HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Wednesday, 3rd June, 2026

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Wednesday, 3rd June, 2026, at 10.00 am
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Anna Taylor**
Telephone: **03000 416478**

Membership

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

UNRESTRICTED ITEMS

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

Item

1. Apologies and Substitutes

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

3. Minutes of the meeting held on 2 April 2026 (Pages 1 - 8)

4. Structural Changes to NHS Kent and Medway Integrated Care Board (Pages 9 - 14)

5. Changes made to commissioning fertility treatments in Kent and Medway (Pages 15 - 20)

6. Bedgebury Ward and proposed service redesign (Pages 21 - 28)

7. Meningitis B Outbreak Response (Pages 29 - 34)

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
Deputy Chief Executive
03000 416814

Tuesday, 26 May 2026

KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Thursday, 2 April 2026.

PRESENT: Mr R Mayall (Chair), Mr T Mole (Vice-Chair), Mr O Bradshaw, Mr M Brice, Mr S Jeffery, Cllr H Keen, Mr A Kibble, Mrs B Porter, Mr A Ricketts, Mrs S Roots, Mr T L Shonk, Dr G Sturley and Cllr K Tanner

ALSO PRESENT: Dr J Jacobs (Local Medical Committee) and Mr M Mulvihill

IN ATTENDANCE: Mr G Romagnuolo (Research Officer - Overview and Scrutiny), Dr Kate Langford (Chief Medical Officer, NHS Kent and Medway), Prof Avey Bhatia (Chief Nurse, Guy's and St Thomas' NHS Foundation Trust), Dr Sara Hanna (Medical Director), Trish Gray (Programme Manager), Dr Steve Fenlon / Jonathan Wade (Deputy Chief Executive, Dartford & Gravesham NHS Trust), John Goulston (Chair, Medway NHS Foundation Trust), Sukh Singh (Director of Primary and Community Care), Dr Ash Bhushan (Deputy Chief Medical Officer)

UNRESTRICTED ITEMS

259. Apologies and Substitutes
(Item 1)

1. Apologies were received from Councillor Moses, Mrs Russell (substituted by Mr Kennedy), and Mr Baker (substituted by Mr Palmer).

RESOLVED that the apologies and substitutes be noted.

260. Declarations of Interests by Members in items on the Agenda for this meeting
(Item 2)

1. Mr Ricketts declared that he may still hold a position as a Council Governor, subject to confirmation.

2. Mr Palmer declared that his spouse was an active Governor of Medway NHS Trust.

RESOLVED that the declarations of interest be noted.

261. Minutes of the meeting held on 4 February 2026
(Item 3)

RESOLVED that the minutes of the meeting held on 4 February 2026 were a correct record and that they be signed by the Chairman.

262. Children's Cancer Principal Treatment Centre Relocation
(Item 4)

Professor Avey Bhatia (Chief Nurse, Guys and St Thomas NHS Foundation Trust), Dr Sara Hanna (Medical Director and Clinical Lead for the Children's Cancer Principal Treatment Centre Programme, Evelina London) and Trish Gray (Programme Manager and Lead for Patient and Public, Evelina London) presented the following item:

1) The Committee received a report outlining the planned relocation of the Children's Cancer Principal Treatment Centre to Evelina London Children's Hospital.

2) The report provided an update on the proposed relocation of the Specialist Children's Cancer Principal Treatment Centre from the Royal Marsden NHS Foundation Trust in Sutton and St George's University Hospitals NHS Foundation Trust in Tooting to the Evelina London Children's Hospital, part of Guy's and St Thomas' NHS Foundation Trust.

3) It was noted that the service had supported child cancer patients from across South London, Kent, Medway and areas of Sussex. Members were advised that the proposed move would align the service with national specifications requiring co-location with a paediatric intensive care unit.

4) In response to questions and comments from Members, the following points were addressed:

   a) Concerns were raised about travel times to London to access radiography and the potential negative impact on families. Officers highlighted that radiotherapy provided at UCLH was in the best interests of patients. This reflected existing patient pathways for therapy and the limited availability of specialist paediatric radiotherapy staff, which would not be sustainable to replicate at Guy's and St Thomas.

   b) Further reflecting on travel times, officers discussed that the service would look to work more closely with regional hospitals, particularly shared care centres. There would be continued support for increasing local deliveries of care.

   c) Discussions would take place with the Transport for London (TfL) and the Greater London Authority (GLA), both of which had been supportive and would assist further in developing a range of travel options for families.

   d) Members were informed that all families accessing the children's cancer service at Evelina London would be offered patient transport which included provisions of suitable vehicles to take them to and from appointments. The national cancer plan, published on 4 February, had included a £10 million commitment to ensuring that children with cancer and their families would not incur travel costs.

   e) Officers discussed the ongoing programmes available to support children and families with additional aspects such as patient transport, dedicated parking, accommodation and how the function can best deliver these support arrangement aspects to the child and family.

   f) Members suggested travel option details be captured in future reports to the committee.

g) Members sought assurance about workforce sustainability. Officers confirmed there was ongoing engagement with staff and that contingency recruitment plans were in place, as well as plan for a robust recruitment model.

5) Members welcomed the focus on improved patient outcomes and national standards, and the concise contents of the report presented.

RESOLVED to note the report.

263. Establishment of a Group between Medway NHS Foundation Trust and Dartford & Gravesham NHS Trust
(Item 5)

Dr Steve Falton (Deputy Chief Executive, Dartford and Gravesham NHS Trust) and John Goulston (Chair, Medway NHS Foundation Trust) presented the following item:

1) The Committee received a report outlining proposals to establish a collaborative group model between Medway NHS Foundation Trust and Dartford and Gravesham NHS Trust.

