

# **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 Wednesday, 3 June 2026.

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### **PRESENT:**

Mr R Mayall (Chair), Mr T Mole (Vice-Chair), Mr MJ Baker, Mr A Hook, Mr O Bradshaw, Mr H Rayner, Mr S Jeffery, Mr D Sian, Mrs B Porter, Mr A Ricketts, Mr Roots, Mr T Shonk, Mr S Mochrie-Cox, Mr M Paul and Mr P Cole.

### **ALSO PRESENT:**

Mr R Yates.

### **IN ATTENDANCE:**

Mr Dominic Cox (Deputy Chief Commissioning Officer), Mrs Claire Robson (The Company Secretary of the Kent and Medway Integrated Care Board) Mrs Rebecca Fox (Director of Quality and Deputy Chief Nurse), Mrs Rose Waters (Service Director for Forensic and Specialist Directorate) Mrs A Taylor,

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## **UNRESTRICTED ITEMS**

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### **Apologies and Substitutes**

*(Item 1)*

1. Apologies were received from Mrs C Russell (substituted by Mr H Rayner), Dr G Sturley (substituted by Mr M Paul), Mr A Kibble (substituted by Mr D Sian) and Mr M Brice (Substituted by Mr A Hook) and Mrs Keen.
2. Mr R Gotham (Healthwatch) was in virtual attendance.

RESOLVED that the apologies and substitutions be noted.

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### **Declarations of Interest by Members in items on the agenda**

*(Item 2)*

1. Mr Mochrie-Cox declared that he was Gravesham Borough Council's representative at the Integrated Care Partnership that oversees the Integrated Care Board (ICB) work.
2. During Item 6 Mr Hook declared that his professional work occasionally involved individuals receiving mental health care and he would therefore not participate in the debate.

RESOLVED that the declarations of interest be noted.

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### **Minutes of the meeting held on 2 April 2026**

*(Item 3)*

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

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### **Structural Changes to NHS Kent and Medway Integrated Care Board (ICB)**

*(Item 4)*

*Mr Dominic Cox (Deputy Chief Commissioning Officer), Mrs Claire Robson (The Company Secretary of the Kent and Medway Integrated Care Board) and Mrs Rebecca Fox (Director of Quality and Deputy Chief Nurse),*

- 1) The Committee received the report outlining the structural changes to the NHS Kent and Medway ICB Mr Cox introduced the item, which included the following key points:
  - a) The purpose of the structural change was to enable a more strategic approach to commissioning services at both national and local levels. The revised structure would aim to support a more proactive and outcome-focused approach in the future.
  - b) A greater consideration would be given to inequalities and population needs, and how these would be addressed with the move towards a more clinically led model of commissioning. There would be increased engagement with partners.
  - c) The new model created more opportunities for joint working between the NHS and councils, including commissioning arrangements.
  - d) The transition involved organisational and restructuring changes providing opportunities for staff to move to different organisations, supporting an

improved integration of services, staff would be supported throughout the changes.

- e) Members were advised that some elements of the transition (including shared services such as procurement and digital) would not be fully established by 1 July.
- f) The programme had operated as a transitional initiative but would now become the general operating model. Appropriate oversight would be maintained through the Integrated Care Board governance arrangements.

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

- a) Further clarification was sought regarding the extent to which integration with local authorities had been considered within the proposals, as the report had referenced only limited collaboration.
- b) Members discussed issues relating to inequalities, noting that in addition to health inequalities, there were wider inequalities that required consideration. Clarification was sought on how the organisation intended to manage and reduce these inequalities.
- c) Additional questions discussed the approach to collaborative working with local authorities. Concerns were expressed about the current approach, including previous experiences of joint working, the pooling of budgets, and instances where there had been a lack of clarity over responsibilities. Additional points raised discussed how accountability would be maintained and whether sufficient safeguards would be in place before progressing further pooled budget arrangements.
- d) Mr Cox acknowledged the points raised and outlined that partnership working with local authorities remained an important priority. Work would be ongoing to address inequalities through collaboration, although the specific approaches and arrangements discussed would continue to develop over time.
- e) Referring to the development of neighbourhood health arrangements across Kent and Medway, Mr Cox outlined a proposed model and how it would be structured around different layers of care of delivery.
- f) Mr Cox outlined the proposed commissioning structure within the model, noting that this would include arrangements for primary care. He explained that single neighbourhoods would comprise groups of general practices operating within defined geographical areas, while multi-neighbourhood arrangements would cover larger populations of approximately 250,000

residents or more. It was further discussed that the final tier of the model related to acute care services.

