KENT AND MEDWAY NHS JOINT OVERVIEW AND SCRUTINY COMMITTEE

Wednesday, 2nd September, 2026

3.00 pm

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

KENT AND MEDWAY NHS JOINT OVERVIEW AND SCRUTINY COMMITTEE

Wednesday, 2nd September, 2026, at 3.00 pm
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Gaetano Romagnuolo**
Telephone: **03000 416624**

Membership

Kent County Council	Mr O Bradshaw, Mr B Fryer, Ms D Morton and Mr A Ricketts
Medway Council	Cllr S Campbell, Cllr D McDonald, Cllr S Shokar and Cllr D Wildey

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

Item

1. Introduction/Webcast Announcement

2. Election of Chair

3. Election of Vice-Chair

4. Apologies and Substitutes

5. Declarations of Interests by Members in Items on the Agenda for this Meeting

6. Minutes of the meeting held on 3 November 2023 (Pages 1 - 6)

7. Bedgebury Unit - Proposed Decommissioning (Pages 7 - 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)

Benjamin Watts
General Counsel
03000 416814

25 August 2026

KENT COUNTY COUNCIL

KENT AND MEDWAY NHS JOINT OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Kent and Medway NHS Joint Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 3 November 2023.

PRESENT: Mr P Bartlett (Vice-Chairman), Mr N J D Chard, Ms K Constantine, Ms S Hamilton, Cllr D Wildey, Cllr D McDonald (Chair) and Cllr S Campbell

IN ATTENDANCE: Mrs K Goldsmith (Research Officer - Overview and Scrutiny)

UNRESTRICTED ITEMS

60. Membership
(Item 1)

The Clerk drew the Committee's attention to the change in membership from Medway Council.

61. Election of Chair
(Item 3)

1. The Clerk explained that as per the Committee's Terms of Reference, the Kent and Medway NHS Joint Overview and Scrutiny Committee (JHOSC) needed to appoint a Chair at its first meeting in each municipal year.

2. Mr Bartlett proposed, and Cllr Wildey seconded, that Cllr McDonald be elected Chair of the Committee. There were no other nominations.

RESOLVED that Cllr McDonald be Chair of the Committee.

62. Election of Vice-Chair
(Item 4)

1. Mr Chard proposed, and Cllr McDonald seconded, that Mr Bartlett be elected Vice-Chair of the Committee. There were no other nominations.

RESOLVED that Mr Bartlett be Vice-Chair of the Committee.

63. Declaration of interests by Members in items on the Agenda for this meeting
(Item 5)

1. Mr Bartlett declared he was a representative of East Kent councils on the Integrated Care Partnership.

2. Mr Chard declared he was a Director of Engaging Kent.

64. Minutes from meeting held on 6 December 2022

(Item 6)

RESOLVED that the minutes from 6 December 2022 were correctly recorded and that they be signed by the Chair.

65. East Kent Transformation Programme

(Item 7)

In attendance for this item: Ben Stevens, Chief Strategy & Partnerships Officer, East Kent Hospitals University NHS Foundation Trust, Karen Sharp, Programme Director & Project Support, East Kent Health & Care Partnership

1. The Chair invited the representatives to provide an overview of the East Kent Transformation programme (EKTP). Mr Stevens explained that two options for acute care transformation had been shortlisted in 2017 and a capital bid of £460 million was submitted in 2021 under the second round of NHS England's New Hospitals Programme. In May 2023 the Trust were informed that they had not been successful in their funding bid. 128 expressions of interest had been received, and the successful bids had all been identified as carrying significant risk from Reinforced Autoclave Aerated Concrete (RAAC).

2. As there was no single source of additional capital funding the programme as described was unable to proceed. The Trust was working with partner organisations to explore further options.

3. Pockets of capital investment in the Trust had been made over the years for specific work, for example £30 million for expansion of emergency departments at the Queen Elizabeth the Queen Mother (QEQM) and William Harvey (WHH) Hospitals. Further details were set out in the report.

4. Mr Stevens explained that significant challenges remained around the state of the Trust's infrastructure and its medical devices. There was no current solution due to the amount of capital funding required.

5. The Trust's capital funding allocation over five years was around £130 million. That funding had already been committed to a list of schemes that had been deemed most critical. In late 2021, the Trust assessed that there was a £211 million gap between the funding available over the next five years (£130 million) and the total cost of the identified critical infrastructure work. That value was being reassessed due to the length of time passed, and it was expected to increase.

6. Mr Stevens noted that there was a national challenge with capital funding, and that EKHUFT were not the only Trust to have aged infrastructure.

7. The Trust were considering specific improvements that could be made, recognising that the maternity estate in particular had been mentioned in both CQC and the Kirkup reports. To replace the two existing maternity units would cost around £123 million.

8. Mr Stevens recognised that clinical pathways had changed significantly since EKTP was first designed. In addition to looking for capital funding, the Trust was working with the Health and Care Partnership (HCP) to identify wider opportunities available both in the NHS and social care estate to deliver pathways differently which might be away from a hospital setting.

9. Ms Sharp explained the role of the East Kent Health and Care Partnership (HCP). Their intention was to complement the work of East Kent Hospitals and look for wider opportunities to deliver clinical services, and she provided examples of work already undertaken or in development. This included how the NHS could work with district councils to ensure Section 106 funding was fully utilised.

10. Ms Sharp referred to the Kent and Medway Estates Strategy, which had allocated specific funding to the East Kent HCP to develop an East Kent Strategy which would cover not only the NHS estate footprint but partners too. The Strategy would complement the internal work East Kent Hospitals was undertaking.

11. Moving to questions, a Member asked how much it cost the Trust to put the New Hospitals Programme bid together, reflecting that multiplied by 128 bids that was a considerable amount of money wasted, especially considering the funding was allocated to RAAC projects which were already known about. Mr Stevens did not have the associated costs for the bid to hand.

12. Asked if the Trust estate met national standards (for example, square inches per bed), Mr Stevens explained that the Intensive Care Unit (ICU) at WHH was built to standard, but older parts of the estate would have been built to standards in place at the time of building. If a unit was refurbished or developed it would have to meet new standards, in the meantime mitigations would be in place.

13. In response to a question about a Major Trauma Centre in Kent, Mr Stevens confirmed East Kent Hospitals was part of a trauma network and that there were no plans to reorganise the network at that time.

14. Regarding the Hyper Acute Stroke Unit (HASU) that was due to be built at William Harvey Hospital, this was still the plan as it needed to be co-located with an ICU. For the time being a stroke unit continued to be hosted at Kent and Canterbury Hospital (but there was no ICU on that site).

15. Mr Stevens said waiting lists for elective care were rising nationally and higher than anyone wanted. There were around 90,000 patients on their active waiting list, varying by specialism. The Trust were focussed on monitoring patients and reprioritising where necessary, at the same time as looking for options to expand capacity and reduce waiting lists.

16. Speaking about recruitment and retention of staff, Mr Stevens acknowledged a key part of original proposals was to make delivery of services attractive for staff. A different lense was required now those proposals would not progress. A workforce plan was being developed, but he noted that turnover had reduced as staff stayed longer and international nurses had been successfully recruited which had

reduced the vacancy rate. The recruitment to specialist clinical roles remained challenging and the Trust were competing for a depleted pool of individuals.

17. Ms Sharp highlighted the benefits of working as system. Noting the high GP to population ratio along the Kent coast, the HCP were looking at ways of exploiting the benefits of living and working in East Kent. A “Ready to Care” campaign had been run which saw health and social care coming together to recruit individuals to entry level roles. They were also part of a national, intermediate care programme where the Community Trust and KCC jointly employed “Home First workers” who supported discharge from hospital by increasing the packages of care available to enable patients to return home. For stroke patients, an additional 15 stroke rehabilitation beds were being opened for the winter to support discharge from acute hospital.

18. Members asked to be sent data relating to GP ratios and the numbers of staff recruited under the campaigns, particularly GPs.

19. A Member questioned what plan had been in place in the event the funding bid was unsuccessful. Mr Stevens explained the Trust had been confident in their submission, recognising if they had been successful, it would still be many years before the programme completed. The Trust’s rolling capital programme allowed them to sustain the current estate, but not to refurbish. The Trust needed to reassess how it best spent the capital funding available, but they had a duty to ensure their quality of care was impacted as little as possible.

20. In answer to a question about being green, Mr Stevens said the Trust had green objectives such as reducing their carbon footprint but noted that the aged estate made that challenging sometimes. The Trust were looking at ways of being greener such as their use of disposable equipment.

21. The use of Artificial Intelligence was an emerging field in the NHS, and East Kent still had some way to go. Much of the opportunity that existed in East Kent hospitals for health care was around digital transformation and how that was used to manage administrative pathways and digital platforms to engage with patients.

22. The Chair spoke of the importance of ensuring healthcare services were adequately funded, and noted the role that HOSC and HASC could play in campaigning for that. He felt it unfair that the New Hospitals Programme had been used to pay for RAAC related work and that it perhaps should have come from a different funding pot.

23. The Chair questioned when a revised funding gap would be identified. Mr Stevens was clear that the Trust needed to look at their investment requirement over the coming decades, not just the short term. The figure would be shared once it was available, but it was greater than £211 million. He explained that whilst the Trust had not been successful in the first two rounds of the New Hospital Programme, that did not preclude them from bidding in any future rounds.

24. The Chair asked what the impact was on patient safety considering the funding decision. Mr Stevens said the risk was stratified and that a significant amount of

manpower was spent mitigating risks to patients. Services could be impacted at times when the Trust was unable to use specialist equipment such as diagnostic machines. Work was adapted to minimise that risk and capital finance was being prioritised to avoid withdrawing services. There were times when unforeseen events meant that prioritisation needed to be reconsidered, such as RAAC.

25. Asked what level of support the ICB provided, Mr Stevens provided assurance they worked alongside the Trust to secure the future of services but he noted that they were equally constrained with funding.

26. The Chair noted that HOSC and HASC both declared the East Kent Transformation Programme a substantial variation of service in 2018, based on the two proposals for reconfiguration at that time. The capital for those proposals was not available and therefore the programme that was declared substantial no longer stood. He proposed the item no longer came to the Kent and Medway Joint HOSC for scrutiny but returned to the home authorities until such time as new proposals were presented and a new decision around substantial variation made.

RESOLVED that joint scrutiny of the East Kent Transformation Programme cease in light of the lack of capital to proceed with the original proposals. The Programme would return to Medway and Kent health scrutiny committees for future scrutiny.

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Item 7: Bedgebury Unit: Proposed Decommissioning and Future Rehabilitation Pathway

By: Gaetano Romagnuolo, Research Officer - Overview and Scrutiny

To: Kent and Medway NHS Joint Overview and Scrutiny Committee, 2 September 2026

Subject: Bedgebury Unit: Proposed Decommissioning and Future Rehabilitation Pathway

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Summary: This report invites the Kent and Medway NHS Joint Overview and Scrutiny Committee to consider the information provided by the NHS Kent and Medway.

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1) Introduction

a) This report was prepared in response to requests from the Medway Health and Adult Social Care Overview and Scrutiny Committee (HASC) and the Kent Health Overview and Scrutiny Committee (HOSC), following each Committee's individual determination that the proposed decommissioning of Bedgebury Unit constituted a substantial variation of service.

b) The report responds to four recurring concerns raised through scrutiny:

i) whether the proposal is financially driven
ii) whether closure would affect acute mental health bed capacity
iii) whether it would increase adult social care demand; and
iv) whether sufficient assurance exists that current and future patients will be supported safely through alternative pathways.

