and Scrutiny Committee, 2 April 2026

Subject: Reconfiguration of Stroke Services in East Kent.

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

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1) Introduction

a) The purpose of this briefing is to update HOSC on the transfer of acute stroke services in East Kent from Kent and Canterbury Hospital to a new, purpose-built unit at the William Harvey Hospital in Ashford.

2) Recommendation

a) RECOMMENDED that the Committee note the update.

Background Documents

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

Kent County Council (2022) Health Overview and Scrutiny Committee (30/11/2022), https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=9048&Ver=4

Kent County Council (2023) Health Overview and Scrutiny Committee (05/10/2023) https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=9318&Ver=4

Kent County Council (2024) Health Overview and Scrutiny Committee (28/02/2024) https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=9320&Ver=4

Kent County Council (2024) Health Overview and Scrutiny Committee (28/01/2025) https://democracy.kent.gov.uk:9071/ieListDocuments.aspx?CId=112&MId=9545

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Reconfiguration of stroke services in East Kent

Purpose of briefing

The purpose of this briefing is to update the Kent Health and Overview Scrutiny Committee (HOSC) on the transfer of acute stroke services in East Kent from Kent and Canterbury Hospital (K&C) to a new, purpose-built unit at the William Harvey Hospital (WHH) in Ashford.

Understanding hyper-acute and acute stroke care

Hyper-acute stroke unit (HASUs) enable patients to have rapid access to the right skills and equipment and be treated 24/7 on a dedicated stroke unit, staffed by specialist teams. Following a stroke, a patient will be taken directly to a HASU where they will receive dedicated expert care, including immediate assessment, access to a CT scan and clot-busting drugs (if appropriate) within 30 minutes of arrival at the hospital.

Acute stroke units (ASUs) are for subsequent (after 72 hours) hospital care. These units offer ongoing specialist care with seven-day therapies services (physiotherapy, occupational therapy, speech and language therapy and dietetics input) and effective multi-disciplinary team (MDT) working.

Overview of the Kent and Medway stroke reconfiguration programme

The Kent and Medway acute stroke reconfiguration programme is a two-phased programme to develop three hyper-acute stroke units (HASUs) at Dartford, Maidstone and Ashford. The background to the programme is detailed in

DRAFT

Appendix 1.

The reconfiguration is being funded by the Kent and Medway health system from its capital allocation over a multi-year period, with the three schemes totaling more than £32m.

The programme is being delivered in two phases. The units at Dartford and Maidstone opened their HASU's in 2024. The unit at WHH is being delivered as a second phase due to the scale and complexity of the works.

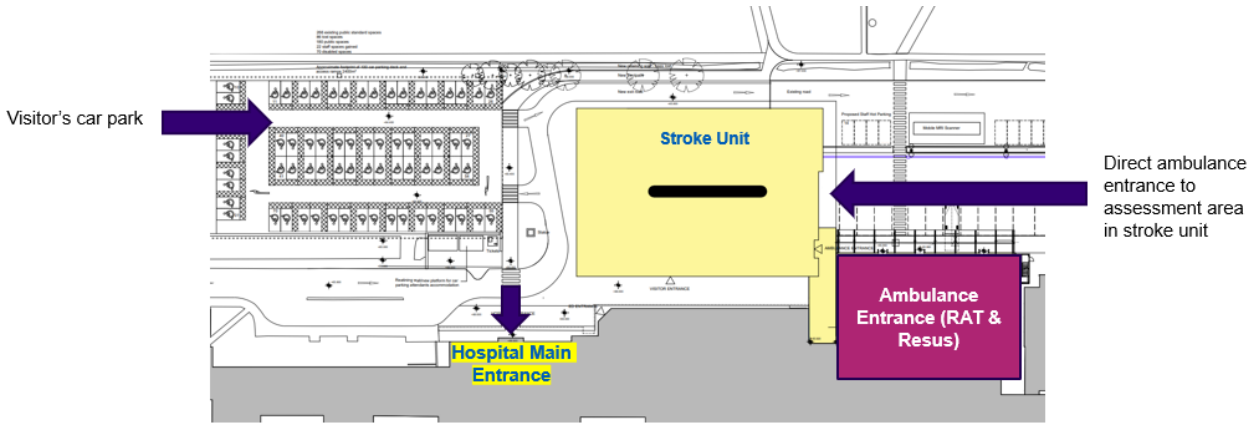
NHS Kent and Medway undertook a review of the East Kent scheme in 2023. The aim was to review the current delivery strategy, ascertain the funding requirement and affordability of the scheme, and ensure the scheme remains value for money. This additional assurance process was discussed with Committee members in February 2023.