- g) In response to further Members questions, aspects such as neighbourhood working would be central to tackling health inequalities and wider determinants, with local authorities already progressing related work and collaboration essential for effective delivery.
- h) The approach aimed to shift services towards prevention, early intervention and community-based provision, in line with longstanding ambitions to reduce reliance on acute care. In response to earlier queries, the Mr Cox confirmed that a commissioning policy had been developed with a renewed emphasis on joint commissioning.
- i) Members were advised that partners would review previous arrangements to identify effective practice, improve future joint working and any potential opportunities through the Better Care Fund. The importance of maximising the impact of shared resources and the commitment to ongoing partnership working to support delivery of the strategic approach was discussed as a priority.
- j) Mr Cox acknowledged that, historically, some processes had not been undertaken as effectively as intended, particularly in relation to engagement and commissioning timelines. Members were advised that a revised approach would be implemented to ensure earlier and more proactive engagement with partners, providers, local authorities and communities took place.
- k) In addition, Mr Cox explained that the new approach would enable commissioning discussions to begin significantly earlier and allow greater opportunity for collective input and challenge. It was further highlighted that this represented the clear expectations from senior leadership and the Board.
- l) In response to concerns regarding governance and accountability, Mr Cox clarified that the Integrated Care Board operated within a formal accountability framework, with oversight from NHS England and, following national changes, continuing accountability to the Department of Health. He emphasised that the organisation was subject to clear lines of scrutiny and could not act independently without accountability.
- j) Mr Cox acknowledged that neighbourhood plans had been submitted to meet national deadlines before full engagement had taken place, noting that these were not final and would continue to develop. Presenters confirmed that there would be further opportunities for collaboration and that the improvement of engagement with partners and communities remained a priority as the plans would continue to develop.

- k) Members raised concerns regarding the scale of historic financial pressures and referred to previous discussions where deficits in excess of £40 million had been identified. It was questioned how the current report addressed the prevention of any similar financial positions arising in the future.
- l) It was acknowledged that the financial position had related to previous historic discussions and Members were assured that work was underway between the Integrated Care Board and the Council to resolve and rectify the situation. It was agreed that the comments and concerns raised would be recorded in the minutes as was the request that future reports for greater financial clarity.
- m) Questions were raised on the lack of patient experiences captured within the paper with additional concerns raised on the benefits and dis-benefits that could possibly occur. Mr Cox responded that the changes had been driven by national requirements and would result in a reduction in headcount however, the primary intention would be to change the way services operated in the future, with a focus towards a more integrated delivery withing teams.
- n) Additionally, Mrs Fox highlighted that the move to a more strategic commissioner model would enable an improved and greater understanding of the patient's experience, including accessibility and the quality of care provided.
- o) A key role of the quality team would be to monitor the experience of individuals accessing the service and to ensure providers would be held to account for delivering high-quality care and Mrs Fox confirmed that the current process for assessing patient experience and holding providers accountable would continue.
- p) Mrs Fox confirmed that, while there had been a requirement to reduce headcount within the ICB, staff who had been transferred out of the organisation had done so under protected employment arrangements and would not be at risk of redundancy. It was highlighted that individual provider organisations would manage their own workforce processes separately.

RESOLVED that the Committee note the report.

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## **Changes made to Commissioning Fertility Treatments in Kent and Medway**

*(Item 5)*

*Mr Dominic Cox (Deputy Chief Commissioning Officer) and Mrs Rebecca Fox (Director of Quality and Deputy Chief Nurse) were in attendance of the item:*

