KENT COUNTY COUNCIL

ADULT SOCIAL CARE AND PUBLIC HEALTH CABINET COMMITTEE

MINUTES of a meeting of the Adult Social Care and Public Health Cabinet Committee held at Council Chamber, Sessions House, County Hall, Maidstone on Wednesday, 11th March, 2026.

PRESENT: Mr M Brown, Mr S Dixon (Chair), Mr S Jeffery, Mr A Kennedy, Mr A Kibble, Mr R Mayall, Mr T Mole (Vice-Chair), Ms C Nolan, Mrs B Porter, Mrs S Roots, Mr C Sefton and Mr T L Shonk

ALSO PRESENT: Mrs G Foster, Miss D Morton and Mr M Mulvihill

IN ATTENDANCE: Miss M Bundy (Democratic Services Officer), Mr J Cole (Lead Performance Analyst), Dr A Ghosh (Director of Public Health), Ms H Gillivan (Interim Director Adults and Integrated Commissioning.), Dr M Gogarty (Strategic Lead Public Health Consultant), Mrs S Hammond (Corporate Director Adult Social Care and Health), Ms S Hill (Director of Operations (Long Term Support)), Ms C Holden (Head of Children's Commissioning), Mr M Scrivener (Head of Risk and Delivery Assurance), Mr M Thomas-Sam (Director of Operations (Short Term Support)) and Mrs V Tovey (Assistant Director of Integrated Commissioning)

UNRESTRICTED ITEMS

57. Apologies and Substitutes
(Item. 2)

No apologies were received.

58. Declarations of Interest by Members in items on the agenda
(Item. 3)

Mr Jeffery declared an interest in Item 9 (Neighbourhood Health) that he was the Leader of Maidstone Borough Council and had expressed views there in relation to Local Government Reorganisation (LGR), which was referenced in the report.

59. Minutes of the meeting held on 21 January 2026
(Item. 4)

1. A Member referred to questions they had asked the Cabinet Member at the previous meeting, which they had subsequently submitted by email for a written response. They stated that they had not yet received a written reply. It was agreed that a response would be provided outside of the Committee.

2. RESOLVED that the minutes of the meeting held on January 21 2026 were a correct record and they be signed by the Chairman.

60. Verbal Updates by Cabinet Member, Corporate Director and Director of Public Health
(Item. 5)

1. Diane Morton, Cabinet Member for Adult Social Care and Public Health, provided a verbal update on the following:

   a) Miss Morton announced that it was National No Smoking Day and cited her own personal experience as encouragement for those that smoked to consider quitting.

   b) The tender for older people's nursing and residential care home contracts had closed. Miss Morton was optimistic about the quality of providers and expected a strong framework to go live in mid-summer. She reported that this would be an important step in stabilising the market and addressing costs that remained above the national average.

   c) Demand for Blue Badges continued to rise sharply, with over 48,000 applications received in the past year. A significant proportion of demand related to Special Educational Needs and Disabilities (SEND). Miss Morton stressed the importance of clear and detailed supporting evidence at application and renewal stages to enable quicker and more accurate decisions. Support was also available through Kent Connector Support Hubs hosted by District and Borough councils.

   d) Members were also informed of proposed national changes to Blue Badge renewals, including extending the standard renewal period to five years and potential changes to the £10 fee, although implementation dates and details were not yet confirmed.

   e) Miss Morton summarised a recent letter from Baroness Casey to the Secretary of State which raised serious concerns about repeated failures in adult safeguarding and called for a national safeguarding board, a review of safeguarding legislation, and strengthened national oversight. The letter also highlighted shortcomings in the national response to dementia, calling for dementia to be treated as a clinical priority, and raised issues around motor neurone disease, including a recommendation for a fast-track passport to speed access to support.

   f) Miss Morton reported that colleagues from the Local Government Association (LGA) and peers from other authorities had visited to support work on safeguarding and on refreshing the model for the Health and Wellbeing Board, ensuring alignment with the NHS Ten Year Plan, Kent's priorities, the Joint Strategic Needs Assessment and the Integrated Care Strategy. A full update would be brought to the Committee once the model was finalised.