2) Officers discussed the Trusts' close working relationship and the desire to pursue a North Kent collaboration. A number of shared services were already in place and well established.

3) There was a desire to move beyond individual service-level collaboration towards a more focused and linked approach. This would enable a consideration of services collectively to respond to challenges and opportunities.

4) Members were advised that the proposed group model aimed to enable a more streamlined approach to collaboration and would facilitate quicker discussions between clinicians, whilst seeking to improve the use of patient and population data to inform decision-making. The approach sought to reduce procedural barriers and allow clinicians to develop optimal solutions.

5) Officers further highlighted that some specialised services across Kent were relatively fragile, often reliant on small teams, and that long-term sustainability must be a key consideration. Collaboration between organisations was seen as a means of addressing this.

6) In response to questions and comments from Members, the following points were noted:

   a) Members queried which clinical collaborations were being explored. Officers recognised the length of time it had taken for projects such as pathology to embed. Data from both organisations would be used to inform future decisions to improve the service and would look to repatriate aspects of work back into Kent.

   b) A high-level roadmap was to be shared, setting out the current service positions and identifying areas that could be targeted for potential joint working.

c) Members raised concerns regarding both Trusts' leadership continuities in light of forthcoming senior appointments. A lack of continuity and the need for robust governance arrangements were also highlighted.

d) Concerns were raised on the collaborative aspects of the scheme and a potential move towards a trust merger. Clarification was provided that the proposal did not constitute a merger and that both organisations would remain separate.

e) The Medway NHS Foundation Trust was accountable through its Board of Directors to the Council of Governors, which included publicly elected governors representing its membership. In addition, the Trust was accountable to local authority scrutiny arrangements, including both HOSC and the Medway Health and Adult Social Care Overview and Scrutiny Committee (HASC).

f) Members suggested exploring the recruitment of a chief executive to oversee both aspects of the combined joint trust. Officers responded that there would be a definitive requirement for chief executives across both trusts.

g) Officers confirmed that any significant changes to services would be subject to the appropriate public engagement and consultation in accordance with NHS requirements.

7) Members recognised the potential benefits of shared services and improved resilience.

RESOLVED to note the report.

264. Reconfiguration of Stroke Services in East Kent
(Item 6)

Dr Kate Langford (Chief Medical Officer, NHS Kent and Medway) presented the following item:

1) The committee received a report providing an update on the proposed reconfiguration of stroke services in East Kent, which would result in the creation of a Hyper-Acute Stroke Unit (HASU) at William Harvey Hospital in Ashford.

2) Dr Langford highlighted that the temporary stroke unit at Kent & Canterbury Hospital (KCH) had delivered strong patient outcomes which would inform and aid the transition to the William Harvey site. She explained that ambulance journey times from Thanet to the William Harvey for the angioplasty service had ranged between 33 to 56 minutes over the past year. She later confirmed this was in the same band as the expected times during the original stroke review which demonstrated travel times did not appear to have changed significantly since then. The comparable blue light times for the stroke service at KCH were not available.

3) Subject to planning permission (expected imminently), construction at William Harvey was expected to commence on 1 June 2026, with an anticipated opening in late 2027/ early 2028.

4) Members discussed the report and the following points were noted:

   a) Dr Langford said she expected equivalent patient outcomes at the William Harvey HASU to the KCH service.

   b) Recognising the increased travel time for Thanet residents, a Member asked how their outcomes would be monitored. Dr Langford confirmed SNNAP data would continue to be collected which would allow comparison between particular geographical areas. Whilst this data was not published, the Committee could request such information in a future paper.

   c) The call to needle times were available but had not been provided for this report.

   d) Future stroke patients requiring the thrombectomy service would be transferred to KCH (once the service was open). Such transfers were common practice, and current transfers from Kent were to London.

   e) Dr Langford explained that a target of 1 hour and 20 minutes had been set to get victims of a stroke into the unit for treatment. The current triage processes had worked well and contributed to meeting this target.

5) The Committee were concerned about the proposals, and wanted to see the stroke unit at KCH retained, for the following reasons:

   a) potential health inequalities, noting that more deprived areas may be disproportionately affected by increased travel distances to a service that was further away from them.

   b) The stroke unit at KCH was already performing very well and achieving positive patients outcomes.

   c) There were limited public funds available, and the capital money could be invested in other areas that were not performing so well.

   d) The relocation was expected to achieve equivalent, not improved, outcomes.

   e) The data and evidence was from 2018 and a lot had changed since then (such as a pandemic, the introduction of a Marmot coastal region and the Sturry Link Road) so it may no longer be reliable.

6) Dr Langford acknowledged those concerns but explained that the changes were part of a whole county service reconfiguration, and reminded the Committee that the KCH unit had always been a temporary arrangement, as it was not suitable for a long-term stroke service, which would typically be located on an acute site with co-located services. She reported that the hospital Trust's preference was to co-locate acute services on a single site to support a more efficient delivery of care.

7) Some Members suggested that the Chair write to the NHS and the Secretary of State for Health to express the Committee's lack of confidence in the changes and that the proposed move would not improve patient outcomes for East Kent.

8) Dr Sturley proposed, and Cllr Tanner seconded, the following motion:

(a)That Canterbury should be retained as the permanent East Kent hyper-acute stroke unit.

(b) That NHS Kent and Medway and NHS England provide further clear evidence supporting the proposed model to William Harvey.

