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 Tuesday, 15 July 2025.

PRESENT: Mr O Bradshaw (Chair), Mr R Mayall (Vice-Chair), Mr J Baker, Mr M Brice, Mr S Jeffery, Miss I Kemp, Mr T Mole, Mrs B Porter, Mr A Ricketts, Mrs S Roots, Mrs C Russell and Cllr K Tanner.

IN ATTENDANCE: Ms N Davies (Chief of Staff, ICB), Dr C Rickard (Medical Director, Kent LMC, Mr E Waller (Chief Strategy and Partnerships Officer and Interim Chief Delivery Officer, ICB) and Mr G Romagnuolo (Research Officer, Overview and Scrutiny, KCC).

UNRESTRICTED ITEMS

224. Election of Chair
(Item 1)

1. Mr J Baker proposed, and Mr T Mole seconded, that Mr Oliver Bradshaw be elected Chair of the Health Overview and Scrutiny Committee.
2. RESOLVED that Mr Oliver Bradshaw be elected Chair of HOSC.

225. Election of Vice-Chair
(Item 2)

1. Mrs S Roots proposed, and Mrs B Porter seconded, that Mr Robert Mayall be elected Vice-Chair of the Health Overview and Scrutiny Committee.
2. RESOLVED that Mr Robert Mayall be elected Vice-Chair of HOSC.

226. Substitutes
(Item 3)

Apologies were received from Cllr H Keen, Cllr K Moses and Dr G Sturley. There were no substitutions.

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

(Item 4)

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

228. Minutes of the meeting held on 12 March 2025
(Item 5)

RESOLVED that the minutes of the meeting held on 12 March 2025 were a correct record and that they be signed by the Chair.

229. Carr-Hill Formula
(Item 6)

Dr Caroline Rickard, Medical Director, Kent Local Medical Committee was in attendance for this item.

1. Dr Caroline Rickard (Medical Director, Kent Local Medical Committee) introduced herself. She said that she worked as a GP two days a week and was a Medical Director of the Kent Local Medical Committee (LMC). Two of her colleagues were also Medical Directors at the Kent LMC. The organisation had a committee of 40 elected GP representatives and had a statutory duty to represent all GPs across Kent and Medway. The organisation was funded directly by practices through a statutory and national levy.

2. Dr Rickard presented her report. She said that general practice funding was quite complex, and there had been some inherent issues with the way that it was calculated nationally. The reason why the Car-Hill formula was called for widely for reform was because the way it was calculated did not adjust for deprivation effectively and accurately. This had led to practices in the most deprived areas having almost 10% less funding than those in the least deprived areas.

3. The Car-Hill formula was developed in 2002. Since then, there had been the digitization of GPs records which had led to a much greater understanding of the impact of deprivation on the local population's health. The impact of the loss of funding as a result of the adoption of this formula was that GP practices were closing.

4. The local population had been increasing and the number of GPs has not kept up. In Kent, there was an average of one full-time equivalent GP to 2 ,702 patients. National data suggested that 142 more full-time GPs were needed to meet effectively the demand in Kent and Medway.

5. The impact was not just about patients' visits; GP's practice workload involved also checking patient's results, examining hospital letters, ensuring that the prescriptions were signed and that they were correct, and producing medication reviews.

6. According to a Kent LMC's survey of local GP practices in 2023, GPs reported that they were feeling more stressed as a result of this increased pressure. GPs and contractors were all working significantly above their core contracted hours.

7. This was not just a trend in Kent and Medway. Nationally, 60% of GPs had reported significant stress, and 30 % of practices had ceased recruitment due to financial uncertainty. So practices had to cease recruiting because they did not have enough core funding to be able to recruit sufficient staff.

8. Dr Rickard said that the GP practices that they represented were advocating for a guaranteed, long-term funding plan for general practice that would give them assurance that they could recruit staff.

9. The ten-year plan outlined the shift from hospital to community, and GP practices were already very experienced at delivering hospital-type care. They already delivered dermatology and urology services, cardiology clinics, eye surgeries and eye clinics. For every pound that was spent in community or primary care, there was up to a £14 return into the economy.

10. In order to keep that continuity of care, investment in core general practice was needed so that newly recruited GPs could be retained.

11. In answer to a question about whether local GP practices were using AI, Dr Rickard said that GP practices were already using digital tools in a number of ways. AI Scribe typed up the consultation automatically and enabled GPs to listen to the recording. Online consultations would become another point of access to general practices.

12. A Member asked how the plan for GPs to cover larger areas would reconcile with the current model.

    a. Dr Rickard replied that it was essential that general practices were equipped so that they could provide their services to wider areas. It was crucial to support them so that they could recruit GPs into long-term posts.

