Medway Council

Meeting of Health and Adult Social Care Overview and Scrutiny Committee

Tuesday, 16 June 2026

6.36pm to 9.28pm

Record of the meeting

Subject to approval as an accurate record at the next meeting of this committee

Present: Councillors: McDonald (Chairperson), Campbell (Vice-Chairperson), Anang, Barrett, Cook, Crozer, Finch, Jackson, Nestorova, Perfect, Mark Prenter, Shokar and Wildey

Co-opted members without voting rights
None

Substitutes: None

In Attendance: Dominic Cox, Deputy Chief Commissioning Officer, Kent and Medway Integrated Care Board (ICB
Adam Doyle, Chief Executive, NHS Kent and Medway ICB
Scott Elliott, Head of Health and Wellbeing Services
Lee-Anne Farach, Director of People and Deputy Chief Executive
Rafey Faruqui, Clinical Director, Kent and Medway Mental Health NHS Trust (KMMH)
John Goulston, Chair of Kent Community Healthcare NHS Foundation Trust (KCHFT)
Su Irving, Head of Adult Partnership Commissioning and the Better Care Fund
Jim MacDonald, Deputy Chief Medical Officer, NHS Kent and Medway ICB
Mairead McCormick, Chief Executive, KCHFT
John Niland, Deputy Chair and Non-Executive Director, Medway Community Healthcare (MCH)
James Pavey, Regional Operations Manager, South East Coast Ambulance Service (SECAmb)
Teri Reynolds, Principal Democratic Services Officer
Adrian Richardson, Director of Partnerships and Transformation, KMMH
Martin Riley, Managing Director, MCH
Jack Rye, Programme Lead, Accommodation and Registered Services
Clare Thomas, Deputy Chief Operating Officer (KCHFT) and Interim Chief Operating Officer (MCH)

71 Apologies for absence

An apology for absence was received from Leanne Trotter (Healthwatch Medway).

72 Record of meeting

The record of the meeting held on 12 March 2026 was agreed by the Committee and signed by the Chairperson as correct.

73 Urgent matters by reason of special circumstances

There were none.

74 Disclosable Pecuniary Interests or Other Significant Interests and Whipping

Disclosable pecuniary interests

There were none.

Other significant interests (OSIs)

There were none.

Other interests

There were none.

75 Chairperson's announcements

The Chairperson, on behalf of the Committee, expressed its deepest sympathies of the recent loss of a colleague from NHS Kent and Medway Integrated Care Board. They had been highly regarded and respected across the system and the Committee sent its deepest sympathies to the individual's family, friends and colleagues.

The Chairperson also informed the Committee that he had been requested to alter the order of the agenda and with the Committee's agreement, items 8 and then 7 were taken first, before returning to item 5.

76 Proposed Pathway Redesign and Decommissioning of Bedgebury Ward

Discussion:

Representatives from both NHS Kent and Medway Integrated Care Board (ICB) and the Kent and Medway Mental Health NHS Trust (KMMH) introduced the report which proposed a mental health pathway redesign that had been developed between both the commissioner (ICB) and the provider (KMMH) and

aimed to redirect resource to a more proactive, assertive outreach model. It was explained that the in-patient service at Bedgebury was an outdated model developed prior to forensic outreach and community based support, which was now sufficiently established to support patients, complemented by assertive outreach treatment. As a result, admissions to Bedgebury Ward had been paused and the remaining five in-patients were expected to leave between September 2026 and January 2027, when the ward would close.

