HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Tuesday, 31st January, 2023

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Tuesday, 31st January, 2023, at 10.00 am **Council Chamber, Sessions House, County Hall, Maidstone**	Ask for: Telephone:	**Kay Goldsmith** **03000 416512**

Membership

Conservative (10):	Mr P Bartlett (Chair), Mr P V Barrington-King, Mrs B Bruneau, Mr N J D Chard, Mr P Cole, Ms S Hamilton (Vice-Chairman), Mr A Kennedy, Mr J Meade, Mr D Watkins and Mr A R Hills
Labour (1):	Ms K Constantine
Liberal Democrat (1):	Mr D S Daley
Green and Independent (1):	Mr S R Campkin
District/Borough Representatives (4):	Councillor J Howes, Councillor P Rolfe, Councillor K Tanner, and 1 vacancy

UNRESTRICTED ITEMS

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

Item		Timings*
1.	Substitutes	
2.	Declarations of Interests by Members in items on the Agenda for this meeting.	
3.	Minutes from the meeting held on 30 November 2022 (Pages 1 - 10)	
4.	Kent and Medway Integrated Care Strategy (Pages 11 - 84)	10:05
5.	Mental Health Transformation - Places of Safety (Pages 85 - 126)	10:25
6.	Specialist Children's Cancer Services (Pages 127 - 146)	10:50
7.	Vascular Services (East Kent and Medway) (Pages 147 - 154)	11:15

8. Children and Adolescent Mental Health Services (CAMHS) Tier 4 provision (Pages 155 - 160) 11:25

9. Work Programme (Pages 161 - 166) 11:35

10. Date of next programmed meeting – 28 March 2023

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)

**Timings are approximate*

Benjamin Watts
General Counsel
03000 416814

23 January 2023

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, 30 November 2022.

PRESENT: Mr P Bartlett (Chair), Mr N J D Chard, Mr P Cole, Ms S Hamilton (Vice-Chairman), Mr J Meade, Mr S R Campkin, Cllr J Howes, Cllr K Tanner, Mr D Jeffrey, Mr R G Streatfeild, MBE, Mrs P T Cole, Mr B J Sweetland and Ms L Wright

PRESENT VIRTUALLY: Ms K Constantine, Mr P V Barrington-King

ALSO PRESENT: Dr J Jacobs (Local Medical Committee), Mr R Goatham (Healthwatch)

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

UNRESTRICTED ITEMS

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

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

The Chair declared he was a representative of East Kent authorities on the Integrated Care Partnership.

88. Minutes from the meeting held on 7 July 2022
(Item 3)

RESOLVED that the minutes from the meeting held on 7 July 2022 were a correct record and they be signed by the Chair.

89. Hyper Acute Stroke Unit (HASU) implementation update
(Item 4)

Kate Langford, Chief Medical Officer (NHS Kent and Medway ICB) was in virtual attendance for this item.

1. Dr Langford highlighted key points from the agenda report, reaffirming the ICB's commitment to the changes which would improve the sustainability, quality and accessibility of stroke care for patients across Kent and Medway. Centralised stroke services were proven to have better clinical outcomes than those that were not centralised.

2. During the covid pandemic, services at East Kent hospitals had relocated to Kent and Canterbury Hospital to free up acute capacity for Covid-19 patients.

Services would return to the William Harvey site. There had also been a move of service from Medway Hospital to Darent Valley and Maidstone hospitals on quality and safety grounds.

3. Dr Langford explained that activity and bed modelling had been completed in 2017, and those assumptions were being reviewed to ensure they were still robust ahead of the business cases being finalised.

4. The ICB had previously committed to showing the Committee data on call to needle times. Dr Langford explained that was not yet possible as the data had not been provided by the Sentinel Stroke National Audit Programme (SSNAP) but she hoped it would be possible in Spring 2023.

5. Kent & Canterbury Hospital did not have an on-site A&E department and a Member questioned what the impact had been on the temporarily relocated Stroke services from William Harvey. Dr Langford said that SSNAP audit data had shown improved outcomes, and the national team were re-looking at the expected dependencies for a site with a HASU. It was expected co-location would with an A&E would remain and the service would return to William Harvey in the future.

6. A Member questioned the slow pace of change, with proposals first introduced in 2014. Dr Langford noted the importance of communication and working together, which the Integrated Care System (ICS) would help with.

7. In light of comments about the length of time elapsed and the positive outcomes from stroke service relocation to Kent and Canterbury Hospital, a Member asked if the decision of where to locate three HASUs was still the right one. Dr Langford confirmed original assumptions were being looked at to ensure those decisions were still right.

8. Members asked to see the latest SSNAP dashboard along with the stroke unit rating.

9. In response to a question about developing skills locally, Dr Langford said Kent and Medway were training an excess of physician associates and there was opportunity to encourage these staff into stroke pathways.

10. Members asked to see data on the number of patients incorrectly directed to a stroke unit. The use of telemedicine and triaging had reduced those numbers but Dr Langford said there would always be some as the rule was to err on the side of caution.

11. RESOLVED that the Committee note the report and that the ICB return with an update at the appropriate time.

90. Maternity Services at East Kent Hospitals University NHS Foundation Trust
(Item 5)

In attendance from EKHUFT for this item: Tracey Fletcher, Chief Executive Officer, Sarah Shingler, Chief Nursing and Midwifery Officer, Dr Rebecca Martin, Chief Medical Officer, Zoe Woodward, Consultant Obstetrician and Gynaecologist and Clinical Director for Women's Health and Carol Drummond, Interim Director Midwifery.

1. On behalf of the Committee, the Chair said his thoughts were with the families over the unimaginable heartache that was the result of avoidable and preventable failures at the Trust. The Trust had not been willing at first to accept those failures, but he hoped to hear that the system had changed significantly to address such concerns.
2. Ms Fletcher said the Trust was deeply sorry for what had happened and fully accepted the themes and findings of the Kirkup report. Improvement work at the Trust had already begun, particularly around listening to families and governance processes, but there was much more to be done.

3. In terms of staff changes, there was a real push to identify any issues at the time and not wait for a future review. Recruitment had taken place, including a new Head of Midwifery. The importance of customer care was highlighted.

4. Locum doctors had to undertake 1 week's mandatory training and would not run a ward independently unless a supervisor approved it. The Royal College of Nursing was overseeing the portfolio of locum doctors which was a positive step to secure professionalism.

5. The importance of shared goals was discussed, along with how staff knew about them and understood expectations. These were important, but staffing pressures and the physical environment did have an impact on their deliverability.

6. Ms Shingler spoke of leadership issues in the postnatal ward and how changes had been made with external candidates. 2-hourly rounds had also been in place for six weeks.

7. The Trust were in contact with 28 out of the 202 families contacted as part of the Kirkup review. They were expecting that number to increase, and were open to working with each family taking into account individual expectations and wishes.

8. There was a discussion about the temporary removal of Entonox at the maternity department in William Harvey Hospital. The Trust became aware of high levels of gas in the air that could be harmful to staff who work in the

labour rooms for long periods and therefore took the decision to suspend its use until the issue could be fixed. Referring to a recent visit to the maternity unit at QEQM, the Chair questioned the funding available to improve the situation and offer piped Entonox at both hospital sites. Ms Shingler explained piped Entonox was used at William Harvey (it was not piped at QEQM) but that air ventilation improvements were needed. Ms Fletcher referenced the physical limitations on the sites and accepted capital improvements were needed but were on a list of Trust priorities that needed addressing with limited capital.

9. A member asked each guest what their key priority for the Trust was, and responses ranged from improving culture and behaviours, to developing skills and creating a safe environment.

10. Asked why a patient would be turned away from one hospital and sent to another, Ms Drummond said there were two elements: 1) the maternity unit being at capacity and unable to safely take more patients, and 2) a woman who goes into labour early may need to go to William Harvey as QEQM can only accept patients who have passed a certain gestation point.

11. Setting out the Board's responsibilities, Ms Fletcher explained they were accountable for enacting the themes identified in the Kirkup report. Change needed to be sustainable, and not create new initiatives. Numerous pillars were in place, and it was down to the Board to agree how to bring those pillars together and communicate them to staff and communities.

12. Since May 2022, women had been offered a follow-up call with a midwife to ask about their experiences of the quality of care received. Common themes were dealt with across the organisation. EKHUFT were the only Trust in Kent and Medway to offer this level of engagement, and they had been asked to talk about it at a regional leadership event. The response rate of 64% was pleasing though they aimed for 80%.

13. The Chair spoke of the future and the level of improvement needed. He referenced a letter he had written to the Secretary of State asking for a swift decision about the East Kent Transformation Programme which would lead of capital improvements. He highlighted the need for a second obstetric unit at QEQM. He asked the Trust to return to the Committee with an update on improvements made.

14. RESOLVED that the report be noted and the Trust return at an appropriate time.

91. Stroke rehabilitation services
(Item 6)

Rachel Jones, Executive Director Strategy, Planning & Partnerships (Maidstone & Tunbridge Wells NHS Trust) was in attendance for this item.

1. The Chair welcomed Ms Jones and asked her to introduce the paper.

2. Ms Jones explained that stroke rehabilitation is most commonly delivered in a community setting, but Maidstone and Tunbridge Wells NHS Trust (MTW) had historically delivered it from an acute bed setting. Due to the pandemic and changes at Medway Maritime, it had been necessary to introduce a new stroke rehabilitation pathways. There were two streams – a home based service delivered in collaboration with Hilton Nursing Partners and a community hospital inpatient service at Sevenoaks Hospital. The pathways had been positively received.

3. The Chair asked to what extent virtual therapy had been successful during the pandemic. Ms Jones said support would commence in hospital, moving to the home and only becoming virtual nearer the end of the pathway once the patient was happy with that. She offered to share outcomes once they were available. It was possible for patients to change pathway if the one they were on was not working for them.

4. Speaking of overcoming challenges, such as delayed discharges, Ms Jones explained that the team physically met weekly to discuss how they could be overcome and that had proved effective. Shared stroke rehabilitation competencies had been developed, which allowed staff to speak a common language to each other and patients. With patient permission, it was also possible to share IT systems. For more difficult challenges, particularly around capacity, these were national issues and the Department of Health and Social Care had announced investment in social care which would help patients move out of acute settings more quickly.

5. MTW were looking into other medical conditions that could benefit from a similar rehabilitation pathway.

6. Ms Jones addressed a question around IT systems, highlighting positive media coverage of implementing tele-tracking, which KCHFT also had and allowed the Trust to see what resource was available. Covid had accelerated the digital programme and had shown the benefits of having IT as a key piece of infrastructure. Where patients did not have access to the necessary technology, it would be provided for them. It empowered patients to take control of their own health.

RESOLVED that the Committee note the report.

92. Provision of Ophthalmology Services (Dartford, Gravesham and Swanley)
(Item 7)

Rachel Jones, Executive Director Strategy, Planning & Partnerships (Maidstone & Tunbridge Wells NHS Trust) and David Peck, Director of Integrated Care Partnership DGS were in attendance for this item.

1. Mr Peck set out the background, explaining that Moorfields Eye Hospital had served notice in February 2020 on providing ophthalmology services from Darent Valley Hospital to the residents of Dartford, Gravesham and Swanley (DGS). Maidstone and Tunbridge Wells NHS Trust (MTW) subsequently became providers of the service. Provision no longer took place from Darent Valley Hospital, but all were committed to finding a suitable site within the DGS footprint despite the estate being at capacity.

2. Ms Jones explained that services were being provided from five sites and patients had provided positive feedback about their quality of care.

3. An independent operating theatre in Gillingham (staffed by the NHS) had been commissioned to provide additional capacity and address a patient backlog. This was not sustainable in the long-term. It was hoped a long-term view would be possible within 3 months, but there was a challenge as the site required an operating theatre.

4. Ms Jones confirmed that transport would be provided for those meeting the eligibility criteria. She was asked to share the criteria outside of the meeting.

5. Asked if they were looking beyond the boundaries of DGS, Ms Jones confirmed they were for site options, but MTW staff would have to travel to work from those sites. Other providers had not previously been interested in taking on the service, but this was something that could be explored again. Mr Peck explained there was a capital cost of around £2.5m to establish a new theatre with rehabilitation capacity, and there was a lack of funding available.

6. Mr Goatham from Healthwatch asked if patients had been involved in the models of care being developed. Mr Peck explained there had been some, with increased community provision being built into models of care. They were looking to consolidate best practice across the county.

   RESOLVED that the Committee note the report.

93. Recruitment of nurses
(Item 8)

Rebecca Bradd, Chief People Officer and Dame Eileen Sils, Chief Nurse (NHS Kent and Medway ICB) were in virtual attendance for this item.

1. Ms Bradd spoke of a national nursing shortage, with the paper setting out the position in Kent and Medway. Dame Eileen Sils confirmed the nursing workforce was a key priority for Chief Nurses across Kent and Medway. She spoke of the actions being taken, both in individual trusts and across the Kent and Medway system in a coordinated way. These included:

    - Working with Christchurch University to ensure students stayed in the county after qualifying.
    - Working across the system to provide staff with greater opportunities.
    - Focusing on retention of staff. Ensuring staff had access to support and opportunities to develop skills.
    - Keeping international recruits.

2. A Member questioned the correlation between a lack of affordable housing and nursing vacancies. Dame Eileen agreed that housing was an area of concern. Some organisations were working with local landlords to house overseas recruits. Ms Bradd added that the move to an integrated system allowed for more partnership working to address those problems, and that a strategic estates review would commence in the new year.

3. A Member questioned how Kent and Medway vacancy rates compared with others. Ms Bradd explained there were six systems in the South East, with the K&M rate slightly higher than neighbours at 15% compared to others of 13-14%. This was due to workforce investment, particularly in East Kent, to increase vacancies to address safe staffing levels.

4. Asked whether some areas had greater vacancies than others, Dame Eileen explained there would always be “hard to recruit” areas. It was the responsibility of a Chief Nurse to deploy nurses across clinical roles to ensure there were safe staffing levels.

5. The impact of removing the nursing bursary in 2014 was discussed. Student nurses were receiving a £5,000 living allowance but applications into the career have fallen. Dame Eileen explained they wanted to see a higher number of conditional job offers made to nursing students to incentivise them to stay after qualifying.

6. Discussing how the profession is promoted from a young age, Ms Bradd explained T Levels were available and that individual Trusts had been

undertaking career activity for some time. They were exploring how this could be carried out in a more collaborative and streamlined way.

7. There was a constraint on nursing placements, but it was hoped these would increase by 15% in the next 2 years. Placements needed to have trained practice supervisors as well as offering quality and opportunity to learn.

8. In terms of monitoring, a new metric was called “care hours per patient day” and data was collected nationally. It considered the needs of patients and whether staff had the skills to meet those needs.

RESOLVED that the Committee note the report.

94. Community Diagnostic Centre (Medway and Swale)
(Item 9)

Nikki Teesdale, Director of Delivery (Medway & Swale Health and Care Partnership) was in virtual attendance for this item.

1. Ms Teesdale explained feasibility studies had been carried out at the Sheppey site and current space would be utilised as opposed to a new build. Building works would commence in April 2023. No capacity would be taken away from the acute hospital, it was additional provision. Services would be offered from 8am-8pm.

2. A trial on targeted lung health checks would utilise mobile facilities, as incidence rates of lung cancer on the Isle of Sheppey were particularly high.

3. There were no questions from the Committee. The Chair set out his view that the proposal was not a substantial variation of service because it was an increment to the current service offering.

RESOLVED that
(a) the Committee deems that the creation of two Community Diagnostic Centres in Medway and Swale is not a substantial variation of service.
(b) NHS representatives be invited to attend this Committee and present an update at an appropriate time.

95. Sexual Assault Referral Centre (SARC) - Kent
(Item 10)

Lisa Briggs, Head of Health and Justice Procurement, Workforce and Provider Development (NHS England South East) was in virtual attendance for this item.

1. Ms Briggs confirmed there were no changes to the agenda paper and the consultation process was beginning. NHS England viewed the work as a minor service change.

2. The Chair expressed his view that the proposal was to the benefit of the community due to accessibility issues at the current site.