(c) That a full, updated Equality Impact Assessment be completed, with specific focus on Thanet and coastal East Kent as well as deprivation and transport access.

(d) That side-by-side modelling between the current (Canterbury) and proposed alternative arrangements, including the impact on Ashford and Thanet.

(e) That independent assessment be undertaken covering travel times, ambulance resilience, access to family support rehabilitation and discharge planning.

(f) Justification be provided from the ICB as to why the existing high-performing service cannot be retained as a permanent East Kent HASU.

9) A vote was carried out and the motion passed. Mr Jeffrey wished to be recorded as abstaining from the motion, which he felt was in breach of Section 2 of the Local Government Act 1986.

10) The Clerk advised the committee that, whilst HOSC could express comments or concerns to the NHS, they remained the ultimate decision maker in regard to proposals, and whilst the committee could request information they had limited ability to require changes. Concern was expressed that the proposed motion may not be enforceable.

RESOLVED that the Committee ask NHS Kent and Medway to address the following concerns:

(a)That Canterbury should be retained as the permanent East Kent hyper-acute stroke unit.

(b) That NHS Kent and Medway and NHS England provide further clear evidence supporting the proposed model to William Harvey.

(c) That a full, updated Equality Impact Assessment be completed, with specific focus on Thanet and coastal East Kent as well as deprivation and transport access.

(d) That side-by-side modelling between the current (Canterbury) and proposed alternative arrangements, including the impact on Ashford and Thanet.

(e) That independent assessment be undertaken covering travel times, ambulance resilience, access to family support rehabilitation and discharge planning.

(f) Justification be provided from the ICB as to why the existing high-performing service cannot be retained as a permanent East Kent HASU.

265. Kent and Medway Community Services Transformation and Neighbourhood Health
(Item 7)

Dr Sukh Singh (Director of Primary and Community Care, NHS Kent and Medway) presented the following item:

1) The Committee received a report outlining proposals for the community services transformation and the development of neighbourhood health models across Kent and Medway.

2) Benefits of the transformation were to accelerate neighbourhood health within Kent and Medway, community service partners working jointly to support multi neighbourhood services, as well as the development of 24/7 urgent community response services.

3) Members were advised that the first year of the neighbourhood health programme had focused on the top 5% in need population, a cohort that accounted for a disproportionate level of urgent and emergency care usage. The aim was to support these individuals to remain at home through targeted interventions and improved integration between primary, secondary, community and mental health services.

4) A Kent and Medway Neighbourhood Health Programme Board had been established and would bring together partners across health, social care, the voluntary sector and local authorities to develop joint neighbourhood health plans. These plans aligned with the national neighbourhood health framework published the previous month.

5) In response to questions and comments from Members, the following points were noted:

    a) Members questioned the level of ambition within the proposals and whether it represented a significant departure from existing models of care. In addition, queries were raised on the use of the Better Care Fund and what key aspects of integration with other agencies would be explored.

    b) Officers responded by describing the current model process and its impact on patients. Proposals focused on delivering treatment responses in a collaborative manner and if successful would represent a significant improvement.

    c) Changes included the development of multidisciplinary teams and proactive care planning. Officers discussed that engagement with Council colleagues would support a more focused approach, enabled by the shared clinical model. It was acknowledged that the first year focused on establishing foundations, with scope for more ambitious proposals in future years.

    d) Members raised concerns regarding patient assessment by private care sectors, the continued delivery in rural areas and the importance of robust and consistent patient assessment processes.

e) Officers outlined the development of a “trusted assessor” model to ensure coordinated and effective care delivery across services. The model was described in detail and the benefits that had already been seen throughout the county was a testament to the ongoing mitigations in place.

6) Members noted the proposals and requested that progress and outcomes be reported in due course.

RESOLVED to note the report.

266. Work Programme
(Item 8)

1) The Committee considered its work programme.

2) Members made the following requests:

(a) to consider establishing a Joint Overview and Scrutiny Committee in relation to the recent meningitis outbreak.

(b) that East Kent Hospitals University NHS Foundation Trust provide a report to the next meeting of the Committee on the handling of the meningitis outbreak, including both operational response and governance arrangements.

3) The Chair noted the requests, saying they would be reviewed and brought forward at an appropriate time.

RESOLVED to note the work programme.

(a) **FIELD**
(b) **FIELD_TITLE**

Item 4: Structural Changes to NHS Kent and Medway Integrated Care Board

By: Kay Goldsmith, Assistant Democratic Services Manager (Operations)

To: Health Overview and Scrutiny Committee, 3 June 2026

Subject: Structural Changes to NHS Kent and Medway Integrated Care Board

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

It provides background information which may prove useful to Members.

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1) **Introduction**

a) NHS Kent and Medway is progressing through a major organisational transition to implement a new operating model from 1 July 2026. They have provided the attached report to update the Committee on progress and provide assurance the programme is being implemented safely, with no impact on patient services.

b) The Committee were notified of the internal changes by the Chief Executive as part of his update in December 2025.

2) Recommendation

a) In line with HOSC's Terms of Reference, the designation of "substantial variation of service" cannot be applied to this change, which relates to a constitutional change.

b) RECOMMENDED that the Committee note the report.

Background Documents

NHS Kent and Medway Chief Executive Update (4 Dec 2025) Agenda for Health Overview and Scrutiny Committee on Thursday, 4th December, 2025, 10.00 am

Contact Details

Kay Goldsmith
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Transition Programme Update

1. INTRODUCTION

NHS Kent and Medway is progressing through a major organisational transition to implement a new operating model from 1 July 2026. This update provides a high-level overview of progress and assurance that the transition is being managed safely, with no adverse impact on patient services. The programme remains on track and is being delivered within the national running cost allowance and in line with statutory requirements.

