NHS
Kent and Medway

Appendix 1

Medway Health and Wellbeing Board:
GP and Neighbourhood Health

20 November 2025

Together, we can

Medway Primary Care Workforce Update

NHS Kent and Medway

2024 to 2025 Delivery Highlights

Workforce trends:

Role	2024 Head Count	2025 Head Count	2024 FTE	2025 FTE	Change in Head Count	Change in FTE
GPs excluding Trainee GPs and Locums	131	154	89.26	94.51	+23	+5.25
Nurses	105	103	65.04	66.70	-2	+1.66
DPC (Direct Patient Care Staff)	137	160	104.48	122.99	+23	+18.51
Admin	539	557	386.94	392.17	+18	+5.23

Placement Expansion:

- 181 students placed across Medway practices (GP, nursing, pharmacy, paramedics, PAs)

New to Practice GP Programme: grown from 1 → 13 GPs; high satisfaction and retention

Workforce Planning: 86% practices completed sessions; targeted support ongoing

Stakeholder Engagement: 1,600 staff subscribed to Primary Care Training Hub updates; strong system collaboration

2025/26 Priorities

Extend focus across Pharmacy, Optometry & Dentistry (POD) workforce

Support Neighbourhood Team (NT) development:

- Build integrated, place-based workforce
- Develop Workforce Development Framework covering skills, planning, retention, leadership, and culture

Continue strengthening relationships and education capacity to sustain workforce growth.

Kent & Medway PRIMARY CARE TRAINING HUB

CQC Medway GP Practice Ratings & Improvements

The Care Quality Commission (CQC) assesses GP practices to ensure safe, effective, and high-quality care. Practices are rated as Outstanding, Good, Requires Improvement (RI), Inadequate, or Unrated.

Rating	Practices	%
Outstanding	0	0%
Good	22	66.6%
Requires Improvement (RI)	7	21.2%
Inadequate	0	0%
Unrated	4	12.1%

Key Updates:

- Orchard & Parkwood Family Practices have yet to merge.
- Since Feb 2024 Health and Wellbeing Board report:
  - Previously 8 RI, 1 Inadequate → now fewer underperforming practices

GP Resilience Matrix

NHS Kent and Medway

This innovative tool is designed to identify GP practices that would benefit from transformational support and highlight those requiring additional assistance from the ICB. It identifies variance and helps target support and intervention to smooth that variance and improve outcomes for patients as well as building greater resilience for the practice improvements to be sustainable

The tool takes a comprehensive, multi-dimensional approach, drawing on a broad range of data to build a holistic view of each practice across four key domains ; Access, Workforce, Outcomes and General (CQC rating, deprivation level and more) from 41 metrics.

Each GP practice is carefully categorised into one of four levels of support, guided by scores from the metrics.

Category	Definition
Higher Achieving	Demonstrates strong performance across the metrics with 6 or more positive variations*
Achieving	Performing well overall, with up to 5 positive variations*
Approaching a review	Practices have more than 4 instances of level 1 or 2 triggers*, indicating emerging risks or concerns
Review Required	Practices have more than 6 instances of level 1 or 2 triggers*, indicating significant concerns across multiple areas

Within Medway there are pockets of higher achieving practices which compare favourably to other areas.
Priority has been given to practices who have been identified as requiring support and intervention via the use of the GP Resilience Profile tool.

Together, we can

*Positive Variation: If a practice is more than +1.5 standard deviations away from the mean in the desired direction, it is classified as a positive variation.
Level 1: A practice is classified as Level 1 if it falls between -1 and -1.5 standard deviations from the relevant mean.
Level 2: A practice is classified as Level 2 if it is greater than -1.5 standard deviations from the relevant mean.

Improvement Programmes

NHS
Kent and Medway

There are currently three improvement programmes, of varying intensity that are designed to provide tailored, hands-on support to practices most in need, helping them address challenges, share learning, and build sustainable improvements in patient care and organisational resilience:

Focused intensive Recovery (FIR) Support: Practice support provided by Delivery Partners (DPs) who are directly commissioned by NHSE.

Specialist Peer Ambassador Programme: Peer led by GPs and managers working in Kent and Medway, providing more intensive PAM support, looking at every aspect of how the practice works.