Members then raised a number of questions and comments, which included:

- **Timeframes** – in response to a question about when decisions were taken to pause admissions, it was confirmed that discussions between the ICB and KMMH had taken place in early 2026 when it was decided to pause admissions while the proposals were considered. Members were reassured that no patient care plans had been accelerated as a result of the timeframes for closure of Bedgebury Ward.
- **Public safety** – in response to concerns around public safety when people with complex mental ill health were treated in the community, it was explained that patients were not discharged into community based provision without support and many were subject to Ministry of Justice Restriction Orders, providing legal requirements of how patients were monitored and supported. If a patient relapsed, they were admitted to the acute setting and where patients improved, they were moved to the Community Mental Health Team. It was added that some patients were known to be difficult to engage and discharge between the forensic outreach service and community mental health services and therefore the assertive outreach treatment would bridge the gap between the two teams and improve patient care and public protection outcomes.
- **Reduction in mental health beds** – concern was raised that there would be an overall reduction of beds across the mental health service within Kent and Medway. In response it was explained that Bedgebury Ward was contained within a medium secure forensic site so had very specific limitations. In addition, the increased utilisation of community based support had reduced reliance on mental health beds.
- **Case study** – the point was made that a case study to demonstrate the care between the two pathway models would have been beneficial in understanding of the rationale provided. In response, an offer to provide more detail on the step down from the in-patient forensic unit was made and would be shared with Members outside of the meeting.
- **Funding resource** – clarification was sought on the resourcing for the service and whether all funding from the closure of Bedgebury Ward would be repurposed into the Assertive Outreach pathway. The ICB confirmed that the funding would be redirected into the new model, with additional investment, anticipated to be at least double the current allocation, being provided.
- **Skills resource** – clarification was sought as to whether staff with the correct skill set were already in place to provide the care for the new pathway or whether training or new personnel was needed. It was

confirmed that current staff within the wider Forensic Psychiatry Service, and those in Bedgebury Ward, would have the relevant skills and once a formal decision was made, KMMH would work with the ICB to allocate current staff or recruit additional staffing as required.

- **Insufficient information** - Members expressed their frustration at the lack of information in the report, particularly around financial implications. It was reiterated that when information was commercially sensitive, it was possible to share with the Committee under confidential papers which would not be published but would provide the Committee with the information they needed to effectively scrutinise the issue.
- **Engagement** – it was confirmed that Healthwatch had not been notified or engaged with in relation to the proposals. Criticism was also made of the late engagement with the Committee, given the decision to pause admissions was already taken and being implemented.
- **New pathway** – clarification was sought about how Bedgebury Ward had been used and it was explained that it was a step down unit for those within the forensic psychiatry service that were discharged from acute secure wards, which meant patients received unnecessary extended hospital stays. It was confirmed that discharging those patients to the Forensic Outreach Service instead, did not mean they were moved to independent living. Many were moved to specialist residential care providers with forensic expertise so continue to receive treatment but within the community.
- **Accommodation funding** – referring to the specialist residential care and accommodation, clarification was sought on how this was funded. In response it was confirmed that there were a variety of sources, included local authorities that would be expected to fund some accommodation provision.
- **Capacity** – concern about the capacity of community provision was raised. It was confirmed that any patient in the acute forensic unit would meet the criteria for the new pathway and would begin transition while in the acute setting. In terms of capacity, robust monitoring would be undertaken and such issues would need to be managed on an individual basis. The ICB were unable to provide detail around capacity and provision mapping for this pathway redesign at the meeting.

Decision:

1) The Committee noted the submission from the ICB, as set out at Appendix 1 to the report and the SV questionnaire, as set out at Appendix 2 of the Supplementary Agenda and determined that the proposal did constitute a substantial variation or development in the provision of health services in Medway because of the lack of engagement through the development stages and decision making process and lack of clarity of cost benefits.

2) The Committee also requested an urgent briefing on the following:

- The funding envelope and financial implications of the proposal;
- Clarification of when the decision to pause admissions to Bedgebury was officially made;
- More information on the additional accommodation placements required and how these would be funded.