13. A Member asked Dr Rickard to comment on the impact of the national insurance annual increase of £38,000 for the average practice.

a. Dr Rickard replied that GP practices were small businesses, and such an increase would have a significant, negative impact on them.

14. A Member asked Dr Rickard whether she knew if becoming a GP was still a good career choice for young people.

    a. Dr Rickard said that many young people were still choosing this profession. However, she cautioned that, nowadays, newly qualified doctors would look for job opportunities in the global market. Also, aside their salary, their working conditions and work-life balance were also important to them.

15. The Chair thanked Dr Rickard for her informative presentation and for answering questions.

16. RESOLVED that the Committee consider and note the report.

230. Winter Plan Review 2024/25
(Item 7)

Ed Waller, Chief Strategy and Partnerships Officer and Interim Chief Delivery Officer, ICB, was in attendance for this item.

1. The Chair welcomed Ed Waller (Chief Strategy and Partnerships Officer and Interim Chief Delivery Officer, ICB) to the meeting. Mr Waller explained that the creation of a winter plan was a statutory requirement for Integrated Care Boards. The Kent and Medway ICB produced a comprehensive plan which linked to national priorities and combined lessons learned from previous years.

2. This ‘whole-system’ winter plan mixed various elements of care service provision, including primary, community, acute, mental health and social care. It used public health information and data to predict demand, particularly in busy periods during winter, and identify the areas most impacted. The plan included surge plans, capacity and demand predictions, improvements to mitigate demand, urgent emergency care assurance and localised Health and Care Partnership (HCP) plans.

3. The reason for the development of the Winter Plan was that there was a surge of demand in the winter season which was driven, for example, by winter viruses and falls. One of the main aims was how to avoid congestion at A&E departments; often hospitals were not the best place to meet the health needs of the population.

4. Another aim was to examine hospitals’ operational mechanisms to make sure that they run smoothly - for instance by ensuring shorter waiting times

in emergency departments. Much depended on putting in place packages of care, in partnership with KCC's Adult Social Care services, that allowed patients who were fit to leave the hospital to return home or to the most appropriate setting for their post-hospital care.

5. Mr Waller said that, this winter, NHS Kent and Medway's performance was relatively strong against several of the national indicators, including ambulance handover times into emergency departments. Efforts were being made to reduce the occurrence of waiting times of more than 12 hours in Emergency Departments.

6. In answer to a question on whether the Discharge to Assess system (where assessments takes place outside hospital in order to speed treatment) was still operational, Mr Waller confirmed that this was still the case.

7. A Member asked about the extent to which the capacity and agility of KCC's Social Care services was able to support this system.

    a Mr Waller said that the challenges that existed in social care and in the discharge pathways out of hospital were common to all NHS services across England. The NHS had a good working relationship with KCC. The ten-year plan set out a very clear vision for creating a range of opportunities and systemic support in the community, when these best met the health needs of the population. For example, there was a joint appointee whose main role was to put together packages of care that included services from both organisations to best serve those with learning disabilities and autism.

    b Mr Waller added that neighbourhood health service provision would ultimately be best delivered if Health and Social Care services worked together in a more integrated way.

RESOLVED that the Committee note the report.

231. Wellbeing Support for NHS Staff during and after Covid
(Item 8)

There were no guests available to present this item.

1. The report outlined the measures that were in place to support the wellbeing of NHS staff in Kent and Medway during and after Covid.

2. During Covid, general safety measures included the use of Personal Protective Equipment (PPE), staff vaccinations and national wellbeing apps. In addition, local NHS organisations offered their staff wellbeing support including Employee Assistance Programmes, access to counselling and trained Trauma Risk Management Practitioners, leadership support circles

(equipping leaders with evidence-based wellbeing interventions), coaching and mentoring.

3. The Talking Wellness service, provided by the Kent and Medway NHS & Social Care Partnership Trust (KMPT), offered therapeutic support for mental health challenges. This included a Mental Wellbeing Information Hub and 24-hour helpline which offered resources and urgent support to all NHS staff.

4. After the Pandemic, support in the county included the continuing provision of Covid clinics, national wellbeing apps and wellbeing support until December 2025. All NHS staff in Kent and Medway were still able to access therapeutic support through Employee Assistance Programmes (EAPs) and counselling services. Leadership support circles, and some formal wellbeing groups, had remained in some organisations.

RESOLVED that the Committee note the report.

232. Urgent Treatment Centre Review Update
(Item 9)

Ed Waller, Chief Strategy and Partnerships Officer and Interim Chief Delivery Officer, ICB, was in attendance for this item.