Following that process, design plans for the construction of the unit were completed. These plans were presented to the Committee in January 2025. Since that time the full business case for the capital investment in the new unit has been approved by NHS Kent and Medway (November 2025).

The new stroke unit at WHH

The new East Kent stroke unit will be a 54-bed two-storey purpose-built facility located directly in front of the Emergency Department (ED) as shown in **Figure 1**. There has been in depth engagement with both the clinical and operational teams throughout the development of the design.

Figure 1: Location of HASU in front of ED



Key features

- A purpose-designed layout with more space and flexibility than refurbishing existing wards could provide.
- Direct ambulance drop-off straight into the stroke unit, bypassing A&E.
- Five triage and assessment bays, ensuring patients are seen immediately on arrival.

- A CT scanner located inside the unit, right next to the assessment area, saving vital minutes.
- A standalone build, avoiding disruption to neighbouring wards during construction.

These features build on the model that is already delivering outstanding results in East Kent, including some of the fastest imaging times in the country.

Improvements already achieved for East Kent patients

The temporary consolidation of stroke services onto a single site has already transformed care for local people, and these improvements have now been recognised nationally. In the latest results from the Sentinel Stroke National Audit Programme (SSNAP), published January 2026, East Kent Hospitals was named the best-performing stroke service in the country. It is the only Trust to achieve the top rating of 'A' for the period July to September last year, which is a significant achievement for patients and staff.

Since bringing teams together and introducing the "direct access" model, East Kent has seen major gains in speed and quality of care:

- 97.2% of patients are scanned within one hour, compared with 62.7% nationally.
- The median time to scan is just 5 minutes, compared with 37 minutes nationally.
- Adjusted mortality has fallen, saving around 65 lives each year.
- The service developed the first pre-hospital video triage for stroke in the country, improving how quickly patients are directed to the right care pathway.

These improvements demonstrate that the current model works well. The new, purpose-built unit at the William Harvey Hospital is designed to embed and build on these gains, ensuring that East Kent patients continue to receive some of the fastest and highest-quality stroke care in England.

Thanet outcomes

Understanding how the stroke service is performing for different communities across east Kent, including those living furthest from the new unit such as Thanet, is an important part of ensuring the programme continues to deliver safe, timely and equitable care for everyone. Thanet residents will continue to be expected to receive safe and timely stroke care under the national call-to-needle standard of 120 minutes following the move to WHH. Travel times were thoroughly assessed and independently tested during the original Kent and Medway stroke review, which concluded that Thanet residents would not be disproportionately disadvantaged by the HASU being located at WHH. Performance for Thanet residents will continue to be monitored closely following the move.

Why move the service to William Harvey Hospital?

Specialist stroke services need:

- highly trained staff working together in one place,
- rapid, reliable access to CT scanning,
- dedicated beds and equipment,
- and a layout designed around urgent assessment and treatment.

The WHH site will provide the space, proximity and clinical adjacencies needed for a full HASU and ASU. The approved Kent and Medway model places one HASU in each major geography (north, mid and east Kent) ensuring the whole county is served equitably.