- 1) The Committee received the report outlining the changes to commissioning fertility treatments in Kent and Medway.
  - a) NHS Kent and Medway had reviewed its policy on NHS-funded treatment and implemented changes on 1 April, 2026. The Committee was advised that the revised policy was based on clinical evidence and had been subject to public engagement, with feedback considered as part of the process.
  - b) It was discussed that the changes aligned with national trends, with approximately 69% of all Integrated Care Boards having introduced similar amendments.
  - c) Mr Cox acknowledged that planned communication with Members prior to the decision had not taken place and confirmed that engagement had been intended but did not occur and expressed regret for the oversight.
  - d) The changes to the Policy would deviate further away from the current NICE (National Institute for Health and Care Excellence) guidelines. Mrs Fox outlined the rationale for the changes, noting that they were made within an established commissioning framework and based on evidence relating to clinical effectiveness, outcomes and equality impact.
  - e) Members were advised of the key changes to NHS-funded fertility treatment policy:
    - i) reduction in the upper age limit for eligibility from 40 to 38
    - ii) reduction in the number of funded treatment cycles
    - iii) reduction in the number of embryo transfers. .
- 2) Members raised the following points:
  - a) Concerns were raised on the lack of information depth captured in the papers provided. Members expressed alarm regarding the process by which the changes had been implemented, noting that the decision appeared to have been taken following engagement and was contrary to any feedback received from the public.
  - b) Members commented on the perceived imbalance between clinically led decision-making and community input, noting that the impact of the changes on residents was substantial and that the revised policy did not align with NICE guidelines, representing a significant departure from recommended standards.

- c) The reduction of both the age threshold and the number of funded cycles /transfers went beyond what would be expected if based solely on clinical evidence. Members suggested that the combined changes could limit access to treatment and create a negative perception that the decision had been driven by cost-saving measures rather than clinical needs.
- d) Members questioned if changes to the IVF treatment impacted individuals on lower incomes disproportionately, potentially increasing inequality and suggested that the combined changes to eligibility and treatment offer should be subjected to greater scrutiny. Additional clarification on adequacy of consultation and the consideration of impacts on affected families was also raised.
- e) Presenters acknowledged the concerns raised and discussed the fertility effectiveness data had indicated that there was a significant decline in IVF success rates due to increasing age, measured by live births per embryo transfer. It was discussed that success rates were approximately 40% at age 35, reducing to around 20% at age 40, and less than 10% at age 42, which was within the age ranges referenced by NICE guidance.
- f) Members challenged the clinical justification for the revised age threshold, noting that the data presented did not clearly demonstrate a significant drop-off in outcomes specifically at age 37. Members raised that available evidence had typically grouped outcomes into broader age cohorts, making it difficult to validate the rationale provided, particularly given the limited supporting detail in the submitted report to the Committee.
- g) Other concerns included that the report, which had been issued shortly after implementation of the decision, did not provide sufficient detail to support effective scrutiny. Members suggested that future reports should more clearly set out the basis for decision-making. Members also queried the extent to which decisions were informed by patient need, clinical evidence, or financial considerations.
- h) It was suggested that the report lacked detail on the financial considerations underpinning the decision and that this had not been clarified in responses. Clarification was sought on the estimated impact and whether this related to specific eligibility changes or the wider policy. The report did not clearly quantify or communicate the anticipated savings and had limited the Committee's ability to fully scrutinise the basis for the decision.

- i) Members also requested that more comprehensive data be captured, including previous birth figures, projected impacts on future births, and the associated financial implications.
- j) Mrs Fox clarified that an engagement activity with service users was undertaken in advance of the change, rather than a formal public consultation. Mr Cox confirmed that this had been conducted in line with the relevant requirements, but apologised again for not notifying the Committee in advance.
- k) Members of the Committee raised concerns that the decision introduced three substantive reductions in service, relating to age eligibility, number of cycles and number of embryo transfers. They also remained unclear on the impact on low-income families and same sex couples whose eligibility was already significantly challenging in terms of criteria and cost.
- l) Mr Cox confirmed that feedback from the Committee would be reflected upon and emphasised that, while engagement could be strengthened, the decision had been based on available evidence and was not taken with adverse intent, reaffirming a commitment to working constructively with Members going forward

3) Mr Jeffery proposed, and Mr Hook seconded, the motion that:

The Committee submit a call-in request to the Secretary of State for Health and Social Care about the decision to change the NHS funded IVF fertility treatment offer for Kent and Medway residents.

The motion was put to the vote and was carried.

RESOLVED that the Committee submit a call-in request to the Secretary of State for Health and Social Care about the decision to change the NHS funded IVF fertility treatment offer for Kent and Medway residents.