2) Joint Scrutiny

a) Regulation 23 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 requires relevant NHS bodies and health service providers to consult a local authority about any proposal which they have under consideration for a substantial development or variation in the provision of health services in the local authority's area. This obligation requires notification and publication of the date on which it is proposed to make a decision as to whether to proceed with the proposal and the date by which Overview and Scrutiny may comment.

b) The Kent Health Overview and Scrutiny Committee (HOSC) considered the proposals relating to the Proposed Pathway Redesign and Decommissioning of Bedgebury Ward on 3 June 2026. They determined that the reconfiguration constituted a substantial variation in the provision of health services.

c) The Medway Health and Adult Social Care Overview and Scrutiny Committee (HASC) considered the item on 16 June 2026. The Committee also deemed the changes to be a substantial variation in the provision of health services in Medway.

d) In line with Regulation 30 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013[1], the Kent and Medway NHS Joint Overview and Scrutiny Committee (JHOSC) is meeting for the first time of this issue. The JHOSC may:

- make comments on the proposal;
- require the provision of information about the proposal;
- require the relevant NHS bodies and health service providers to attend before it to answer questions in connection with the consultation.

e) Under the Health and Care Act 2022, any interested party can request the Secretary of State to call-in a proposed substantial health service development or variation. There are no timing requirements for when call-in requests should be submitted - as long as a proposal for reconfiguration exists, a request may be made at any point during that process. However, local attempts to resolve the issue must have been exhausted before this happens.

f) The JHOSC has delegated powers from both HASC and HOSC to request the Secretary of State to call-in the proposal should it wish to.

4. Recommendation

RECOMMENDED:

1. Note the findings of the Bedgebury service review.
2. Note that Bedgebury comprises 10 ring-fenced forensic pre-discharge beds and is not part of the wider acute mental health inpatient bed base.
3. Note the significant reinvestment in community rehabilitation pathways, Assertive Outreach and step-down provision.
4. Note the evidence available regarding patient outcomes, crisis presentations and wider system impacts, including adult social care.
5. Consider whether the additional assurance requested through the substantial service variation process has been satisfactorily addressed.
6. Provide any recommendations for consideration by the ICB prior to any final commissioning decision.

[1] When NHS bodies and health services consult more than one local authority on a proposal which they have under consideration for a substantial development of or variation in the provision of health services in the local authorities' areas, those local authorities must appoint a Joint Overview and Scrutiny Committee (JHOSC) for the purposes of the consultation.

Item 7: Bedgebury Unit: Proposed Decommissioning and Future Rehabilitation Pathway

Background Documents

Kent County Council (2026) *'Health Overview and Scrutiny Committee (3/06/2026)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=9723&Ver=4

Medway Council (2026) 'Health and Adult Social Care Overview and Scrutiny Committee (16/06/2026), https://democracy.medway.gov.uk/ieListDocuments.aspx?CId=131&MId=6636&Ver=4

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NHS
Kent and Medway

Report to	Joint Health and Adult Social Care Committee (HASC) and Health Overview and Scrutiny Committee (HOSC)
Meeting date	2nd September 2026
Report title	Bedgebury Unit: Proposed Decommissioning and Future Rehabilitation Pathway
Key question	Members are asked to consider whether the additional assurance requested through the substantial service variation process has been satisfactorily provided, including assurance on the clinical rationale, patient impact, governance process, financial implications and future rehabilitation pathway.
Executive Lead	Ed Waller - Deputy Chief Executive and Chief Strategic Commissioning Officer – Kent and Medway ICB
Author	NHS Kent and Medway Integrated Care Board (ICB) Kent and Medway Mental Health Trust (KMMH)

Which of the organisation's strategic objectives does the report support:	
☒ Commission the right services each year	☒ To ensure financial sustainability over three years
☒ Lead strategy and ensure commissioning levers deliver impact	☒ Develop into a high-performing Commissioning Organisation
☒ Renew our culture for long-term sustainability	

Recommendation (outcome / action requested):

Meeting action required:

☒ Seek assurance ☐ Decision/approval required ☐ For noting/information

Recommendation(s) to the meeting:

The Joint HASC and HOSC are asked to note the findings of the Bedgebury service review; note that Bedgebury comprises 10 ring-fenced forensic pre-discharge beds within the Trevor Gibbens Unit estate and is not part of the wider acute mental health inpatient bed base; note the proposed reinvestment in community rehabilitation pathways, including Assertive Outreach and step-down provision; and consider the evidence provided in relation to patient outcomes, crisis presentations, adult social care impact and future pathway arrangements.
Members are asked to consider whether the additional assurance requested has been satisfactorily addressed and to provide any recommendations for consideration by the ICB before any final commissioning decision is made.

Executive summary:

This report has been prepared in response to requests from the Joint Health and Adult Social Care Committee (HASC) and Health Overview and Scrutiny Committee (HOSC), following their determination that the proposed decommissioning of Bedgebury Unit constitutes a substantial service variation. The ICB recognises Members' concern that scrutiny engagement could have occurred earlier and has prepared this paper to provide transparent assurance before any final commissioning decision is made.

In particular, the report responds to four recurring concerns raised through scrutiny: whether the proposal is financially driven; whether closure would affect acute mental health bed capacity; whether it would increase adult social care demand; and whether sufficient assurance exists that current and future patients will be supported safely through alternative pathways.

Bedgebury Unit is a 10-bed forensic pre-discharge rehabilitation service commissioned by NHS Kent and Medway Integrated Care Board (ICB) and provided by Kent and Medway Mental Health NHS Foundation Trust (KMMH). Established in 2016, the service was intended to support individuals transitioning from medium secure forensic services into community living.

It is important to clarify the scale and scope of Bedgebury. The unit comprises 10 commissioned beds within the Trevor Gibbens Unit forensic estate. It is a highly specialised, ring-fenced forensic pre-discharge arrangement for a defined cohort of Kent and Medway patients progressing from medium secure care. It is not part of the wider acute mental health inpatient bed base and is not a generally available rehabilitation pathway for the wider mental health inpatient population.

A comprehensive service and clinical review undertaken jointly by the ICB, KMMH and the Kent, Surrey and Sussex Secure Care Provider Collaborative concluded that the service is no longer aligned with:

- Its original service specification.
- Current NHS England rehabilitation commissioning guidance.
- Contemporary rehabilitation and recovery models.
- Current expectations regarding care in the least restrictive environment.

The review identified that Bedgebury:

- Does not operate as a recognised Level 1 or Level 2 rehabilitation service.
- Does not have a dedicated multidisciplinary rehabilitation team.
- Does not have a dedicated management structure.
- Is embedded within a medium secure environment that is more restrictive than would be expected under contemporary rehabilitation models.

The current model can also lengthen a patient's overall care pathway by introducing an additional inpatient step between medium secure care and discharge. This has the potential to extend time spent in restrictive inpatient settings, rather than supporting proportionate admission and progression to the least restrictive appropriate setting.

National discharge guidance for mental health inpatient settings is clear that discharge planning should start on admission or before and continue throughout the inpatient stay; the revised pathway is intended to bring discharge planning to the beginning of the patient journey, rather than delaying it until a later transfer to Bedgebury.

The proposal does not represent a reduction in mental health investment. Alongside the proposed decommissioning, the system has secured:

- £3.5 million investment in a countywide Assertive Outreach Team (AOT).
- £1 million investment to improve step-down capacity and patient flow.
- Ongoing Mental Health Investment Standard (MHIS) funding to strengthen rehabilitation and recovery pathways.

This proposal is not being driven by a requirement to make a financial saving. It is a clinical service redesign intended to provide a more appropriate, less restrictive, community-based model of care for people who would otherwise have required, or remained within, the inpatient unit.

There will be some reinvestment of funding currently associated with the unit into the new community model. However, transition is being deliberately phased so that existing patients are supported safely and appropriately. For a period, the ICB will fund both the existing inpatient provision and the new community model simultaneously.

This is therefore not a cost-reduction exercise. It represents a net investment in mental health services and a deliberate shift in how resource is used: from a small, bed-based forensic pre-discharge model towards a more intensive community-based model designed to support people closer to home.

The annual commissioned value aligned to Bedgebury is approximately £1.73 million, of which around £680,871 has been identified as potentially releasable. This is significantly lower than the full annual value of the unit and lower than the cost of the proposed future community model. The countywide Assertive Outreach Team is costed at approximately £3.5 million per annum, alongside approximately £1 million to improve step-down capacity and patient flow.

Following the clinically informed service review and clinical concerns raised, a clinically informed decision was made to pause new admissions to Bedgebury. Since admissions to Bedgebury were paused, there has been no identified increase in mental health crisis service presentations by patients discharged from the unit, and no evidence of additional adult social care demand attributable to the proposed service changes.

For these reasons, the proposal should be understood as service transformation and reinvestment, not as a reduction in acute mental health bed capacity or a transfer of cost and responsibility to adult social care.

The proposed change is not expected to create a new cohort of people requiring adult social care. Rather, it brings forward the need for housing, social care and community support planning earlier in the pathway, in line with national guidance that discharge planning should begin on, or before, admission.

Proposed next steps:

Subject to Members' consideration, the ICB will review any recommendations made by Joint HASC and HOSC before making any final commissioning decision. If the proposal is progressed, implementation will continue through a phased, clinically led transition plan. This will include individual patient-level planning, continued engagement with system partners, oversight through an implementation/decommissioning steering group, and monitoring of patient safety, continuity of care, crisis presentations, adult social care impact and delivery of the future rehabilitation pathway.

Governance pathway to date:		
Meeting name:	Date:	Outcome:
Service review completed	May 2025	Review identified that Bedgebury was no longer aligned with original specification, contemporary rehabilitation practice or current national guidance.
Strategic Commissioning Sub-Group	June 2025	Findings considered.
Workforce, finance and risk review	July 2025	Further information reviewed to inform commissioning options.
Strategic Commissioning Sub-Group	February 2026	Decommissioning recommended.
Executive Management Committee	March 2026	Proposal approved in principle, subject to appropriate scrutiny and assurance.
HASC scrutiny	March 2026	Members considered the proposal and requested further assurance.
HOSC scrutiny	June 2026	Members considered the proposal and requested further assurance.
Joint HASC/HOSC	September 2026	Members asked to consider whether the additional assurance requested has been satisfactorily provided.

Contact for further information	Louise Clack - Associate Director Mental Health, Learning Disabilities and Autism louise.clack@nhs.net

COMPLIANCE NOTES:
Equality, health inequalities and quality impact assessment
If this report is presented for decision/approval, please complete: Has an assessment been undertaken? ☒ Yes (please attach the action plan in Appendix E) ☐ No/Not applicable (please indicate why an assessment was not required)

COMPLIANCE NOTES:

Conflicts of interest

Are there any conflicts associated with authors or reporting officers?

☐ Yes ☒ No

If yes, please confirm how the conflict has been managed.

FOI status

Is this report disclosable under FOI?

☒ Yes ☐ No

If no, please specify why:

Financial implications

Are there financial implications associated with this report?

☒ Yes ☐ No

If yes, please describe:

Yes. The proposal has financial implications relating to the current commissioned value of Bedgebury, the proportion of expenditure that may be releasable, retained estate and infrastructure costs, and the additional investment required to deliver the future community rehabilitation model. The proposal is not presented as a cost-saving exercise. Further detail is provided in the main paper and Appendix A.

Legal implications

Are there legal implications associated with this report?

☒ Yes ☐ No

If yes, please describe:

Yes. The proposal has legal and governance implications relating to statutory duties for service change, including appropriate scrutiny, engagement, equality considerations and robust decision-making. The ICB must ensure that any final commissioning decision is informed by the scrutiny process, relevant impact assessments, patient and stakeholder considerations, and appropriate governance.

Quality and safety implications

Are there quality or safety implications associated with this report?