The temporary use of K&C during COVID-19 was vital during a period of exceptional demand. It also provided important learning that is now being built into the WHH design. But K&C does not have the space or infrastructure needed for the permanent unit agreed through public consultation and national scrutiny, particularly a co-located emergency department. The WHH unit is purpose-built, larger, and designed around national standards.

Travel times and patient outcomes

We recognise concerns about how long it takes patients, especially from Thanet, to reach the William Harvey Hospital. Travel times have been carefully modelled and independently validated and remain within nationally recognised safe parameters. What matters most for survival and recovery is the speed and quality of specialist assessment and treatment once a patient arrives, which the WHH design is built to optimise through direct access and an on-unit CT scanner.

Modelling shows that, with HASUs based in Dartford, Maidstone and Ashford:

- 98.3% of Kent and Medway residents can reach a HASU within 60 minutes by blue-light ambulance.
- For Thanet, the average travel time is around 55 minutes, with a maximum of about 63 minutes.

These figures are based on thousands of real-world journeys collected over a full year and cross-checked with actual ambulance data. Off-peak car times, nationally recognised as a reliable proxy for blue-light travel, were compared with real ambulance journeys, which were found to be slightly faster.

Clinical timings

There is no single “golden hour” for stroke, and most patients do not need clot-busting drugs within the first 60 minutes of arriving. The national standard is:

- Call-to-needle within 120 minutes,
- including door-to-needle within 60 minutes.

The design of the WHH unit, especially direct ambulance access and on-unit CT, is specifically intended to protect these minutes and achieve faster treatment on arrival.

Communities and equality

Stroke risk is influenced by age, long-term conditions and lifestyle factors, and some communities experience these risks more heavily than others. It is therefore essential that no area, including those with higher levels of deprivation, is disadvantaged by the reconfiguration. The evidence shows that the single biggest driver of better outcomes is rapid access to high-quality hyper-acute stroke care, which the new HASU network is designed to provide consistently, seven days a week.

Preventing avoidable disability and saving lives depends most on the specialist care delivered on arrival at hospital, supported by wider prevention work such as smoking cessation, blood pressure management and healthy living programmes. The locations of the three HASUs were chosen through extensive clinical modelling, public consultation and independent scrutiny to create a balanced, countywide network, ensuring every part of Kent and Medway, including coastal and more deprived areas, can reach specialist care within safe timeframes.

During public consultation, residents consistently told us that their highest priority was access to the best possible clinical service, even if this meant travelling further.

The Integrated Impact Assessments also found that although some communities may travel longer distances, the benefits of faster, more specialist hyper-acute care are expected to outweigh this and are likely to reduce health inequalities overall, particularly for groups at higher risk of stroke.

Thrombectomy and future specialist treatments

A separate NHS England-commissioned programme is developing mechanical thrombectomy capability at K&C as part of the Kent Interventional Radiology Centre.

This will work in partnership with the HASUs. Patients who need this highly specialised procedure will be transferred quickly from WHH (or other HASUs) to K&C.

This approach is fully consistent with national best practice and ensures East Kent patients can benefit from both the hyper-acute unit and advanced endovascular treatment.

The business case

The Full Business Case for capital investment, approved in November 2025, confirms that the development is affordable within the Kent and Medway system's capital allocation and has been structured to ensure the service can be delivered safely and sustainably.

The unit will be funded from the system's £23.9m capital allocation for the East Kent scheme. This funding has been approved through NHS Kent and Medway's governance process and covers the full design and construction of the unit.

The revenue requirements for running the expanded service are being reviewed and are expected to be finalised in the coming months.

Next steps

The programme is now moving into the delivery phase. Key milestones currently include:

- Planning application approval expected 20/03/2026
- Start of construction 01/06/2026
- Go live estimation is late 2027/early 2028 dependent on the outcome of planning permission.

Regular updates will continue to be provided to HOSC as the programme progresses.