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## **Bedgebury Ward and Proposed Service Redesign**

*(Item 6)*

*Mr Dominic Cox (Deputy Chief Commissioning Officer) and Mrs Rose Waters (Service Director for Forensic and Specialist Directorate) presented the item:*

- 1) Mr Cox introduced the item, which was about a proposed pathway redesign which would see Bedgebury Ward in Maidstone decommissioned. The officer

explained that a recent review had identified that the existing model was not aligned with national expectations for rehabilitation and was not delivering the most appropriate outcomes for service users and their families.

- 2) Mrs Waters provided further detail, noting that Bedgebury Ward was a 10-bed unit located within a medium secure setting, which limited its effectiveness as a rehabilitation environment.
- 3) Members were advised that:
  - a) The proposal was to redirect resources towards a more proactive, community-based model of care, including assertive outreach and more intensive multidisciplinary support, in line with recognised best practice.
  - b) The unit had opened in 2016 but had not been fully utilised as part of a typical rehabilitation pathway and was not regarded as a high-quality setting. Admissions and transfers to the unit had already been paused, reflecting concerns about its suitability.
  - c) Additionally, the unit's location had limited opportunities for patients to reintegrate into the community, including maintaining contact with family and social networks, which were key components of a successful and effective rehabilitation.
  - d) The established Forensic Outreach and Liaison Services (FOLS) would be supporting patients on discharge pathways from secure settings. Discharge planning had involved partnership working with local authorities, including care needs assessments and panel considerations, with a range of outcomes identified based on individual need, such as supported or independent living, rehabilitation units, or residential care options.
  - e) There were currently five patients within the Bedgebury unit. All five patients were on established discharge pathways and would not require the new assertive outreach provision. Discharge planning was progressing appropriately. It was anticipated that all patients would be discharged by early 2027.
  - f) The Committee was informed that the proposal was to reinvest resources into community-based support, including the development of an assertive outreach service to support patients transitioning from secure settings to the community.
  - g) The new model aimed to:
    - i) provide care closer to home

- ii) improve rehabilitation outcomes
- iii) reduce reliance on inpatient step-down beds
- iv) better align with national clinical models and best practice.

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

- a) Members queried how patients would be supported during the interim period between the cessation of admissions to the Bedgebury unit and the implementation of the new community-based arrangements in the Autumn, seeking assurance that appropriate care would be maintained during this transition. Mrs waters confirmed the individuals would continue to be supported by the FOLS team.
- b) In response, Members were advised that that resources would be reinvested into a community-based model, including multidisciplinary and assertive outreach support, as the current service was not aligned with best practice.
- c) Officers emphasised that this represented a redesign rather than a reduction in service, aimed at improving integration and patient outcomes. The number of patients affected was small and issues with the current model, including its suitability and location, had informed the proposed changes.
- d) Additional queries were raised on the assessment of impacts arising from the proposed change. Further clarification was sought on the potential impact on local authorities, referencing earlier comments in the meeting.
- e) Members expressed concerns that insufficient information was available to fully assess the implications and that the proposal should be treated as a substantial variation due to the current uncertainty regarding its impacts. They asked for clearer and more definitive information on resources and finances.
- f) Officers responded to concerns that the specific areas may become disenfranchised by the removal of specific provisions and explained that multiple sites of rehabilitation were present throughout the County.
- g) Members considered that there was a lack of patient experience and engagement in the presented paper. Officers acknowledged the concern and suggested this aspect be presented in a returning paper.
- h) The Committee discussed patient outcomes and transition arrangements, a number of patients had already been discharged over recent months and years with positive outcomes.

- i) Remaining patients had been progressing well, and many were already on extended trial leave and benefiting from community placements. Currently there was no indication that remaining patients would need to return to inpatient care.
  - j) Officers responded to questions from Members regarding how a redistribution of resources and investment into community resources could be an overall better model. Officers referred to national evidence which indicated that such approaches could lead to improved outcomes for individuals' rehabilitation and recovery and that the intention was to utilise existing investment more effectively by reallocating resources to areas where they could have a greater impact.
  - k) The importance of strengthening community-based services was highlighted. The officer acknowledged that, as services shifted further into the community, there would be a need to ensure sufficient capacity and capability to manage increased demand. It was noted that this consideration would form a key part of the ongoing work to implement the model.
  - l) A Member questioned the proportion of bed discharges that had required rapid readmission within 12 to 24 months, including through crisis team interventions or Accident and Emergency attendance, and sought clarification on how these outcomes would be monitored in the context of any decommissioning. Officers acknowledged that the data was not available at this time.
- 5) Mr Rayner proposed, and Mr Jeffery seconded, the motion that:
- a) the Committee deem the Bedgebury Ward pathway redesign as a substantial variation of service, and
  - b) that the NHS, Kent and Medway representatives be invited to attend the Committee and present an update at an appropriate time, including the information requested regarding the proportion of bed discharges that had required rapid readmission within 12 to 24 months, including through crisis team interventions or Accident and Emergency attendance, and sought clarification on how these outcomes would be monitored in the context of any decommissioning

The motion was carried by majority vote.