   g) As the financial year end approached, the forecast for Adult Social Care (ASC) showed stability with a continuing downward trend in the overspend. Miss Morton reminded Members that the overspend had peaked over the previous summer and had since been brought under greater control through spending controls and strategic measures. Risks remained, but progress was documented in quarterly reports to Cabinet.

   h) Miss Morton reported that the Adult Social Care and Public Health Performance Indicator Suite had undergone a refresh. The full ASC suite

was not yet ready for publication but would be shared once finalised. Work was ongoing to present indicators in a more resident-friendly way, possibly online, by early summer.

i) Miss Morton highlighted the imminent launch of the coastal Marmot Programme in Dover, with Sir Michael Marmot attending. She commended the Public Health team for establishing the first coastal regional Marmot Programme in the country.

2. Dr Anjan Ghosh, Director of Public Health gave a verbal update on the following:

a) Dr Ghosh reported that Public Health had been experiencing a busy and productive period both strategically and operationally. Work was underway to redevelop and re-energise the Health and Wellbeing Board in light of national changes, including the abolition of Integrated Care Partnerships referenced in the NHS Ten Year Plan. A further update would be brought once more detail was available.

b) Dr Ghosh reiterated the importance of the upcoming Marmot launch and highlighted the focus on wider determinants of health and work, including a recent Kent and Medway summit on employment, skills and health, and participation in an LGA and Association of Directors of Public Health conference on the built environment.

c) Members were advised that Kent was a training site for public health consultants, general practitioners (GPs) and other registrars. Work was underway with universities and deans to develop a centre of excellence for Public Health in Kent, and further details would be brought back when available.

d) Dr Ghosh explained that the childhood immunisation schedule had changed from January 2026 with the introduction of an additional chickenpox (varicella) vaccine. The measles, mumps and rubella (MMR) vaccine had become MMRV with doses at one year and 18 months, followed by a booster at three to four years.

e) The Kent Public Health Observatory had produced an alcohol licensing tool to support public health and licensing authorities in making representations on applications. A set of mental health indicators had also been developed to inform a strategic approach to mental health due to be discussed by the Integrated Care Partnership Board.

f) Work on age-friendly communities continued, with Ashford and Faversham being accepted into the UK Age-Friendly Communities Network, supporting people to age well and live fulfilling later lives.

g) A stroke prevention pilot with partners including the Integrated Care Board (ICB) and a local GP federation was underway in Dartford, Gravesham and Swanley, focused on identifying undiagnosed atrial fibrillation and supporting healthier lifestyle choices.

h) Dr Ghosh announced the launch of the “Forever Active” programme, an evolution of the Postural Stability and Falls Prevention Service delivered through Active Kent and Medway. Grants had been awarded to 28 Kent charities, social enterprises and clubs.

i) Work with Gypsy, Roma and Traveller communities had included training around 600 people in culturally competent practice, developing stay and play sessions, closer working with family hubs, and health bus checks for residents who had not previously accessed a GP.

j) Dr Ghosh highlighted that Canterbury Health Alliance had won a Healthwatch award for excellence in integrated working, particularly in relation to a neighbourhood team which had positively impacted health inequalities.

k) Further work was underway within the ASC framework on social prescribing, unpaid carers’ health and wellbeing needs, and data analysis on people living alone. A new sexual health clinic was also due to open at the Discovery Centre in Dover later in March.