RESOLVED that the Committee deems that the relocation of Kent's Sexual Assault Referral Centre is not a substantial variation of service.

96. Learning from the closure of Cygnet Hospital, Godden Green (CAMHS tier 4 provision) - written item
(Item 11)

1. The Committee remained unclear on why the previously promised tier 4 beds were not available. At HOSC in Sept 2021, the Committee were told there would be 3 new beds at Woodlands and 3 new 72-hour beds. In January 2022, HOSC were told that the current position at Woodlands was that there were 11 beds and three day places. By April 2022, there was due to be 3 more beds and three day beds. Over £1m had been spent in fitting out the units but the additional beds had still not been delivered.

2. In relation to the eating disorders day clinic due to open in Hove, a Member noted that accessibility was limited. They questioned if partnership with other providers such as in London was possible to make services more accessible?

3. The Committee requested a written response before the next HOSC to answer the above questions.

97. Work Programme
(Item 12)

1. Following discussions during the meeting, the following items would be added to future agendas:
    a. Ophthalmology Services (Dartford, Gravesham and Swanley)
    b. Capital investment at the QEQM Hospital maternity unit
    c. HASU implementation

2. Members also requested the following items be added:
    a. Nurse recruitment
    b. Delayed discharges from hospital

3. RESOLVED that the work programme be noted.

98. Date of next programmed meeting – Tuesday 31 January 2023
(Item 13)

Item 4: Kent and Medway Interim Integrated Care Strategy

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 31 January 2023

Subject: Kent and Medway Interim Integrated Care Strategy

Summary: This paper draws the Committee's attention to the recently published Kent and Medway Interim Integrated Care Strategy and sets out possible impacts on Health Overview and Scrutiny.

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1) Introduction

a) July 2022 saw the statutory introduction of Integrated Care Systems (ICS). These are a partnership of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area.

b) Sitting within the ICS is the Integrated Care Partnership (ICP), a statutory committee jointly formed between the NHS Integrated Care Board (ICB) and all upper-tier local authorities that fall within the ICS area. The ICP brings together a broad alliance of partners concerned with improving the care, health and wellbeing of the population, with membership determined locally. The ICP is responsible for producing an Integrated Care Strategy ("Strategy") on how to meet the health and wellbeing needs of the population in the ICS area.

c) The Integrated Care Partnership was required by the Department for Health and Social Care ("the Department") to produce a Strategy for Kent and Medway and publish it by the end of December 2022. Statutory guidance states that Strategies must inform the first Five-Year Joint Forward Plans which ICBs must agree for the next financial year.

d) Given the tight deadline to produce a complex partnership document the guidance recognised that 2022/23 would be a transitional period and that Integrated Care Partnerships would want to refresh and develop their Strategies as they grow and mature. Therefore, an interim version has been published that will be further developed throughout 2023.

e) The Kent and Medway Interim Integrated Care Strategy can be found online here and is attached in Appendix 3.

2) The role of HOSC

a) The Strategy has been produced by the Kent and Medway ICP. Membership of the partnership can be found in Appendix 1.

b) HOSC's role is not to provide comment on or contribute to the Strategy, but it will need to scrutinise local health services in context, and this could include taking into account the Strategy and other relevant documents (such as the Joint Strategic Needs Assessment – JSNA - and local health and wellbeing strategies).

c) In its guidance for HOSCs (published 29 July 2022), available in Appendix 2, the Department set out its expectations along with those of the Local Government Association (LGA) and the Centre for Governance and Scrutiny (CfGS) on how integrated care boards (ICBs), integrated care partnerships (ICPs) and local authority health overview and scrutiny committee (HOSC) arrangements should work together to ensure that new statutory system-level bodies are locally accountable to their communities.

d) The guidance sets out that proactive and constructive scrutiny of health, care and public health services, done effectively, could build constructive relations that deliver better outcomes for local people and communities.

e) The guidance set out 5 principles for best practice ways of working across system partners. These were:

i. **Outcome focused** – looking at the outcomes of plans and strategies as well as place-based service changes.
ii. **Balanced** – keeping a balance of being future focused and responsive.
iii. **Inclusive** – effective scrutiny allows for an inclusive conversation between all those effected in a decision or plan. HOSCs are a "fundamental way for democratically elected councillors to voice their views of their constituents." "HOSCs, subject to time and resource constraints, may be well placed to engage with members of the public directly".
iv. **Collaborative** – committee work plans should be informed by communities, providers and planners of health and care services. Recognising the importance of Joint HOSCs.
v. **Evidence informed** – scrutiny should be based on the right insight, reflecting all voices and opinions. This includes qualitative and quantitative evidence. Local Healthwatch are an important source of information.

3) Next steps

a) HOSC procedures are at the discretion of individual committees. However, the Department recommends that individual HOSCs develop a framework to help them ensure that their scrutiny work is effective, focused and adds value. It is recommended a framework considers:

- Risks, effects, and impacts to individual populations
- Risks, effects, and impacts to the whole local population
- Risks, effects, and impacts to local health colleagues

b) The Committee is invited to discuss whether the current procedures are still effective in light of the Department's guidance and publication of the Strategy. It may wish to consider developing a framework and/ or establishing a base set of information that the NHS should provide for possible substantial variations of service which includes how the proposals meet the outcomes set out in the local Strategy.

4. Recommendation

RECOMMENDED that the Committee

a) note the contents of the Kent and Medway Interim Integrated Care Strategy

b) delegate authority to the Clerk, in consultation with the Chair of the Committee, to develop a future way of working, that will be shared with Committee Members for comment ahead of implementation.

Contact Details

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Appendix 1
Kent and Medway's Integrated Care Partnership

Membership of the Joint Committee will be made up of elected, non-executive and clinical and professional members as follows:

- Leader of Kent County Council (KCC)
- Leader of Medway Council
- Chair of the NHS Kent and Medway Integrated Care Board (ICB)
- Two additional local authority elected executive members from KCC, who hold an appropriate portfolio Committee membership responsibility related to Joint Committee business
- Two additional local authority elected executive members from Medway Council, who hold an appropriate portfolio responsibility related to Joint Committee business
- One additional ICB Non-Executive Director
- An ICB Partner Member who can bring the perspective of primary care
- The Chairs of the four Kent and Medway Health and Care Partnerships
- An elected District Council representative from within the geographies of each of the four Kent and Medway Health and Care Partnerships

Non-voting participants

- Medway Council Chief Executive
- Kent County Council Head of Paid Service, or nominated representative
- Kent and Medway ICB Chief Executive
- Kent and Medway Directors of Public Health
- Kent and Medway ICB Medical Director
- A representative from each of Kent Healthwatch and Medway Healthwatch
- A representative from the Kent and Medway Voluntary, Community and Social Enterprise Steering Group
- Kent and Medway local authority directors of adult and children's social care

Department
of Health &
Social Care

Guidance

Health overview and scrutiny committee principles

Published 29 July 2022

Applies to England

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Purpose of this document

In advance of the statutory guidance on the Secretary of State's new powers in relation to service reconfigurations, this document sets out the expectations of the Department of Health and Social Care (DHSC), the Local Government Association (LGA) and the Centre for Governance and Scrutiny (CfGS) on how integrated care boards (ICBs), integrated care partnerships (ICPs) and local authority health overview and scrutiny committee (HOSC) arrangements will work together to ensure that new statutory system-level bodies are locally accountable to their communities.

HOSCs, local authorities, ICBs, ICPs and other NHS bodies should use this document to ensure that scrutiny and oversight are a core part of how ICBs and ICPs operate. Leaders from across health and social care should use these principles to understand the importance of oversight and scrutiny in creating better outcomes for patients and service users and ensure that they are accountable to local communities.

Further information on the role of health scrutiny can be found in the Local authority health scrutiny: guidance to support local authorities and their partners to deliver effective health scrutiny (https://www.gov.uk/government/publications/advice-to-local-authorities-on-scrutinising-health-services).

Integrated care systems

The Health and Care Act 2022 (https://www.legislation.gov.uk/ukpga/2022/31/contents/enacted) builds on the work of existing non-statutory integrated care systems (ICSs) to encourage more integrated system working, and to improve local population health outcomes through the planning and provision of services.

The act also provides for the creation of new NHS bodies, ICBs, and for each ICB and its partner local authorities to form a joint committee to be known as the ICP.

42 ICBs will be established, and the 106 existing clinical commissioning groups (CCGs) will be abolished. The ICB will take on the commissioning functions of the CCG and have a governance model that reflects the need for integration and collaboration across the system.

Each ICP will have, as a statutory minimum, a representative from the ICB and a representative from each of the partner local authorities. It may decide locally to include a broad range of representatives in its membership – including those from the independent and voluntary, community and social enterprise (VCSE) sector – concerned with improving the care, health and wellbeing of the local population. The ICP will be tasked with developing an integrated care strategy to address the health, social care and public health needs of its system. The ICB and local authorities will have to have regard to that strategy when exercising their functions. It is important to note that ICPs, as a joint committee between the ICB and partner

local authorities as well as other members agreed by the ICP locally will be within the scope of HOSCs.

There will be a continuing role for HOSCs, health and wellbeing boards (HWBs) and the local Healthwatch as their roles are protected and preserved in the new system.

HOSCs will continue to play a vital role as the body responsible for scrutinising health services for their local area. They will retain their legal duties to review and scrutinise matters relating to the planning, provision and operation of the health service in the area. As is currently the situation, some local authority areas may have separate scrutiny committees for health and for adult social care. ICBs and ICPs should develop a trusting relationship with HOSCs to enable effective scrutiny.

HWBs will continue to bring together leaders at a place level to develop joint strategic needs assessments and prepare joint local health and wellbeing strategies for their local area. HOSCs should consider these strategies when scrutinising outcomes for their local area.

Local Healthwatch organisations will retain their statutory duty to obtain the views of people about their needs and experience of local health and social care services and will need to continue working with HOSCs to make these views known.

The benefits of scrutiny

Proactive and constructive scrutiny of health, care and public health services, done effectively, can build constructive relationships that deliver better outcomes for local people and communities; the people who represent them, and the commissioners and providers of health and care services. It also has other benefits including:

• providing an opportunity for local people and their elected representatives to contribute to and comment on the local priorities for improving health and care services and outcomes

• giving a voice to local people and communities on the quality, safety, accessibility and effectiveness of local health and care services

• assuring local elected members and the public that health and care services are safe and effective, address local health priorities and reduce health inequalities

• helping health and care providers and commissioners gain insight into the health needs and concerns of particular groups

• enabling health and care providers and commissioners to develop new services and care pathways to address local health priorities more effectively

While the procedures of review and scrutiny are at the discretion of the local authority, we recommend that each individual HOSC develops a framework to help them ensure that their scrutiny work is effective, focused and adds value. While this will be informed by other partners in the system, the assessment of risks,

effects and impacts should be the HOSC's own. In particular, we recommend that a framework should consider:

• risks, effects and impacts to individual populations

• risks, effects and impacts to the whole local population

• support and input from local health colleagues

Responsibilities

HOSCs, HWBs, local Healthwatch and NHS bodies collectively have a role to play in good governance and accountability across the health and care system.

The [Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013](https://www.legislation.gov.uk/uksi/2013/218/contents/made) (https://www.legislation.gov.uk/uksi/2013/218/contents/made) will continue to apply although the formal statutory route for local authorities to report to the Secretary of State will be removed when the new reconfiguration provisions in the Health and Care Act 2022 take effect.

Local authorities

Local authorities will retain the power to:

• review and scrutinise matters relating to the planning, provision and operation of the health service in the area. This may well include scrutinising the finances of local health services

• require information to be provided by certain NHS bodies about the planning, provision and operation of health services that is reasonably needed to carry out health scrutiny

• require employees, including non-executive directors of certain NHS bodies, to attend before them to answer questions

• make reports and recommendations to certain NHS bodies and expect a response within 28 days

• set up joint health scrutiny and overview committees with other local authorities and delegate health scrutiny functions to an overview and scrutiny committee of another local authority

• have a mechanism in place to respond to consultations by relevant NHS bodies and relevant health service providers on substantial reconfiguration proposals

• have a mechanism in place to deal with referrals made by local Healthwatch organisations or local Healthwatch contractors

• report disputed reconfiguration proposals to the Secretary of State until the new reconfiguration provisions take effect

NHS bodies

NHS bodies will retain the power to:

• provide information about the planning, provision and operation of health services as reasonably required, depending on the subject by local authorities to enable them to carry out health scrutiny

• attend before local authorities to answer questions necessary for local authorities to carry out health scrutiny

• consult on any proposed substantial developments or variations in the provision of the health service

• respond to health scrutiny reports and recommendations: NHS service commissioners and providers have a duty to respond in writing to a report or recommendation where health scrutiny requests this, within 28 days of the request. This applies to requests from individual health scrutiny committees or sub-committees, local authorities and joint health scrutiny committees or sub-committees

Health and wellbeing boards

HWBs will retain the power to:

• provide assessments of the current and future health and care needs of the local population

• develop joint strategic needs assessments

• develop joint local health and wellbeing strategies at a place level

Local Healthwatch

Local Healthwatch organisations will retain the power to:

• obtain the views of people about their needs and experience of local health and social care services, and to make these views known to those involved in the commissioning and scrutiny of care services

• make reports and make recommendations about how those services could or should be improved

• promote and support the involvement of people in the monitoring, commissioning and provision of local health and social care services

The design of new models of integrated care and support that are being introduced through the Health and Care Act 2022 will inevitably lead to changes in how and where services are provided.

HOSCs will have an invaluable role to play during the initial transition and implementation of ICBs and ICPs, and beyond, in scrutinising the impact and effectiveness of integration on health services and outcomes. Under this new structure, there will be a need for scrutiny of health services and outcomes at a local place-based level, as well as more strategic scrutiny of health services and system-level outcomes. Both levels of scrutiny are important; HOSCs should maintain an appropriate balance between the 2, and establish joint health overview and scrutiny committees (JHOSCs) where appropriate and necessary. Individual local authorities hold responsibility for carrying out scrutiny tests.

Scrutiny can play a valuable role in improving the evidence base for decisions about integration and in holding local authorities, NHS bodies, and health service providers to account for the level of local ambition to improve health and integrate services in ways that benefit people who use services and in the interests of taxpayers. It can also help to ensure that the views of people in an area are fully reflected in the consideration of any proposals.

Principles and ways of working

The following 5 principles set out best practice for ways of working between HOSCs, ICBs, ICPs and other local system partners to ensure the benefits of scrutiny are realised and should form the basis of ongoing discussions between these partners about how they will work together.

The 5 principles are:

- outcome focused
- balanced
- inclusive
- collaborative
- evidence informed

1. Outcome focused

Outcome-focused scrutiny can provide a valuable and relevant platform for looking at cross-cutting issues, including:

- general health improvement
- wellbeing
- specific treatment services and care pathways
- patient safety and experience
- overall value for money

Health scrutiny also has a strategic role in taking an overview of how well integration of health, public health and social care is working and in making recommendations on how it could be improved locally.

By focusing on outcomes, ICPs, ICBs, local political leaders, professionals and communities can explore and consider the complexities of health and wellbeing and help to evaluate the planning, delivery and reconfiguration of health and care services. A strategic approach should be taken to consider how best to apply scrutiny to evaluating key strategies and outcomes of the ICB and ICP, including the integrated care strategy and the ICB joint 5-year forward plan.

Within the wider ICB area, HOSCs will have a valuable role to play in scrutinising and evaluating place-based outcomes at local authority level. HWBs will continue to develop joint strategic needs assessments and establish joint local health and wellbeing strategies; HOSCs will continue to scrutinise place-based health services in relation to these.

However, HOSCs will also play a valuable role in scrutinising the health services of the wider ICB area and should work with other local authority areas, forming JHOSCs where appropriate, to scrutinise outcomes against the joint 5-year forward plan and the integrated care strategy.

2. Balanced

Good scrutiny needs to maintain balance between being future focused and responsive. When scrutiny is future focused it can help system partners to understand how local needs are changing, as well as understand the issues that communities face and suggest and test solutions. Future-focused scrutiny can also add value to integration planning and implementation by improving the evidence base for holding local decision makers to account for the level of local ambition to integrate services and improve population health.