☒ Yes ☐ No

If yes, please describe:

COMPLIANCE NOTES:
Yes. Quality and safety implications relate both to the risks of maintaining a service model that no longer aligns with contemporary rehabilitation guidance, and to the need to ensure safe transition for current patients if decommissioning proceeds. The review concluded that Bedgebury does not operate as a recognised Level 1 or Level 2 rehabilitation service, does not have a dedicated multidisciplinary rehabilitation team, and is located within a more restrictive environment than would usually be expected for rehabilitation provision. Implementation would therefore need to be phased and clinically led, with individual multidisciplinary review, agreed alternative pathways, risk management arrangements and ongoing clinical oversight for each patient.

Patient and public engagement
Are there patient and public engagement implications associated with this report? ☒ Yes ☐ No *If yes, please describe. If no, please specify why:* Yes. Patient and public engagement implications relate to ensuring that patients, carers, scrutiny members, local authority partners and wider system stakeholders are appropriately informed and that feedback is considered before any final commissioning decision is made. The ICB recognises Members' concerns that earlier engagement would have been preferable and has reflected this learning in the main paper.

Bedgebury Unit: Proposed Decommissioning and Future Rehabilitation Pathway

1. INTRODUCTION

This report sets out the rationale, evidence and assurance relating to the proposed decommissioning of Bedgebury Unit and the development of a future rehabilitation pathway for Kent and Medway patients. Bedgebury is a small, specialist forensic pre-discharge provision within the Trevor Gibbens Unit estate and was originally commissioned to support people approaching discharge from medium secure care. Since the service was established, national policy, clinical practice and commissioning expectations for mental health rehabilitation have changed significantly, with a stronger emphasis on recovery-focused care, earlier discharge planning, community-based support and care delivered in the least restrictive appropriate setting.

Members have requested further assurance about the clinical rationale, patient impact, financial implications, governance arrangements and future service model. This report responds to those requests and provides a transparent account of the review findings, the decision-making process to date, the proposed reinvestment in community rehabilitation services and the safeguards that will apply to current and future patients.

2. PURPOSE OF THE REPORT

The purpose of this report is to:

1. Explain the rationale for the proposed decommissioning of Bedgebury Unit.
2. Summarise the findings of the service review.
3. Provide transparency regarding governance and decision-making.
4. Clarify the respective roles of the ICB and KMMH.
5. Describe the financial implications and reinvestment programme.
6. Assess impacts on patients, carers and wider system partners.
7. Outline implementation arrangements and governance oversight.
8. Provide assurance requested through the substantial service variation process.

The report also acknowledges that Members would have preferred earlier engagement. The ICB accepts that concern and has therefore set out the chronology transparently, including where the proposal moved from internal review and commissioning governance into formal scrutiny as a substantial service variation.

3. BACKGROUND AND CONTEXT

Bedgebury Unit is located within the Trevor Gibbens Unit forensic estate and comprises six female beds and four male beds. Although commonly referred to as a single rehabilitation unit, the service operates as beds embedded within existing medium secure wards rather than as a dedicated stand-alone rehabilitation service.

This creates an anomaly within the rehabilitation pathway. Bedgebury is not a commissioned pathway available across the wider mental health system; rather, it is a specific arrangement linked to Kent and Medway patients on Walmer and Emmetts medium secure wards. Its proposed decommissioning therefore does not remove beds from the acute mental health inpatient estate and does not change the number of general adult acute mental health beds available across Kent and Medway.

The original 2016 service specification described Bedgebury as a forensic pre-discharge rehabilitation service intended to support individuals approaching discharge from medium secure care through structured rehabilitation interventions, recovery planning and preparation for community living.

Expected lengths of stay were:

Patient Group	Expected Length of Stay
Male Patients	12 months
Female Patients	18 months

The service specification anticipated access to multidisciplinary support, individual care planning and rehabilitation-focused interventions.

Since the service was commissioned, rehabilitation practice and commissioning guidance have evolved significantly.

4.0 Evolution of National Guidance Since 2016

When Bedgebury was commissioned in 2016, rehabilitation was frequently delivered through inpatient step-down units designed to bridge the transition between secure care and community living.

Since that time, there have been significant developments in national policy, rehabilitation practice and commissioning guidance.

NHS England's 2024 Guidance for Commissioners of Adult Mental Health Rehabilitation Inpatient Services places greater emphasis on:

- Recovery-focused rehabilitation.
- Care delivered in the least restrictive environment.

- Dedicated multidisciplinary rehabilitation teams.
- Community integration and social inclusion.
- Early discharge planning.
- Strong links with housing, employment and social care.
- Timely progression through rehabilitation pathways.
- Minimising unnecessary lengths of stay.

The guidance views rehabilitation as part of a wider integrated pathway and expects rehabilitation services to:

- Operate within clearly defined pathways.
- Deliver active rehabilitation and recovery interventions.
- Support progression through services into community settings.
- Work closely with housing, social care and community services.
- Promote independence and social inclusion.

The fundamental shift in national policy is away from prolonged inpatient rehabilitation and towards rehabilitation delivered within community settings supported by specialist multidisciplinary outreach services.

The Department of Health and Social Care and NHS England guidance on discharge from mental health inpatient settings is clear that discharge planning should begin on, or before, admission and continue throughout a person's inpatient stay. This reinforces the need for pathways in which admission is purposeful and proportionate, discharge planning is embedded from the outset, and people are supported to leave hospital safely and promptly once they are clinically ready.

The review concluded that Bedgebury's design, location and operating model no longer align with this direction of travel.

5.0 Key Assurance Points for Members

- **Scale and scope:** Bedgebury comprises 10 ring-fenced forensic pre-discharge beds and is not part of the acute mental health inpatient bed base.
- **Clinical rationale:** The review concluded that the current model no longer aligns with the original specification, contemporary rehabilitation practice or current national guidance.
- **Financial position:** The proposal is not a cost-saving exercise. The future model requires additional recurrent investment, including funding through the Mental Health Investment Standard and the Kent, Surrey and Sussex Secure Care Provider Collaborative.
- **Adult social care impact:** No evidence has been identified that the pause in admissions has created additional adult social care demand. Patients would have

required community planning and accommodation support as part of ordinary discharge progression irrespective of Bedgebury's future.

- **Implementation safeguards:** Current patients will only move when clinically appropriate alternatives are identified and agreed through multidisciplinary planning.
- **Scrutiny and engagement:** The ICB recognises Members' concerns about earlier consultation and is seeking to address this through transparent reporting, formal scrutiny and continued engagement before any final commissioning decision.

6.0 Findings of the Service Review

6.1 Overall Findings

The review concluded that Bedgebury:

- Is not operating in accordance with its original service specification.
- Does not sit within a clearly defined contemporary rehabilitation pathway.
- Does not meet current NHS England expectations for rehabilitation services.
- Operates within an environment that is more restrictive than would ordinarily be expected for rehabilitation provision.

The review therefore recommended that the ICB consider decommissioning the service and reinvesting resources into pathways more consistent with current guidance.

6.2 Patient Cohort

At the time of the review:

Indicator	Position
Commissioned Beds	10
Occupied Beds	5
Average Male Length of Stay	23 months
Average Female Length of Stay	30 months
Average Length of Stay for Discharged Patients Since 2020	Approximately 50 months

These lengths of stay substantially exceed those anticipated within the original service specification.

The review also identified significant delays in progression and discharge planning for some patients, often linked to accommodation and community support arrangements.

In this context, Bedgebury may unintentionally prolong the inpatient pathway by adding a further pre-discharge stage after medium secure care. This risks shifting key arrangements for housing, social care and community support to a later point in the pathway, rather than embedding discharge planning from the outset. This does not align with the principle that

inpatient admission should be purposeful, proportionate and focused on supporting people to move to the least restrictive appropriate setting as soon as they are clinically ready.

7.0 Governance and Decision-Making Process

Following the review process a clinically informed decision was taken to pause admissions to Bedgebury because the review demonstrated that the current clinical model was not working as intended.

The ICB's role has been to:

- Undertake a commissioning review.
- Assess whether the service continues to meet population need.
- Consider future commissioning intentions.
- Ensure appropriate governance and assurance processes.

The proposal has subsequently progressed through established governance arrangements. The ICB acknowledges that scrutiny members have expressed concern that committees were not engaged earlier in the process. The chronology below is intended to provide transparency about the sequence of internal review, commissioning governance and subsequent scrutiny. The ICB recognises the importance of maintaining confidence in future changes and will ensure learning from this process informs earlier engagement planning where service changes may be considered substantial.

The ICB has reflected on the process and recognises that earlier engagement with scrutiny colleagues would have helped build confidence, support shared understanding of the specific nature of the Bedgebury pathway, and reduce the risk that the proposal was perceived as a financial or capacity-driven decision. Learning from this process will be applied to future service change proposals, including earlier identification of potential substantial service variation issues, earlier discussion with local authority scrutiny leads where appropriate, and clearer early communication about the scale, scope, rationale and expected impact of proposed changes.

Date	Governance Activity
May 2025	Service review completed
June 2025	Strategic Commissioning Sub-Group considered findings
July 2025	Workforce, finance and risk information reviewed
February 2026	Strategic Commissioning Sub-Group recommended decommissioning
March 2026	Executive Management Committee approved proposal in principle

March 2026	HASC scrutiny
June 2026	HOSC scrutiny
Current	Joint HASC/HOSC scrutiny process

8.0 Collaborative Working with KMMH and System Partners

The review was undertaken collaboratively by clinicians, operational service leads and commissioners from:

- NHS Kent and Medway ICB
- Kent and Medway Mental Health NHS Foundation Trust (KMMH)
- Kent, Surrey and Sussex Forensic Provider Collaborative

Clinical input was embedded throughout the review process. KMMH contributed clinical evidence regarding the needs and characteristics of the current patient cohort, alongside operational information on service delivery, workforce and staffing, discharge planning and patient progression. KMMH clinicians and service leads also contributed to the options appraisal and to the redesign of the future pathway.

KMMH has continued to support the work through:

- ongoing clinical review of current patients
- development of individual discharge and transition plans
- workforce planning
- design of future clinical pathways
- governance discussions relating to implementation

The review also benefited from senior clinical oversight. This included input and oversight from the Chief Nursing Officers of both NHS Kent and Medway ICB and KMMH, together with Dr Mike Kingham, Clinical Director of the Kent, Surrey and Sussex Forensic Provider Collaborative.

This ensured that the review was informed by appropriate clinical expertise, alongside operational, commissioning and system considerations, and that the proposed future model has been considered in the context of patient need, clinical safety, quality of care and appropriate progression through the pathway.

9.0 Substantial Service Variation and Scrutiny Process

Both HASC and HOSC determined that the proposed decommissioning of Bedgebury Unit constituted a substantial service variation requiring formal scrutiny.

Members requested additional assurance regarding:

- Clinical rationale.
- Patient impact.
- Financial implications.
- Future service arrangements.
- Governance arrangements.
- Stakeholder engagement.

The purpose of this report is to address those concerns and support informed consideration of the proposal.

The annual commissioned value of Bedgebury Unit is approximately £1.73 million.

Financial analysis identified approximately £680,871 of potentially releasable expenditure. However, not all costs can be removed due to continuing estate, infrastructure and secure-site overheads associated with the Trevor Gibbens Unit.

The proposal should therefore not be viewed as a cost-saving exercise.

This distinction is important for Members because the potentially releasable expenditure is substantially lower than the full annual value associated with the unit, and the proposed replacement community model costs more than the funding released through decommissioning. The ICB is therefore committing additional recurrent investment rather than withdrawing resource from mental health services.

Alongside the proposed decommissioning, the system has secured substantial investment in alternative rehabilitation and recovery services.

The future model includes implementation of a countywide Assertive Outreach Team (AOT), additional step-down capacity and continued investment through the Mental Health Investment Standard.

The countywide Assertive Outreach Team is costed at approximately £3.5 million per annum and will provide multidisciplinary support including:

- Consultant psychiatrists.
- Clinical psychologists.
- Occupational therapists.
- Social workers.
- Mental health nurses.
- Case managers.
- Community service navigators.
- Pharmacy support.