1. This paper provided an update on the review of Urgent Treatment Centres (UTCs) in Kent and Medway. The main aim of the review was to provide a consistent urgent treatment offering to reduce variation in access and outcomes, support the reduction of emergency department attendances for minor conditions and deliver effective services to drive value for money.

2. UTCs were established to provide accessible services for treating non-life-threatening conditions, aiming to reduce pressure on A&E departments and ensure that patients received the most appropriate care.

3. It was recognised that there was inconsistency in local service provision, with UTC services using diverse providers and offering different opening hours. National standards for UTC services included: being open 7 days a week for at least 12 hours a day; seeing both booked and walk-in patients; treating minor injuries and ailments, and; having a named senior clinical leader supported by a multi-disciplinary workforce. They also needed to have access to patient records, accept appropriate ambulance conveyance, and report daily on the Emergency Care Data Set (ECDS).

4. One of the areas that were being explored was whether some of the UTCs which were co -located next to emergency departments needed to increase their hours of operation in order to avoid people remaining in these departments unnecessarily through the night. This was now common practice around the country.

5. The other area was the future of minor injuries units, and whether they should be provided with the same specifications as those in Urgent Treatment Centres, so that they would all are operate on a similar basis.

6. In answer to a question about when this model would become operational, Mr Waller replied that, while some activities would be relatively easy to implement rapidly, others would require more time. The intention was to complete them in the course of 2026.

7. In answer to a question about the integration of the GP out-of-hour services with UTCs, Mr Waller explained that there were some parts of the county where, in effect, patients were undergoing two lots of triage. It was the ICB's view that the NHS did not have the resources for this, and for the patients it was frustrating to repeat the same process twice. Wherever possible, it was important to streamline mechanisms so that patients would undergo a single triage process to determine their needs.

8. In reply to a question about the need to refresh some of the UTCs' infrastructure, Mr Waller acknowledged that, while there were some high-quality facilities in Kent and Medway, there were others which needed replacing or improving. The main constraint was the limited amount of capital funding available to the NHS in order to do so. There was a very large national backlog on capital maintenance and replacement, and in Kent and Medway this was greater than the national average.

9. It was crucial to consider how best to invest to make sure that facilities were in the right place to deliver the clinical services that the population needed. There had to be close collaboration between organizations that were not co-located to enable this vision.

RESOLVED that the Committee note the report.

233. Community Services Procurement and Engagement Update
(Item 10)

Ed Waller, Chief Strategy and Partnerships Officer and Interim Chief Delivery Officer, ICB, and Natalie Davies, Chief of Staff, ICB, were in attendance for this item.

1. This report provided an update on the Kent and Medway Integrated Care Board (KMICB) Community Services procurement. It also outlined the next steps to contract sign-off and service 'go live', and described the communication and engagement plans which were employed.

2. The Kent and Medway ICB's Community Services procurement followed the decision by the ICB Board in February 2023, in line with its legal obligations, to re-procure for a period of 5 years the three main Community Services provider contracts:

- the HCRG Care Group (HCRG), which is a private provider of community health and social services
- Kent Community Health NHS Foundation Trust (KCHFT) and
- Medway Community Healthcare.

3. A Community Services Review (CSR) was developed to support the procurement and ensure the long-term delivery of community health services, while addressing health inequalities.

4. Further to challenge in September 2023 that the proposed procurement represented a Substantial Variation of service provision, the procurement was paused while the ICB worked with HOSC and its equivalent HASC in Medway to clarify their position.

5. The CSR was then re-launched in February 2024 and progressed, in line with the Programme Plan, to ensure a full and transparent procurement of the services to be in place by 27 October 2025.

6. Natalie Davies (Chief of Staff, ICB) explained that this re-procurement received particular media coverage because of the value of the contract, which was in the region of £1.8 billion. The contract effectively brought together the community service provision across Kent and Medway into a single contract. It made provision for the ICB to work closely with the Kent Community Health NHS Foundation Trust **(**KCHFT), in order to transform and improve such provision.

7. As part of the submission process, providers were asked to set out their plans for engaging with service-users and their staff. A Community Services Transformation and Improvement Group, which comprised providers, Voluntary and Community sector groups, Kent's Health Advisory and Scrutiny Committee, Healthwatch and HOSC, would work together to determine how best to fulfil this initiative's ambitions.

RESOLVED that the Committee consider and note the briefing.

234. Work Programme
(Item 11)

1. A Member commented that it was important to ensure that, in its future meetings, the Committee explored issues that were current and forward-looking.

    a. The Chair endorsed this view.

RESOLVED that the Committee note the Work Programme.