ICBs and ICPs should take an inclusive and future-focused approach to agreeing a clear set of arrangements for scrutiny to be built into the whole cycle of planning, commissioning, delivery and evaluation. Leaders from across health and social care should work with openness and candour to establish a clear shared set of priorities and a future work programme to improve health and social care outcomes.

Scrutiny also needs to be reactive and responsive to issues of concern to local communities, including service performance and proposed NHS reconfigurations, local authorities, and other system partners, should ensure that HOSCs have the capacity to respond reactively to public concerns and reconfigurations. ICBs can assist with this by working with HOSCs to shape their forward plans. ICBs should take a proactive approach to sharing at an early stage any proposals on reconfigurations, drawing a distinction between informal discussions and formal consultations. ICBs should also take a proactive approach to involving relevant bodies on any other matters which system partners expect to be contentious, to help navigate complex or politically challenging changes to local services.

With regard to concerns about service performance, ICBs should be open and transparent with HOSCs, bearing in mind that in some cases there may be legal or assurance proceedings. Equally, HOSCs must appreciate the need for regulatory

and legal processes to run their course, but ICBs should update HOSCs on the progress of these processes.

3. Inclusive

The primary aims of health scrutiny are to strengthen the voice of local people and provide local accountability. They should ensure that local people's needs and experiences are considered as an integral part of the commissioning and delivery of health services, and that those services are effective and safe. Effective scrutiny allows for more inclusive public conversation than might be delivered as part of a formal consultation exercise. As such, it is important for scrutiny to engage the community, involving the right people at the right time in the right place.

HOSCs are a fundamental way for democratically elected local councillors to voice the views of their constituents, hold the whole system and relevant NHS bodies and relevant health service providers to account and ensure that NHS priorities are focused on the greatest local health concerns and challenges. Flexible and accessible arrangements to scrutinise integration issues provide the best opportunities for councillors to hear from people and groups with whom they may not have previously had much contact, for example primary care practitioners or people who use services. HOSCs, subject to time and resource constraints, may be well placed to engage with members of the public directly.

Systems and NHS bodies should form trusting working relationships with HOSCs, and work together to ensure that this important community intelligence is fed directly into system-wide decision making. Engaging with scrutiny is a way for ICBs and ICPs to add richness to their understanding of local need, and a way to connect strategic planning at system level to the nuances of local pressures and requirements.

4. Collaborative

Work plans that detail the future decisions and issues to be scrutinised by HOSCs should be informed by communities, providers and planners of health and care services to ensure that scrutiny is focused on achieving the most value for its population. Effective health scrutiny requires clarity at a local level about respective roles between the health overview and scrutiny committees, ICBs, ICPs, the NHS, local authorities, HWBs and local Healthwatch.

Service change and integration are typically not challenges that are confined to one local authority's area; these are issues that can straddle one or more local authority population. Under the new system-level structures, health scrutiny may increasingly need to cover issues that cut across local authority boundaries. Therefore, local authorities on ICB boundaries, and neighbouring councils within an ICB area should take a collaborative approach in order to identify any strategic issues that would benefit from joint scrutiny. Under Regulation 30 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, local authorities must appoint a joint health overview and

scrutiny committee where a relevant NHS body or health service provider consults more than one local authority health scrutiny function about substantial reconfiguration proposals; however local authorities also have the discretion to set up joint committees in other circumstances.

The role of JHOSCs is particularly important in assessing strategic issues that cover 2 or more local authority areas, and will be even more important under the new arrangements as ICB areas will span more than one local authority area in most cases. In particular, JHOSCs will have a strategic role to play in scrutinising the delivery and outcomes of the integrated care strategy.

It is important for ICBs, councils and scrutiny committees to develop joint protocols in advance of the need for any joint scrutiny arrangements, whether these arise under legislation or are optional arrangements. This includes having a clear view about how councils should work together, the structure of joint arrangements, and the time needed to establish these arrangements. JHOSCs will also need to recognise and take into account the potential difficulties of working together, particularly around the political balance between different local areas, as well as resourcing. Developing this shared understanding helps build the foundations for effective joint working. ICBs should have an active role in providing support in these situations and should recognise the complexity and time involved in establishing formal JHOSCs.

5. Evidence informed

Scrutiny informed by evidence can help make the case for better integration of services, better joint working around service improvements and better approaches to major service reconfigurations. Scrutiny adds value to decision making by ensuring that evidence is sound and based on the right insight, so that no voice is unheard or evidence overlooked. The types of evidence that aid effective scrutiny include evidence on quality and safety of services and evidence on population health needs. Qualitative evidence from those with lived experience – including patients, the public and those who are most likely to be excluded from services – are particularly valuable forms of evidence for aiding scrutiny.

Health scrutiny has a role in proactively seeking information about the performance of local health services and institutions; in challenging the information provided to it by commissioners and providers of services for the health service locally and in testing this information by drawing on different sources of intelligence. Local Healthwatch are an important source of evidence and should work with HOSCs to pass on the views of people about their needs and experience of local health and social care services.

HOSCs can request evidence from systems and NHS bodies, and should ensure that their requests for evidence are reasonable, proportionate and relevant.

The health system has a responsibility to provide information needed for health scrutiny. Health and care providers and commissioners should respond positively and constructively to the requests for information from HOSCs. Where an NHS

body cannot provide a response to a request for information, it should work with the HOSC to attempt to provide information and support where possible. ICBs should have plans and protocols in place for sharing information for the purpose of scrutiny, as this will avoid the need for continual ad-hoc decision-making when information is requested.

Next steps

The Health and Care Act 2022 introduces a power for the Secretary of State to call in and take decisions on or connected to reconfiguration proposals at any stage in the proposal's process. This does not change local authorities' scrutiny responsibilities for service change. To support this intervention power, the local authority referral power, which is set out in regulations, will be amended to reflect the new process.

DHSC will also issue statutory guidance on the new powers outlining how the Secretary of State proposes to exercise their functions during this new process, including the new Secretary of State call in power. This guidance will also include information for NHS commissioning bodies, NHS trusts and NHS foundation trusts about how they should be exercising their functions under the new reconfigurations process. We expect that these principles will complement the new guidance to help ensure that scrutiny is embedded across the new statutory system-level bodies.

Exact timelines are still to be determined; however, any changes to the reconfiguration process introduced through the Health and Care Act 2022 will not be implemented immediately following Royal Assent. We will work with the system to help prepare for any proposed changes and to develop the new statutory guidance.

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Kent and Medway
Integrated Care System

Kent and Medway Interim Integrated Care Strategy

Kent and Medway
Integrated Care System

Version control

Version no	Purpose	Date
1.0	Issued to core project team for review.	17/10/22
2.0	Issued to project team for second review and commissioning of additional material from content leads, where gaps have been identified. Not for wider distribution - content lead and steering group members' editing only.	19/10/22
3.0	Consolidated version of chapters shared with project team at Canterbury symposium feedback workshop 2 December 2022. Includes initial review of symposium outputs and response to comments on. v2.0. Outstanding actions are as agreed at workshop for completion by 4 November 2022.	1/11/22
4.0	Incorporating comments and additional content from symposium and content leads. Distributed to steering group for review.	10/11/22
5.0	Incorporating comments from steering group and inequalities prevention and population health (IPPH) committee colleagues.	16/11/22
6.0	Incorporating integrated care partnership comments.	22/11/22
7.0	Approved by steering group.	22/11/22

Kent and Medway Integrated Care System

Foreword

Welcome to Kent and Medway's Interim Integrated Care Strategy. The integrated care system is an opportunity for the NHS and local authorities to work together in different ways, putting our residents at the heart of everything we do. This interim strategy sets out the shared purpose and common aspiration of partners to work in increasingly joined up ways. It is rooted in the needs of people, communities and places and will help us drive forward the agreed priorities for action in health and social care across Kent and Medway.

The breadth of the integrated care system, across Kent County Council, Medway Council, the NHS, district councils, the voluntary, community and social enterprise sector (VCSE) and Healthwatch puts us in a unique position to identify opportunities for wider partnerships to strengthen our collective approach to improving longer-term health and wellbeing outcomes. For example, across education, housing, environment, transport, employment, and community safety; these wider social determinants of health, and others, have a significant bearing on the health and wellbeing of communities and health inequalities, particularly for people experiencing deprivation. The integrated care partnership will champion joint approaches and look for opportunities to embed and accelerate these in our strategy.

We truly believe that *together, we can*.

That is why we, as the leaders of Kent and Medway Integrated Care System are signing this pledge and making this commitment through the integrated care strategy.

Our pledge

Recognising that citizens' health, care and wellbeing are impacted by economic, social and environmental factors more than the health and care services they can access, we pledge to bring the full weight of our organisational and individual efforts to collaborate to enable the people of Kent and Medway to lead the most prosperous, healthy, independent and contented lives they can.

Through this collaborative movement, we will work together to reduce economic and health inequalities, support social and economic development, improve public service outcomes, and ensure services for citizens are excellent quality and good value for money. Together, we can.

Cedi Frederick,
NHS Kent and Medway

Cllr Alan Jarrett,
Medway Council

Cllr Roger Gough,
Kent County Council

Kent and Medway Integrated Care Strategy

We will work together to make health and wellbeing better than any partner can do alone

Shared outcome 1

Give children the best start in life and work to make sure they are not disadvantaged by where they live or their background, and are free from fear or discrimination.

Shared outcome 2

Help the most vulnerable and disadvantaged in society to improve their physical and mental health; with a focus on the social determinants of health and preventing people becoming ill in the first place.

Shared outcome 3

Help people to manage their own health and wellbeing and be proactive partners in their care so they can live happy, independent and fulfilling lives; adding years to life and life to years.

Shared outcome 4

Support people with multiple health conditions to be part of a team with health and care professionals working compassionately to improve their health and wellbeing.

Shared outcome 5

Ensure that when people need hospital services, most are available from people's nearest hospital; whilst providing centres of excellence for specialist care where that improves quality, safety and sustainability.

Shared outcome 6

Make Kent and Medway a great place for our colleagues to live, work and learn.

Enabler: We will drive research, innovation and improvement across the system

Enabler: We will provide system leadership, and make the most of our collective resources

Enabler: We will engage our communities on this strategy and in co-designing services

Kent and Medway
Integrated Care System

SYMPOSIUM
28th October 2022

TOGETHER, WE CAN

"DEVELOPING a MOVEMENT ACROSS KENT & MEDWAY"

WORKING in the INTEREST of the PEOPLE we serve!

- Addressing the SOCIAL DETERMINANTS of HEALTH & WELLBEING.
- CREATING SOLUTIONS ROOTED in PEOPLE, COMMUNITY and PLACE!

We have a LEGISLATIVE MANDATE to do things DIFFERENTLY! We will only SUCCEED if ALL PARTNERS make it WORK!

- PROVIDING SOLUTIONS with, not to, MEMBERS of the COMMUNITY!
- ENGAGING PEOPLE in the way they PREFER
- RECOGNISE PEOPLE are COMPLEX and UNPREDICTABLE.

LISTEN, TALK and LEARN from EACH OTHER!

- ALL PARTNERS WORKING TOGETHER AT PACE... & create BETTER and FAIRER health OUTCOMES across our COMMUNITIES.
- WORKING with a SHARED PURPOSE ...and a COMMON ASPIRATION.

WE are FACING MANY CHALLENGES:
- SPENDING RESTRAINT
- INCREASED NEED.

...BUT we have LEARNED many LESSONS on how to WORK TOGETHER during COVID.

OUR VISION:
- ENSURING CHILDREN have the BEST POSSIBLE START in LIFE.
- HELPING the MOST VULNERABLE and DISADVANTAGED.
- HELPING PEOPLE manage their own HEALTH
- SUPPORTING PEOPLE with MULTIPLE HEALTH CONDITIONS.
- ENSURING HOSPITALS are AVAILABLE to those WHO NEED THEM.
- MAKING KENT and MEDWAY a GREAT PLACE to WORK and LIVE.

G.P.
HOSPITAL
COMMUNITY CENTRE

- We must SHARE DATA BETTER... creating a SINGLE SOURCE OF TRUTH!
- MOVING from being a SICKNESS SERVICE to a HEALTH SERVICE - this will require TRUST from MANAGEMENT.

FOCUS on WHOLE SYSTEM CHALLENGES

CAPTURING the VOICE of EVERY PART of the COMMUNITY!

- ADDRESSING HEALTH INEQUALITIES across the REGION

- NO ONE ORGANISATION can ADDRESS our CHALLENGES on their OWN!

...we need to EMBRACE new ways of WORKING TOGETHER!

- VOLUNTARY SECTOR
  - EMPOWERING COMMUNITIES
  - & MAXIMISING COMMUNITY INSIGHT!
- It's about ENGAGEMENT! including communities in CO-DESIGNING SOLUTIONS.

JOINING the DOTS between SMALL VOLUNTARY ORGANISATIONS

REFER KENT!

MANY SMALL VOLUNTARY ORGANISATIONS CANNOT GATHER QUALITATIVE DATA on their PROJECTS.

- IDENTIFY and REPLICATE BEST PRACTICE wherever it HAPPENS!

PREVENTION IS BETTER than CURE! - it will be the KEY to our SUCCESS!

- We need MUTUAL RESPECT & TRUST between LOCAL AUTHORITIES & VOLUNTARY ORGANISATIONS
- INVEST in our PEOPLE & BUILD MORALE
- AS LEADERS we must learn to LISTEN DIFFERENTLY
- ...learning from FRONTLINE STAFF and VOLUNTARY ORGANISATIONS.

- RESEARCH, INNOVATION & DATA
  - WE MUST BUILD TRUST in RESEARCH and RESEARCHERS.
  - BARRIERS: DATA SETS; LACK OF AWARENESS OF ALL THE RESEARCH in the REGION.
  - FOCUS on RESULTS while ENABLING INNOVATION.
  - PEOPLE WANT TO WORK in REGIONS that ENCOURAGE RESEARCH.
  - WE need QUALITATIVE and QUANTITATIVE DATA.

- MIND & BODY
  - HOLISTIC SUPPORT & REDUCE INEQUALITY.
  - GET the DATA RIGHT!
  - HOUSING SAFETY & QUALITY & HEALTH IMPACTS
  - ENCOURAGING PEOPLE & ACCESS SERVICES.
  - SHARED DATA RECORDS.
  - WORKING with VOLUNTARY ORGANISATIONS.
  - ONE AGENCY NEEDS to LEAD!
  - creating EMPOWERMENT & ASPIRATION.
  - MULTI-PARTNER APPROACH - like a WEB?

- ECONOMICS & SHARED PROSPERITY.
  - JOINED UP STRATEGY IS REQUIRED
  - CAREER advice & SKILLS for SCHOOL CHILDREN
  - GIVE YOUNG CHILDREN EXPERIENCE OF HEALTH & SOCIAL CARE.
  - ADDRESS INCOME GAP.
  - IMPROVE the IMAGE of the AREA.
  - ANCHOR INSTITUTIONS.

- DELIVERING FOR LOCAL PEOPLE.
  - HEALTH EDUCATION IS KEY!
  - MOST PEOPLE AREN'T INPATIENTS!
  - BE PREPARED to PUSH BACK vs. GOVERNMENT & TAKE RISK.
  - LESS REPORTING & MORE DOING.
  - STRATEGY ACTION PLAN & PRIORITISE.
  - LOOK AFTER our WORKFORCE as well as the COMMUNITY.