77 Changes to NHS Funded IVF Treatment in Kent and Medway

Discussion:

The Chief Executive (CE) of NHS Kent and Medway Integrated Care Board (ICB) introduced the report and apologised for failures in the process of engagement around the fertility services review, acknowledging that both Medway HASC (this Committee) and the Kent Health Overview and Scrutiny Committee (HOSC) should have been consulted at the beginning of the process. The ICB had therefore taken the decision to re-instate the previous IVF offer, backdating that decision to the 1 April 2026, and would re-open dialogue and consultation in relation to the proposal. He also wanted to use the opportunity to work with other ICBs across the South-East to potentially create more parity and fairness across the landscape in terms of the eligibility criteria, which differed across the region. He also emphasised the financial difficulties and the £200m deficit the ICB was trying to address, hence the need to make difficult decisions.

The Deputy Chief Medical Officer explained that in the climate of limited funding, the proposals had been developed to maximise successful outcomes. He also explained that of the 28 women that had been accepted for fertility treatment in the year 2025-26, had those changes been in place during that period, six would have no longer been eligible.

Members then raised a number of questions and comments, which included:

- **Mitigations for future engagement** – in response to what mitigations had been put in place to avoid a future error in the engagement process, the ICB CE described the broader organisational issues inherited since he joined the ICB in 2025, including cultural issues, a major headcount reduction, the significant financial deficit position and a need to reset commissioning processes.
- **Commissioning intentions** – the ICB CE explained that he intended to share with the Committee in the summer, the ICB's commissioning intentions which would outline its considerations for commissioning decisions that the Committee could then have early sight of and comment on. He also referred to the Memorandum of Understanding between the Committee and NHS bodies which was being developed, which would help to reaffirm expectations of relationships.
- **Lack of detail** – Members expressed their frustration of the lack of information within the report, including financial modelling. It was explained that estimated average savings from the changes had been

approximately £900k by reducing the number of cycles from 2 to 1 and approximately £480k by reducing the upper age limit from 40 to 38.

- **Retrospective eligibility** - Concern was raised about how many women had been denied treatment since 1 April, who would now be eligible and how they would be notified, along with women less easy to identify, who had not been in the formal system but may have been working to prepare for it, such as losing weight in preparedness and had not pursued an application because they had believed they were no longer eligible under the new criteria. In response the ICB confirmed this was their immediate priority. They did not believe at this stage that anyone had been directly impacted by the decision but they were working on a communication strategy to ensure a wide reach and were contacting all fertility providers.
- **Wider cost of proposals** – reference was made to the potential wider cost implications of the proposals, such as poor mental health of families who would be denied treatment under the new criteria, who would have otherwise been eligible. It was explained that understanding further the views of those with lived experiences was vital which had been one contributory factor to re-opening the engagement process. Reference was also made to the falling birth rate and the negative impact the proposals would have on addressing that national issue.

Decision:

The Committee noted the submission from the ICB, as set out at Appendix 1 to the report and the SV questionnaire, as set out at Appendix 2 of the Supplementary Agenda and determined that the proposal did constitute a substantial variation or development in the provision of health services in Medway because of the lack of consultation and lack of information in the report.

78 Update from South East Coast Ambulance Service NHS Foundation Trust

Discussion:

The Divisional Director of Operations Kent, at the South East Coast Ambulance NHS Trust (SECAmb) introduced the report which provided an update on the group model between SECAmb and the South Central Ambulance Services (SCAS). He explained that the move towards a group model was still at an early stage and that a new Group Chair had been appointed, with a new Group Chief Executive expected in the autumn. He emphasised that there would be no immediate impact on Medway residents in the short term and impact in the medium term was unlikely.

Members then raised a number of questions and comments, which included:

- **Future resourcing** – in response to a concern raised that the group model would result in a reduction in ambulances or stations, it was explained that the rationale was about sharing learning and improving

resilience between the organisations, rather than reducing services in Medway.