RESOLVED that:

- a) the Committee deem the Bedgebury Ward pathway redesign as a substantial variation of service, and

- b) that the NHS, Kent and Medway representatives be invited to attend the Committee and present an update at an appropriate time, including the information requested regarding the proportion of bed discharges that had required rapid readmission within 12 to 24 months, including through crisis team interventions or Accident and Emergency attendance, and sought clarification on how these outcomes would be monitored in the context of any decommissioning.
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## **Meningitis B Outbreak Response**

*(Item 7)*

*Mr Dominic Cox (Deputy Chief Commissioning Officer) and Mrs Claire Robson (The Company Secretary of the Kent and Medway Integrated Care Board)*

- 1) The Committee received a report about the response to the recent Meningitis B outbreak, and Mr Cox highlighted the following aspects of the report:
  - a) a coordinated local response had been delivered in March 2026 involving Kent County Council, the NHS, UK Health Security Agency, education providers and the venue concerned. It was highlighted that strong collaboration had enabled effective management of the incident.
  - b) A declaration of a major incident and activation of the NHS's role as a Category 1 emergency responder and had resulted in the swift implementation of a mass antibiotic prophylaxis programme and vaccination response.
  - c) Responses had been clinically led with strong joint leadership from the Council and NHS, ensuring it was safe and evidence based. Additionally, the response had been rapid, well-coordinated and supported by proactive communication. Approximately 13,500 antibiotic treatments and 12,000 vaccinations delivered across multiple sites, and the overall scale and effectiveness of the mobilisation were highlighted as positive, proactive and organised.
  - d) Officers discussed areas for improvement, including the need to strengthen coordination between local and national partners in the event of a future incident. Further discussion raised that workforce resilience required further consideration, as responses of a large scale could place significant pressure on a small number of staff. Ongoing reflections were being undertaken across the NHS and partner organisations to address the challenges encountered.
- 2) Members responded to the report with the following:

- c) They raised concerns that the East Kent Hospitals University Foundation Trust was not present at the Committee to discuss the incident. Concerns on how long it took the organisation to flag the incident and how other organisations were also not present to discuss their role in the incident.
- d) Members raised that awareness of the meningitis outbreak among students appeared to have arisen only after a video circulated showing an emergency response, rather than through formal communication and expressed worries regarding the timeliness and urgency of the University's response and if there had been shortcomings on how the incident was communicated.
- e) Conversely, Members praised the speed in which KCC and the administration had dealt with the incident and it was discussed that the recommendation go beyond noting the report by formally recognising the efforts of those involved in delivering the response, and by recording the Committee's sympathies for the friends and families of the individuals who had died, as well as those affected by the incident
- f) Following a question, officers confirmed that a formal debrief was either underway or pending to identify lessons learned and address gaps, noting the complexity of multi-agency coordination and information-sharing constraints.
- g) Additionally, it was discussed that social media had supported the official response through community awareness, and that Members sought reassurance on whether the overall outcome reflected system effectiveness or favourable circumstances.
- h) In response Mr Cox explained that the UK Health Security Agency (UKHSA) review was understood to be in progress, though its status was not yet confirmed.
- i) It was discussed that factors such as the timing of the incident during the academic term and the movement of students between campus and home had been considered as part of the response and had presented additional challenges for managing and communicating the situation.
- j) A motion was proposed by the Chair that the Committee's recommendation be amended to formally thank the teams who delivered the response and to record the Committee's sympathies with the friends and families of the two individuals who had died, as well as those who had suffered as a result of the incident.

RESOLVED that the Committee:

- a) note the report
  - b) formally thank the teams who delivered the response,
  - c) express its sympathy with the families and friends of the two people who had died and all those affected by the incident.
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**END**