- Administrative support.

In addition, the system has secured approximately £1 million to improve 10 step-down capacity and patient flow across the mental health pathway.

Collectively these investments are intended to create a more comprehensive community pathway than currently exists and support individuals in community settings consistent with NHS England guidance.

The ICB's position is that the proposal represents service transformation and reinvestment rather than disinvestment from mental health services.

11.0 Impact Assessment

11.1 Impact on Patients

The review recognised that patients currently residing within Bedgebury have differing levels of clinical need and require differing levels of rehabilitation support.

All current patients have undergone multidisciplinary review and individual discharge planning.

The review identified that, with the exception of one patient who requires ongoing secure care, the remaining patients require one or more of the following forms of support:

- Ongoing secure care.
- Supported accommodation.
- Community rehabilitation support.
- Assertive Outreach Service (AOT)
- Specialist forensic outreach community services.

Patients will only move when appropriate alternative pathways have been identified and agreed by the multidisciplinary team.

11.2 Impact on Mental Health Crisis Services

Information provided by KMMH indicates that none of the patients discharged from Bedgebury have subsequently presented to mental health crisis services.

11.3 Impact on Adult Social Care

The review identified that delays in discharge were often associated with housing and community care packages. Importantly, Bedgebury was only ever intended as a transitional rehabilitation service. All patients would ordinarily have progressed into supported community living at some point, with housing, social care and community support considered as part of normal discharge planning.

The proposed change is therefore not expected to create a new cohort of people requiring adult social care. Rather, it brings forward the need for joint discharge planning earlier in the

pathway, in line with national guidance that discharge planning should start on admission or before and continue throughout the inpatient stay.

The future pathway has been designed to strengthen links with social care, housing and community services through Assertive Outreach and rehabilitation support.

12.0 Future Rehabilitation Pathway

The proposed future model reflects changes in national rehabilitation guidance and the wider move towards community-based rehabilitation and recovery services.

The intention is not simply to remove Bedgebury from the pathway but to redesign the pathway around earlier intervention, multidisciplinary support and community integration.

12.1 Current Pathway

The current pathway operates as a linear inpatient step-down model, with individuals moving from medium secure care to Bedgebury before progressing towards accommodation, community discharge and routine community mental health support. The service review found that this arrangement can delay discharge planning and extend time spent in restrictive inpatient settings. A detailed pathway description is provided at Appendix B.

12.2 Proposed Future Pathway

The proposed future pathway is intended to embed discharge planning earlier, strengthen links with housing and social care, and support people through community-based rehabilitation, Assertive Outreach, forensic outreach liaison and step-down provision where clinically required. This model is designed to reduce reliance on restrictive inpatient environments and support recovery in the least restrictive appropriate setting. A detailed pathway description is provided at Appendix B.

13.0 Patient Transition and Decommissioning Plan

The ICB will manage transition and decommissioning through a phased, clinically led process designed to protect patient safety, maintain continuity of care and ensure that no closure takes place until appropriate alternative pathways are confirmed. Further detail on the proposed transition phases, placement planning, discharge arrangements and ongoing monitoring is provided at Appendix C.

14.0 Governance Following Decommissioning

The ICB proposes establishing a Decommissioning Steering Group comprising:

- NHS Kent and Medway ICB.
- Kent and Medway Mental Health NHS Foundation Trust.
- Kent, Surrey and Sussex Secure Care Provider Collaborative.
- Local authority partners.

- Clinical representatives.
- Quality and programme leads.

The Steering Group will oversee:

- Patient safety.
- Risk management.
- Workforce arrangements.
- Financial reinvestment.
- Delivery of replacement services.
- Benefits realisation.

Success will be measured through:

- Safe transition of all existing patients.
- Mobilisation of the Assertive Outreach Team.
- Improved patient flow.
- Reduced reliance on restrictive inpatient settings.
- Delivery of reinvestment plans.
- Improved access to community rehabilitation support.

15.0 Conclusion

The evidence presented through the service review demonstrates that Bedgebury Unit no longer operates in a manner consistent with its original purpose, contemporary rehabilitation models or current NHS England guidance.

The proposal seeks to replace an inpatient pre-discharge model with a strengthened community rehabilitation pathway supported by substantial additional investment, multidisciplinary support and improved integration across health, housing and social care.

The proposal should therefore be viewed as a service transformation and reinvestment programme designed to modernise forensic rehabilitation pathways, improve patient outcomes and ensure services align with contemporary standards of care.

It would also support a more proportionate inpatient pathway by removing an additional inpatient step that can lengthen overall stay. The future model is designed to ensure discharge planning begins at admission, or before where possible, with housing, social care and community support considered from the outset rather than deferred to a later stage in the pathway.

The ICB considers that the information contained within this report, together with the supporting appendices, provides the additional assurance requested by HASC and HOSC regarding the clinical rationale, governance process, financial implications, patient impact and future service arrangements associated with the proposal.

4. RECOMMENDATIONS

Members are asked to:

1. Note the findings of the Bedgebury service review.
2. Note that Bedgebury comprises 10 ring-fenced forensic pre-discharge beds and is not part of the wider acute mental health inpatient bed base.
3. Note the significant reinvestment in community rehabilitation pathways, Assertive Outreach and step-down provision.
4. Note the evidence available regarding patient outcomes, crisis presentations and wider system impacts, including adult social care.
5. Consider whether the additional assurance requested through the substantial service variation process has been satisfactorily addressed.
6. Provide any recommendations for consideration by the ICB prior to any final commissioning decision.

Appendices:

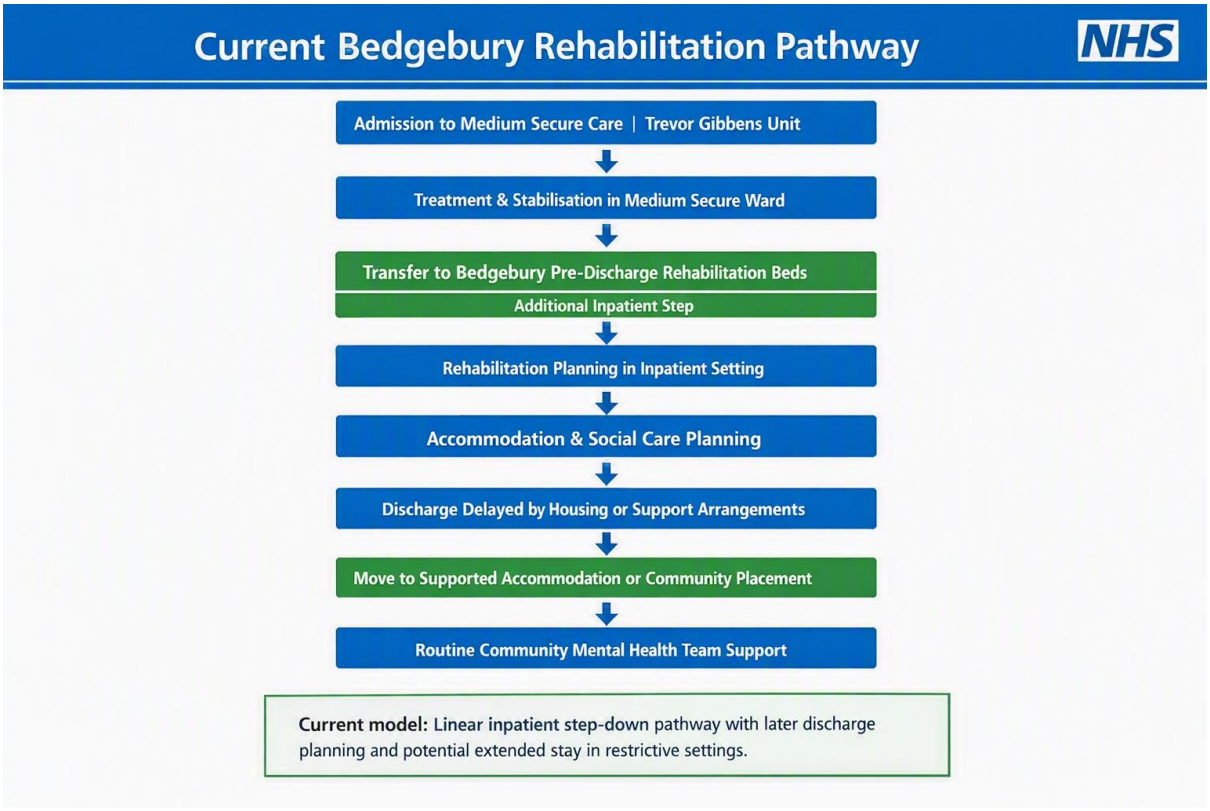
- Appendix A – Financial Breakdown and Reinvestment Programme
- Appendix B – Current and Proposed Rehabilitation Pathways
- Appendix C – Patient Transition and Decommissioning Plan
- Appendix D – Key Questions Raised by HASC and HOSC and Responses
- Appendix E - Equality, health inequalities and quality impact assessment

Appendix A: Financial Breakdown and Reinvestment Programme

Finance Area	Summary Position	Value
Total cost aligned to Bedgebury	Total annual cost currently aligned to Bedgebury, including direct costs, indirect costs, facilities and overheads.	£1,733,048
Potential cash-releasing expenditure	Costs identified as potentially releasable through Bedgebury closure, mainly direct staffing and some facilities costs.	£680,871
Non-cash-releasing or retained costs	Costs that may remain within the wider TGU estate or be reapportioned to other services, including shared staffing, indirect costs, site costs and overheads.	£1,052,177
Assertive Outreach Team annual cost	Full annual cost of the proposed countywide AOT model, including staffing, other operating costs, indirect costs and corporate overheads.	£3,526,584

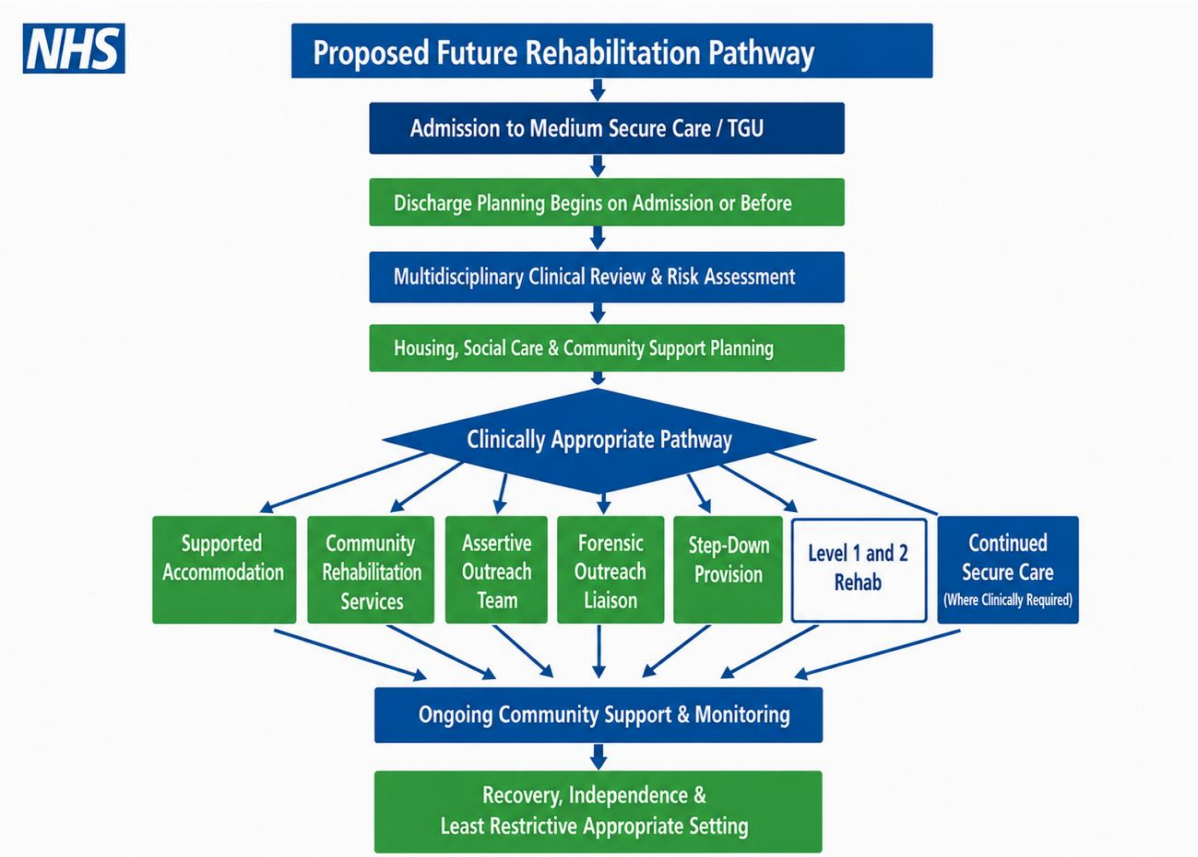
Appendix B: Current and Proposed Rehabilitation Pathways

B.1 Current Pathway



To Note: *The majority of patients did not transition through Bedgebury Ward as part of their discharge pathway. Most patients were and are discharge to a suitable discharge destination straight from the TGU medium secure wards.*

B.2 Proposed Future Pathway



Future model: earlier planning, community rehabilitation and least restrictive care.