Peer Ambassador Programme: Peer led by GPs and managers working in Kent and Medway providing support with a focus on areas such as The Modern General Practice Access Model (MGPAM), signposting, workplace culture, clinical triage, adoption of digital tools etc.

- 11 Practices have been engaged with the Focussed Intensive Recovery Programme (FIR) 18 sessions
- 2 have been engaged with the Specialist Peer Ambassador Programme (12 sessions)
- 5 practices have been engaged with the Peer Ambassador programme (4-6 sessions)

Peer Ambassador (PAM) Programme Case Study: Court View Surgery, Rochester

NHS Kent and Medway

Court View Surgery: Transition to Total Triage Model Using Anima

- With support from PAM, the practice moved to a Total Triage model using the digital platform, Anima.
- All patient requests are assessed and prioritised remotely, improving appointment allocation and resource use.
- Enabled online appointment requests to ease patient access and reduce the 8am phone rush.

Results:

- Friends and Family Test → "Very Good" ratings increased from 69% (Mar 2025) to 80% (Jun 2025).

Patient Feedback Highlights:

- "Responded same day; seen and treated that evening."
- "Quick, convenient, and easy to use."
- "Fast appointment booking via the app."
- "Efficient and kind service from GP Nurse Practitioner."

Together, we can

Maximising the Impact of Community Pharmacies

NHS Kent and Medway

Programme Overview

- ICB's Pharmacy Integration Programme expands nationally commissioned community pharmacy clinical services.
- Supports the NHS Delivery Plan for Recovering Access to Primary Care (PCARP).

Performance (2024/25)

- 170,000 consultations across Kent & Medway
- 127% of target achieved

Medway Consultations: Services and Sign-Up

Service	Sign-up	May 2025
Pharmacy First	50 out of 51 (98%)	3406
BP Check Service	49 out of 51 (98%)	651
Oral Contraception Service	56 out of 51 (90%)	295

Key Initiatives & Next Steps

- Collaboration with Local Pharmaceutical Council (LPC) to improve access
- Embedding services into local treatment pathways
- Raising patient awareness through advertising, social media, and healthcare professional resources
- Digital referral rollout from GP practices to pharmacies for all clinical services (following Pharmacy First testing)
- Continuation of PCN engagement lead roles for 2 more years to strengthen GP-pharmacy collaboration
- **Aim: Ease patient access and reduce pressure on wider healthcare system.**

Community Pharmacy Kent

Neighbourhood Health Guidance 2025/26

NHS
Kent and Medway

1. Apply a **consistent system-wide population health management approach** which draws on quantitative data and qualitative insights to understand needs and risks for different population cohorts

2. Use this information to **design and deliver the most appropriate care for each population cohort** and to inform best-value commissioning decisions that empower frontline staff to provide more person-centred care

3. Continue to **embed, standardise and scale the core components of a neighbourhood health service** and ensure capacity and structures across providers are aligned to best meet demand

4. Improving coordination, personalisation and continuity of care for people with complex needs including:
   - a **single electronic health and care record** that is actively used in real-time by frontline health and social care staff
   - A **care co-ordination function** between the person or their carer and the wider MDT supporting them

5. Tackling health inequalities through:
   - Adjusting services to ensure **accessibility to people with disabilities**
   - **Engaging local communities** and working with them as equals to design and deliver services
   - **Analysing outcomes** by population demographics, deprivation, age, ethnicity and disability

Population health management
Using system-wide linked data to understand pop. need and stratify risk by complexity & future health/care resource use.

Modern general practice
Together with the broader primary care choices that improve patient access including use of the NHS App and Pharmacy First.

Community services universal offer
Describes the core components of NHS ICB funded community health services for adults and children and young people.

Integrated Neighbourhood Teams to support people with complex needs
Multi-agency teams jointly responsible for people with multiple complex needs, requiring coordinated access to a range of services – building on broader vision for integrated neighbourhood teams.

Urgent out of hospital services
Virtual wards and Urgent Community Response services accessed via a multidisciplinary single point of access for clinicians and professionals.