3. Sarah Hammond, Interim Corporate Director of Adult Social Care and Health, provided a verbal update on the following:

a) Ms Hammond reported that the Adults’ budget deficit, while still significant at around £45m, had reduced from a projected position close to £60m based on the trajectory in September 2025.

b) The total number of individuals receiving a package of care from ASC had decreased, which Ms Hammond attributed to the growing preventative agenda and earlier community-based support. However, individual costs continued to rise above inflation, which was acknowledged as a concern.

c) Engagement with providers had increased, with evidence of providers wishing to work more closely with the Council on quality and affordability. Ms Hammond held regular discussions with the Chair of the National Association of Care Home Providers and acknowledged that more work was needed to ensure a wider range of provider voices were heard.

d) Work with the ICB and NHS Trusts was underway to address the high number of people admitted to hospital without a treatable or acute medical need, particularly in East Kent. Ms Hammond highlighted concerns that some people were spending their final days in Accident and Emergency (A&E) or leaving hospital with greater levels of need than when admitted. It was agreed with NHS partners that the issue extended beyond discharge pressures, with too many people being admitted to A&E to begin with.

e) Ms Hammond referenced a recent Partners in Care and Health visit funded by Central Government, involving experts from the Association of Directors of Adult Social Services (ADAS) and the LGA. Initial feedback was that progress had been made in some areas but that further improvement was needed, particularly in throughput of work. A written report with recommendations was awaited.

f) Ms Hammond outlined six high-level business priorities for 2026-27 for Adult Social Care:

   i. Delivering major recommissioning programmes and strengthening market stability, quality and value for money
   ii. Developing the workforce and digital infrastructure to support safe, efficient and modern practice
   iii. Strengthening practice, safeguarding decision-making and quality assurance including delivering the improvement plan
   iv. Managing demand and affordability through better pathways, decision-making and commissioning rather than in-year savings
   v. Shifting investment upstream into prevention, enablement, community support and technology-enabled lives
   vi. Improving discharge, intermediate care and joint working with health partners to reduce delays and system pressures

g) Ms Hammond informed the Committee that she and Dr Ghosh had submitted statements on behalf of Adults' and Children's Social Care to the Manston Inquiry, which was examining overcrowding and poor health outcomes, including a death, at the Manston facility between June and November 2022. The public hearings were expected in November 2026.

4. In response to questions and comments from Members, discussion covered the following:

a) Ms Hammond confirmed that Kent County Council (KCC) and NHS colleagues were in agreement concerning people being admitted to A&E without a treatable medical condition. She explained that anxiety among care home and community providers about supporting people at the end of life was potentially leading to ambulance calls and hospital admissions. Work was underway with the NHS to provide reassurance and support to care providers, including clarifying appropriate responses and avoiding unnecessary admissions where there was no acute medical solution.

b) It was advised that more people were leaving ASC services than starting, which was not unusual in winter but was slightly more pronounced than in previous years. There had also been a slight decrease in requests for care assessments, suggesting that some needs were being met differently or earlier. Miss Morton highlighted that local GP provision had reduced in some areas, increasing barriers to timely healthcare and contributing to avoidable admissions.

c) Ms Hammond confirmed that right to reside patient figures could be provided in a written response outside of the Committee and stated that many of those admitted without a treatable need were already known to ASC, either in residential care or with existing packages.

d) Ms Hammond explained that the data on ambulance conveyances from care homes were being analysed in new ways and historic comparisons were limited. Nevertheless, it was clear that too many residents without acute needs were being admitted to hospital. She explained this was an opportunity for joint work with providers and the Care Quality Commission

(CQC), including reviewing training and support, and addressing concerns that inspection expectations may be contributing to defensive referrals.

e) Dr Ghosh explained that Kent commissioned the Institute of Health Equity in October 2025, with the Marmot launch in Dover delayed from its original date. The ten-year Marmot Programme would begin with a focus on work and health and on coastal inequalities, before expanding to all eight Marmot principles across the county. The Dover launch event was designed to build momentum and issue a call to action, featuring contributions from Sir Michael Marmot, the Leader of the Council, Miss Morton and the Chief Executive.