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Kent and Medway
Integrated Care System

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3. Tackling inequalities and wider social determinants of health
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6. Hospital services and specialist care
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10. What next? Engaging our communities on the issues that matter

Kent and Medway
Integrated Care System

Chapter 1

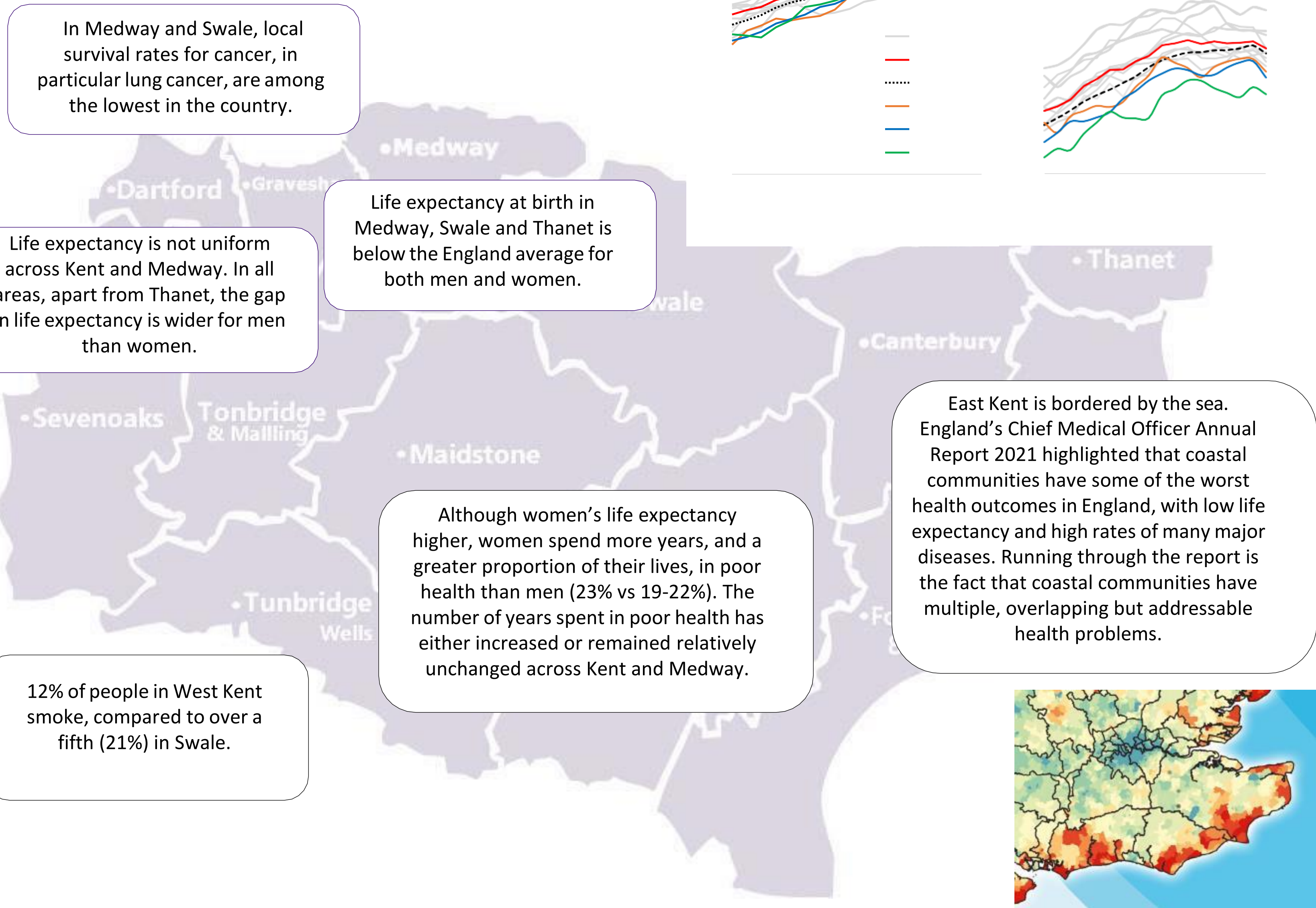
Introduction and vision

Kent and Medway
Integrated Care System

Introduction and context

Kent and Medway is an attractive place for so many who choose to make their lives here. With close proximity to London and mainland Europe, and a plethora of green spaces known as the 'garden of England', it is home to some of the most affluent areas of England. Nevertheless, it is also home to some of the most (bottom 10%) socially deprived areas in England. This correlates with the health outcomes achieved. With the current cost of living crisis, these disparities will persist or worsen without our concerted, collective effort.

Kent and Medway Integrated Care Partnership was formed in 2022. This strategy is our initial blueprint for delivering a healthier future for the population of Kent and Medway over the next 5 years. We will continue to develop and refine this integrated care strategy as we engage with, and listen to, our communities. The strategy is underpinned by our joint strategic needs assessments, individual strategies on selected areas, and our Joint Forward Plan, Medway Joint Health and Wellbeing Strategy, and Kent Public Health Strategy to follow.



Map showing prevalence of coronary heart disease in England

Kent and Medway
Integrated Care System

System

1.9m people

- At system level we come together at scale to set overall system strategy, manage resources and performance, share research and good practice, plan specialist services, and drive strategic improvements. **All** partners constitute the system. System-wide partners include NHS Kent and Medway, Kent County Council and Medway Council.

Places

260,000 – 720,000 people

- Alliances of health and care partners working together to design and deliver services to improve outcomes for the population of Kent and Medway, within delegated responsibilities and budgets. We have four place-based health and care partnerships in Kent: Dartford Gravesham and Swanley, East Kent, Medway and Swale, and West Kent.

Neighbour-hoods

Typically 30,000-50,000 people

- Local decision making and integrated teams to meet the unique needs of their populations – including local health and care organisations and the voluntary, community and social enterprise (VCSE) sector, primary care networks, community groups and community assets.

Kent and Medway Integrated Care Partnership (ICP)

Members include: Kent and Medway Integrated Care Board (ICB), Kent County Council, Medway Council, health and care partnerships, district councils, VCSE representative.

Owns this integrated care strategy.

NHS Kent and Medway Integrated Care Board
Responsible for the joint forward plan.

Kent County Council and Medway Council.

NHS England.

Four place-based health and care partnerships.

12 district and borough councils.

Provider collaboratives.

41 primary care networks.

Individual providers including voluntary and community services, independent sector, NHS trusts and NHS foundation trusts.

Kent and Medway
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What affects our health and wellbeing?

Health and wellbeing is the embodiment of how we live, learn, work and play: it does not start at the GP's door. The overwhelming evidence is that the **wider determinants of health -** socioeconomic factors, our physical environment and our health behaviours - have the most impact on our health.

Variation in people's experience of wider determinants, for example the quality of their housing, their level of education or how safe they feel in their community, has a fundamental effect on their health – creating **health inequalities.** These are the preventable, unfair and unjust differences in health status between groups, populations or individuals. The integrated care system (ICS) is committed to tackling health inequalities to improve the health of our population.

This is why this strategy deliberately addresses **health**, rather than solely **health*care***. We will have a new focus on working together to address the wider determinants of health, tackle inequalities, and prevent people becoming ill in the first place.

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Developing Kent and Medway as a place where people thrive

To address the wider determinants of health, we need to create an environment where everyone can thrive. This means having all of the right building blocks in place, such as stable jobs, high quality housing, good education, green spaces and the opportunity to make healthy choices.

There are several major developments underway in Kent and Medway, with health and wellbeing considered from the outset. For example, **Otterpool Park** is a proposed garden town located in the Kent countryside, close to the seaside towns of Folkestone and Hythe. Otterpool Park will offer the best of a rural and urban lifestyle. Everything that's needed will be there: homes, workspaces, schools, shops, community facilities, spaces for leisure, arts and culture. It will be a healthy and inspirational place to live, work and visit, characterised by large amounts of green space and its strong culture and community.

At place level, the things partners will focus on to make a difference include:

- Good access to jobs, facilities and social opportunities.
- Ensuring everyone has access to education and skills development to fulfil their potential and support a thriving economy.
- Ensuring high quality homes available to all, including the most vulnerable, and tackling homelessness.
- Attracting and retaining high quality sustainable employment to local areas.
- Ensuring people can live in safety with little fear of crime.
- Developing places where active travel, such as walking and cycling, is favoured, and healthy choices are easier to make.
- Ensuring there are systems with sufficient capacity to deliver health protection.
- Recognising and supporting communities as key partners in delivering local solutions.

Kent and Medway
Integrated Care System

How we will work differently

Demand for health and social care services is at higher levels than ever before and there are increasing pressures on public spending. This means we must not only push further and faster in integrating health and care services, we must also cast our net more widely than our traditional organisational boundaries to build the foundations of improved health and wellbeing for the Kent and Medway population.

The Kent and Medway Integrated Care Partnership (ICP) provides a unique opportunity for the NHS and social care to work together with local government and other partners to ensure those chances to improve population health are recognised and maximised, and to ensure that we use our resources to address our population's most pressing needs.

Some examples of how we will work together include embedding population health management across the system and working together on improving the economic prosperity of the county to improve health and wellbeing.

We recognise that integration will not happen without our concerted, collective effort. We are determined to lead by example and create a culture of collaboration and trust, putting the health and wellbeing of the people of Kent and Medway at the heart of everything we do.

Population health management (PHM)

Our vision is to ensure that Kent and Medway's population has the best health possible**.** PHM uses historical and current data to understand what factors are driving poor health outcomes in different population groups, taking a broad view across the wider determinants. Local services can then design new proactive models of care which will improve health and wellbeing today as well as in future years.

Our key goal will be to ensure a whole system collaborative approach to adopting PHM, working across the NHS, council services including public health and social care, the voluntary and community sector and the communities and neighbourhoods of Kent and Medway, to design new models of proactive care and deliver improvements in health and wellbeing which make best use of our collective resources.

People accumulate harms to health across the course of their lives, starting from conception through to old age. Approaches to PHM and prevention need to consider and address each of the stages of people's lives.

A new **economic strategy for Kent and Medway** is being developed.

Three objectives: By 2030 we want our economy to be more...

Productive | Sustainable | Inclusive

To 2030: **Five ambitions** to...

- Enable innovative, productive and creative businesses
- Widen opportunities and unlock talent
- Secure resilient infrastructure for planned, sustainable growth
- Place economic opportunity at the centre of community renewal and prosperity
- Create diverse, distinctive and vibrant places

Leading to economic and wider environmental, health and wellbeing outcomes

Kent and Medway
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Our vision

'We will work together to make health and wellbeing better than any partner can do alone.'

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By doing this, we will:

1. **Give children the best start in life and work to make sure they are not disadvantaged by where they live or their background, and are free from fear or discrimination.**

2. **Help the most vulnerable and disadvantaged in society to improve their physical and mental health; with a focus on the social determinants of health and preventing people becoming ill in the first place.**

3. **Help people to manage their own health and wellbeing and be proactive partners in their care so they can live happy, independent and fulfilling lives; adding years to life and life to years.**

4. **Support people with multiple health conditions to be part of a team with health and care professionals working compassionately to improve their health and wellbeing.**

5. **Ensure that when people need hospital services, most are available from people's nearest hospital; whilst providing centres of excellence for specialist care where that improves quality, safety and sustainability.**

6. **Make Kent and Medway a great place for our colleagues to live, work and learn.**

The remainder of this document sets out our strategy for achieving each of these six strategic outcomes. We also set out our key enablers of system leadership focus, how we will drive research, innovation and improvement across the system, and our next steps, including engaging with our communities.

Kent and Medway
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Chapter 2

We will give children the best start in life and work to make sure they are not disadvantaged by where they live or their background and are free from fear or discrimination.

We will achieve this by:

- delivering effective maternity services
- supporting families to start well
- adopting a whole family approach
- safeguarding children.

Kent and Medway Integrated Care System

Maternity services

We are committed to improving outcomes and experience for families using our maternity and neonatal services. We will continue to implement the ambitions of the NHS Long Term Plan and use the learning from the Independent Inquiry into East Kent maternity services (known as the Kirkup Report) to help us hear the voices of families who use services and involve them in helping us make positive changes.

Through the existing clinically led partnership of our local maternity and neonatal system (LMNS) we will:

- Ensure that we have robust processes to identify quality concerns across all of our trusts, enabling shared learning and taking proactive actions to improve patient safety.
- Continue to develop local Maternity Voices Partnerships as our main way of hearing service user feedback and involving people who have used services in making improvements.
- Embed personalised care and support planning to increase choice and control for women throughout their pregnancy and postnatal period.
- Take targeted action on workforce recruitment, retention and training to ensure that all of our maternity and neonatal services achieve sustainable, safe and effective staffing levels.
- Support all of our trusts to implement maternity continuity of carer, initially focusing on black, Asian and mixed ethic groups and those living in our most deprived communities.
- Take targeted action to improve equity of outcomes for those from local minority groups and deprived communities, engaging closely with voluntary sector groups who support these communities, and developing a more diverse workforce.
- Procure a new shared maternity information system across all of our trusts to give families improved access to their records and enable better information sharing.
- Ensure community maternity services work in close partnership with health visiting and other community services for families, particularly in the development of Family Hubs.

Kent Start for Life – we have built our awareness and understanding of the impacts of perinatal mental health on infant health. Training has been offered and delivered to different groups such as non-health professionals. This has included highlighting the differing needs and ways in which ethnicity or culture may change the way mental health need is expressed by pregnant or post-natal women and recognising that partners' and carers' mental health is impacted as well. Focus groups in Kent contributed to the findings which reiterated the need to help inform and support parents – to-be and parents in the workforce which led to the development of parental workplace wellbeing recommendations.

- Continue to develop our specialist perinatal mental health community services, enabling more people to access them, including assessment and signposting for partners.
- Complete implementation of Thrive, our new maternal mental health service offering psychological support for birth trauma and perinatal loss.
- Complete the implementation of other new services that support families who need extra help during their maternity journey, including smoking cessation pathways, pelvic health services, and specialist maternal medicine.

Kent and Medway Integrated Care System

Starting well

Health inequalities begin early in life. Differences exist between population groups in many key health outcomes for children. These differences include smoking in pregnancy, breastfeeding and childhood obesity, which can affect health and wellbeing outcomes in later life.

We need to take a holistic and family-centered approach. Integrated support for families must include a wide offer that spans housing, communities, health, education, social care and the voluntary sector.

The prevention of poor health and wellbeing outcomes before birth and the promotion of good health and wellbeing at the start of life lays the foundation for better health outcomes. The wider socio-economic context of the family and community also contributes, for example, if fewer children experience child poverty, adult health outcomes and healthy life expectancy will improve.

Services need to evolve to meet the needs of the population, be evidence based and co-produced with our partners and users that have lived experiences. Therefore, a focus on growing our place and system workforce to work together to deliver care closer to home and within a wider network of support at local level (for example VCSE) is required.

Through this we will:

- support parents to be the best parents they can be
- ensure high quality preschool education and school readiness
- provide inclusive education that will optimise every child's potential
- support practices to increase uptake of childhood immunisations, including a targeted media campaign to improve coverage of pre- school vaccination.

We know that we need to rapidly improve the support we provide to children with special educational needs and disabilities (SEND) in Kent and Medway, including those who are neurodiverse, and we will work as a system to do this. Short-term actions will include better and faster clinical assessment of SEND needs, improving the experience that parents have when they contact us and strengthening SEND provision in mainstream schools. In the longer-term, we will explore arrangements to bring services for children with SEND together to maximise our resources and deliver better outcomes and experience for children and families.

Medway Council is committed to its child-friendly Medway programme, demonstrating that the voices, needs, priorities and rights of children are an integral part of public policies, programmes and decisions.

Being **overweight or obese** increases the risk of developing a host of diseases. In Kent and Medway, over a third of children aged 10 to 11 are overweight or obese and are more likely to stay obese into adulthood. At a practical level, establishing widespread use of initiatives such as the 'daily mile' in schools can reduce obesity, increase fitness and improve classroom focus. Our built environment also has a role to play, for example, access to green spaces and safe walking and cycling routes to schools. **MedwayGO** by Medway Council provides healthy meals and activities including sport and nature walks during school holidays for children eligible for benefits-related free school meals.

Kent and Medway
Integrated Care System

Whole family approach

A whole-family approach, with early help and a focus on preventing rather than responding to crises, is an essential component to reducing inequalities. Taking an approach like this across Kent and Medway Integrated Care System will better enable families to have the confidence to take ownership of their health and care journey. It will ensure improved outcomes by addressing issues such as generational trauma, housing challenges and other components that inhibit families from thriving.

We are committed to developing a **family hub** model, including access to Start for Life universal services: midwifery, health visiting, mental health, infant feeding, safeguarding and special educational needs and disabilities (SEND).