Assurance

The programme has been through extensive consultation, legal scrutiny, clinical assurance and national decision-making. The programme has also undergone independent scrutiny through two judicial reviews and a referral to the Secretary of State, all of which upheld the decision. Progress will continue to be overseen through EKHUFT governance, the Kent and Medway ICB, with ongoing reporting to HOSC.

Appendix 1

Background on the reconfiguration of acute stroke services

The Kent and Medway Stroke Review was commissioned in 2014 in response to concerns by Kent and Medway Clinical Commissioning Groups (CCGs) about the performance and sustainability of hospital stroke services across all units in Kent and Medway. The CCGs and hospital trusts were tasked with developing proposals to improve outcomes for patients, reducing deaths and disability.

The review recommended a model of care involving specialist stroke services consolidated at three hospitals, each with a hyper-acute stroke unit (HASU) and an acute stroke unit (ASU), to ensure rapid access to specialist staff, equipment, and imaging to improve quality and outcomes for patients.

Public consultation on the proposal was undertaken in 2018 and the decision to establish HASU/ASUs in Dartford, Maidstone and Ashford was made the following year. This decision was challenged via two judicial reviews and a referral to the Secretary of State for Health and Social Care. The judicial reviews found in favour of the NHS in February 2020. Following the judgement, Medway Council and a claimant applied to the Court of Appeal requesting the right to appeal the decision. The request was refused and the high court decision in favour of the NHS cannot be contested. The Secretary of State confirmed support for the reconfiguration in November 2021.

Since the NHS decision in 2019, there have been three emergency temporary changes to stroke services in Kent and Medway:

- Tunbridge Wells Hospital stroke service transferred to Maidstone Hospital in September 2019 due to staffing challenges.
- In April 2020, in response to Covid, East Kent Hospitals University Foundation Trust (EKHUFT) transferred its stroke services at William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQM) to the Kent and Canterbury Hospital (K&C). The stroke service remains at Canterbury at this time.
- Medway Hospital stroke service closed in July 2020 due to staffing challenges. The majority of stroke patients that would previously have gone to Medway Hospital are now going to Maidstone Hospital with a small number going to Darent Valley Hospital.

Following the consolidation of stroke units onto three sites, service performance has increased significantly. Data from the Sentinel Stroke National Audit Programme (SSNAP), which measures the quality and organisation of stroke care in the NHS, demonstrates the improvement across provider organisations. Further improvements are anticipated following the full implementation of the three HASUs.

SSNAP ratings pre and post consolidation of stroke units

Hospital	Dec 16 - Mar 17	April - Jul 17	Aug - Nov 17	Dec17 - Mar 18	Apr - Jun 18	Jul - Sep 18	Oct - Dec 18	Jan - Mar 19	Apr - Jun 19	Jul - Sep 19	Oct - Dec 19	Jan - Mar 20	April - Jun 20	Jul - Sep 20	Oct - Dec 20	Jan - Mar 21	April - Jun 21	Jul - Sep 21	Oct - Dec 21	Jan - Mar 22	April - Jun 22	Jul - Sep 22	Oct - Dec 22	Jan - Mar 23	April - Jun 23	Jul - Sept 23	Oct - Dec 23	Jan - Mar 24	April - Jun 24	Jul - Sept 24
DVH	D	D	D	E	D	D	D	D	C	D	D	D		C			D	C	B	B	B	B	C	C	B	B	B	C	B	B
QEQM	D	C	D	D	D	D	D	D	D	C	D	D																		
WHH	C	B	B	B	B	C	C	D	D	C	D	D																		
K&C														A			A	A	A	B	B	B	A	A	A	A	A	A	A	A
MGH	A	A	B	B	B	B	A	A	B	B	C	D		A			A	A	B	B	B	A	B	A	A	A	A	A	A	A
TWH	C	C	C	C	C	B	C	B	C	C																				
MMH	D	D	D	E	E	E	E	D	D	D	E	E																		

Clinical audit was suspended for the duration of this quarter.