Appendix C: Patient Transition and Decommissioning Plan

C.1 Phase 1 – Individual Clinical Review

- Comprehensive multidisciplinary assessment.
- Review of legal status and risk profile.
- Review of accommodation requirements.
- Review of forensic and rehabilitation needs.
- Confirmation of the most appropriate future pathway.

C.2 Phase 2 – Identification of Future Placements

- Supported accommodation.
- Community rehabilitation services.
- Assertive Outreach Team support.
- Forensic Outreach Liaison Services.
- Alternative specialist pathways.
- Continued secure care where clinically required.

C.3 Phase 3 – Transition Planning

- Named clinical lead.
- Named commissioner oversight.
- Agreed discharge plan.
- Risk management arrangements.
- Multi-agency contingency plans.

C.4 Phase 4 – Final Patient Discharges

The review recommended that closure should not occur until all patients have safely transferred to appropriate alternative pathways. Patients whose needs cannot safely be met through community services will continue to receive support through specialist forensic or secure services.

C.5 Ongoing Monitoring

- Patient outcomes.
- Crisis service presentations.
- Community service demand.
- Adult social care demand.
- Rehabilitation outcomes.
- Patient flow through forensic pathways.

Appendix D: Key Questions Raised by HASC and HOSC and Responses

D.1 Purpose

This appendix provides responses to the principal questions and concerns raised by Members during consideration of the proposed decommissioning of Bedgebury Unit. It is intended to provide additional assurance regarding the rationale for the proposal, governance arrangements, patient impact, financial implications and future service provision.

Question Raised by Members	Response
Why is Bedgebury Unit being proposed for decommissioning?	The service review concluded that Bedgebury is no longer operating in accordance with its original service specification and does not align with current NHS England rehabilitation guidance. The service does not function as a recognised Level 1 or Level 2 rehabilitation service, lacks a dedicated multidisciplinary rehabilitation team and is located within a medium secure environment that is more restrictive than would ordinarily be expected for rehabilitation provision.
Is the proposal driven by financial savings?	No. The proposal is based on clinical, operational and strategic considerations identified through the service review. Although approximately £680,871 of potentially releasable expenditure was identified, the proposed future model requires additional recurrent investment and costs more than the funding released through closure. The proposal should therefore be viewed as service transformation and reinvestment rather than a cost-saving exercise.
Will this reduce acute mental health bed capacity?	No. Bedgebury comprises 10 ring-fenced forensic pre-discharge beds within the Trevor Gibbens Unit forensic estate. It is not part of the wider acute mental health inpatient bed base and is not a generally available rehabilitation pathway for the broader mental health inpatient population.
Why were scrutiny committees not engaged earlier?	The ICB recognises Members' concern that earlier engagement would have been preferable. The proposal initially progressed through review and commissioning governance as the ICB assessed whether the service continued to meet need and whether the model remained clinically appropriate. Once HASC and HOSC determined that the proposal constituted a substantial service variation, the

	ICB entered the formal scrutiny process and has prepared this report to provide further assurance. The ICB has reflected on the process and will apply the learning to future service change proposals, including earlier assessment of potential scrutiny implications, earlier engagement with scrutiny leads where appropriate, and clearer early communication about scale, scope, rationale and expected impact.
Has the proposal increased demand on adult social care?	The review found no evidence that cessation of admissions has directly increased adult social care demand. Bedgebury was always intended as a transitional rehabilitation service, meaning patients would ordinarily have progressed into community settings at some point. The future model is intended to bring housing, social care and community support planning earlier in the pathway, rather than create a new or additional cohort requiring adult social care.
What services will replace Bedgebury?	The future model includes a countywide Assertive Outreach Team, enhanced forensic outreach support, community rehabilitation services, Level 1 and 2 inpatient rehabilitation, stepdown beds and supported accommodation. These services are intended to provide a more integrated rehabilitation pathway than currently exists and support recovery in the least restrictive appropriate setting.
What assurance can be provided that current patients will be safe?	All current patients have undergone multidisciplinary review and have individual discharge and transition plans in place. Patients will only move when appropriate alternative arrangements have been identified and agreed by clinical teams. No patient will be discharged without suitable support being in place.

D.2 Key Assurance Message

The proposed decommissioning of Bedgebury Unit is based on the findings of a comprehensive, clinically informed service review involving commissioners, clinicians and operational leaders from NHS Kent and Medway ICB, Kent and Medway Mental Health NHS Foundation Trust and the Kent, Surrey and Sussex Forensic Provider Collaborative.

The review concluded that the current Bedgebury model no longer aligns with its original service specification, contemporary rehabilitation practice or relevant NHS England guidance. These conclusions were informed by clinical evidence relating to the current

patient cohort, patient progression and discharge needs, alongside operational and workforce considerations.

The proposal is supported by significant reinvestment in community-based rehabilitation services, detailed individual patient transition planning and ongoing clinical and operational governance arrangements intended to maintain patient safety, continuity of care and appropriate progression through the rehabilitation pathway.

Members are therefore asked to consider whether the additional assurance requested through the substantial service variation process has been satisfactorily provided, including assurance that the proposed change has been subject to appropriate clinical scrutiny and that implementation will continue to be clinically overseen.

NHS
Kent and Medway

Impact Assessment Information

This is Version 3.0 of this tool - current as of 14/07/2025

EHQIA	This tool has been developed for use across all Kent and Medway NHS organisations If you have any feedback, experience any problems or require advice on completion, please contact: kmicb.kmehqia@nhs.net Where there is a red marker please hover over with mouse for instructions to guide completion of the QIA tool The Project Lead should review the EHQIA monthly during the development phase in order to identify any potential equality, health inequality and quality impacts not previously considered. If there are any changes required to the EHQIA please update the EHQIA tool - identifying that the update is V2 (or subsequent version if indicated) - make any changes in red but keep original details in place. **Authors - Please ensure you scroll down on the EHQIA summary tab to complete the EHQIA summary boxes and ensure you complete at least both the QIA Stage 1 and EHIA Screening tool**
Virtual Tab (Panel Members Only)	EACH ORGANISATION WILL DETERMINE WHICH BUSINESS DECISIONS ARE REVIEWED VIRTUALLY. The virtual review tab is highlighted 'yellow'. Here are the instructions on how to complete it. 1. Review the EHQIA summary, stage one and two and EIA as normal. 2. Instead of providing verbal feedback complete the free text and drop down boxes against your name on Virtual tab. 3. The virtual tab should be completed in order. This is the process that will need your patience and feedback. If it works well there should be one email trail. a. X to review, complete virtual tab and email it to XX b. XX to review, complete virtual tab and email it to XXX c. XXX to review, complete virtual tab and email it to XXXX d. XXXX to review, complete virtual tab and email it to committee chair (X) i. Please only email it to person beneath your name (or chair). Always copy in to your completed review the kmicb.kmehqia@nhs.net This way we can monitor that it is completed in order and if one review in the chain is absent the EHQIA chair can make alternative arrangements. 4. Timescale for review a. As the last person to complete, XXXX should email it to the chair (X) by COB on the DAY BEFORE THE PANEL. This is the time the face to face panel should finish. Therefore, all members of the chain should complete it as soon as possible.
Organisation internal EHQIA panels	If assessment identifies potential system wide impact it should be escalated to the K&M EHQIA Panel for further review. **To do this please send completed tool to kmicb.kmehqia@nhs.net and advise your SRO.**

Kent and Medway

Authors - Please ensure you scroll down on the EHQIA summary tab to complete the EHQIA summary boxes and ensure you complete at least both the QIA Stage 1 and EHIA Screening tool tabs

Equality, Health Inequalities and Quality Impact Assessment

Summary

	Organisation (Free Text)					
	Type of EHQIA (to be completed by Panel Chair)					
	Project, policy, function or service Title:	Decommissioning the Bedgebury Unit		URN Number (if appropriate):		Version Number: 1
	Project, policy, function or service Lead Name:	Louise Clack		Has your Division / Committee / Team has generic email		
	Project, policy, function or service Lead Job Title:	Deputy Director Adult Mental Health				
	Project, policy, function or service Division					
	Project, policy, function or service Lead Contact Details	Phone		BLANK		
		Email	CLACK, Louise (NHS KENT AND MEDWAY ICB - 91Q) <louise.clack@nhs.net>			
	Project, policy, function or service clinical lead	Name				
	Project, policy, function or service Manager (if applicable):	Name		Email		
	Project, policy, function or service Sponsor/SRO:	Name		Email		
	Who has been consulted to support and inform completion of this EQIA - i.e. Clinical Lead, relevant commissioning lead, provider, stakeholder, patient experience leads	The Clinical lead for the ICB Mental Health Commissioning Team, The Chief Nursing Officer Nhs Kent and Medway, NHS Kent and Medway Pateint saftey and Quality Team. NHS Kent and Medway Director of Strategic Change and Population Health				
	Recommendation (in chronological order (first to last))	Date of Recommendation	BLANK			
V	Virtual panel recommendation (to be completed by panel):					
1	EHQIA panel recommendation (*to be completed by Panel*):					
2	EHQIA panel recommendation (*to be completed by Panel*):					
3	EHQIA panel recommendation (*to be completed by Panel*):					
4	EHQIA panel recommendation (*to be completed by Panel*):					
5	EHQIA panel recommendation (*to be completed by Panel*):					

Please complete the Review Sheet

EHQIA Panel Comments (***to be completed by EHQIA Panel***)

V	
1	
2	
3	
4	
5	

Project, policy, function or service Overview, purpose and or objectives

Current Service

Bedgebury Ward is provided by Kent and Medway Mental Health NHS Trust (KMMH Trust) and was originally commissioned as a step-down rehabilitation service for individuals discharged from forensic inpatient services. Over time, the service has drifted away from its original commissioned model.

The commissioning review undertaken in May 2025 identified that both the original commissioning intention and the service's current function are no longer aligned with current best practice or the NHS England Inpatient Rehabilitation Commissioning Framework. The review also concluded that the service does not align with current Integrated Care Board–commissioned care pathways.the review confirmed that there is already existing provision within the system that is more suitable and appropriate to meet the needs of individuals as part of discharge planning from forensic inpatient services.
As a result, the review concluded that Bedgebury Ward is no longer required within the current commissioning landscape and recommended that the service be considered for decommissioning

Planned Changes

To de-commission Bedgebury Ward to ensure that patietns access thealready avilable appropriate indivudalised care pathways to meet their needs in line with NICE Guidance and best practice.