Together, we can

Neighbourhood Health Design Principles

NHS
Kent and Medway

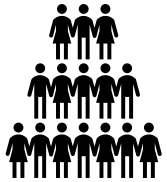
As a system, we have developed core principles to guide how we build Integrated Neighbourhood Teams (INTs), while recognising that each INT will look different, based on the population and the partners involved.

- More proactive, personalised and multi-disciplinary care
- Workforce as team of teams
- Data-led population health management approach
- Shared access to patient records
- Appropriate clinical governance
- Appropriate estates
- Strong leadership
- Fully engaged VCSEs
- Continuous improvement and robust approach to evaluation
- INTs have “ownership” of the wellness of their population

What impact will this way of working have?

NHS
Kent and Medway

Benefits for providers:



Improves joint working between professionals, with less duplication.

Creates resilience around GP practices to connect to a practitioner who can meet the patient need, rather than increasing referrals to other services.

Reduces Emergency Department attendance as emergency admissions are addressed before they escalate.

Reduces demand for GP appointments as continuity is provided by a multi-skilled team working together to manage needs, releasing capacity for GPs to focus on the most complex needs and prevention.

Supports building a culture of shared responsibility with staff feeling better supported making potentially difficult decisions about patients' care.

Improves staff wellbeing through development of a collaborative culture, with many staff feeling that working in an integrated team is both more effective and more enjoyable.

Addresses health inequalities by working collectively across health and care.

Together, we can

What impact will this way of working have?

NHS
Kent and Medway

Benefits for patients:

Improved patient experience through continuity and coordination of care, with greater choice about how care is accessed.

Improved outcomes, especially in the management of long-term conditions, and reduce inequalities in outcomes.

Streamlined access to care and advice in the community, reducing the requirement to travel to hospital for care.

Proactive, personalised and multi-disciplinary care for people with more complex needs.

Enables people to stay well for longer, through a joined-up approach to **prevention**

More independence in own home and fewer hospital admissions

Families and carers feel more supported

Together, we can

Patient Need Group (PNG) segmentation takes a multimorbidity approach to categorising patients