2. STRATEGIC ALIGNMENT

The transition supports the ICB's ambition to become a more streamlined, resilient and strategically focused commissioning organisation. The new operating model strengthens our ability to plan services, use resources effectively, and work with partners across the Kent and Medway system.

3. PROGRAMME UPDATE: WORKFORCE TRANSITION

The ICB has completed consultation on its new organisational structure. Most colleagues have now been confirmed into roles, with recruitment under way to remaining vacancies. Support is in place for staff affected by change, and the programme remains on track for full implementation by July. This work has been carefully managed to ensure no impact on patient services and to maintain organisational stability during the transition.

4. PROGRAMME UPDATE: ORGANISATIONAL DEVELOPMENT AND CULTURE

Staff experience continues to be monitored closely. National survey results show improvement across several indicators, while recent pulse surveys reflect the uncertainty typically associated with large-scale change. Wellbeing indicators remain stable, and sickness absence is below target. These findings are overseen by the ICB's People Committee, and there is no evidence that the transition is adversely affecting service delivery or organisational resilience.

5. PROGRAMME UPDATE: MAJOR SERVICE TRANSFERS

Between March and April 2026, 195 staff transferred safely from the ICB to provider organisations as part of the transition to the new operating model. All transfers were completed with no disruption to services. Key changes include:

- **Cancer Alliance and Diagnostic Network Services** transferred to Maidstone and Tunbridge Wells NHS Foundation Trust on 1 April.
- **All Age Continuing Care and Medicines Optimisation** transferred to Kent Community Health Foundation Trust on 1 May.
- **Health and Care Partnership staff** transferred to Kent and Medway Mental Health Trust, with further redesign planned by providers.
- Planning continues for the transfer of **Specialised Mental Health and Section 117 services**, ensuring the most appropriate hosting arrangements are in place.

These changes support clearer accountability, stronger clinical leadership and improved alignment with provider-led service models.

6. PROGRAMME UPDATE: SHARED SERVICE MODELS

In response to the national closure of the Commissioning Support Unit (CSU), the ICB is developing shared service arrangements to maintain resilience and reduce duplication. Current priorities include:

- **Procurement** – planning for transfer of functions and development of a South East shared model.
- **Digital, Data and Technology** – joint service development with Surrey and Sussex ICB, including future hosting of GP IT services.

These arrangements are being designed to ensure continuity of business-critical functions and to support the ICB's reduced organisational footprint.

7. KEY RISKS, MITIGATIONS AND CONTROLS

Most major strategic risks have now been mitigated, including those relating to workforce reductions and service transfers. Remaining risks relate primarily to the safe implementation of shared service models including ensuring appropriate hosting arrangements for services previously supported by the CSU. These risks are being actively managed, with clear mitigation plans in place.

8. NEXT STEPS

Next steps for the programme include:

- **Complete workforce transition and recruitment** by June 2026.
- **Finalise transfers and shared service arrangements**, including procurement and digital/technology functions, to ensure continuity and resilience post-CSU closure.
- **Produce the formal Transition Closure Report**, capturing assurance, lessons learned and handover to business-as-usual governance.
- **Transition programme oversight to standard ICB governance from 1 July**, ensuring continued monitoring of risks, workforce stability and service continuity.

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Item 5: Changes made to commissioning fertility treatments in Kent and Medway

By: Kay Goldsmith, Assistance Democratic Services Manager (operations)

To: Health Overview and Scrutiny Committee, 3 June 2026

Subject: Changes made to commissioning fertility treatments in Kent and Medway

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

It provides background information which may prove useful to Members.

Introduction

a) Officers from NHS Kent and Medway have asked to present the attached paper to HOSC, to inform Members about the changes to the NHS funded IVF fertility treatment offer in Kent and Medway. Members of HOSC were notified of the changes via a written briefing on 9 April 2026.

b) The paper shows the previous policy compared to the new policy, which came into effect on 1 April 2026. This includes the reduction of cycles from 2 to 1, and a reduction in maximum age from 40 to 38.

2) Context

a) The following information may be useful for Members when scrutinising the new policy.

b) HOSC were initially consulted about an Assisted Reproductive Technology review in 2018. Both HOSC and Medway's HASC deemed the proposals to be a substantial variation of service and scrutiny passed to the Kent and Medway NHS Joint Overview and Scrutiny Committee (JHOSC). At that time, the regulations allowed proposals to be referred to the Secretary of State. The regulations related to health scrutiny changed in 2024, replacing the referral regime with a call-in request.

c) Scrutiny of the review was suspended in 2020 when the Kent and Medway CCG (the forerunner to the ICB) declared they were not progressing the changes at that time, but scrutiny was to resume when the review restarted.

d) NHS Kent and Medway recognise in their report (part 5) that HOSC should have been formally consulted ahead of these changes being approved and implemented on 1 April 2026.

3) Recommendation

a) The Committee is asked to note the report.

Background Documents

Assistive Reproductive Technologies Policy Review - written update (28 Sept 2020)
Agenda for Kent and Medway NHS Joint Overview and Scrutiny Committee on Monday, 28th September, 2020, 2.00 pm

Contact Details

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KCC Health Overview and Scrutiny Committee – Briefing

1. CHANGES TO NHS FUNDED IVF TREATMENT IN KENT AND MEDWAY

This briefing informs Kent Health Overview and Scrutiny Committee (HOSC) of changes made by NHS Kent and Medway to the NHS-funded IVF fertility treatment offer for Kent and Medway residents. These took effect on 1 April 2026.