Item 7: Kent and Medway Community Services Transformation and Neighbourhood Health

By: Gaetano Romagnuolo, Research Officer - Overview and Scrutiny

To: Health Overview and Scrutiny Committee, 2 April 2026

Subject: Kent and Medway Community Services Transformation and Neighbourhood Health

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

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1) Introduction

a) This paper sets out the transformation priorities for community services across Kent and Medway, with a particular focus on the evolving Neighbourhood Health Model.

b) The report outlines the strategic direction of the Kent and Medway Integrated Care Board following the re-procurement of community health services and the award of a new long-term contract.

2) Recommendation

a) RECOMMENDED that the Committee note the report.

Background Documents

None.

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NHS
Kent and Medway

Kent and Medway
Community Services Transformation
and
Neighbourhood Health

1. Introduction

This paper sets out the transformation priorities for community services across Kent and Medway, with a particular focus on the evolving Neighbourhood Health Model. It outlines the strategic direction of the Kent and Medway Integrated Care Board (KMICB) following the reprocurement of community health services and the award of a new long-term contract.

In response to changing national priorities and local needs, the paper examines how the ICB is driving improvements in service integration, accessibility, and quality through a targeted community services transformation plan, ensuring care is increasingly delivered within neighbourhoods including alignment with Primary Care Networks. The following sections detail the ambitions, investment plans, and specific schemes aimed at enhancing community-based care for local populations.

2. ICB Community Services Ambitions

KMICB has established clear ambitions for the future of community health services, building on the foundation of a new long-term contract. Following a comprehensive reprocurement process, a decision was made in April 2025 to award a 5+3-year contract to Kent Community Health NHS Foundation Trust (KCHFT) as Lead Provider, with HCRG and Medway Community Healthcare (MCH) acting as subcontractors. After a successful six-month mobilisation period, the new contract commenced on 27 October 2025.

At the heart of the ICB's vision is a fully funded 3–4 year transformation plan, informed by the ICB's 'Ambitions' document developed in 2024 and published as part of the reprocurement process. This ensured that providers understood the scope of work required to achieve best practice in community services during the life cycle of the contract.

A significant development since publication has been the strengthened focus on neighbourhood health, which was elevated to a national priority within the NHS 10-Year Health Plan. The shift represents a move away from fragmented, acute-centric care towards an integrated, community-based approach, where services are embedded within local neighbourhoods and aligned with Primary Care Networks.

In collaboration with the new provider, the ICB is redirecting the planned £4.6 million p.a. community services transformation investment towards neighbourhood health delivery, with a particular focus on the development and expansion of multi-neighbourhood (MNH) services.

Multi-neighbourhood (MNH) services

This investment supports schemes designed to deliver timely, flexible care and reduce unnecessary hospital admissions, including:

- 24/7 Urgent Community Response teams (covering both in-hours and out-of-hours home visiting)

- Virtual Wards
- Frailty Services
- Dementia Care.

The intermediate tier also plays a vital role in bridging the gap between hospital and home, supporting patients with complex needs who do not require acute hospital care but benefit from enhanced community support. Key services in this tier include:

- Community nursing
- Reablement
- Short-term crisis response
- Therapy-led interventions
- Transfer of Care Hubs

Community services underpin this entire model by providing personalised care through multidisciplinary teams. These teams offer a broad spectrum of support, including management of chronic diseases, rehabilitation, palliative care, and health promotion.

By working alongside GPs, social care and VCSEF organisations, community services ensure that residents receive holistic, tailored support. This integrated approach is key to improving health outcomes and quality of life across the population.

Healthcare Inequalities

In line with local and national strategic ambitions, the transformation plan will also focus on addressing healthcare inequalities throughout Kent and Medway. The ICB and KCHFT are working together to offer a harmonised service, actively closing gaps that resulted from historic variations in commissioning by former Clinical Commissioning Groups (CCGs).