The programme presents an opportunity to streamline and improve early identification, assessment and interventions for children and families through the hub model.

The funding will enable improved integration, particularly in relation to perinatal mental health and parent infant relationships, parenting support, infant feeding and home learning environments. It is also an opportunity to deliver more young person's mental health services in the community. Early and targeted identification will also prevent unnecessary escalation and identify families with complexities earlier.

Consistent contact with lead practitioners will enable better engagement with families to help grow their confidence to navigate the system and manage their health and care needs.

All transitions are important points in a child's or their family's lives. We recognise that children and their families' experiences of transitions can be difficult and sometimes traumatic. This can destabilise families, making it harder for them to cope, especially when the people supporting them - practitioners, services, interventions – move on or change.

Implementing a strategic approach to integration, whole-family, patient-led, asset-based health and care can help to address some of the challenges children and families face at a time of transition. Needs-led and outcome-based systems help to reduce unnecessary and unwanted change.

Families should feel seen, heard and enabled to ask for help and to feel confident to help themselves. The system should have a clear understanding of the local communities, demographics and needs to build a workforce and offer that meets the diverse needs of the population. Growing neighbourhood and place-based solutions and innovations outside of (but connected to) specialist services will target populations that are seldom engaged.

We aim to build a system where a family is met with understanding and empathy when they tell their story, and we respond with a coordinated solution that addresses their needs.

Kent and Medway Integrated Care System

Safeguarding and looked after children

Protecting children and young people is one of our most important responsibilities. As partners, we need to bring together our collective information, skills and resources to provide fully joined up support for children and families. In everything that we do to support and protect children and young people, we will put them at the centre, ensuring their voice is listened to and they have a say in decisions about them.

We will safeguard and promote the welfare of looked after children and care leavers, supporting them to live a positive and fulfilled life and transition into independence with confidence and ambition for the future. This means ensuring they have a stable and supportive place to live, a good education, full assessment and support for their physical, mental and emotional needs and feel part of their community.

Many partners will play a role in this, for example:

- Medway Council and Kent County Council have a statutory duty to provide services for safeguarding children and the NHS is a statutory partner
- working with council housing teams to ensure that permanent housing is available for care leavers
- working with VCSE organisations to provide advocacy for young people.
- We will ensure the information that all agencies collect about looked after children and care leavers is used to the best advantage to plan and deliver support for them, including to support a smooth transition into adulthood.

A particular challenge for our system is the large number of unaccompanied asylum-seeking children that arrive in the county due to Kent's border location. These children and young people are extremely vulnerable, and we have a responsibility to provide care for them, which stretches system resources. We will continue to work closely with Government to support the National Transfer System and ensure new arrivals are cared for fairly and safely without disproportionate impact on our area.

Multiagency safeguarding arrangements are in place for Kent and Medway through safeguarding children's partnerships, however, there is more work to be done. For example, Medway's children's services has been inadequate since 2019 and are working under statutory notice from Central Government. The ICS presents opportunities to strengthen our partnership approach so we can ensure children and young people grow up in safe, strong communities free from adverse situations that could harm them.

'Virtual School Kent' champions the educational achievement of looked after children and care leavers, ensuring they receive a good quality of education and out of school learning, closing attainment gaps and encouraging the voice of young people to be heard.

Priorities for safeguarding children and young people that partners have identified include:

- reducing significant harm to children under two
- reducing injuries as a result of serious youth violence
- identifying and responding to risks of child sexual exploitation
- preventing other forms of exploitation including 'County Lines' drug trafficking
- implementing the Prevent strategy to safeguard from radicalisation and extremism
- preventing domestic abuse and providing effective support for victims and their children
- helping, and where necessary, protecting children in households where neglect is a feature.

Delivering our priorities for children's safeguarding will require a strong partnership response, enhancing the sharing of information to understand the risks and root causes and putting in place a coordinated multiagency response where everyone plays their role. We will more widely embed learning from practice reviews and other learning opportunities to continuously improve practice right down to the frontline across all services for children and families.

Kent and Medway
Integrated Care System

Chapter 3

We will help the most vulnerable and disadvantaged in society to improve their physical and mental health; with a focus on the social determinants of health and preventing people becoming ill in the first place.

We will achieve this by:

- tackling inequalities and preventing ill health, targeting those most in need
- supporting people deal with the current cost of living crisis
- tackling mental health issues with the same energy and priority as physical illness
- addressing the social determinants of health, such as community support and employment and skills
- developing the Kent and Medway physical environment as a place where people thrive.

Kent and Medway
Integrated Care System

Tackling inequalities and preventing ill health

The challenge…

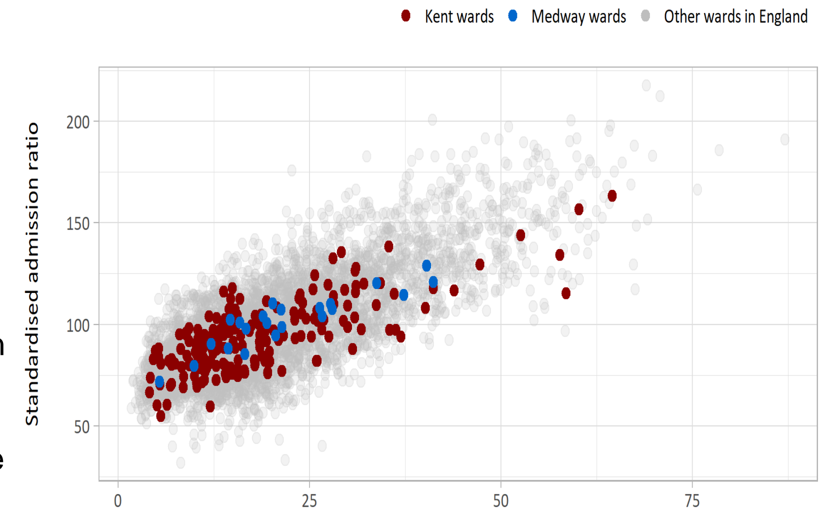
Everyone deserves the same opportunities to lead a healthy life, no matter where they live or who they are.

In Kent and Medway people in more affluent areas live longer than those living in more deprived areas. Life expectancy is significantly shorter for some groups of people, including homeless people, people with learning disabilities and people with severe mental illness compared to the general population. Another important group is looked after children, who are at significant risk of being disadvantaged in a number of ways that can lead to poor health and wellbeing outcomes and considerable demand on health and care services.

There are inequalities in the access to both primary care (general practice, community pharmacy, dental services) and secondary care (hospital or clinic). Digital exclusion can also play a key role in inequality of access to services.

Emergency admissions to hospital are more common in areas with higher levels of deprivation. Research also shows that individuals from more deprived communities are less likely to engage in preventative programmes, such as immunisations, screening, dental check-ups and eye tests, when facing no immediate discomfort or disability. People from deprived areas are more likely to present to health care providers at a later stage of illness.

Services are often poorest in the areas that need them most - an issue known as the "inverse care law". It is hard to attract and retain high quality clinicians to areas with high deprivation and needs. The work may be harder due to the high needs of the local people. There may also be more VCSE services in more affluent areas where it is easier to attract volunteers. A strategic approach to tackling inequalities will need to address these issues.



Ministry of Housing, Communities & Local Government, IMD 2019.
Office for Health Improvement and Disparities. Fingertips. Indicator ID: 93227.
Hospital Episode Statistics (HES), NHS Digital.

The Kent and Medway Listens programme was a community engagement process which (via community organisations) heard the voices of vulnerable people throughout Kent about their experience of living through Covid-19 and took those voices directly to the integrated care board (ICB) leadership to create a series of pledges and actions, listening to the voices of people in need.

The Armed Forces community includes serving personnel (Regular and Reservists), former service personnel and their family and carers. In Kent and Medway, this community is about 8-10 per cent of our population and is a group that frequently experiences health inequalities and poorer access to healthcare as a result of developing more complex needs during or following their service. Those with the most needs often live in areas of high deprivation. Their families can also be disadvantaged though the frequent moves, and associated absence due to military service. We will have due regard for the needs of this community in implementing this strategy.

Our solutions

We can deliver sustainable and resilient approaches and evidence-led change; putting people and communities at the heart of the conversation which focus on reducing health inequalities. Our key goal will be to ensure a whole system collaborative approach to **population health management**, reducing and, where possible, removing avoidable unfairness in people's health and well-being outcomes.

This means that our health and social care provision needs to be made available to all, with increasing attention needed for those who are more disadvantaged - an approach known as **'proportionate universalism'** - helping everyone, whilst improving the lives of those with the worst health, fastest.

We will empower our **local neighbourhood and place-based partners** to tailor services and interventions to meet the needs of their communities. We will support the development of local prevention plans.

We aim to make promotion of healthy choices part of every encounter with individuals - **making every contact count (MECC).** This can help ensure individuals are signposted to additional support that they need, for example, support for health behaviours such as weight loss, social issues such as loneliness or economic challenges such as access to benefits.

All public sector workers and services who are in contact with people should offer MECC supported by simple signposting systems that minimise the work involved for the front-line worker. The approach is also appropriate for voluntary, community and social enterprise (VCSE) sector workers. Each service will wish to consider what the likely challenges those they serve may face, and ensure signposting to that support is available, for example health visitors in areas with high child poverty could signpost to advice on access to benefits.

Carers' Support East Kent is a charity that provides carers with the information and support they need. Their services are available to people who look after a relative or friend, who due to physical or mental illness, age-related difficulties, disability, or an addiction, cannot manage without their support.

East Kent's social prescribing platform is managed by Social Enterprise Kent for the East Kent area. The service can support with short term issues such as: food and fuel support, form filling, social isolation, as well as long term support such as: housing, debts, benefits and more.

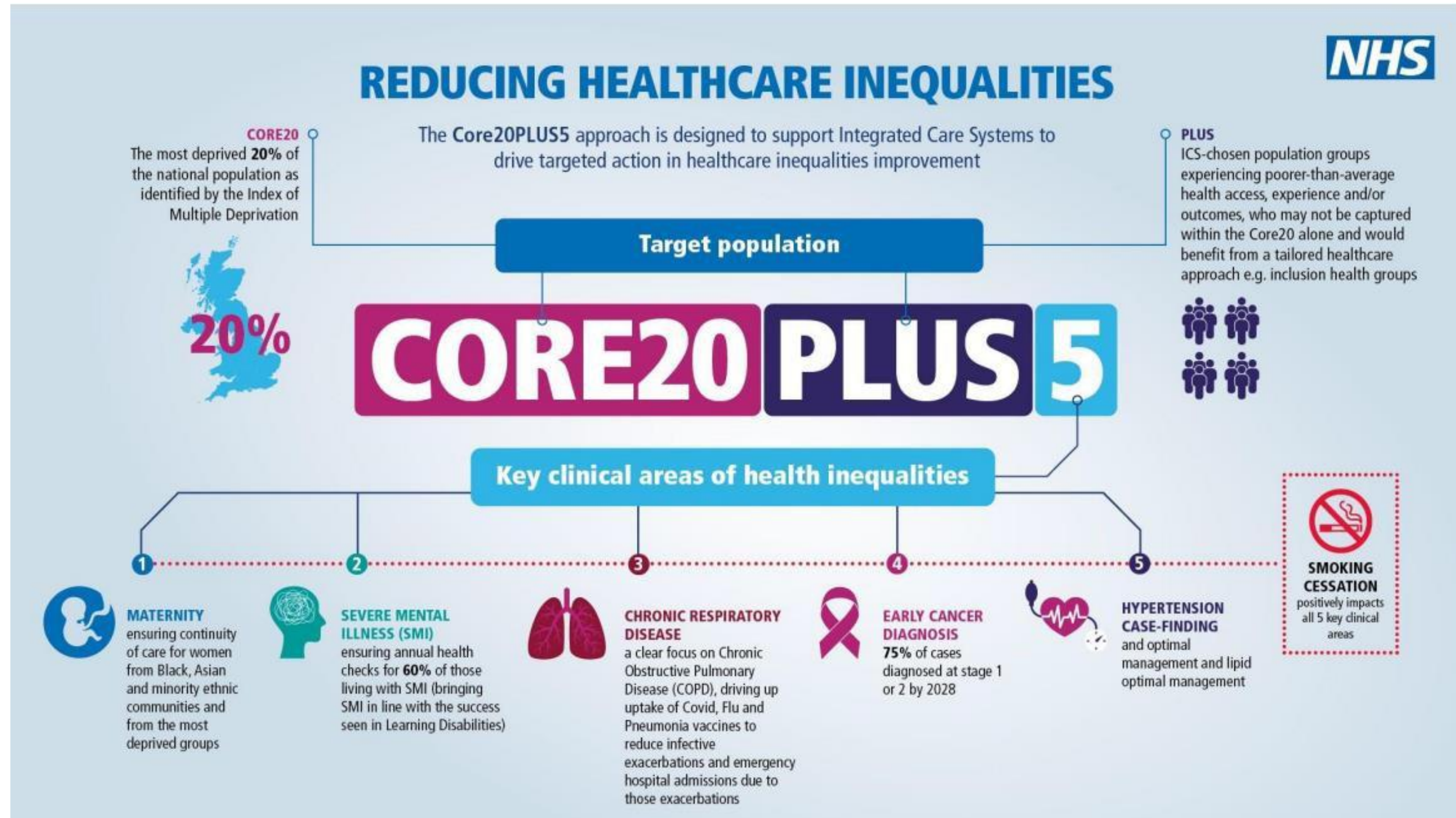
Kent and Medway
Integrated Care System

Our NHS organisations will also continue to adopt the **Core20PLUS5 model** to target those most in need.

Core20PLUS5 is a national NHS approach to support the reduction of health inequalities at both national and system level.

The approach defines a target population group – the 'Core20PLUS' – and identifies 'five' focus clinical areas requiring accelerated improvement. We will also respond to the recent additions for children and young people.

Core20PLUS5 will support us to drive targeted action in improving healthcare inequalities. This aligns with our approach to population health management and gives a foundation on which to build future joint action, engaging our local communities in design and delivery, which will lead to health and care partnerships aligning to this approach, and identifying specific local population groups.



Kent and Medway
Integrated Care System

Cost-of-living crisis

The cost-of-living crisis is likely to have a detrimental effect on people's health and could widen health inequalities. It is an issue of high importance for the system and an early opportunity to work together better.

Alongside national interventions, partners across the Kent and Medway integrated care system (ICS) are putting in place support for local people. Kent County Council and Medway Council are ensuring vulnerable people can access help including food and fuel vouchers and community services are working to identify people who are struggling and refer them to support. The district councils in Kent are responding to local needs through their housing and benefits teams and providing advice. NHS Kent and Medway is factoring cost-of-living pressures into winter planning, identifying transport options to help patients access appointments and supporting staff wellbeing. The VCSE sector provides a range of support for people experiencing financial hardship including food banks, employment support and debt advice.

It is a challenging time for all partners, for example the VCSE itself is under pressure with costs increasing, whilst for some donations are falling, and demand for support is likely to continue to increase.

The integrated care partnership (ICP) has agreed to coordinate activity where this will add value and agree collectively how best to focus resources to have the greatest positive impact on health and wellbeing.

The Kent County Council financial hardship programme addresses a strategic need to develop a solution which allows frontline teams greater visibility of individual vulnerability, both financially and socially (for example: homelessness, falls prevention) to enable a proactive response in providing support. It involves, among other things, district frontline teams using risk stratification for case finding. It also includes a 'no wrong door' approach for referring people to support - the 'ReferKent' system.

Kent and Medway Integrated Care System

Mental wellbeing

The challenge

Our mental health and physical health must be treated equally. The Covid-19 pandemic has shone a spotlight on the importance of mental wellbeing and the vital role of communities in tackling issues such as loneliness and isolation.

People in Kent and Medway who have a serious mental illness experience significantly worse health outcomes than people who do not. For example:

- Adults in Kent and Medway with a serious mental illness are 3.6 times more likely to die prematurely.
- In 2021, nearly one in five six to 16yearolds had a probable mental disorder and we have seen this increase in recent years.
- The prevalence of people with more than one long-term illness or condition is around 50 per cent higher amongst those with a serious mental illness than the rest of the population.
- The rate of suicide across the county was 10.9 per 100,000 in 2015-17. This is higher than the England average rate which was 9.6.