2. SUMMARY OF THE CHANGES

NHS Kent and Medway reviewed its policy on NHS-funded fertility treatment and made three changes:

Element	Previous ICB offer	Revised offer (from 1 April 2026)
Age eligibility	Under 40 years	Treatment to start before 38th birthday
Number of IVF/ICSI cycles	Up to 2 cycles	1 cycle
Number of embryo transfers	Up to 4 transfers	Up to 2 transfers

These changes apply to people who have their treatment eligibility agreed from 1 April 2026 onwards. People who were approved for NHS fertility treatment before this date are not affected and will receive the previous ICB treatment offer.

The other eligibility criteria for NHS-funded treatment in Kent and Medway remain unchanged. The updated policy can be found on the NHS Kent and Medway's website kent-and-medway-art-policy-document-final-31012026pdf.pdf

Rationale for Change

The changes focus resources on patients most likely to benefit, maximising outcomes, value for money and the sustainability of fertility services in Kent and Medway.

Age of Patient: The reduction in age eligibility is aligned with the evidence-based clinical effectiveness of IVF treatment. This indicates that after 37 years, live births by embryo transfer reduce significantly year on year.

Number of Cycles: Reduction of the IVF treatment offer from two cycles to one is consistent with other integrated care boards (ICBs). There is some evidence to show that even when more cycles are available, take up is between 1.3-1.5 cycles.

Number of Embryo Transfers: Evidence shows the average pregnancy and birth rate using frozen embryo transfers has been increasing in line with progress in freezing techniques and the quality of embryos placed into storage.

Decision making was supported by national and regional precedents. Nationally, 69% of ICBs in England are currently offering a single cycle of IVF treatment.

The updated NICE fertility guideline (NG257), published on 31 March 2026, recommends three full IVF cycles for eligible women under 40, with consideration of a further three if

conception is not achieved — a substantial expansion from most current national commissioning arrangements.

NICE guidance is not mandatory; local NHS commissioners decide what can be funded within available resources. As the previous Kent and Medway offer was already below the earlier NICE recommendation, the new offer continues a position of providing fewer cycles than NICE recommends, rather than introducing a new departure from it.

3. EQUALITY, HEALTH INEQUALITIES AND QUALITY IMPACT ASSESSMENT (EQHIA)

A full EHQIA was completed. Age was identified as the main area of impact with all other protected characteristics (such as race, disability, sexual orientation) not directly affected. It is important to be clear that NHS Kent and Medway remains committed to an offer of fertility treatment for patients with health-related fertility problems.

Based on activity in 2024/25, the change in age eligibility means that annually around 60 women aged from 38 to 40 would no longer be eligible. The reduction from two cycles to one will affect a wider group.

4. WHAT WE HEARD FROM THE PUBLIC

Between 26 November 2025 and 26 January 2026, NHS Kent and Medway ran public engagement on the proposals through an online survey, social media and outreach to voluntary and community organisations and stakeholders, with a separate survey for fertility services staff. Forty-nine members of the public and seven staff responded.

The public engagement process yielded clear insights from people across Kent and Medway, reflecting the experiences, concerns and priorities of a broad range of fertility treatment service users and non-users.

Feedback showed strong support for maintaining current IVF provision, particularly two funded cycles, alongside a clear desire for national consistency, fair eligibility criteria, improved access and better psychological support.

Views on NHS prioritisation were mixed, but concerns about equity, inequality and the personal impact of change were prominent throughout.

NHS Kent and Medway carefully considered this feedback alongside clinical evidence, advice from healthcare professionals, and what is currently offered in other parts of the country. The views helped shape how these changes will be implemented — including the need for clear communication, fairness, and appropriate support for those affected. The full engagement report is available on our website here: Have your say about IVF and Fertility services | NHS Kent and Medway

While the change does not align with the public preference for two cycles, it responds to the call for national consistency, as 69% of ICBs in England currently fund a single cycle. The decision to fund one cycle focused on the age group with the highest chance of success balances clinical evidence, best use of resources and service sustainability. We acknowledge this will be a difficult decision for many.

5. OUR COMMITMENT TO HOSC

NHS Kent and Medway recognises HOSC should have formally heard about the proposals for the changes from the ICB before their implementation. We apologise this did not happen on this occasion and have taken steps to make sure that is not the case going forward.

To provide assurance, the ICB commits to informing HOSC of proposed changes to commissioned maternity, neonatal and women's health services at the point of public engagement. We will share the final engagement report and updated EQHIA with HOSC and return 12 months post-implementation to report on how the change is working, including activity, complaints and any patterns in who is affected.

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Item 6: Bedgebury Ward: Proposed pathway redesign

By: Kay Goldsmith, Assistance Democratic Services Manager (operations)

To: Health Overview and Scrutiny Committee, 3 June 2026

Subject: Bedgebury Ward: Proposed pathway redesign

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

It provides background information which may prove useful to Members.

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1) Introduction

a) Officers from NHS Kent and Medway have asked to present the attached paper to HOSC, to inform Members about a proposed pathway redesign which would result in Bedgebury Ward in Maidstone no longer commissioned.