Future Services

There are already well established appropriate care pathways in place to meet the needs of patients being discharged from Medium Secure Services. However NHS Kent and Medway will be further strengthening those with the introduction of an Assertive Outreach Service .

National, local policy/strategy

The NHS 10-Year Health Plan and 2025/26 operational guidance are driving a significant shift from hospital-based care to community-based care, aiming to move care closer to home. The patients will be found arrpaotitre care packages and pathways in the community .

Who is intended to benefit and in what way?

Patinets currently admitted on Walmer and Emmett's ward as they will now be offered the same NICE guidance and best practice, community care pathways inline with the principle of least restrictive environment

What is the intended outcome

All Medium secure patients are offered the same appropriate community care pathways wherever they are admitted .

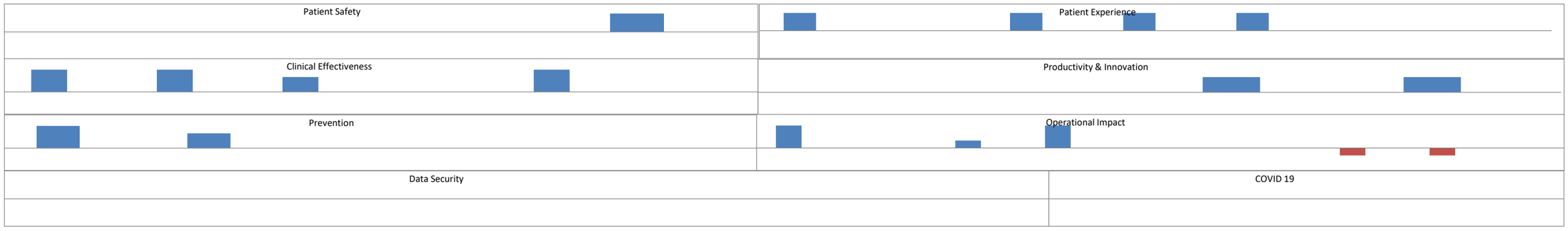
What factors may contribute to the outcomes of this policy, function or service? Identifying these will help you to design any public-facing communications to support your initiatives

What factors may detract from the outcomes of this policy, function or service? Identifying these will help you to design any public-facing communications to support your initiatives

PLEASE NOTE: Panel are unable to consider incomplete EQIAs

Summary - Stage 1 Assessment

	Questions Answered	*Questions NOT Answered*	Positive Scores	Neutral Scores	Negative Scores
Patient Safety	4	*0*	1	3	0
Patient Experience	7	*0*	4	3	0
Clinical Effectiveness	6	*0*	4	2	0
Productivity & Innovation	4	*0*	2	2	0
Prevention	5	*0*	2	3	0
Operational Impact	9	*0*	3	4	2
Data Security	2	*0*	0	2	0
COVID 19	1	*0*	0	1	0
Risk	1	*0*	0	1	0
WHOLE PROJECT	39	0	16	21	2



RISK LEVEL

LOW Risk

No negative scores for Patient Safety, Patient Experience or Clinical Effectiveness, and scores of no less than -1 for Productivity & Innovation, Prevention and Operational Impact

RISK TO BE MITIGATED PRIOR TO COMMENCEMENT

Who will own this risk? (e.g. Organisation. Committee, Individual)

POST MITIGATION (MODERATED) RISK LEVEL

NO Risk

JUSTIFICATION FOR MODERATED RISK LEVEL

Quality Impact Assessment

Stage 1

NHS
Kent and Medway

Domain		Criteria	Answer (select from drop down list)	Score	Next Stage required	Rationale (Please provide rationale for scoring for each question ie. If the project might increase number of admissions then there may be more incidence of HCAI)
Patient Safety	Q1	Is there an impact on staffing levels or staffing acuity	no impact on staffing			There will be a reduction of 13.74 posts but KMMHT have confirmed that they do not believe there will be any redundancies
	Q2	Is there an impact on avoidable harm / incidents?	No impact on harm/incidents	+ 0		
	Q3	Is there an Impact on Health Care Associated Infection (HCAI)?	No impact on HCAI	+ 0		
	Q4	Will there be an impact on the number of safeguarding incidents?	No impact on safeguarding	+ 0		
	Q5	Does the Business Decision impact on ability to follow current guidance from professional bodies?	Increase in ability to follow current guidance from professional bodies likely.	+ 2		Staff working with patients on Walmer and Emmetts will follow best practice in helping patients access their personalised and appropriate community care pathways in line with the least restrictive principle.
Patient Experience	Q6	Is there an impact on patient experience (complaints / PALS)?	Improved patient experience likely (decrease in complaints)	+ 2		Instead of remaining in an inpatient service which they not longer require, patients will be accessing the appropriate community care pathway to meet their individual needs in line with the least restrictive principle . Which will bring their care into line with other MSU patients moving towards discharge
	Q7	Is there an impact on patient and staff consent and confidentiality?	no impact on consent and confidentiality	+ 0		
	Q8	Is there an impact on informed choice and involvement in care planning?	Increase in choice and involvement likely	+ 2		Instead of remaining in an inpatient service which they not longer require, patients will be accessing the appropriate community care pathway to meet their individual needs in line with the least restrictive principle . Which will bring their care into li
	Q9	Is there an impact on personalised care?	Increase in personalised care and involvement likely	+ 2		Instead of remaining in an inpatient service which they not longer require, patients will be accessing the appropriate community care pathway to meet their individual needs in line with the least restrictive principle . Which will bring their care into li
	Q10	Is there an impact on quality of the environment for patients?	Improved quality of patient environment likely	+ 2		Patients will be living in a community setting and able to personalise their environment, rather than placed inappropriately on an inpatient service which they do not require
	Q11	Has there been involvement of patients / carers in Business Decision development?	No patient / carer involvement required	+ 0		None required as the current patients have individual personalised discharge plans in place as per best practice and patients and carers are involved in these and there will be no more admissions to the unit
	Q12	Have lessons learned from patient experience been used to develop scheme?	Nothing available	+ 0		

Clinical Effectiveness	Q13	Has evidence based practice been utilised?	Project fully developed using EBP	+ 3	Yes the decommissioning of the service will mean that patients will be bale to access community pathways that are in line with NICE guidance, Best practice and principle of least restrictive practice as outlined in the Mental Health Act , in the same way as other patients being discharged form modicums secure services
	Q14	Does the Business Decision have clinical leadership / engagement?	Clinical leader / engagement in place	+ 3	Yes, the NHS Kent and Medway ICB mental health lead has been engaged and supports the decision to move towards de-commissioning . The clinical lead for the service form KMMHT has also been involved as has the executive director of nursing and both support the recommendation .
	Q15	How does the Business Decision reduce variations / improve consistency in care?	Reduction in variation / improvement in consistency likely	+ 2	All patients admitted to Medium Secure services will be accessing the same appropriate and least restrictive care pathways .
	Q16	Will quality metrics that measure outcomes be used to measure success?	Not required	+ 0	
	Q17	Does the Business Decision impact on ability to follow current NICE guidance?	Improved ability to follow current NICE guidance.	+ 3	There will be access to the appropriate NICE pathways for the patients , the current service is not in line with NICE Guidance .
	Q18	How will the Business Decision impact upon re-admission to inpatient facilities?	Not applicable/no impact	+ 0	
Productivity & Sustainability	Q19	Does the Business Decision help to eliminate inefficiency and waste or improve value by economy, efficiency and effectiveness?	Not applicable/no impact	+ 0	
	Q20	Does the Business Decision support sustainable development e.g. low-carbon pathways, efficient energy use, reduced waste?	No impact	+ 0	
	Q21	Will the Business Decision help to improve organisational performance?	Improvement in provider performance is likely	+ 2	The provider will be offering appropriate community discharge care pathways to patients in Walmer and Emmetts, in line with other Medium secure units
	Q22	Will the Business Decision improve care pathways?	Improvement in care pathways likely	+ 2	The plan is to reinvest the funding from Bedgebury into an Assertive outreach team which will further enhance the community pathway offer
Prevention	Q23	Will the Business Decision promote people to stay well?	Promotion of wellness expected	+ 3	Promoting wellbeing is part of the community pathways offer that patients will be accessing in future.
	Q24	Will the Business Decision promote self care for long term conditions?	Promotion of self care for LTC likely	+ 2	Promoting self care is part of the community pathways offer that patients will be accessing in the future
	Q25	Will the Business Decision help reduce health inequalities?	Not applicable/no impact	+ 0	No change envisaged
	Q26	Will the Business Decision prevent inappropriate hospital admissions or A&E attendance/ use of emergency services?	Not applicable/no impact	+ 0	No change envisaged
	Q27	Will the Business Decision prevent people dying prematurely?	Not applicable/no impact	+ 0	No change envisaged

Operational Impact	Q28	Will staff have relevant capability, knowledge and skills?	All staff will have the relevant capability and knowledge	+ 3		The patients will be accessing the current community care pathways and KMMHT are responsible for ensuring that all staff have the relevant capabilities and knowledge for their posts.
	Q29	Will this Business Decision impact upon the level of violence & aggression experienced by patients, service users and staff?	Not applicable/no impact	+ 0		
	Q30	Could there be impact on service reputation / media coverage	Positive impact on service reputation / media coverage possible	+ 1		Potential coverage of this pathway re-design has been considered and covered in the plan for de-commissioning.
	Q31	Does the Business Decision affect effective support in the community?	Improved effective support in the community expected	+ 3		There will be investment into an AOT service to enhance the effectiveness of the community care pathways
	Q32	Does the Business Decision impact on waiting times?	Not applicable/no impact	+ 0		
	Q33	Will the Business Decision impact on current Clinician availability?	No impact	+ 0		Not clear depends on outcome of the discussions around staffing
	Q34	Are staff engaged in the scheme?	A few staff are engaged	- 1	Stage 2 Required	senior service managers are aware of the proposal and support the pathway re-design
	Q35	Any impact on staff (e.g.Staff experience, Staff wellbeing, terms and conditions, base change, role change etc.)?	Minor negative impact expected	- 1	Stage 2 Required	there are 13.74 posts on the unit but KMMHT have confirmed they do not expect any redundancies as a result to the decommissioning
	Q36	Any impact on any other services or stakeholders.	No impact	+ 0		None envisaged
Data Security	Q37	Will this Business Decision change the way data is used in the organisation.	No impact	+ 0		
	Q38	Could the Business Decision pose a risk to the confidentiality, integrity or availability of data?	No impact	+ 0		
COVID 19	Q39	Is the proposed business decision a result of new ways of working developed in response to the COVID-19 pandemic	NO	+ 0		
RISK	Q40	Does this business decision reduce a recognised risk as contained on the Provider risk register?	NO	+ 0		

There are still 15 rationales you have not answered

RISK LEVEL

LOW Risk

No negative scores for Patient Safety, Patient Experience or Clinical Effectiveness, and scores of no less than -1 for Productivity & Innovation, Prevention and Operational Impact