Key areas of focus include:

- Children's audiology
- Children's therapies
- Community paediatrics
- Diabetes (covering nutrition and dietetics, podiatry, and education)
- Looked After Children
- Lymphoedema
- Respiratory services, including COPD and pulmonary rehabilitation
- Self-care and shared care – inc tracheostomy consumables, catheters
- Speech and Language Therapy
- Transition from children's to adults' services
- Wound management, including podiatry and tissue viability nursing

This comprehensive approach aims to deliver equitable, high-quality care for all residents, ensuring that people receive consistent support regardless of where they live.

3. Kent and Medway's neighbourhood health model

Kent and Medway's neighbourhood health (NH) model is an integrated approach to healthcare, designed to bring services closer to people's homes and communities. It reflects national NHS priorities and the Government's 10-Year Health Plan, focusing on three strategic shifts:

- **From hospital to community** – reducing reliance on acute settings by strengthening primary and community-based care.
- **From sickness to prevention** – investing in proactive health measures such as early cancer diagnosis, cardiovascular disease prevention, and respiratory care improvements.
- **From analogue to digital** – using tools like the NHS App and Kent and Medway Care Record (KMCR) to provide joined-up, accessible care.

The model anchors services in local neighbourhoods, aligning with Primary Care Network (PCN) footprints (typically 30,000–50,000 people) to ensure care is person-centred and community-driven.

Local neighbourhoods will also scale into 'multi-neighbourhoods' (MNH), representing footprints of an average of 250,000 people, for services that work better at scale.

Key components include:

- Integrated intermediate care ('Home First')
- Modern general practice
- Neighbourhood multidisciplinary teams
- Population health management
- Standardised community health services
- Urgent neighbourhood services

This approach is not just about clinical care—it involves partnership working across NHS providers, local authorities, voluntary and community organisations, and social care. It aims to reduce health inequalities, improve outcomes, and make services more equitable.
It builds on areas of good practice developed by local teams of primary and community healthcare professionals.

There will be a 'core offer' for the whole of Kent and Medway, then population health data will be used to inform neighbourhood-specific priorities to address local health issues and inequalities

The Kent and Medway NH model has been developed by clinicians from across the system. It was clinically approved in December 2025 by a steering group with representation from the ICB, all Kent and Medway community providers, the Kent and Medway mental health trust, primary care representatives, all Kent and Medway acute hospitals, and hospice providers, alongside local authority partners and VCSEF representatives.

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Neighbourhood health provides the strategic framework for the transformation of community services across the system, enabling a shift from fragmented, reactive provision to proactive, integrated, neighbourhood-based care through the MNH footprint, providing scale, flexibility and higher-acuity community-based care. This will be delivered in close partnership with Single Neighbourhoods (SNH) to ensure seamless pathways, effective step-up and step-down arrangements, and a consistent neighbourhood offer across Kent and Medway.

The model is underpinned by the Johns Hopkins population risk stratification approach, ensuring that neighbourhood services are systematically aligned to population need and system impact. In its first year of implementation, the NH Model will focus on the highest-need 5% of the population—individuals with the most complex proactive, ongoing and reactive care requirements, who account for around 25% of urgent and unplanned activity.

For this cohort, neighbourhood services will play a central role in delivering coordinated, 24/7 neighbourhood-based support, with clear interfaces to primary care, mental health, social care and acute services.

The strategic emphasis is on strengthening proactive, accessible and coordinated community-based care, enabling earlier intervention, improved continuity and better outcomes, while reducing reliance on hospital-based services.

Delivery of this ambition requires integrated working across all four sectors—primary care, community services, mental health and social care—supported by shared governance, population health analytics and aligned incentives. This approach directly supports the NHS 10 Year Health Plan and Medium-Term Planning priorities and is grounded in the system ethos of Our Population, Our Resources and Our Responsibility.