Our solutions

We will deliver **high quality mental health and wellbeing support to our population**, **giving it equal energy and focus as supporting physical health.** We will:

- Promote positive mental wellbeing in all communities.
- Work through communities to tackle the wider drivers of mental ill health in all age groups including: loneliness, financial distress, abuse, addiction, housing and relationships.
- Ensure people of all ages with mental health issues can access the support they need, whether that's clinical treatment or wider support such as housing, access to and retention in employment etc.

The NHS Long Term Plan sets out an ambitious mental health service model, taking more action on prevention. The **Kent and Medway Mental Health Learning Disability and Autism Provider Collaborative Board (MHLDA PCB)** brings together all the mental health and wellbeing partners with those with lived experience to design a new way of working, integrate service models and develop a shared accountability for improving the mental health and wellbeing of our communities.

"As local authority, third sector and health partners we will build on the foundations we have put in place in recent years to transform the way Mental Health, Learning Disability and Autism services are delivered across Kent and Medway and, vitally, significantly improved the outcomes and experiences for service users, families and carers."

The MHLDA Provider Collaborative Board

Through our community mental health framework, **Mental Health Together,** we are implementing an entirely new service model to support people with complex mental health difficulties. It will provide a person who is living with serious mental illness care that is centred around them, their family and local community, by joining up support from different services that can help. The model focusses on supporting mental ill health in the context of someone's whole life, for example how debt, relationships and employment can impact someone's mental wellbeing, as well as how physical health can impact them too.

We will also deliver our **local transformation plan for children, young people, and young adults' emotional wellbeing and mental health**. The plan outlines how we will widen access to services closer to home, reduce unnecessary delays and deliver specialist mental healthcare. It is based on a clearer understanding of young people's needs, provided in ways that work better for them.

Kent and Medway
Integrated Care System

Community Support

Our **communities** can provide us with support, resilience and a feeling of belonging that help us to lead healthy and fulfilled lives and reduce the need for health and care services. We will continue to work in partnership to promote **community safety**, tackling issues such as crime, antisocial behaviour and discrimination that can make people feel unsafe or unwelcome.

Alongside the important role of public sector partners, it is often the informal support from the thousands of local organisations, community networks and local volunteers that help to make a community and create a sense of identity. As a system we will recognise, value and support the vital role that these groups and individuals play, and engage in a way that utilises these community assets for our population's health and wellbeing.

Befriending offers supportive, reliable relationships through volunteer befrienders to people who would otherwise be socially isolated. Medway Voluntary Action are working in partnership with Carers FIRST, Medway Health and Care Partnership (HCP) and other local voluntary and community organisations to deliver and co-ordinate befriending support in Medway.

Social prescribing helps to connect people to community services and groups local to them that can help to support their mental and physical health. For example, environmental sustainability activity can play a key role in supporting people with mental health problems. When social prescribing works well, people can be easily referred to link workers from a wide range of local agencies, including general practice, pharmacies, multi-disciplinary teams, hospital discharge teams, allied health professionals, fire service, police, job centres, social care services, housing associations and voluntary, community and social enterprise (VCSE) organisations. Self-referral is also encouraged.

The profile and level of investment in social prescribing has increased considerably over the last few years. This rapid progression has led to an increase in the number of providers and services such as link workers, community navigators and community wardens.

Kent and Medway is in a good position, through the development of a number of initiatives, to now go further by building on and strengthening what is in place through the system.

South Kent Mind Provides coffee, cakes, and lunches at low cost, as well as fresh bread sold separately, for all members of the community. The café also runs classes on coping with life, and food and mood, as well as general wellbeing activities.

A strategy board was set up in June 2022 to set the strategic direction and a steering group began in July 2022 to take the work forward and develop a **social prescribing and community navigation strategy** that sets the framework for social prescribing and community navigation across the Kent and Medway system.

Kent and Medway councils are an integral part of the strategy board and are working collaboratively to ensure future commissioning is aligned and meeting common goals and outcomes for the people in our communities.

We are also working together to implement **a single social prescribing platform** that will be launched in 2023. It will enable the public and referrers to search a single directory of services and provide the infrastructure for a single Kent and Medway referral pathway, helping to contribute to an approach with "no wrong door" to access services.

Kent and Medway
Integrated Care System

Employment and skills

Access to good, stable work with fair pay is one of the building blocks of good health and wellbeing. Loss of employment can lead to financial hardship, increased social isolation, loss of self-esteem and purpose and insecure housing tenure, and lead to poor health outcomes. A healthy population is also an essential component of a successful and productive economy.

Our ambition is to grow the Kent and Medway economy and ensure that everyone can benefit from increased prosperity. This will include working with partners to boost skills levels, attracting more good-quality jobs into the area and supporting businesses to grow. We will particularly focus on areas that are falling behind the rest of the county on measures like employment and skills levels, helping reduce inequalities in opportunity. We will also seek to close gaps between Kent and Medway's economic performance and the rest of the south east.

The ICS will work with the partners involved in economic development, employment and skills to ensure it plays its role in achieving our ambition. As major employers and purchasers we can also play a direct role in improving local economic prosperity.

Priorities already identified by partners to improve access to good quality employment and skills include:

- Supporting young people into work through dedicated support and guidance, exploring opportunities for work-based learning and increasing access to higher education.
- Supporting the existing workforce by increasing access to training that reflects new technologies being used in the workplace and helping people re-skill and move between jobs and sectors over their career.
- Building stronger relationships between employers and education and skills providers to put in place the skills that the local area needs to grow.
- Building on Kent and Medway's strengths, including in life sciences, to promote innovation and create more high-quality jobs.
- Promoting Kent and Medway as a great place to live and work to attract and retain skilled workers.
- Helping people with mental health or learning disabilities into sustained work.

The new Kent and Medway Economic Strategy will set out shared objectives.

Where people are finding it hard to access or remain in work due to mental or physical health issues, there needs to be sufficient support in place to help them find appropriate, good-quality work. We will do this by working together to maximise uptake of Department of Work and Pensions (DWP) support programmes and continuing to work with experts in the VCSE sector, who can provide support to address all of the issues that a person might be facing in returning to work, including: improving confidence, securing training to develop new skills and practical support on applying for jobs. We will also work with employers to help them adapt and accommodate the needs of all employees.

The built environment

The ICS continues to recognise the fundamental impact that the homes and environment that we live in have on our health and wellbeing.

Everyone who lives in Kent and Medway should have access to a decent, safe, secure, warm and affordable home.

We will work with housing providers, VCSE partners and others to continue to improve the quality of housing of all tenures. Our key priorities include improving the energy efficiency of private rented households to reduce fuel poverty and addressing issues like dampness that can cause health problems.

We will encourage housing that is designed with health and wellbeing built in, promoting healthy lifestyles, and responding to the impacts of climate change and changes to the way we all live and work.

We will continue to work together to prevent and respond to homelessness, addressing the root causes.

As Kent and Medway continues to grow, partners will work together to plan housing development and regeneration in a way that improves quality of life for new and existing communities, with the physical infrastructure in place that we all need. This includes good transport links, high speed internet connection and sufficient childcare, school places and health and care services to meet local needs.

Access to green space and nature is beneficial for physical and mental health. The physical environment is one of Kent and Medway's greatest natural strengths. We will continue to support everyone to be able to access open spaces including at parks, at the coast, and via safe walking and cycling routes.

Protecting and enhancing our environment is a priority across the system. There are clear health and wellbeing benefits to reducing carbon emissions, improving air quality and managing the impacts of climate change. Reaching our challenging environmental targets and adapting to climate change will require all partners to play their part and system partners to coordinate their activity to go further and faster. We will play our role as anchor institutions, minimising our environmental impact and promoting sustainable practices across the system.

For example, as Swale Borough Council started to give consideration to the future expansion of Faversham to meet local needs, the Duchy of Cornwall's land at the south east edge of the town was identified as the most sustainable location for growth.

Careful consideration is being given to the architecture and materials but also the landscape ecology, soil, air and water of the land which can all be improved over time by sensitive development, intelligent land uses and management practices.Public spaces and streets will be designed around the pedestrian rather than the car. They will provide a sense of wellbeing and connection to nature for people and the planet; helping to create a new community that will thrive in the long term.

Kent and Medway
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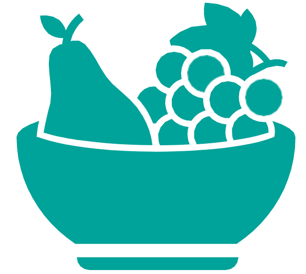


Chapter 4

We will help people to manage their own health and wellbeing and be proactive partners in their care, so they can live happy, independent and fulfilling lives; adding years to life and life to years.

We will achieve this by:

- supporting our population to adopt positive health behaviours
- protecting the public from diseases such as Covid-19
- supporting people to age well - championing resilience and independence
- delivering personalised care so people have choice and control over their care
- providing palliative and end-of-life care to those in the last stages of their life.

Kent and Medway
Integrated Care System

Health behaviours

Health behaviours, for example, our diet or whether we are physically active, have a direct impact on health outcomes.

As part of our population health management approach, we will deliver **evidenced-based support,** including emotional and mental health support, at an appropriate scale to help people: maintain a healthy weight, eat a healthy diet, participate in physical activity, maintain good sexual health, and minimise alcohol, substance and tobacco use. Increasing activity and preventing diabetes is identified as a priority by all 14 councils within Kent and Medway.

We will continue to conduct system-wide health needs assessments to help us to target where we need to mitigate against health and social inequalities, and test and learn from new approaches to promoting **positive health behaviours**. For example, we will build on current health inequalities pilots to provide targeted, improved **access to proactive reviews and screening**, **including dental checks,** supported by patient-focused support services that understand and address barriers and behaviours which prevent people from engaging in their wellbeing and long-term health.

We will learn from and develop schemes delivered through the voluntary sector to provide holistic support to the public in accessing care and meeting preventative goals. With nearly two thirds of adults within Kent and Medway already overweight or obese, local community support for weight management is vital to help our population to thrive.

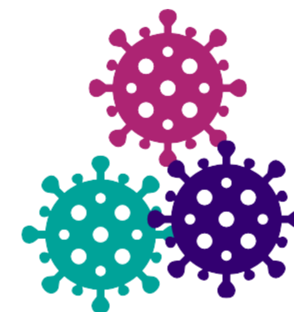
We will engage with and raise awareness of National programmes - such as the **NHS Digital Weight Management Programme and the Diabetes Prevention Programme -** and incorporate these into existing pathways in a coherent way to ensure that we optimise their impact within Kent and Medway.

Smoking is the most important cause of preventable ill health and premature mortality in the UK. It is a major risk factor for many diseases, such as lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease. While smoking rates in Kent and Medway have significantly fallen over the last decade, rates remain high in some areas and occupations, for example, routine and manual. Furthermore, in 2020/1 over a tenth of mothers in Kent and Medway smoked at the time of delivery, which is significantly higher compared to England average.

Cancer Research UK reports that, whilst smokers from more deprived areas are more likely to access stop smoking services, when they do, they are less likely to successfully quit. This pattern is also seen in Kent and Medway. It is therefore important that every aspect of referral and treatment pathways are focused on helping reduce the smoking rates in these higher prevalence groups. We will **make every contact count** to signpost support.

Contraceptive services providers will work together to ensure a seamless service for the public and will also consider the wider health and sexual health needs of the patients. With the additional pressures on GP practices and sexual health services, the ICS will monitor and evaluate accessibility to ensure people have good access to contraception.

Kent and Medway Integrated Care System



Health protection

The past two years have shone a spotlight on the important role that our health protection responsibilities play in delivering improved outcomes for our population and the communities we serve.

Health protection is multi-faceted and there are many agencies involved in protecting the public from communicable diseases, non-infectious environmental hazards and the risks of a future in which antimicrobials are no longer effective.

A cross-cutting theme is to ensure that particularly vulnerable groups are being identified, and their needs around the prevention and response to health protection issues are addressed. These groups include: refugees and asylum seekers - a particular challenge for Kent and Medway - homeless people, Roma, Sinti, Travellers and other groups.

Health Protection includes:

- **infection prevention and control** (IPC) arrangements within health and social care settings as well as in the community
- tackling antimicrobial resistance in the community, primary, secondary and tertiary care
- managing and controlling communicable diseases, and new and emerging infections
- environmental hazards including: air and water quality, food safety, contaminated land, and control of biological, chemical, radiological and nuclear threats
- reducing the impact of vaccine-preventable diseases through **immunisation**
- national **screening** programmes
- **emergency preparedness**, resilience and response (EPRR) across all hazards, including epidemics and pandemics.

The Kent and Medway Health Protection Board is a multi-agency board on health protection across Kent and Medway, with a focus on protecting the public. Originating from a multi-agency board that coordinated the system response to the Covid-19 pandemic, this board has now taken charge of the wider remit of health protection, building on the effective partnerships and networks developed over the last two years.

The board provides oversight of existing health protection issues, as well as horizon scanning for any emerging situations and threats to support a joined-up and coherent system. The boardprovides assurance and system leadership to directors of public health in Kent and Medway in relation to their statutory functions around health protection.

The board oversees the appropriateness of strategies and plans in place on health protection and emergency prevention, planning and response matters. It receives updates on areas of health protection and recommends steps for system-wide improvement, system alignment and the commissioning of services with a focus on reducing health inequalities in our populations.

In addition, task and finish groups support the board around specific health protection areas to recommend steps.

Kent and Medway Integrated Care System

Ageing Well

Our adult social care services support people of all ages to live as full and safe a life as possible. They will continue to promote people's wellbeing prevent, reduce or delay the need for care and support and safeguard vulnerable adults. We will do this by focusing on the individual strengths of people with care needs, their families and carers.

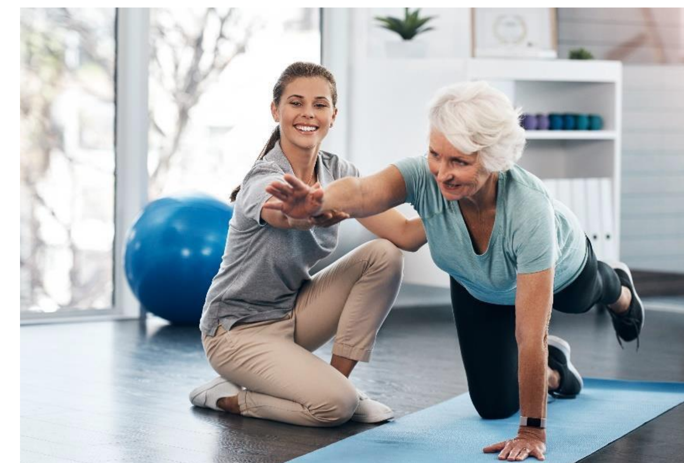
Accessible and integrated health and social care services where partners work together will enable people to live independently and safely within their local community.

We are committed to:

- Giving people choice and control about the care and support they receive throughout their lives.
- Empowering people to maintain good physical and mental health and well-being.
- Offering people relevant support, information, guidance and interventions to enable them to be proactive and address any lifestyle or related issues, promoting healthy ageing and reducing the likelihood of escalation of health or care need.
- Connecting people with their community, for example, through social prescribing, to help to combat social isolation and loneliness, and enrich later life.

Key priorities and pathways include:

- Promoting a multidisciplinary approach where professionals work together in an integrated way to provide tailored support that helps people live well and independently at home for longer.
- Developing community response teams to support people with health issues before they need hospital treatment and help those leaving hospital to return and recover at home.
- Making the system more coordinated so it is easier to navigate and get the right care to maintain independence.
- Proactive identification of those that are frail or at greater risk of future hospitalisation, care home admission or death so that we can target prevention strategies and support people to manage their health and wellbeing as they age and provide support on the basis of their needs through to the end of their life.
- Offering more support in care homes including making sure there are strong links between care homes, local general practices and community services.
- Embedding technology-enabled care such as wearable devices and home monitors as core tools to support long term health problems in new ways, and support people to remain at home safely where possible.
- The Kent and Medway Care Record will support continuity of care and a holistic approach for people at higher risk of deteriorating health.