- **Virtual care** – The shift in the health and care demands was referenced, particularly in the context of an aging population, which was causing the trust to change how it served residents. There was a growth in managing people with less urgent need and assisting them in navigating the health and care system, providing virtual care and so development of pathways and exploring how to best use the frontline work force, whilst ensuring ambulances were sent to those that need them most was underway. This shift was enabling paramedics to make more use of their clinical skills in a virtual setting.
- **Safeguarding** – reference was made to safeguarding in the context of the group model. It was confirmed that safeguarding practices was a strength of SECAmb who had robust procedures in place and was a strength that the trust brought to the Group model.

Decision:

The Committee noted the report.

79 Proposed Integration between Kent Community Health NHS Foundation Trust and Medway Community Healthcare Community Interest Company

Discussion:

Representatives from both Kent Community Healthcare NHS Foundation Trust (KCHFT) and Medway Community Healthcare Community Interest Company (MCH) introduced the report which provided an update on plans to integrate the two organisations, which would involve the transfer of MCH staff and services into KCHFT. During the tender process for Community Services provision across Kent and Medway, the two organisations had provided a collective and collaborative bid, which was successful. The integration was to strengthen that further by improving access to community services; reducing duplication; strengthening neighbourhood-based care; improving consistency across Kent and Medway; making better use of digital and data and increasing resilience for smaller, specialist teams. The Boards of both organisations had therefore decided to progress with integration in April 2026.

Members then raised a number of questions and comments, which included:

- **Local services** – the point was raised that historically MCH was seen to provide a better, more local service to meet the specific needs of Medway, and it was asked why that position had now shifted. In response it was explained that the health and care landscape had significantly changed and the collaboration in the context of community services would be less sustainable if MCH remained as a separate, small organisation. The integration would enable more resilient services and more opportunities for workforce. Assurance was sought around whether services would continue to be provided from existing premises in Medway. It was confirmed that no immediate changes were proposed

and therefore services would continue to run as they currently were when they formally transfer to KCHFT on 1 October 2026. The likely longer term impact was that more services would be delivered in Medway as a neighbourhood health area, with an ambition to deliver services in a modern estate that was fit for purpose.

- **Staff survey** – reference was made to the outcome of the MCH staff survey, which resulted in 88.6% of respondents being in favour of the reintegration. The survey was in addition to a number of staff engagement events where the organisation was able to hear and respond to staff views. It was added that of around 1700 MCH staff, approximately 250 had responded to the survey.
- **Key performance measures** – In order to measure the benefits for Medway residents, it was asked whether the Committee could be given current baseline figures for Medway services so there was something to compare data with going forward. MCH undertook to provide that. In addition, it was asked what measurable performance indicators there would be to hold KCHFT to account on the proposed benefits going forward and KCHFT confirmed they would share data for key measures. The point was also made that one of the key longer-term outcomes anticipated from the integration was improved health outcomes for residents.
- **Governance and oversight** – in response to a question about how the wider organisation would work and who would lead the services in Medway, it was explained that the Deputy Chief Operating Officer at KCHFT was also the Interim Chief Operating Officer at MCH so was working across both organisations to understand how MCH worked and how to manage the move across of MCH staff and services. It was reiterated that staff would move over and continue to deliver the same services in the same teams at the start of the contract, with transformation towards neighbourhood health ambitions overtime. The importance of Executive Team presence in overseeing the transfer and bedding the service and staff in was also acknowledged.
- **Strength of integration** – Frailty was provided as an example of a service that would benefit from the integration. Across Kent and Medway there was an aging population and many had complex health and care needs. Investment in frailty services in Medway had historically been low compared to other areas and the integration and transformations towards neighbourhood health would benefit older people in Medway who would be better supported to receive treatment at home and remain at home where safe to do so. It was also felt that the innovation and opportunities that would be brought by the transformation would assist in the attraction of GPs to Medway, which had historically been under-resourced compared to other areas.
- **MCH Executive Team** – reference was made to the fact that none of the Executive Team from MCH would be transferring to KCHFT, but it was explained that this had been through personal choice, due to their own decisions around retirement, secondments or other opportunities in other organisations. This was a disappointment for KCHFT as some of the

MCH organisational memory would be lost but the dual-hatted member of staff currently working across both organisations would mitigate risks around lack of continuity.