NHS Kent and Medway

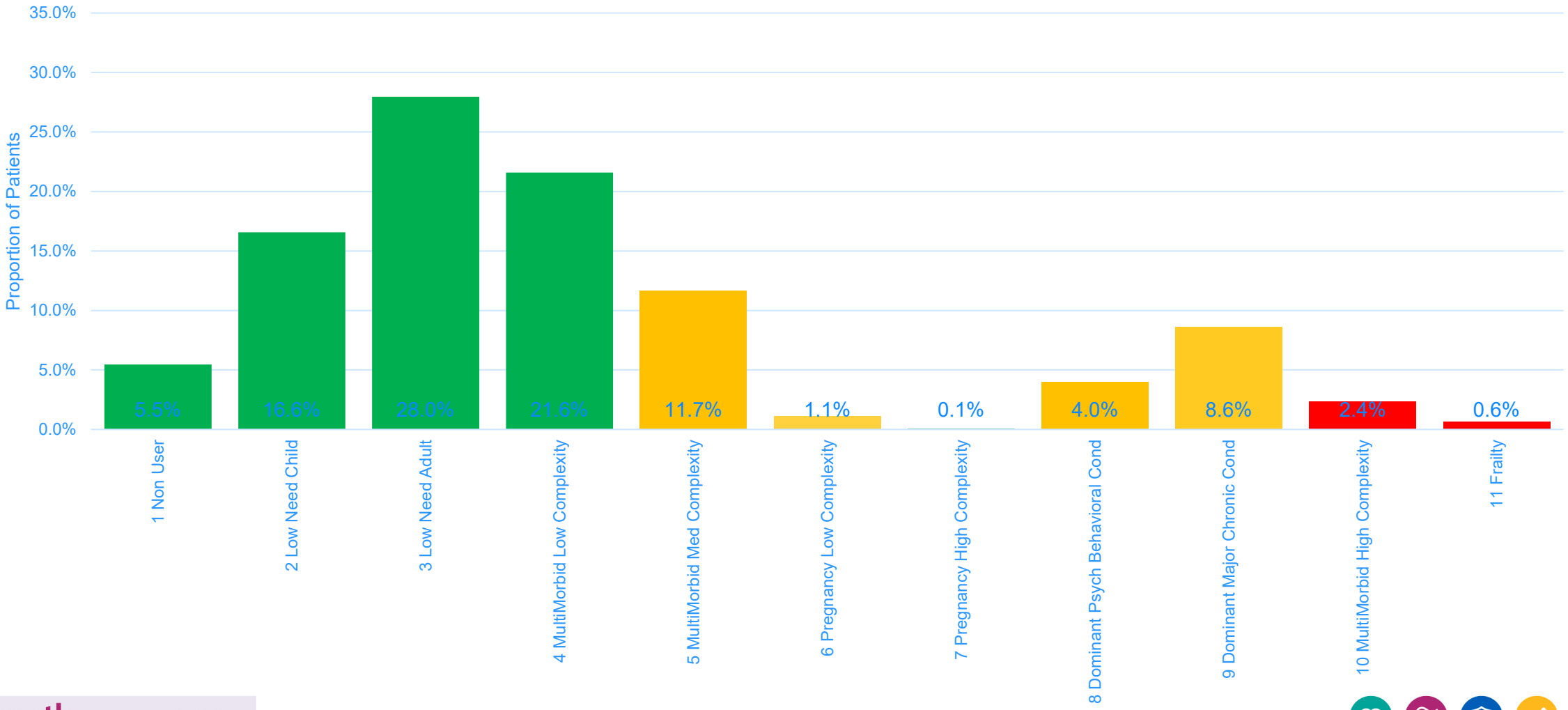
Increasing Health Need/Complexity

Description	RAG	PNG No.	PNG Category	PNG Description
High Complexity; Multi-Morbidity	Red	11	Frailty	*Adults aged ≥65 with evidence of ≥**2 frailty concepts** (e.g. difficulty walking, weight loss, cognitive impairment of incontinence)*
		10	Multi-Morbidity, High Complexity	*Multi-morbidity with **high complexity** (major and unstable chronic conditions).*
Dominant Chronic	Amber	09	Dominant Major Chronic Condition	***Somatic condition with high impact on health**, without treatment the condition is progressive and unstable over time (e.g. chronic liver disease; type 1 diabetes with complications).*
		08	Dominant Psychiatric/ Behavioural Condition	***Psychiatric condition with high impact on health**, without treatment the condition is progressive and unstable (e.g. bipolar disorder; personality disorders; major depression).*
Pregnancy		07	Pregnancy, High Complexity	*Pregnancy with or without delivery among women with **high morbidity burden.***
		06	Pregnancy, Low Complexity	*Pregnancy with or without delivery among women with **low morbidity burden.***
Moderate Needs		05	Multi-Morbidity, Medium Complexity	*Multi-morbidity with **moderate complexity** conditions.*
Healthy	Green	04	Multi-Morbidity, Low Complexity	*Multi-morbidity with **low complexity** conditions.*
		03	Low Need Adult	*Adults aged ≥18 with **acute morbidity** and no more than one low complexity condition.*
		02	Low Need Child	*Children aged 0 to 17 with **acute morbidity** and no more than one low complexity condition.*
		01	Non-User	*Individuals who have **no diagnosis.***

Together, we can

There are 1.88 million people in Kent & Medway: 72% PNG 1-4, 25% in PNG 5-9 and 3% in PNG 10-11