Kent and Medway Integrated Care System

Personalised Care Delivery

***Personalised care** means people have choice and control over the way their care is planned and delivered. It is based on 'what matters' to them and their individual strengths and needs.*

NHS England

Personalised care represents a new relationship between people, professionals and the health and care system. It provides a positive shift in power and decision-making that enables people to have a voice, to be heard and be connected to each other and their communities. It takes a whole system approach, integrating services around the person including health, social care, public health and wider services.

Kent and Medway's personalised care approach is underpinned by the ESTHER philosophy, this emphasises the '***what matters to me***' methodology.

We currently have 1,700 ESTHER ambassadors across Kent and Medway in social care and the voluntary, community and social enterprise (VCSE) sector, and more than 100 in partner NHS organisations.Both Kent and Medway councils work with ***'Think local, act personal'*** to make personalised care real.

Shared decision-making and patient and resident choice

- Encouraging our workforce to carry out training for shared decision making and patient and resident choice via the Personalised Care Institute (PCI).
- Enabling our residents to have discussions on their treatment and care including what is important to meet their needs.

Personalised care and support planning (and review)

- Encouraging take up of the Personalised Care Institute (PCI) Personalised care and support planning module across all Primary Care Networks (PCNs_ and our delivery partners.
- Encouraging local maternity services to utilise the PCI for personalised care planning.
- Addressing the disparity in data collection of personalised care and support plans. There is inconsistency across the system in approach and coding across the PCNs.

Social prescribing and care navigation (community-based support)

Tailored to local strengths but with a more consistent, equitable and joined up approach across the Kent and Medway system.

Personal health budgets (PHBs) and integrated personal budgets

Increasing our offer of PHBs and direct payments through continuing to support and evaluate pilot projects working with our system partners.

Work **with** Better Care Fund to support early discharge across the system.

Enabling choice (including legal right to choose)

Legal right to choose a provider in respect of first outpatient appointment and a suitable alternative provider, if people are not able to access certain services within the national waiting time standards.

Supported self - management

Encouraging people with lived experience to carry out peer leadership training to support others with their experience.

For example, a project developing volunteers to teach others to check their own blood pressure, and what to do if this is not normal.

Enablers: Leadership - co-production and change - workforce - finance - commissioning and payment

Kent and Medway Integrated Care System

Dementia care

We are committed to ensuring that every person living with dementia is supported to live as well and as independently as possible. The means receiving high quality, compassionate care from diagnosis through to end of life. This applies to all care settings, whether home, hospital or care home. We will:

Empower and support people and their carers: Promoting individual health and wellbeing, empowering people and their carers to effectively access better information and support.

Empower our workforce: Developing a more productive, competent, and confident workforce (including in the care sector) to use the tools and information they need to provide high quality care and support.

Improve partnerships: Working closely with partners to seek opportunities to collaborate, innovate, and share information to deliver better outcomes for people.

Improve standards, safeguarding and quality of care: Working with all providers to continually improve the quality of dementia care, delivered in an integrated way, with the person with dementia at the centre.

Key priorities and pathways include:

- Increasing awareness and education on how to avoid the risks by promoting individual health and wellbeing, empowering people and their carers to effectively access better information and support.
- Increase Kent and Medway's dementia diagnosis rate (DDR), ensuring that individuals and their families are able to access timely and accurate diagnosis. We aim to create an improved referral pathway that is individualised and person-centred.
- Support people living with dementia to live happy, healthy, fulfilled lives remaining safely at their normal place of residence with appropriate support, and making a smooth transition into other residential settings when needed.
- Enable carers to be able to access support at the right time, helping them to continue in their caring role, whilst also maintaining a life of their own.
- Ensure that people living with dementia are able to die with dignity in a place of their choosing; for those living with dementia and their families to feel supported during this difficult time and ensure the end of life care provided is excellent.
- To work in partnership across health, social care, community, voluntary and independent provision to develop services that reflect the wants and needs of people living with dementia in Kent and Medway, which will:
  - recognise the need for a collaborative journey where people’s values and opinions are recognised
  - be delivered with care, compassion, kindness, and friendliness
  - keep people well informed
  - treat people as individuals and not make assumptions
  - offer consistent support and motivation
  - ensure that people are listened to and not disregarded.

Kent and Medway
Integrated Care System

Palliative and End of Life Care (PEoLC)

The Palliative and End of Life Care Strategy (Adults and Children and Young People) in Kent and Medway 2022-2027 published in May 2022 provides a steady basis from which to grow. The strategy was based upon the six national ambitions for palliative and end of life care:

Our strategy aims to make sure that individuals who are in the last stages of their lives and dying receive the care they need to preserve their dignity and wellbeing, to keep them independent for as long as possible and to be comfortable, dying in a place of their choosing.

Since July 2022, the Integrated Care Board also has become responsible for PEOLC as part of the Health and Care Bill with both statutory guidance and a handbook for implementation published in late September 2022.

Key local, regional and national priorities include:

- Improving the identification of those who are likely to be within the last year of life with targeted support to manage their changing health needs over time.
- Supporting people to die in their place of choice by ensuring models of care and services evolve over time, always keeping the individual's wishes at the heart of decision making.
- Raising community awareness of death and dying to enable 'compassionate communities' to grow, and providing robust bereavement services for all.
- Providing a single point of access, available 24-hours-a-day, seven-days-a week to provide an alternative to 111/999 in times of crisis and to enable more people, where appropriate, to live well and die well, at home or the place of their choosing such as a hospice.
- Developing advance care plans for every individual enabling joined up care through the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) roll out across Kent and Medway.
- Prescriptions for medicines that support comfort at the end of life will be the norm and readily available in pharmacies and we will aim to broaden training for informal carers on how to administer these 'just in case' medications.
- Supporting people and their families during the transition between children's and adults' services.
- Learning from individuals and families to improve comfort, dignity and ensure wishes are being met.
- Providing a comprehensive end of life care training programme across all in Health and Social Care in Kent and Medway.

Kent and Medway
Integrated Care System

Chapter 5

We will support people with multiple health conditions to be part of a team with health and care professionals working compassionately to improve their health and wellbeing.

We will achieve this through:

- high quality primary care
- patient empowerment and multidisciplinary teams
- support for carers.

Kent and Medway Integrated Care System

Primary care

Primary care is, and will remain, the bedrock of the NHS. It is the first point of contact with the NHS and is highly valued by people. It plays a vital role in supporting those with complex conditions. With the right tools, skills and investment, our primary care workforce can continue to deliver world class, place-based patient care.

We know that it is still too difficult for people to get an appointment to see their GP and primary care team, and we must do all we can to support people and general practices.

We want **general practice** to offer a consistently high-quality service to everyone in Kent and Medway, delivered by a skilled multidisciplinary team working in partnership with other health and care services to maximise benefits for our population.

We want general practice to remain true to its core principles of continuity of care and a person-centred approach whilst playing an active part in developing the integrated care system for Kent and Medway. The patient consultation will remain at the heart of general practice but the ways in which that care will be delivered is changing.

Our general practices will increasingly work with neighbouring practices through **primary care networks (PCNs)** to deliver place-based care for their local patient populations. People will benefit from more joined up care in the community, with care being received in the most appropriate setting at a local level and with local accountability.

Practice teams will widen the range of services provided with an extended range of clinical and support staff providing care for both physical and mental health and allowing patients to see the right professional more quickly.

Technology will be used to best effect for patients and general practice staff, offering better care, helping people stay healthier and more independent and improving efficiency for general practice teams. For those unable to use technology other options will be available offering care of equal quality.

Kent and Medway ICB has recently taken over delegated authority for commissioning **pharmacy, optometry and dentist** services.

Harnessing the role of **pharmacy** as part of a PCN approach to the delivery of local health and care services, we will ensure all pharmacies are supporting people with health care, self-care, signposting and healthy living advice.

We will improve and increase access to **dentist** services, maximising capacity and improving urgent care, minimising deterioration of oral health and reducing health inequalities.

We will also improve people's access to NHS sight tests and other locally commissioned eye health services, focussing on improving equality of access for everyone. We will ensure that **optometry** services are integrated into wider system as a key component of vital community-based services.

Medicines optimisation

Spanning health, social care and justice, total spend on medicines across the ICS is estimated at c.£500m, with an estimated annual growth of eight per cent. Our ICS has developed a pharmacy and medicines optimisation strategy to ensure that medicines are utilised safely and effectively to improve patient outcomes, whilst reducing wastage in medicines usage.

Patient empowerment and multi-disciplinary teams

The increasing number of people living with long-term conditions means that the needs of our population are often complex, requiring agencies to work in partnership to provide the desired outcomes for our population.

People with multiple health conditions are best served by teams made up of multiple disciplines. This will ensure a holistic approach to common conditions such as cancer, cardiovascular disease, dementia, respiratory disease, and frailty.

Identifying people that require multi-disciplinary care earlier and being proactive in their referral will lead to better outcomes.

Primary care will be supported in targeting proactive referrals for people based on their individual needs and choices. Complex care teams and multi-disciplinary teams working with primary care and social care will co-ordinate identified groups of people and respond to needs and opportunities at a local level.

A strategic joint needs assessment, in support of Better Care Fund improvements between health and social care, will identify opportunities to invest in sustainable improvements in housing, environments and access to care close to home with the aims of enabling independence through system design with timely access to care where appropriate. This strategy will be informed by evidence including lessons learned from patient-centred services such as complex care nursing and multi-disciplinary teams.

A model of shared decision-making will empower the people of Kent and Medway to make informed choices about how, when and where they receive care. This will utilise personal health budgets and social prescribing where appropriate, alongside patient-centred services such as complex care teams encompassing physical, mental health and social care disciplines, enabled by the Better Care Fund.

Where possible, delivering care in a person's own home will help maintain independence and quality of life. This needs to coincide with easy, local access to support services and where appropriate, assistive technologies to continue independence.

We will develop a strategy to build links with the voluntary, community and social enterprise (VCSE) sector to facilitate the business as usual approach to linking people with non-NHS and local authority services.

Cardiovascular disease outcomes are improving but remain the biggest cause of premature mortality nationally. A person dies of cardiovascular disease in Kent and Medway every two hours.

As a system, we are strengthening collaborative working in our cardiovascular networks to improve earlier detection of those at risk, and working with prevention programmes to manage cardiovascular risks, for example, high blood pressure or cholesterol, at an earlier stage. This includes increasing access to education and support to enable people to manage their own condition.

Our networks are committed to reducing the variation of services and outcomes across the system by adopting population health management approaches to identify gaps and target resources.

Kent and Medway
Integrated Care System

Support for carers

We recognise the important role of formal and informal carers in a person's care team. There are many different types of carer and they come from all walks of life, ages, ethnicities, and backgrounds. Anyone can find themselves in a caring role at some point in their life. However, they have one thing in common, their role directly benefits the people they look after and society as a whole, so we must recognise their needs and support them too.

A carer's role can make paid work, study, maintaining social connections and getting involved in leisure activities difficult and sometimes almost impossible. Carers are more likely to suffer with physical, emotional and mental health problems.

Young carers can experience lower educational attendance and attainment, isolation and physical and mental health problems due to their caring responsibilities. We are committed to working as a partnership to address this. We will continue to work together to ensure there is good understanding across all services that work with children about the impacts of being a young carer, how to identify 'hidden carers' and how to put support in place for them. Voluntary, community and social enterprise (VCSE) organisations provide vital support for carers of all ages, including: one-to-one support for young carers to build resilience and help them cope with challenges, respite activities and in-school support.

Source: Kent Adult Carers' Strategy 2022-2027

Kent and Medway
Integrated Care System

Chapter 6

We will ensure that when people need hospital services, most are available from people's nearest hospital; whilst providing centres of excellence for specialist care where that improves quality, safety and sustainability.

We will achieve this through:

- providing quality healthcare as close to home as possible
- continuing to develop centres of excellence for specialised services
- a range of alternatives to hospital care, shorter stays and safe discharge enabling effective flow through the system.

Kent and Medway
Integrated Care System

Hospitals and centres of excellence

We recognise the importance of providing **quality healthcare as close to our populations as possible** and we will continue to plan our services in to enable this to happen.

Access to hospital care at the right time is not just about location, it is also about how we look at how services are configured within a place. Partners within the integrated care system (ICS) must join up health and care around individuals so that they can access the service and receive the requisite quality. Some hospital services will continue to move to community-based settings. For example, during the Covid-19 pandemic, virtual wards and consultations helped ease pressure on hospitals and enabled primary care and other parts of the system to provide essential services.

There is a compelling case for investment and change in the way acute care is delivered to the population of East Kent. Since 2015, we have worked closely with East Kent Hospitals University NHS Foundation Trust, other partner organisations, and the public to review how hospital services should change. The proposals form the basis of a bid to become one of the government's new hospitals programme. Over the next few years, we will continue to support the Trust to further develop their plans to improve the care it provides for East Kent residents.

Nevertheless, there is compelling evidence that creating centres of clinical excellence provides improved outcomes for patients. Increasing the volume and variety of cases within a specialism in centres of excellence that have all the necessary supporting clinical adjacencies, helps to address major geographical inequalities in life expectancy, infant mortality and cancer mortality. These centres of clinical excellence are also proven to attract and retain quality staff and enhance clinical research and innovation.

Here in Kent and Medway, we have already established a number of centres of excellence. We already have two neo-natal intensive care units, one single inpatient renal centre, one single centre for primary percutaneous coronary intervention (PPCI), and a small number of specialist cancer surgical centres.

We are also in the process of creating three hyper acute stroke units, and we will shortly be centralising all inpatient vascular surgery at Kent and Canterbury Hospital. We will continue to work will all partners to further develop centres of excellence where there are clear clinical benefits from doing so.

The recent Health and Care Act gave NHS England the powers to delegate commissioning responsibility to integrated care boards for NHS specialised services and there is a national ambition to delegate commissioning responsibility for 67 of the 154 specialised services from NHS England to integrated care boards.

From April 2024, Kent and Medway Integrated Care Board (ICB) will take over commissioning responsibility for 67 services, such as complex neurology and tier four child and adolescent mental health services and will become the lead commissioner for these specialised services for Kent, Surrey and Sussex.

Kent and Medway
Integrated Care System

Improving flow through the system

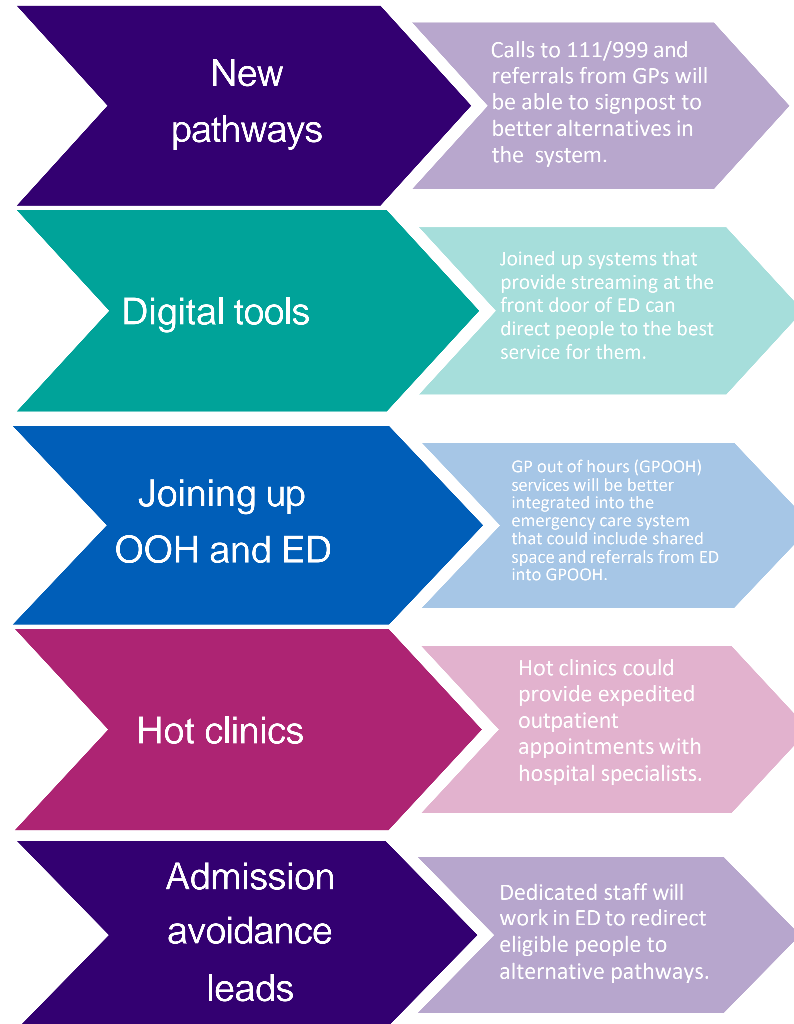
Demand on our emergency departments (EDs) is at an all-time high nationally, exacerbated by seasonal pressures such as winter-related illnesses as well as overflow from primary care and inappropriate referrals. In turn, this leads to full hospital wards, made worse by the challenges of discharging patients from the acute hospital setting.