- **Ongoing engagement** – it was confirmed that engagement for staff, patients and the wider community was ongoing and the importance of this to continue was emphasised by the Committee, including its own involvement in ongoing engagement.

Decision:

The Committee noted the update on the proposed integration of KCHFT and MCH and the SV assessment attached at Appendix 1 and determined that the proposal did constitute a substantial variation or development in the provision of health services in Medway because there had not been sufficient engagement and this would result in significant deviation of contract through transformation.

80 Residential and Nursing Care for Older People (Aged 65+)

Discussion:

The Programme Lead for Accommodation and Registered Services introduced the report which provided the Committee with an update on the recent procurement exercise for residential and nursing care in Medway. The key changes to the new contract were that bandings were linked to need rather than a formal dementia diagnosis and a fifth band had been created for highly specialist care due to the increase in complexity of need for some individuals. In addition, there was a robust key performance indicator framework to which all providers were required to submit monthly, quarterly and annual data to enable the commissioning team to ensure quality of service and performance. In terms of the tender process, 36 providers applied and 18 were accepted onto the framework, representing 29 care homes. This had been lower than had been desired and therefore the tender would be reopened in the summer to encourage additional providers to apply/re-apply.

Members then raised a number of questions and comments, which included:

- **Supporting smaller businesses** – the point was made that larger organisations would have access to staff or consultants who specialise in tender bids, whilst smaller businesses would be less equipped and may need support. This was acknowledged by officers who would be looking to support such providers as best they could within the confinements of procurement legislation.
- **Number of bed** – information on the number of beds available across the 29 homes in the contract was requested and would be shared with Members outside the meeting.
- **Fees** – in response to a question about fees and how they compared with other areas, officers confirmed that the team engaged with the market daily and rates was a common theme of discussions. The Council benchmarked with other local authorities as much as was

possible. There had been no direct feedback to commissioning officers that rates had dissuaded providers from bidding.

- **Encouraging engagement** – it was asked how the service would be encouraging more providers to bid when the tender process was reopened. It was explained that there would be a significant campaign to demonstrate the benefits of working with the Council, such as the strong relationships that compared well to other authorise due to the significant offer of collaboration through monthly forums and fortnightly newsletters. Officers were also working with Category Management to mitigate the issues for those that were not successful last time due to technicalities rather than concerns in standards of service provision

Decision:

The Committee noted the report and requested additional information on the total number of beds covered and the relationship between framework capacity and local demand.

81 The One Medway Council Plan Performance Monitoring Report and Strategic Risk Summary - Quarter 4 2025/26

Discussion:

The Director of People and Deputy Chief Executive introduced the report which outlined how the Council had performed in Quarter 4 on the delivery of the Council's priorities, based on the areas covered by the remit of the Committee. She highlighted two indicators in particular; 1.15 (page 147) which stated that by 2027/28 the proportion of closed safeguarding enquiries where risk is reduced or removed is better than the national percentage, and 1.22 (page 154) which stated that by 2027/28, the proportion of long-term clients receiving support via a Direct Payment is similar to or better than the national percentage. She referred the Committee to the narrative for both indicators and reassured the Committee that these were both areas of focus for her to improve performance on.

Decision:

The Committee noted the progress of performance in Q4 as set out at Appendix 1 and the strategic risk summary set out at Appendix 2.

82 Work programme

Discussion:

The Principal Democratic Services Officer introduced the report which set out the Committee's work programme. She highlighted the Committee's informal development session that was taking place on 23 June 2026 where it was hoped a draft version of the Memorandum of Understanding between the Committee and the NHS would also be shared for early discussion, but she would keep Members informed.

Decision:

The Committee noted the report and agreed the work programme as set out at Appendix 1 to the report, subject to accepting the proposed changes, outlined in italic text on Appendix 1.

Chairperson

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