2) Potential Substantial Variation of Service

a) The Committee is asked to review whether this proposal constitutes a substantial variation of service. There are no formal criteria setting out what a substantial variation of service is, and it is down to the Committee to decide.

b) Where the Committee decides a proposal is substantial, the NHS is required to consult with it prior to a final decision being made. The NHS always remains the decision-maker though must take the comments of the Committee into account.

c) In considering substantial variations of service, the Committee will take into account the resource envelope within which the relevant NHS organisations operate and will therefore take into account the effect of the proposals on the sustainability of services, as well as on their quality and safety.

3) Recommendation

a) If the proposals relating to the Bedgebury Ward pathway redesign are deemed substantial:

RECOMMENDED that:

i. the Committee deems that the proposed Bedgebury Ward pathway redesign is a substantial variation of service.

ii. NHS Kent and Medway representatives be invited to attend this Committee and present an update at an appropriate time.

b) If the proposals relating to the Bedgebury Ward pathway redesign are not deemed substantial:

RECOMMENDED that:

i. the Committee deems that the proposed Bedgebury Ward pathway redesign is not a substantial variation of service.

ii. NHS Kent and Medway representatives be invited to attend this Committee and present an update at an appropriate time.

Background Documents

None.

Contact Details

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NHS
Kent and Medway

Bedgebury Ward – proposed pathway redesign

Briefing paper for Kent Health Overview and Scrutiny Committee

1. PURPOSE OF THIS PAPER

This paper provides Kent Health Overview and Scrutiny Committee with information on a proposed pathway redesign, which would see Bedgebury Ward in Maidstone no longer commissioned.

It explains the rationale for the change, how patient safety and continuity of care will be maintained, and how released resource will be reinvested to strengthen community mental health provision.

The core aim is to improve patient experience by supporting people to move from secure inpatient care directly into appropriate community-based support wherever clinically safe to do so.

2. RECOMMENDATION

The Committee is asked to note:

- the proposed decommissioning of Bedgebury Ward;
- that admissions to the ward have already been paused and current patients are progressing through individual discharge plans;
- that the change is clinically and strategically driven, with resource retained within the mental health baseline;
- that recurrent funding released from the service will be reinvested into community mental health capacity, including Assertive Outreach provision; and
- that the ICB will manage the transition through a formal decommissioning governance process, including patient, quality, workforce, finance and communications oversight.

3. SUMMARY OF THE PROPOSAL

Bedgebury Ward comprises 10 step-down beds located within the Walmer and Emmetts Medium Secure Units at the Trevor Gibbens Unit in Maidstone. Although physically embedded within secure services, the beds are commissioned and funded by NHS Kent and Medway through the Kent and Medway Mental Health NHS Trust block contract.

The ward was established in 2016 as a pre-discharge rehabilitation unit for people stepping down from forensic inpatient care. Since then, national rehabilitation standards, NICE guidance and local community rehabilitation pathways have changed significantly. A commissioning review undertaken in 2025 concluded the current Bedgebury model no longer aligns with contemporary expectations for rehabilitation care.

The proposal is therefore to decommission Bedgebury Ward and redirect the released recurrent funding into community-based mental health provision. This will support more timely discharge, reduce unnecessary time in restrictive inpatient environments and strengthen alternatives to inpatient and out-of-area placements.

4. WHAT THIS MEANS FOR PATIENTS

The proposed change is expected to support a better patient experience for five main reasons.

1. Care will be delivered in the least restrictive appropriate setting. Bedgebury is located within a medium secure environment. For people who no longer require that level of restriction, remaining in such a setting can be unnecessarily restrictive and can slow recovery.
2. People will be supported to move more directly from secure care into the community. The review identified that Bedgebury has sometimes functioned as an additional step in the pathway rather than an essential therapeutic stage. Strengthened community support will enable more appropriate direct discharge where clinically safe.
3. The model will be more consistent with modern rehabilitation standards. Bedgebury does not operate as a standalone rehabilitation ward and does not have a dedicated multidisciplinary team or clearly defined therapeutic model. Reinvestment into assertive community support is better aligned with current best practice.
4. The change will improve equity across Kent and Medway. Rather than a small ward accessible only through two medium secure wards, the investment will support broader community pathways and a more consistent discharge offer.
5. It will support recovery, independence and social inclusion. Community-based support enables care planning around housing, relationships, employment or meaningful activity, physical health and social care needs in the person's own environment.

5. WHY THINGS NEED TO CHANGE

The commissioning review identified the following issues with the current service model:

- the service does not align with current NHS England rehabilitation standards
- it does not meet Level 1 or Level 2 rehabilitation definitions
- it does not operate as a standalone ward and lacks a dedicated multidisciplinary team or defined therapeutic model
- patients may experience prolonged lengths of stay in a more restrictive environment than clinically necessary
- alternative, evidence-based community pathways now exist to support discharge from forensic inpatient services
- the current cost profile is not aligned with the therapeutic input delivered.

The proposal is not to remove clinically necessary acute or forensic inpatient capacity, it is to close a small, anomalous step-down ward that no longer provides a distinct evidence-

based rehabilitation function and to reinvest the resource into services that better support discharge and community recovery.

Admissions to Bedgebury have been paused.

Current patients are progressing towards discharge, with most expected to leave the service by September 2026. No new referrals are planned. Should a person relapse or require admission in the future, they would be admitted to the most appropriate acute or forensic setting based on their assessed clinical need.

The proposal reduces reliance on an outdated pathway step, rather than removing necessary inpatient treatment for people who are acutely unwell or who require secure care.

6. REINVESTMENT INTO COMMUNITY HEALTH PROVISION – NEW MODEL

The funding released will remain within the protected mental health baseline under the Mental Health Investment Standard and will be used to support development of local Assertive Outreach capacity.