5. RESOLVED that the Adult Social Care and Public Health Cabinet Committee note the verbal updates.

61. Adult Social Care Performance Dashboard
(Item. 6)

1. The report was introduced by Joe Cole, Lead Performance Analyst, which set out the Key Performance Indicators (KPIs) covering Quarter 3 2025-26. Mr Cole provided a brief overview of performance whereby 3 of the 7 KPIs were RAG rated green, 3 were amber and 1 was red. The KPI that had been rated red (ASH7) was partly due to recent inspections and a number of homes awaiting outcomes.

2. Mr Cole outlined that activity levels remained high and contacts received were higher than in the same quarter of previous years. Safeguarding concerns remained at a high level, and applications for Deprivation of Liberty Safeguards continued to exceed completions, reflecting a long-standing pattern. The quarter recorded the highest number of care and support plan reviews completed in the last two years.

3. In response to questions and comments from Members, discussion covered the following:

a) Helen Gillivan, Director of Adults and Integrated Care, reported that she had met with the new Deputy Director of the CQC to discuss inspection timeliness and partnership working. She confirmed that the Council's internal measurement of ASH7 would be reviewed, and further discussions would take place with the CQC regarding inspections. The current rating, however, remained an accurate reflection of the Council's internal quality monitoring approach. Miss Morton also highlighted potential concerns surrounding inspector capacity within the CQC, indicating it could take some time before all necessary roles were filled.

b) Mr Cole explained that some indicators, such as those linked to the Better Care Fund and people aged 65 and over in long-term support, were nationally comparable, while others were local measures reflecting Kent's operational structures.

c) It was recognised that there was a reduction in ASH13 (average cost of new support packages) and suggested that an additional indicator reflecting the

average cost of all support packages to support broader budget monitoring be considered.

d) Ms Gillivan explained that officers visit care homes to monitor contractual and quality standards and work with providers on improvement plans where needed. Sydney Hill, Director of Operations (Long Term Support), added that, when concerns arise, the Council worked jointly with the CQC and NHS colleagues to review residents' needs, support improvements, and, where necessary, move residents or, in rare cases, support home closures.

e) It was asserted that Kent had approximately 370 residential and nursing care homes, meaning visit activity must remain proportionate and risk-based. It confirmed a more detailed figure could be provided outside of the Committee, if necessary.

4. RESOLVED that the Adult Social Care and Public Health Cabinet Committee note the performance of Adult Social Care services in Quarter 3 2025/2026.

62. Public Health Performance Dashboard for Quarter 3
(Item. 7)

1. The item was introduced by Victoria Tovey, Assistant Director of Commissioning, who set out the Key Performance Indicators (KPIs) covering Quarter 3 2025-26. Ms Tovey provided a brief overview of performance whereby all 14 available KPIs were broadly rated green or amber and none were red. 4 indicators, mostly related to substance misuse and smoking services, were unavailable at the time of the report, but trends were generally positive. She also provided an outline of the KPIs that had been refined as part of the service transformation programme to improve outcome focus and align with national targets.

2. In response to questions and comments from Members, discussion covered the following:

a) In response to a question on vaccination- related indicators, Dr Ghosh explained that the dashboard was a subset focussed on commissioned services over which the Council had direct control. Vaccination performance was monitored within a broader internal dashboard and through joint work with the NHS, which was responsible for delivery, but was not currently included as a KPI for the Cabinet Committee.

b) Ms Tovey explained that indicator PH06 (number of adults accessing structured treatment for substance misuse) had been refined to align with national priorities of the Office of Health Improvement and Disparities (OHID), supported by recent additional funding. This measured formed part of a wider set of KPIs, which remained important for monitoring outcomes at both service and corporate levels. Therefore, the change reflected a national focus rather than a removal of existing performance detail.

c) Dr Ghosh outlined that Kent had historically had an issue with low numbers entering treatment relative to need, and that increasing access was a positive step because people in need often faced stigma, chaotic lifestyles and overlaps with mental health and the criminal justice system, which

hindered engagement. Increasing numbers in treatment therefore aligned with unmet need.

3. RESOLVED that the Adult Social Care and Public Health Cabinet Committee note the performance of Public Health commissioned services in Quarter 3 (Q3) 2025/26 and the proposed Key Performance Indicator target changes for 2026/27.