4. Neighbourhood model priorities - year one

Key priorities for the first year of development include:

- Defined neighbourhood responsibility for **Frailty, Dementia and Palliative & End of Life Care** (P&EOLC), delivered through integrated teams spanning primary care, community services, mental health, acute providers and the VCSEF, operating on a 24/7 basis where required.
- A **Neighbourhood Community Front Door**, providing a single, consistent access point for patients, families, carers and professionals, supporting step-up and step-down across neighbourhood pathways.
- A '**No Wrong Door'** approach, underpinned by robust MDT working, ensuring needs are triaged, prioritised and coordinated until safe discharge back to general practice or PCN-led care.

- Clear **interdependencies and mutual aid arrangements** between neighbourhoods, ensuring continuity of agreed inputs where local capacity is constrained.
- A consistent **Care Homes** offer, with defined neighbourhood support and MNH escalation where required.
- A **system-wide** data and outcomes framework, aligned to the NH Model of Care, with agreed proactive, ongoing and reactive measures.
- **Workforce planning, education and development** aligned to current and projected population need.
- A commitment that **resources follow the patient**, with SNH and MNH contracts designed around defined neighbourhood populations rather than organisational boundaries.

5. Collective Out-of-Hospital priorities

The collective out-of-hospital priorities are framed around coordination, rapid response and continuity, rather than individual service lines. Key priorities include:

1. Neighbourhood community front door (24/7)
A single point of access for neighbourhood populations and professionals, supporting triage, coordination and step-up/step-down across SNH and MNH pathways.

2. Integrated Neighbourhood MDTs
MDTs operating as one team, combining proactive, ongoing and reactive functions. Referrals are managed through a No Wrong Door approach, avoiding fragmentation or re-referral between community teams, and ensuring seamless interfaces with PCN hubs, acute providers, ambulance services, hospices and the VCSE.

3. Urgent community response (UCR) and virtual ward / hospital at home (H@H)
UCR services provide a consistent 24/7 response, including rapid assessment, point-of-care testing and oral/IV therapies. These services operate as part of the wider Frailty Virtual Ward and H@H model, supporting both reversibility and, where appropriate, palliative trajectories in line with ReSPECT plans.

4. Care homes, hospices and ambulance services
Care homes, hospices and ambulance services are enabled to use neighbourhood pathways as the default route, including out-of-hours, weekends and bank holidays, where community-based care is clinically appropriate.

5. Shared care records and digital enablement
While native systems will continue initially, KMCR will be used as the shared record for key NH interventions.

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6. **Remote monitoring and surveillance**
Agreed remote monitoring solutions will support early identification of deterioration, with inclusive access for acute partners as the model matures.

7. **Acute interfaces and flow**
Structured interfaces with ED, SDEC, AFU and inpatient units, including daily multi-agency flow discussions, support admission avoidance and timely discharge.

8. **Intermediate capacity and step-down options**
Community beds, hospice partnerships and selected nursing home capacity will support short-term step-down and admission avoidance for high-need cohorts.

9. **Data-led improvement**
A shared NH dashboard will enable monthly review of activity, outcomes and variation, supporting continuous improvement across neighbourhoods.

6. Specific programme priority needs

In Year one, the KCHFT Community Services Transformation Plan will prioritise delivery of the NH Model for the highest-need 5% of the population, working in close collaboration with system partners.

1. **Frailty**
Community teams will lead delivery of proactive identification, CGA, anticipatory care planning and 24/7 response, expanding UCR, Virtual Ward and H@H capacity, and strengthening workforce capability through targeted training (e.g. DiaDEM).

2. **Dementia**
Dementia pathways will be embedded within neighbourhood frailty models, with structured post-diagnostic support and crisis response, and expansion of dementia crisis services in partnership with mental health and VCSE providers.

3. **Palliative & End of Life Care**
Community nursing capacity, verification of expected death, syringe driver support and anticipatory prescribing will be strengthened. For the highest-need cohort, ACP, ReSPECT and medication reviews will be systematically completed and maintained.