Assertive Outreach is an intensive, multidisciplinary model of community mental health care for people with severe and complex mental health needs who may find it difficult to engage with standard services, and who may have a history of relapse, repeated admission, detention, unstable accommodation, substance use or other risks.

Rather than relying on clinic-based appointments, the team works proactively with people in their own homes and communities, maintaining regular contact, building trusted relationships, supporting medication and psychological interventions, involving families and carers where appropriate, and coordinating practical support such as housing, social inclusion and daily living.

In the context of Bedgebury, Assertive Outreach is not a like-for-like replacement for a ward; it is a better pathway enabler, providing the intensive community support needed to help people move safely and more directly from secure care into the least restrictive appropriate setting, while reducing avoidable inpatient stays and out-of-area placements.

7. PATIENT SAFETY AND TRANSITION

The transition will be managed carefully. Admissions to Bedgebury have been paused to allow a managed run-down of the service. Each current patient will have an individual discharge plan, including Section 117 aftercare arrangements where applicable.

NHS Kent and Medway will maintain commissioner oversight of patient discharge planning and will work with Kent and Medway Mental Health NHS Trust and the Kent, Surrey and Sussex Provider Collaborative to ensure safe continuity of care.

A Decommissioning Transition Group will be established to oversee implementation. This group will provide assurance on:

- patient discharge planning and onward care arrangements
- workforce transition and redeployment planning
- financial reconciliation and timing of resource release

- implementation of reinvestment into community mental health provision
- risk management, quality assurance and service continuity
- communications with staff, patients, families and stakeholders.

8. WORKFORCE

The ICB will seek assurance that any workforce implications are managed sensitively.

9. ENGAGEMENT AND SCRUTINY

Given that Bedgebury is accessed only by referral from two secure wards, is not publicly accessible, admissions have already been paused, alongside the existence of clear alternative pathways already used for the majority of patients, NHS Kent and Medway believes the proposal to be a pathway redesign rather than a substantial service change.

The ICB, KMMHT and KSS Provider Collaborative will develop a coordinated communications approach, with messaging focused on quality, patient experience, least restrictive care and reinvestment into community alternatives.

Patients currently at the unit have been engaged during this process.

10. EQUALITY, QUALITY AND LEGAL CONSIDERATIONS

A Quality Impact Assessment and Equality and Health Inequalities Impact Assessment have been undertaken.

Implementation will follow the ICB Safe Exit Protocol and the Decommissioning and Disinvestment Policy to ensure due process and a safe, managed transition.

The proposal supports the principles of least restrictive care, recovery-focused support and equity of access to community-based pathways.

It also aligns with national and local policy direction to reduce unnecessary inpatient care and strengthen community mental health provision.

11. RISKS AND MITIGATIONS

Risk	Mitigation
Patient transition risk during service run-down	Individual discharge plans, Section 117 planning, commissioner oversight and escalation routes to appropriate acute or forensic beds if clinical need changes.
Community capacity not fully mobilised at closure	Phased implementation, reinvestment into Assertive Outreach, use of existing community pathways and monitoring through the Decommissioning Transition Group.
Workforce uncertainty	Provider-led workforce plan, redeployment opportunities and regular assurance through implementation governance.

Financial timing mismatch between closure and reinvestment	Contractual notice, financial reconciliation and tracking of released resource within the mental health baseline.
Reputational or scrutiny concern	Transparent engagement with the Committee, consistent communications and emphasis on improved patient experience and least restrictive care.

12. TIMELINE

• Admissions to Bedgebury paused to support a managed run-down of the service.

• Current patients to continue through individual discharge planning, with most expected to exit by September 2026.

• Formal contractual safe exit process to be initiated subject to approval.

• Decommissioning Transition Group to oversee patient, workforce, financial, quality and communications workstreams.

• Released funding to be reinvested into community mental health capacity, including Assertive Outreach provision.

13. IN SUMMARY

The decommissioning of Bedgebury Ward is a positive and necessary step in modernising the mental health pathway in Kent and Medway.

It will move resource away from a small, outdated and restrictive step-down model and into community-based support that better reflects current standards, supports recovery and enables people to live more independently.

The proposal is clinically led, quality driven and consistent with the strategic direction for mental health services: earlier intervention, stronger community provision, reduced reliance on inpatient and out-of-area care, and better outcomes for patients.

Lead officers	Dr Jihad Malasi, Adult Mental Health Clinical Lead Louise Clack, Deputy Director, Adult Mental Health

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Item 7 – Meningitis B Outbreak Response

By: Kay Goldsmith – Assistant Democratic Services Manager (operations)

To: Health Overview and Scrutiny Committee, 3 June 2026

Subject: Meningitis B Outbreak Response

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

It provides background information which may prove useful to Members.

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1) Introduction

a) In March 2026, there was a Meningitis B outbreak in Canterbury which required urgent public health action. NHS Kent and Medway has provided the attached report on their response to the outbreak, which involved cross partnership working.

2) Recommendation

a) RECOMMENDED that the Committee note the report.

Background Documents

None.

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NHS
Kent and Medway

Meningitis B (MenB) Outbreak Response – Summary of Incident and System Response

1. INTRODUCTION

In March 2026, a cluster of invasive Meningitis B cases was identified in Canterbury, prompting urgent public health action.

During the outbreak, 21 cases were confirmed - all of whom were hospitalised, nine required intensive care, and two individuals sadly passed away.