63. Risk Management
(Item. 8)

1. The item was introduced by Mark Scrivener, Head of Risk and Delivery Assurance, who presented the strategic risks related to both the ASC and Public Health Directorate, in addition to the risks featuring on the Corporate Risk Register. The report also covered the management process for review of key risks.

2. In response to questions and comments from Members on the Adult Social Care and Health Directorate, discussion covered the following:

   a) Ms Gillivan advised that uplift decisions had been applied during the year where appropriate and emphasised that the Council's responsibility under the Care Act was to maintain the overall sustainability of the social care market rather than individual providers. She explained that the Council commissioned approximately one third of the market, with the majority funded by self-funders. The commissioning team continued to work closely with providers and representative bodies, including the Kent Integrated Care Alliance (KICA) and the National Care Association. Regular provider forums had also been established, and work was ongoing to support workforce development and market capacity across the county. Ms Gillivan also highlighted that alternative models of care were being considered to enable patients to be able to live in their own homes.

   b) Mrs Hammond emphasised that over four years, the Council had increased residential care prices by around 87%, significantly above inflation, and that research showed Kent paying higher fees per head than statistical neighbours and some other counties for similar providers. She outlined that while some providers offered good quality at affordable prices, for others the Council was paying substantially more than comparable authorities. She stated that the Council did not believe the market was close to collapse, though risk remained high, and reported examples of providers recently reducing their charges to retain Council business.

   c) Mr Scrivener explained that the report had been finalised ahead of the listed review date as part of the approval process, which meant it fell between internal review cycles.

   d) Mr Scrivener explained that risk ratings were set by risk owners and were under ongoing review. Recent discussions at the Directorate Management Team included whether ratings should be adjusted in light of new information, including the outcome of current recommissioning.

e) Miss Morton stated that allowing care homes to set charges without constraint would not be affordable for the Council.

3. In response to questions and comments from Members on the Public Health Directorate, discussion covered the following:

   a) Dr Ghosh agreed that the Marmot Programme and wider Public Health work had the potential to implement positive change but emphasised that improvements took time and depended on contributing from the NHS, District and Borough Councils, voluntary sector and residents.

   b) Dr Ghosh acknowledged the importance of wider determinants such as food security, climate change, biodiversity loss and related health impacts. He agreed to consider how these areas might be reflected within the Public Health risk register, stating that responsibilities were shared with partner organisations, including the Environment Agency. Mr Scrivener advised that he would raise the point with the Growth, Environment and Transport (GET) Directorate to consider how such risks were captured.

4. RESOLVED that the Adult Social Care and Public Health Cabinet Committee considered the risks presented for both the Adult Social Care and Health and Public Health directorates.

64. Neighbourhood Health
(Item. 9)

1. The item was introduced by Dr Ghosh who explained that Neighbourhood Health was a key element of the NHS Ten Year Plan and that the report set out emerging national and local models. He highlighted tensions due to differing definitions of “neighbourhood” used by the NHS, local authorities and residents, and between the NHS’s immediate focus on reducing hospital admissions and the longer-term preventative aims of local government. He also reported that an internal KCC group was being developed to consider the Council’s role across various directorates. National guidance that had yet to be published would also shape detailed plans.

2. The report was introduced by Dr Mike Gogarty, Strategic Lead and Public Health Consultant, who gave a short PowerPoint presentation, the slides of which can be found HERE.