RISK TO BE MITIGATED PRIOR TO COMMENCEMENT

Quality Impact Assessment

Stage 2 Assessment

NHS
Kent and Medway

		Question	Answer	Score	Stage 2 required?	What are the issues?	How will they be mitigated?	When can this be completed by?	Who will own it?
Patient Safety	Q1	Is there an impact on staffing levels or staffing acuity	moderate impact on staffing	+ 0	NO	there will be a loss of 13.74 WTES if the service closes.	KMMHT have vacancies in other services that may be suitable for these post holders		
	Q2	Is there an impact on avoidable harm / incidents?	No impact on harm/incidents	+ 0	NO				
	Q3	Is there an Impact on Health Care Associated Infection (HCAI)?	No impact on HCAI	+ 0	NO				
	Q4	How will the reporting of safeguarding incidents be affected?	No impact on safeguarding	+ 0	NO				
	Q5	Does the Business Decision impact on ability to follow current guidance from professional bodies?	Increase in ability to follow current guidance from professional bodies likely.	+ 2	NO				
Patient Experience	Q6	Is there an impact on patient experience (complaints / PALS)?	Improved patient experience likely (decrease in complaints)	+ 2	NO				
	Q7	Is there an impact on consent and confidentiality?	no impact on consent and confidentiality	+ 0	NO				
	Q8	Is there an impact on informed choice and involvement in care planning?	Increase in choice and involvement likely	+ 2	NO				
	Q9	Is there an impact on personalised care?	Increase in personalised care and involvement likely	+ 2	NO				
	Q10	Is there an impact on quality of the environment for patients?	Improved quality of patient environment likely	+ 2	NO				
	Q11	Has there been involvement of patients / carers in project development?	No patient / carer involvement required	+ 0	NO				
	Q12	Have lessons learned from patient experience been used to develop scheme?	Nothing available	+ 0	NO				
Clinical Effectiveness	Q13	Has evidence based practice been utilised?	Project fully developed using EBP	+ 3	NO				
	Q14	Does the project have clinical leadership / engagement?	Clinical leader / engagement in place	+ 3	NO				
	Q15	How does the project reduce variations / improve consistency in care?	Reduction in variation / improvement in consistency likely	+ 2	NO				
	Q16	Will quality metrics that measure outcomes be used to measure success?	Not required	+ 0	NO				
	Q17	Does the Business Decision impact on ability to follow current NICE guidance?	Improved ability to follow current NICE guidance.	+ 3	NO				
	Q18	How will the project impact on re-admission?	Not applicable/no impact	+ 0	NO				
Productivity & Innovation	Q19	Does the Business Decision help to eliminate inefficiency and waste or improve value by economy, efficiency and effectiveness?	Not applicable/no impact	+ 0	NO				
	Q20	Does the project support sustainable development e.g. low-carbon pathways, efficient energy use, reduced waste?	No impact	+ 0	NO				
	Q21	Will the project help to improve provider performance?	Improvement in provider performance is likely	+ 2	NO				
	Q22	Will the project improve care pathways?	Improvement in care pathways likely	+ 2	NO				

Prevention	Q23	Will the project promote people to stay well?	Promotion of wellness expected	+ 3	NO				
	Q24	Will the project promote self care for long term conditions?	Promotion of self care for LTC likely	+ 2	NO				
	Q25	Will the project help reduce health inequalities?	Not applicable/no impact	+ 0	NO				
	Q26	Will the Business Decision prevent inappropriate hospital admissions or A&E attendance/ use of emergency services?	Not applicable/no impact	+ 0	NO				
	Q27	Will the project prevent people dying prematurely?	Not applicable/no impact	+ 0	NO				
Operational Impact	Q28	Will staff have relevant capability, knowledge and skills?	All staff will have the relevant capability and knowledge	+ 3	NO				
	Q29	Will this project impact upon the level of violence & aggression experienced by patients, service users and staff?	Not applicable/no impact	+ 0	NO				
	Q30	Could there be impact on service reputation / media coverage	Positive impact on service reputation / media coverage possible	+ 1	NO				
	Q31	Does the project affect effective support in the community?	Improved effective support in the community expected	+ 3	NO				
	Q32	Does the project impact on waiting times?	Not applicable/no impact	+ 0	NO				
	Q33	Will the Business Decision impact on current Clinician availability?	No impact	+ 0	NO				
	Q34	Are staff engaged in the scheme?	A few staff are engaged	- 1	YES	KMMHT are the provider and senor managers, clinical staff including ward managers were aware of the review . KMMHT requested to manage staff communications	KMMHT are looking to see what the options will be for staff including moving to other services		
	Q35	Any impact on staff (e.g.Staff experience, Staff wellbeing, terms and conditions, base change, role change etc.)?	Minor negative impact expected	- 1	YES	13.74 WTES will no longer be required if the service is decommissioned so there will need to be staff consultation	KMMHT are looking to see what the options will be for staff including moving to other services.		
	Q36	Any impact on any other services or stakeholders.	No impact	+ 0	NO				
Data Security	Q37	Will this Business Decision change the way data is used in the organisation.	No impact	+ 0	NO				
	Q38	Could the Business Decision pose a risk to the confidentiality, integrity or availability of data?	No impact	+ 0	NO				
COVID 19	Q39	Is the proposed business decision a result of new ways of working developed in response to the COVID-19 pandemic	NO	+ 0	NO				
RISK	Q40	Does this business decision reduce a recognised risk as contained on the Provider risk register?	NO	+ 0	NO				

Equality and Health Inequality Impact Assessment (EHIA) Screening

Kent and Medway

The screening EHIA can be used as an initial screening tool if you are unsure about the level of impact the project may have on groups of people. This tool can be completed as a stand-alone document (e.g. for a minor policy update) or as a precursor to the Extended EHIA.

1	**Introduction and Overview** **The main purpose of this Screening Tool is to help you decide whether or not you need to undertake a more in-depth Equality and Health Inequality Impact Assessment (EHIA) for your project or piece of work**	
	Does your project, service, policy, strategy or function impact on the community or service users? • Protected characteristic groups (as outlined in the Equality Act 2010) • Social / health inclusion groups • Deprivation and socio-economic disadvantage within local communities • Local health inequalities for groups and communities	**Yes** If yes please complete sections 2, **3a**, 4, 5, 6 and 7 If no - please explain your rationale
	Does your project, service, policy, strategy or function impact on the workforce? This includes the ICB workforce, but may also include the wider health and social care workforce in the K&M Integrated Care System. In undertaking this EHIA screening, current and relevant workforce data must be considered to ensure that: • No group is experiencing disproportionate disadvantage • No group is experiencing discrimination • All opportunities to advance equality, diversity and inclusion are considered proactively	**Yes** If yes plese complete sections 2, **3b**, 4, 5, 6 and 7 If no - please explain your rationale

2	Equality Impact Assessment - Protected Characteristics	Positive	Neutral	Negative	Comments In supplying comments please consider both negative impacts and ways in which the work could proactively address known inequalities. Please also consider where there is a cumulative impact over time of the proposed change or for those who have more than one protected characteristic. If there is no data available please add an action to capture.
	Race		x		
	Sex		x		
	Gender reassignment		x		
	Age		x		
	Religion and belief		x		
	Disability		x		
	Sexual orientation		x		
	Marriage or civil partnership		x		
	Pregnancy and maternity		x		
3a	**Health inequality impact Assessment - Disadvantaged, inclusion groups and communities** Does this project, service, policy, strategy or function impact on any health and social inclusion groups? Please give details. *Other health or social inclusion groups (please note below list are examples, consider which groups may be relevant to your work – there may be others you think are important)**. please note that if this is an internal workforce related change / project then it is only necessary to complete section 2 and section 3b**	**Positive**	**Neutral**	**Negative**	**Comments** **In supplying comments please consider both negative impacts and ways in which the work could proactively address known inequalities.** **If there is no data available please add an action to capture.**
	Homeless people		x		
	Lone parents		x		
	People with substance misuse issues		x		
	Geographically isolated and rural		x		
	Carers		x		
	Refugees, migrants and asylum seekers		x		
	Ex-offenders and unrelated convictions		x		
	Those surviving domestic and sexual violence		x		
	Armed forces communities		x		
	Children and young people in care and/or care leavers		x		
	Those who may be digitally excluded		x		
	People with literacy and/or numeracy issues		x		
	People who have experienced female genital mutilation		x		

	People who have experienced human trafficking or modern slavery		x		
	Does this service, policy or function impact on deprivation and socio-economic disadvantage of local communities? Please give details.		x		
	e.g. people on a low income/people living in the most deprived areas		x		
3b	**Impact Assessment - Disadvantaged, health inclusion groups of staff** Does this project, service, policy, strategy or function impact on any health and social inclusion groups? Please give details. *Other health or social inclusion groups (examples to consider could include part time workers, carers, low income workers – there may be others you think are important)	**Positive**	**Neutral**	**Negative**	**Comments Please note that when assessing impact for staff a greater weighting will be placed on the protected characteristics set out in the Equality Act (in section 2). The ICB's public sector equality duty does not extend to consideration of the groups set out in section 3b. However we recognise that there are broader aspects of workplace inclusion beyond the protected characteristics described and it is important to consider these when developing or reviewing processes / policies etc.** **In supplying comments please consider both negative impacts and ways in which the work could proactively address known inequalities.** **If there is no data available please add an action to capture.**
4	**Engagement**				
	Has there been any engagement activity relating to this project, service, policy, strategy or function? If not, why not?		No	The provider KMMHT and KSS Secure care provider collabartive were inovled in the review and this inlcuded clinical , and service managers from both organisations (inlcuding exectuvie level).	
	Does there need to be any further engagement? If yes please provide details here and add this as an action to the action plan below.	Yes		Comments:There may need ot be a formla staff consutlations this will need to be over seen by KMMHT and it has been suggested that the Oversight comittees shoud be aware of this service clousre , there is a communicaitons plan to adress comunicaitons across the system	
5	**Extended EHIA**				

	Is an Extended EHIA required?	Yes		There are 13.74 WTE posts that will no longer be required and so there is an impact on the staff group working in the TGU.	
6	**Actions** Record your Screening EHIA assessment concerns, opportunities and actions below:				
	Concerns	Action		Deadline	Lead Person and Job Title
1a					
1b					
1c					
1d					
7	**Person to implement, monitor and review EHIA post decision**	**Note: The EHIA should now form part of BAU activity for the proposal with actions embedded and reviewed.**			
	Name	**Job title**			**Contact details**

Equality and Health Inequality Impact Assessment (EHIA)

Extended

The extended EHIA is also the appropriate tool to use to assess larger scale change programmes including new commissioning and / or any decommissioning.

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1	**Introduction**	**Comment (if staff only are affected please do not complete sections 4a and 4b)**					
	Who will be affected: *Staff* *Carers* *Patients/service users* *Communities* *Other*	**Staff - loss of 13.74 WTE posts if service closes.**					
	What patient and public and/or staff engagement has already taken place in relation to this proposal?	The provider organisation and the KSS PC were involved in the service review and accepted the recommendations , some staff ward managers , clinical and senior managers were part of the review group.					
2	**Update on previous EHIA and outcomes of actions**						
	Does a previous EHIA exist? And if so outline what actions have already been taken / describe outcomes and identify any outstanding actions	no					
3	**Equality Impact Assessment - Protected Characteristics**	**Positive**	**Neutral**	**Negative**	Comment: **Include quantitative and qualitative insights; engagement/feedback and information to support your assessment on each group/community; actions to be taken forward. Please ensure you have considered cumulative impact for those with negative impacts associated with multiple protected characteristics.*		
	Race		x				
	Sex		x				
	Gender reassignment		x				
	Age		x				
	Religion and belief		x				
	Disability		x				
	Sexual orientation		x				
	Marriage or civil partnership		x				
	Pregnancy and maternity		x				
4a	**Health inequality assessment - please consider the impact on groups particularly identified in the EHIA screening and detail these below.**	Positive	Neutral	Negative	Comment: **Include quantitative and qualitative insights; engagement/feedback and information to support your assessment on each group/community; actions to be taken forward. Please ensure you have considered cumulative impact for those who face multiple health inequality factors.*		
			x				
			x				

			x				
			x				
4b	**Health inequalities**						
	Will this initiative help to reduce health inequalities for any specific groups or communities? Provide evidence to support your assessment .	x			Yes patients admitted to walmer and emmetts ward will access the appropriate community care pathways in a timely manner, in the same way as Kent and Medway Secure pateints admitted in other unit are able too.		
5	**Impact Assessment - Disadvantaged, health inclusion groups of staff** Does this project, service, policy, strategy or function impact on any health and social inclusion groups? Please give details. *Other health or social inclusion groups (examples to consider could include part time workers, carers, low income workers – there may be others you think are important)	**Positive**	**Neutral**	**Negative**	**Comments Please note that when assessing impact for staff a greater weighting will be placed on the protected characteristics set out in the Equality Act (in section 2). The ICB's public sector equality duty does not extend to consideration of the groups set out in section 3b. However we recognise that there are broader aspects of workplace inclusion beyond the protected characteristics described and it is important to consider these when developing or reviewing processes / policies etc. In supplying comments please consider both negative impacts and ways in which the work could proactively address known inequalities. If there is no data available please add an action to capture.**		
6	**Equalities or health inequalities data gaps**	**Comment**					
	As a result of undertaking this EHIA, are there any gaps in inequalities or health inequalities data or information?	**Provide evidence to support your assessment and include this as an action below where there are gaps in data or information.*					
7	**Action plan**	**Priority**	**Actions to mitigate impact**		**Staff or patient engagement**	**Action owner/s**	**Target completion date**
	provide details of action here and complete a line for each separate action identified including actions to address data gaps						
8	**Person to implement, monitor and review EHIA post decision**	**Note: The EHIA should now form part of BAU activity for the proposal with actions embedded and reviewed.**					
	Name	**Job title**			**Contact details**		