NHS Kent and Medway, working in partnership with the UK Health Security Agency (UKHSA) and system partners, including Kent County Council (KCC), declared a Major Incident and coordinated a system-wide response to prevent further spread of infection and protect those at highest risk. The response required rapid mobilisation of services at scale, including the delivery of antibiotics and vaccinations to a defined population cohort within a compressed timeframe.

This response has been recognised nationally. It demonstrated the ability of the Kent and Medway system to respond rapidly and effectively to a significant public health risk, protecting local communities through coordinated action at scale.

The Committee is asked to:

- Note the scale and pace of the system-wide response to the Meningitis B outbreak
- Recognise the impact of the response in protecting the health of the population
- Note the key successes and headline outcomes delivered through a coordinated multi-agency response

2. STRATEGIC ALIGNMENT

The response to the Meningitis B outbreak directly supports the ICB's strategic objectives by ensuring the timely commissioning and mobilisation of services to meet urgent population health needs. It demonstrates the system's ability to deliver coordinated, high-impact interventions at pace, and reflects the ICB's statutory responsibilities as a Category One Responder under the Civil Contingencies Act 2004.

It is important to recognise the cooperation and support of the four affected schools, the University of Kent and the nightclub, Club Chemistry. These organisations worked closely with system partners to facilitate communication with students, parents and staff, support identification of eligible individuals, and enable access to vaccination and antibiotic provision. Their engagement played a critical role in ensuring rapid reach into affected populations and supporting high levels of uptake. Without this collaboration, delivery at the required pace and scale would have been significantly more challenging.

3. MENINGITIS B OUTBREAK – SYSTEM RESPONSE

The system response was initiated following a request from UKHSA to deliver a mass antibiotic prophylaxis programme (and later deliver a vaccination programme). A Major Incident was declared by NHS Kent and Medway, enabling the rapid activation of established

emergency response arrangements and coordinated action across NHS organisations, local authorities and wider partners. This was further supported by the Kent and Medway Resilience Forum declaring a Major Incident and establishing Strategic Coordination Groups chaired by the Director of Public Health form Kent County Council and Tactical Coordination Groups Chaired by NHS Kent and Medway.

The response was clinically led, with input from KCC public health and NHS clinical leaders to ensure safe and evidence-based delivery. Eligibility for antibiotics and vaccination was determined using UKHSA-defined clinical criteria, applied consistently across all delivery sites to ensure a fair and robust approach.

Significant activity was delivered within a short timeframe. By the time the major incident was stood down on 1 April 2026, 13,524 antibiotic courses had been administered and 11,747 vaccinations delivered as part of the first phase of the programme. A second phase vaccination programme was subsequently mobilised across seven sites within the county to ensure completion of the vaccination course which continues to date.

Delivery arrangements of both Phase 1 and 2, were designed to maximise accessibility for the affected population. This included the use of multiple geographically distributed sites and targeted communication approaches to ensure equitable access for those identified as at risk. High levels of uptake were achieved across defined cohorts, and no evidence of unmet need has been identified.

Clear and timely public communications were issued throughout the incident to support awareness, manage demand and direct individuals to appropriate services. This contributed to maintaining public confidence and ensuring that those eligible were able to access treatment and vaccination promptly.

The response demonstrated a number of key strengths. The speed and scale of mobilisation enabled the system to move from identification of the outbreak to delivery of antibiotics within a few hours. Likewise with vaccinations, delivery to individuals began within 24 hours of the announcement. This ensured that large numbers of individuals received antibiotics and vaccination safely within a very short timeframe. Strong multi-agency collaboration supported a coordinated and unified response, with organisations working effectively together to deliver shared objectives. Established emergency preparedness resilience and response arrangements were activated successfully, with staff across all agencies clear on their roles and responsibilities, reflecting the effectiveness of prior planning and training.

The overall public health impact of the response was significant. The rapid implementation of antibiotics and vaccination reduced the risk of further transmission and protected the local population. There is no evidence of ongoing uncontrolled transmission linked to the original cluster following the response. The level of anxiety in communities has significantly reduced.

As with any response of this scale and complexity, learning has been identified. This includes areas relating to coordination between national and local arrangements and workforce resilience. These are being addressed through structured improvement plans to further strengthen future response capability.

4. KEY RISKS, MITIGATIONS, AND CONTROLS

The immediate risks associated with the outbreak were mitigated through the rapid implementation of antibiotics and vaccination at scale. Ongoing risks are being managed through continued delivery of the second phase vaccination programme and the embedding of learning identified through debrief processes.

Financial impacts associated with the response are being captured and reviewed through established governance processes. Actions arising from lessons identified are being developed with clear ownership and timescales and will be monitored through NHS Kent and Medway's governance arrangements.

The response was delivered during a period of organisational change across the system, requiring significant flexibility and resilience from staff and partners. The response also required a substantial contribution from staff across multiple organisations, delivered at pace alongside existing service pressures.

Despite these challenges, the system maintained effective delivery, demonstrating adaptability, commitment and strong partnership working throughout the incident.

5. REQUIRED OUTCOMES AND NEXT STEPS

The Committee is asked to note the contents of this report, recognise the scale, pace and effectiveness of the response, and acknowledge the contribution of system partners in protecting the population.

The next steps are to complete the second phase vaccination programme, continue monitoring population health, embed learning from the incident into future planning, and further strengthen system readiness through improvements to emergency preparedness arrangements.

Executive Lead	**Author**
Ed Waller, Deputy Chief Executive and Accountable Emergency Officer Strategic Incident Commander during Major Incident	Rebecca Pullen, Associate Director for System Discharge and Flow Tactical Incident Commander during Major Incident and Men B Recovery Lead

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