3. In response to questions and comments from Members, discussion covered the following:

   a) Dr Gogarty explained that a range of models were in use nationally and that the Johns Hopkins model, selected by NHS colleagues, was a reasonable option among several available approaches. He stated that the current Neighbourhood Health programme, as defined by the NHS, was primarily focused on short- term hospital admission avoidance rather than the broader spectrum of public health determinants. He confirmed that the Council continued to address wider determinants of health, such as environmental and housing factors, through other programmes and areas of work.

b) Dr Ghosh stated that Neighbourhood Health was not the only mechanism for addressing wider determinants, and that the Council and other agencies, were working on issues such as air quality and housing through other channels. He reported that the Neighbourhood Health Board for Kent and Medway was chaired by the ICB's Chief Operating Officer but would move to joint chairing by the Directors of Public Health for Kent and Medway, which would provide an opportunity to bring a broader perspective into the programme. Dr Ghosh also disclosed that Neighbourhood Health plans would be held under the Health and Wellbeing Board.

c) Dr Gogarty advised that a significant shift of resources from hospital to community settings was unlikely in the short term due to current national priorities. However, he highlighted opportunities to redesign existing services, strengthen prevention work within hospitals, and undertake small-scale pilots to test new approaches ahead of any wider implementation.

d) Dr Ghosh reported that the local ICB Chief Executive had begun to shift some funds from acute services into community health trusts via strategic commissioning, which was a positive step though it was too early to assess long-term impact.

4. RESOLVED that the Adult Social Care and Public Health Cabinet Committee note the report.

65. 26/00013 - All Age Home Care Services - Key Decision
(Item. 10)

1. The item was introduced by Miss Morton who explained that the decision concerned the Council's second largest framework and covered commissioning a new "all-age" home care service covering both adults and children.

2. Ms Gillivan provided an overview of the current service delivery arrangements for Homecare, Care and Support in Prisons and Community Support Services for disabled children and outlined information about the commissioning activity to establish a new Open Framework contract for an All Age Homecare Service (for adults and children). She also detailed recommendations for the future of these services to ensure continued high- quality support, good outcomes for people and value for money. Ms Gillivan reported that the Prisons Service aspect may be required to go live at a later date, due to additional requirements for that contract, with minimal financial cost to KCC.

3. In response to questions and comments from Members, discussion covered the following:

a) Concerns were expressed about the £807m framework value and the perceived lack of sufficient financial and service-model detail for a contract of this scale. The use of an 8% annual growth assumption was questioned and clarity was sought on how this related to demand increases versus inflation, considering recent demand trends could imply reductions in unit prices and potential sustainability risks. It was also argued report did not clearly set out how the service model for adults and children would change.

b) In response to these concerns, Ms Gillivan stated that detailed profiling and financial modelling had been undertaken but that it was not possible to include the full detail in the public report. She undertook to reflect on the Member's comments in relation to the 8% assumption and to provide further information as appropriate outside the meeting. She emphasised that, for adults and prisons, there would not be a radical change in the nature of service delivery: it would remain regulated home care aimed at supporting people to remain independent at home, with some specification changes informed by detailed market engagement.

c) Christy Holden, Assistant Director for CYPE Commissioning, explained that for children the new arrangements would allow needs to be categorised more flexibly so that families could be moved between categories in line with changing needs, with costs better aligned to complexity. The underlying nature of care would not change significantly, but the specification and way the service was managed would better reflect children's needs and help keep them out of care where possible.

4. RESOLVED that the Adult Social Care and Public Health Cabinet Committee endorsed the proposed decision by the Cabinet Member for Adult Social Care and Public Health to:

a) APPROVE the commissioning of an Open Framework All Age Home Care Service for adults and children to include Homecare, Care and Support in Prisons and Community Support Services for disabled children with the new arrangements to start on 1 April 2027

b) DELEGATE authority to the Corporate Director, Adult Social Care and Health in consultation with the Cabinet Member for Adult Social Care and Public Health, to take relevant actions including but not limited to, finalising the terms of and entering into required legal agreements, as necessary to award the contract; and

c) DELEGATE authority the Corporate Director, Adult Social Care and Health to open the Framework at regular intervals to allow new providers to join.

In accordance with paragraph 16.31 of the Constitution, Mr Stuart Jeffery requested for it to be recorded in the minutes that he voted against endorsing the proposed decision.

66. Work Programme
(Item. 11)

RESOLVED to note the Work Programme.