EHIA Guidance notes

Within the Equality Act, **NHS Kent and Medway as a public authority has a legal requirement** to **promote equality** and set out how we **plan to meet the "general" and "specific" duties specified in Section 149 (1) of the Public Sector Equality Duty.**

As a public authority NHS Kent and Medway is required to pay "due regard" to the three aims of the **general equality duty to**:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Having "due regard" for **advancing equality** involves:

- Removing or minimising disadvantages people encounter due to their protected characteristics
- Taking steps to meet the needs of people with certain protected characteristics where these are different from the needs of other people
- Encouraging people with certain protected characteristics to participate in public life or in other activities where their participation is disproportionately low.

NHS Kent and Medway are legally bound to demonstrate that we are taking action to promote equality in relation to policy making, development of policies and procedural documents, alongside the delivery of services, service developments and employment.

Within the Act, we also have **a legal duty to show that we have given due regard to the nine protected characteristics** below:

Sex
Ethnicity
Gender
Disability
Religion / belief
Sexual orientation
Gender reassignment
Marriage or civil partnership
Pregnancy / maternity
Age.

Case law known as the Brown Principles sets out **a broad indication of what public sector organisations need to do** to in respect of the aims set out in the general equality duties and they provide useful insight into how courts interpret the duties although they are not additional legal requirements.

In summary, the Brown principles say:
Decision-makers must be made aware of their duty to have "due regard" to the three aims of the general equality duty.
Due regard is fulfilled before and at the time a particular policy that will or might affect people with protected characteristics is under development and consideration, as well as at the time a decision is taken.
Due regard involves a conscious approach and state of mind. A body subject to the duty cannot satisfy the duty by justifying a decision after it has been taken as this is unlawful. Attempts to justify a decision as being consistent with the exercise of the duty, when it was not considered before the decision, are not enough to discharge the duty.
The duty must be exercised in substance, with rigour and with an open mind in such a way that it influences the final decision.
The duty must be integrated within the discharge of the public functions of the body subject to the duty. It is not a question of "ticking boxes".
The duty cannot be delegated and will always remain on the body subject to it
It is good practice for those exercising public functions to keep an accurate. record showing that they had considered the general equality duty and pondered relevant questions. If records are not kept it may make it more difficult, evidentially, for a public authority to persuade a court that it has fulfilled the duty imposed by the equality duties.
Equality and Health Inequality Impact Assessments provide a robust process to demonstrate how our legal duties have been considered in commissioning, design and delivery of services, and is a systematic continuous process which involves analysing and reviewing local equality and health inequality information and the results of any engagement to understand the impact (or potential impact) of functions, policies, strategies, services, projects, practices or decisions on people with different protected characteristics.

When to use EQIA and enhanced EQIA

EHIAs are an essential tool to use when:
Developing and reviewing a policy, strategy, function, or project.
Designing, delivering and evaluating services.
Commissioning and decommissioning services.
Undertaking transformation and change.
Reconfiguring services.
Carrying out our role as employers.
Minor changes that will not impact on people are unlikely to require an EHIA, however, all significant and major changes will require an EHIA.

The **screening EHIA can be used as an initial screening tool** if you are unsure about the level of impact the project may have on groups of people. This tool can be completed as a stand-alone document (e.g. for a minor policy update) or as a precursor to the Extended EHIA.

The extended EHIA is a more in-depth assessment and additional engagement is expected to have taken place with staff / and or patient groups as part of this assessment. The extended EHIA will be completed when the proposed change has potential negative impact, e.g. if any groups or communities are identified in the Screening EHIA as being potentially disadvantaged or negatively impacted upon by the proposed change. The **extended EHIA is also the appropriate tool to use to assess larger scale change programmes including new commissioning and / or any decommissioning**.

Gathering relevant equality information and undertaking analysis

The information that you will use in the assessment will vary to identify important impacts on people with different protected characteristics. It may be useful to look at:
Knowledge - e.g. about the culture or needs of a particular group.
Comparisons with similar policies in other departments or NHS Trusts to help you identify relevant equality issues.
Analysis of enquiries or complaints from the public to help you understand the needs or experiences of different groups of people.
Recommendations from inspections or audits to help you identify any concerns about equality matters from regulators.
Information about the local community, including census findings to help you establish the numbers of people with different protected characteristics.
Internal equality reporting statistics and data for patients and staff.
Recent research from national, regional and local sources that includes information on relevant equality issues.
Results of engagement activities or surveys to help you understand the needs or experiences of people with different protected characteristics (this can be sourced from the public engagement team).
Information from the public, and voluntary organisations to help you understand the needs or experiences of people with different protected characteristics.
If you do not have equality information about people with protected characteristics, part of the analysis process is considering whether you need this information and how you will fill these information gaps.

This may mean undertaking short studies or surveys, or some engagement work. If it is not possible to collect this in time to inform your assessment, consider how you can increase your understanding in the short term before undertaking more robust research later. This could mean, for example, meeting with stakeholders. The information that you collect later will be valuable for your monitoring and review work. The information you gain from engagement with stakeholders will help you to understand the potential impacts of your plans on different groups.

Bringing together equality information and analysing it will enable a judgement to be made about what the likely impact of the policy will be on equality. Remember that assessing impact on equality is not simply about identifying, and mitigating or removing, negative effects or discrimination. It is also an opportunity to identify ways to advance equality of opportunity and foster good relations. This may involve using positive action measures within your services or employment, as permitted under the Equality Act 2010.

Considering impact

Discriminatory - a negative or adverse impact. An impact that could disadvantage people who share a particular protected characteristic. This disadvantage may be differential, where the negative impact on people with one characteristic group is likely to be greater than on another (e.g. steps into a building will disadvantage both wheelchair users and those pushing prams, but whereas small children might be carried in, wheelchair users will not be able to enter).

Sometimes a negative impact may be intended and justified (e.g. a Safeguarding Children's policy will have no or little reference to adults).
The aim of an EHIA is to identify where any disadvantage lies, to identify whether it is discriminatory and the extent to which any discrimination can be eliminated, minimised or justified.

A positive impact (advancing equality): An impact that could have a positive effect by improving equality in opportunity. A positive impact may be differential where the positive impact on one group of people with a shared protected characteristic is likely to be greater than on another

Cumulative Impact. It is important to recognise that impacts may not be isolated and / or may affect more than one group or community. Furthermore, impacts may be multiple and / or be increased over time. Therefore, the EHIA process requires people to record
"cumulative impact" in relation to three aspects:
The impact on specific groups from more than one effect of the change, so the group may experience a greater impact, e.g. the effect on patients if there is a proposal to change a service location, opening hours and access route
The impact on some individuals who have more than one protected characteristic (intersectionality) and / or be a member of more than one disadvantaged group and therefore experience the impact of the change in a greater way
The impact of the proposed change over time, e.g. the long-term impact on wellbeing for staff members required to travel greater distances between office locations because of the change
The impact of several proposals and changes at the same time or in quick succession which may have more impact for some groups than others e.g. a decision to relocate or decommission several services in one area of deprivation.
Making a decision

The consideration given to equality in your decision-making should be proportionate to the importance of the policy to advancing equality and fostering good relations. In some cases, the policy will be critical to those aims. In other cases, it will be less so. In all decisions, financial and other considerations will inevitably also be important. You should ensure that appropriate weight is given to equality, alongside other considerations. The weight given to different factors can be challenged in court if a decision is deemed to be irrational or based on irrelevant considerations or facts.

Your decision-making may mean that your policies will benefit certain groups of people. A strong evidence base and transparency about how you reached your decision should help you to explain and justify your decisions internally and externally. Having your decisions and rationale easily accessible should also help to counter any misconceptions.

As a result of your analysis, you will take one of the following courses of action:
Continue – Your assessment demonstrates no potential for discrimination, and you have taken all appropriate opportunities to advance equality of opportunity and foster good relations between people with different protected characteristics. Document the reasons for this and the information you used to make this decision
Justify and continue – Ultimately, there may be other factors (such as other policy aims or financial constraints) which make it reasonable for you to decide to continue despite adverse equality impact. This is an option where your policy does not unlawfully discriminate, or where the discrimination can be objectively justified. If your decision is challenged, you will need to be able to satisfy a court that you had due regard to the aims of the general equality duty when you reached your decision. It is therefore particularly important that you document your reasons and the information you used to reach them.
Make Changes – This involves making changes to ensure it does not adversely affect certain groups of people or miss opportunities to affect them positively. This can involve taking steps to mitigate adverse impacts, or to bolster or tailor positive ones. It is lawful under the Act to treat people differently in some circumstances, such as putting in place single-sex provision where there is a need for it. Document the reasons for this and the information you used to make this decision.
Stop - If a policy shows unlawful discrimination that cannot be changed or objectively justified, it is a potential breach of the Equality Act 2010. Document the reasons for this and the information you used to make this decision.

EHIA actions

Any mitigating actions identified in the EHIA to address the impact of the decisions proposed should be achievable, proportionate and relevant. Actions that proactively enable the advancement of equality and / or the opportunity for NHS Kent and Medway to reduce inequalities should also be recorded.

Any actions arising from the impact assessments should feed into team and service plans, ensuring that the impact assessment process is integral to service planning and improvement. Any risks should also be noted. Furthermore, actions from EHIAs can inform processes for monitoring the quality of commissioned services. EHIA action planning and review is a live part of normal business planning processes.

Sign off

The Senior Responsible Officer (SRO) for a policy, strategy, service, change, transformation, project or procedure has responsibility for “signing off” the EHIA to ensure that the assessment and actions are appropriate and proportionate, and they are also responsible for ensuring that actions are embedded in core business planning and review as part of business as usual (BAU).

NHS
Kent and Medway

TO BE COMPLETED BY PANEL MEMBERS ONLY

Virtual Assessment Authorised By Chair	Name of Chair	Date Authorised	Instructions: 1. Only complete a virtual assessment if indicated on Outcome Form 2. Assess Summary, Stage 1,Stage 2 & S14Z2 as you would face to face. 3. Complete all text boxes on this sheet 4 Last Assessor on List to Email Completed form to QIA Inbox.	Virtual Assessment Complete. (Select from drop down list).
Yes				

Virtual Assessment

Panel Member Name (Free Text)	Date Assessed	Comments (Free Text)	Recommendation (Select from drop down list)	
Clinical Quality				

Are you the last colleague to review/complete? If yes, please email to it Chair.

Chair Only

Reviewed by All Panel Members	Virtual Review Complete?	Final Recommendation	1. Complete Virtual Recommendation on QIA Summary Tab 2. Email to Admin Support

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