NHS Kent and Medway

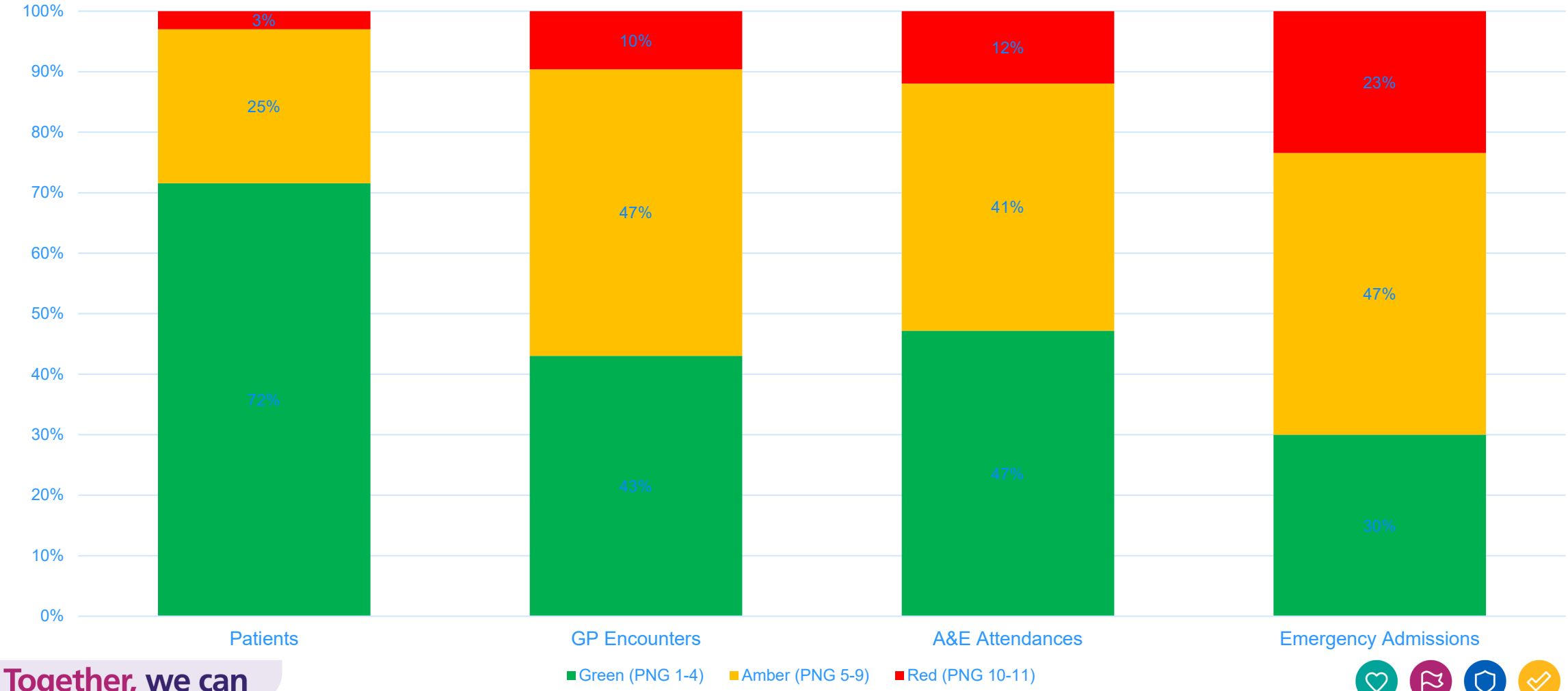


Together, we can

See appendix for PNG definitions. Note: There are 2,102 patients in Kent & Medway who have not been allocated a PNG due to opt-out/confidentiality

Across K&M, PNG 10-11 patients account for 3% of the pop. but almost a quarter of all emergency admissions

NHS Kent and Medway



Together, we can

Note: GP encounters defined as the number of entries recorded on a patient's record in the last 12 months (includes both clinical and administrative encounters).

NHS
Kent and Medway

South east Neighbourhood Health Accelerator Programme

Chatham Central Neighbourhood Health Model

- Medway was successful in bid for SE NH Accelerator Programme – a collaborative leadership programme to build teams and develop evidence-based models for NH.
- Supported by Chatham Central PCN the vision is to deliver NH model in the new James Williams Healthy Living Centre (JWHLC).
- Bid moves away from traditional frail and elderly models to support young adults (25-45 years) with multiple complex physical and mental health needs as well as wider determinants such as homelessness/temporary accommodation, substance misuse, unemployment.
- Through the JWHLC we are seeking to develop a co-ordinated wrap around care for complex and chaotic residents to reduce health inequalities as well as pressure on the system across health and social care.
- The model will likely build on existing practice such as MIST.
- Partners in the SE Programme include Social Care, Public Health, Primary Care, DWP and Substance Misuse Providers and first two days were completed in October with a focus on team building and engagement.
- The aim is to create a local steering group made up of wider partners including HCP, VCSEF, KMMH.