4. **Care homes**
Neighbourhood-led care home support will be strengthened, with UCR as the first response for urgent needs, proactive follow-up and expanded training to support quality and reduce avoidable admissions.

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5. **Falls**
Falls prevention and response will be optimised using pooled resources and data-led targeting, with responsive rehabilitation and rapid community support.

6. **Specialist community services**
Specialist nursing and therapy services (e.g. heart failure, respiratory, diabetes, Parkinson's, LD, CYP) will be aligned to neighbourhood population need, supporting both frailty and rising-risk cohorts.

7. **Children and young people**
Community services will focus on high-risk CYP cohorts, working with acute partners to deliver integrated neighbourhood care and reduce avoidable admissions, with an expanding role over time for rising-risk children.

8. **Mental health, learning disabilities and autism**
Community teams will work in partnership with mental health providers to deliver 24/7 wraparound support, improve physical health monitoring, support carers and reduce admissions, with standardised health checks and improved flagging and reasonable adjustments.

9. **Professionalism, Digital and Feedback**
Reflective MDT practice, shared learning, KMCR-enabled care coordination, point-of-care testing and structured patient and staff feedback will underpin safe, high-quality delivery.

7. Engagement

KMICB has unified its engagement work to drive the transformation of community services and advance Neighbourhood Health priorities. By collaborating with KCHFT and a wide range of partners, neighbourhood health objectives are being woven directly into the community services transformation plan, ensuring both strategy and practical delivery are shaped by collective input.

To promote inclusive participation, four workshops are taking place, commencing from the end of January, inviting community representatives and stakeholders to discuss the proposed model, highlight challenges, and share suggestions. This collaborative forum gathers a diversity of views early in the process.

We are working collaboratively with public health teams to align the work to local health and wellbeing strategy through HWB boards.

Next Steps

After the engagement workshops, the draft community services transformation plan will be further developed by KCHFT, who have played an active role in the workshops. The final draft plan will reflect all feedback—including that relating to neighbourhood health priorities to give a strengthened focus on enhanced neighbourhood health planning. The final draft

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will be submitted to the ICB by 31.03.26 for approval. This is subject to alignment with other ICB planned investments to support the neighbourhood health programme.

Once approved, preparations for implementation will commence, including the development of detailed action plans for neighbourhood health, the establishment of monitoring and evaluation frameworks tailored to neighbourhood objectives, and ensuring ongoing involvement and collaboration with stakeholders to facilitate smooth delivery and continuous improvement.

Regular updates and opportunities for continued involvement and input will be provided, guaranteeing transparency and accountability in neighbourhood health planning within the wider context of community services transformation.

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Item 8: Work Programme

By: Gaetano Romagnuolo, Research Officer - Overview and Scrutiny

To: Health Overview and Scrutiny Committee, 2 April 2026

Subject: Work Programme

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

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1) Introduction

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

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

c) 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 consider and note the items within the proposed work programme and to suggest additional topics to be considered for inclusion on the agenda of future meetings.

2) Recommendation

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

Background Documents

None.

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Health Overview and Scrutiny Committee

Work Programme

1. Proposed items for upcoming meetings

3 June 2026

Item	Item Background	Substantial Variation?
Meningitis outbreak in Kent.	To receive an update on the meningitis outbreak in Kent and the measures that have been implemented to contain it.	-
Structural Changes to NHS Kent and Medway Integrated Care Board (ICB) – update.	To receive an update on the planned structural changes to the NHS Kent and Medway ICB.	-
South East Coast Ambulance Service NHS Foundation Trust (SECAmb) and South Central Ambulance Service NHS Foundation Trust (SCAS) Group Model Collaboration - update.	To receive an update on the Group Model collaboration between SECAmb and SCAS.	-
Proposed integration between the Kent Community Health NHS Foundation Trust (KCHFT) and Medway Community Healthcare (MCH) – update.	To receive an update on the proposed integration between KCHFT and MCH.	-

2. 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.

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