Embedding new models and services will allow us to not only reduce pressure on emergency departments (Eds) but also deliver more appropriate care faster and closer to the patient's home.

Urgent treatment centres (UTCs) and facilities that can provide **same day emergency care** are able to redirect people who would otherwise have visited an emergency department. By reviewing the provision of these services across our region, we will ensure they are reflective of best practice, and we will champion these services to reach the best standards.

Working together during surge

In peak times, we want to improve the communication channels of our services throughout the system, so they can escalate and de-escalate to support the wider system and take proactive decisions to balance demand.



We will continue to develop relationships with our partners and get better at using data and evidence to inform commissioning decisions. By improving our commissioning relationships with providers of **adult social care**, including the private sector and voluntary, community and social enterprise (VCSE) sector we will ensure sufficiency of the adult social care market and aid discharge from the acute setting.

Community services play a significant role in supporting acute hospitals both in prevention of the exacerbation of health issues, reducing the need for admission, and in rehabilitating people to prevent re-admission.

A focus on discharge

Our ambition is that the Kent and Medway system jointly plans, commissions, and delivers discharge services that maintain flow and are affordable within existing budgets available to NHS commissioners and local authorities, pooling resources where appropriate and responding to seasonal pressures.

We will leverage the benefits of being able to work at system-level to support improved flow and faster, more successful discharges. This will include reducing the transactional behaviour and competition that exists for health and local authority placements.

We will be able to manage the market better, providing joint commissioning and shared tariff and payment mechanisms for care.

Similarly, being able to evaluate our performance at system level will unlock new insights. We will monitor quality effectiveness, outcomes and value for money through new frameworks.

Kent and Medway
Integrated Care System

Alternatives to hospital

Local enhanced services

Certain investigations and treatments which could traditionally only be provided in hospital will increasingly be available in primary care, with wider skill mixes, more estate options and extended hours.

Community diagnostic centres

A system-led network solution for diagnostics aims to reduce time to diagnosis through improved patient flow. They provide convenience for patients, away from acute hospital, with rapid results.

Virtual wards

Patients can get the care they need at home safely and conveniently, rather than being in hospital thanks to virtual wards, enabled by telemetry and wearables, support is delivered by a multi-disciplinary team at a distance.

Urgent community response (UCR)

We are bolstering our UCR services that aim to see patients within two hours of referral in their own home.

Shorter in-patient stays

Single electronic patient record

As part of a our system-wide digital transformation, we're aiming for a single, electronic patient record that will allow clinicians to provide continuity of care with easy access to important clinical information.

Same day emergency care

Providing rapid and targeted treatment to applicable patients without prolonged admission can reduce the risks with long stays in hospital.

Better testing and pathology

Consolidating pathology services allows for more consistent, clinically appropriate turnaround times, ensuring the right test is available at the right time.

Urgent treatment centres

These community services can be used to relieve pressure on larger A&E departments, which are better placed for treating the seriously unwell, shortening waiting times for both ambulances and patients.

Successful discharge

Discharge pathways programme

Kent and Medway Integrated Care Board has used the Better Care Fund (BCF) to help deliver closer collaboration and joint risk sharing when funding and delivering discharge pathways.

Single, integrated discharge teams will have access to system-wide knowledge and resources to plan discharge.

Reablement

Joint commissioning of care will have a stronger focus on reablement and therapy and reduce the number of handovers needed between services.

Data-supported discharge services

Improved discharge flow is underpinned by system-level demand and capacity modelling as well as accurate and contemporary data to support us in identifying inequality across the system, allowing us to implement steps to improve pinch points and equality.

Better experience and reduced delays

Kent and Medway
Integrated Care System

Chapter 7

We will make Kent and Medway a great place for our colleagues to live, work and learn.

We will achieve this through:

- championing an inclusive workforce
- looking after our people
- growing our local workforce
- building ‘one’ workforce.

Kent and Medway
Integrated Care System

Our context

There are over 80,000 health and care colleagues across a range of services based in Kent and Medway.

We have a multi-generational workforce with differing needs and there are opportunities to work more closely together to offer attractive employment at each stage of people's careers.

While good examples of collaboration and innovation exist and should be adapted and scaled up where we can, there are differing experiences across our teams which should be tackled. This is especially true for colleagues from ethnic minority groups and those with disabilities or long-term conditions.

The demand for staff is outstripping supply and, along with an ageing workforce, this is putting increased pressure on our teams.

There are many opportunities to work together as a system to grow and develop our workforce and make Kent and Medway a great place for our colleagues.

Our ambition

Wherever you work in health and care in Kent and Medway, we want it to be a great place to work and learn.

We see our future as one where our people champion Kent and Medway as a great place to work; where they are empowered to drive improvement, innovation and are active in research.

We want our people to work together across organisations and collaborate with local residents to create communities that are amongst the healthiest in England.

We want our workforce to: work together, across health, care and voluntary sector, enjoy their work, learn and develop in their jobs, be empowered, engaged and develop to be excellent at what they do.

To do this, organisations within the integrated care system (ICS) will work together to attract and retain professionals, work with education and training providers to develop exciting and diverse careers and training opportunities, provide talented and capable leadership and offer flexible and interesting careers.

Kent and Medway
Integrated Care System

Homegrown doctors
Kent and Medway Medical School is a ground-breaking new collaboration between local universities and NHS partners. The curriculum is delivered with integration in mind, with early exposure to a range of health and care professionals, and early experience in general practice. In the future, locally trained doctors will be able to serve our local communities and work within the integrated care system (ICS) to meet the challenges of modern health and social care.

Championing inclusive teams

We will work with all our partner organisations to embed cultures that promotive civility, respect and inclusion, providing shared talent and development opportunities and education for leaders and teams, with shared action to grow and celebrate our diversity and be representative of our communities including systematically addressing bias, empowering and developing colleagues from underrepresented groups and celebrating diversity at all times.

We will build from best practice, working with colleagues with lived experience to build inclusive teams and cultures and tackle racism and discrimination.

Looking after our people

We will develop wrap-around wellbeing services for our workforce. These will support those with illnesses as well as empowering colleagues to proactively manage their wellbeing. We will identify specific interventions that align with our population health priorities, particularly with colleagues who are experiencing health inequalities.

Growing our workforce and skills

We will build on our Kent and Medway Health and Care Academy by working in partnership with local employers, schools, careers services and education partners to create a robust pipeline of local workforce for future years, developing new roles such as apprenticeships, new ways of working such as cross-organisational portfolio roles with the skills and digital capability to be ready for the modern workplace.

We want to develop programmes that help to reduce long term and youth unemployment, bring young people into work and support carers as part of our wider workforce. We will create an attractive employment proposition for health and care. One that develops and retains our exceptional local workforce and attracts people into careers in health and care from within and beyond Kent and Medway, reducing the need for expensive agency workers.

Building 'one' workforce at place

Working across health and care partnerships, we will use our anchor institutions to develop one workforce at place, create integrated neighbourhood teams with embedded flexible working, mobility and enabled through digital technology and capabilities.

Through this, we hope to reduce unnecessary commuting and reduce our carbon footprint. We also have a vital and valued volunteer workforce - we will ensure that that we celebrate their invaluable work but also seek their input to shape, improve and deliver services.

The Kent and Medway people strategy is being developed alongside the integrated care strategy and five-year joint forward plan, and is being led by the chief people officers across Kent and Medway, with engagement of a range of partners. The strategy development will be overseen by the Integrated Care Board's People Committee.

Chapter 8

We will drive research, innovation and improvement across the system

We will achieve this through:

- establishing ways to better collaborate on research across our system
- unlocking additional capacity by empowering our workforce to take part in research and improvement in their everyday work
- championing innovation and being open to trying new ideas
- sharing and using data safely and effectively to achieve better outcomes
- embracing digital transformation as a system.

Kent and Medway
Integrated Care System

Our research context

There is a large amount of high-quality research already taking place across Kent and Medway. However, this research is not always as widely shared as it could be, and it is difficult to find out what research is under way across the system.

The data that our partners hold is a rich source of information that can provide valuable insights and, in turn, can drive improvement. Trusted frameworks and governance structures are needed to facilitate combined data sets.

The formation of our integrated care system (ICS) presents an opportunity to establish new ways of working and reshape the focus of our research. Our aim is to bring the research activity, data and innovation of our organisations closer together. This will allow for better **collaboration**, unlock additional research **capacity**, and help share **innovation** across our system, collectively to improve the lives of people who reside and work in Kent and Medway.

Our six research and innovation outcomes are set out below:

1. People are well informed and understand it’s their right and choice to participate in research.

- We’ll achieve this by integrating research messaging into everyday communications.
- We’ll achieve this by making available an expansive and diverse portfolio of studies that unites system partners for equitable access to patients, carers and the general public.

3. Research evidence is utilised to support improved outcomes.

- We’ll achieve this by enabling system-wide capability to access and synthesise new evidence.

4. Co-develop new research projects in response to local evidence gaps and in line with local strengths.

- We’ll achieve this by commissioning local research, with university collaboration in response to local needs and priorities.

5. Increase the number and diversity of the research and innovation workforce.

- We’ll achieve this by supporting our workforce, promoting research as a career and jobs that span multiple disciplines.

6. Enabling and supporting the adoption and spread of proven innovation, for better outcomes and thriving lives.

- We’ll achieve this by horizon scanning and industry engagement to generate a rich pipeline of useful Innovation.

Kent and Medway
Integrated Care System

Research Collaboration

Involving all of our partners will allow us to apply a more holistic approach, considering more of the wider determinants of health and challenging partners to view prevention as our primary focus.

Our own research should be utilised to help us plan and commission services more effectively. By consulting with our research community on modelling and appropriate methodologies, we can commission services based on local, evidence-based research.

As our confidence in collaborative research grows, we will understand the needs of our communities better, and identify collective solutions to address them.

Joint research collaborative (JRC)

The JRC brings established NHS trust research and innovation units and local academic partners together, and now has been extended to public health and social care teams. This will support better prioritisation of research objectives and improve representation of otherwise under-represented service users.

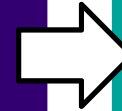
Health determinants research collaboration

Medway Council, in collaboration with the University of Kent, has been successful in bidding for £5m in funding to establish a Health Determinants Research Collaboration, one of just 13 in the country. The team will conduct research on wider determinants of health which will inform council and ICS policy on how we work to improve health and wellbeing.

Kent County Council public health has recently set up a research, innovation and improvement unit working with adult social care (known as Kent Research Partnership) and the wider council to strengthen existing research infrastructure, capacity and culture. This will build upon KCC public health's track record on international research activities (health and Europe), experience in linked dataset development and associated education and training activities such as Darzi Fellowship and other university placement programmes.

Units

- Pockets of expertise
- Small, highly skilled teams
- Health-focused
- Specific geographies and groups



Hubs

- Holistic approaches to research
- Shares knowledge widely throughout system
- Trains and upskills wider workforce

Our research and innovation units are key centres of talent and expertise that need to be harnessed to disseminate learning throughout the system. Our aim is to develop these into hubs that broaden our outlook and equip more people with skills to carry out research and improvement work.

With a system-wide overview, we can deploy additional support, such as in general practice and district councils, to bolster their research output and align it to wider system priorities.

Lastly, there is the opportunity to create new integrated research roles that traverse different sectors as well as advocating for adding research activity into job descriptions.

Kent and Medway Integrated Care System

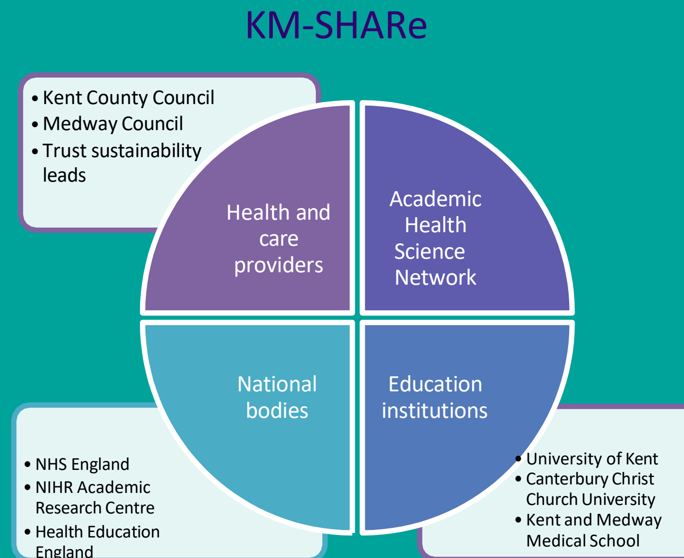
Quality Improvement and Innovation

We will make a commitment to, and adopt, a **single methodology and philosophy** (such as Quality, Service Improvement and Redesign – QSIR), and develop capacity and capability at all levels of the integrated care system (ICS). We will change culture to increase focus on experimentation and rapid improvement cycles.

Upskilling our workforce and empowering colleagues to take on research, innovation and quality improvement across a wider cross-section of our system will provide greater capacity. In doing so, we can instil continual improvement across the entire system.

Quality improvement and innovation are activities already underway across the system. As an ICS, we will be better able to share best practice and learning. We will work with regulators, such as the Care Quality Commission (CQC) and Office for Standards in Education, Children's Services and Skills (Ofsted), where appropriate to drive improvement through the system.

KM-SHARe is a collection of local and national partners who are coming together, hosted by the ICS, to overcome traditional boundaries to focus on sustainability and environmental initiatives in support of our green plan.



Covid-19 driving innovation
Throughout the pandemic, additional research activities were undertaken by social care, public health and primary care teams in order to respond to issues directly affecting local populations. Maintaining this momentum and capitalising on reduced barriers to work between organisations can be facilitated by the joined-up approaches of working as an integrated system.

We will build a partnership between the University of Kent and key partners, such as the Kent and Medway Medical School, to build a centre of excellence in delivering research that creates evidence and solutions for local health and care providers and commissioners.

Kent and Medway
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We will ensure a focus on key system enablers, with strategic attention to digital, including shared data and analytics.

Data and Information Sharing

Easy access to information when and where it is required through **the Kent and Medway Care Records Programme** will help guide our decision making, allowing for informed decisions on real-world, local knowledge.

Allowing this data to be more routinely shared throughout our system will be enabled through better legislation at both a national level and through local arrangements.

Through the **My Care Record** programme we will provide the residents of Kent and Medway with access to their own medical record.

Our long-term ambition is to build a **trusted research environment**, based on national guidance, that will allow for a safe, secure space for linked data across our local region.

A shared information governance model across local government and NHS will be developed to enable data sharing and integration for secondary uses such as population health.

Digital transformation

The integrated care system (ICS) digital charter describes how we want to work together on both a data and digital standpoint. Our collective aim is to **reduce complexity, communicate digital plans** and **deliver healthcare transformation** through a series of digital and data programmes.

Some of the ways to do this include empowering digital champions to lead transformation, building confidence within our workforce around digital and data and developing a sustainable service that does away with waste and consolidates in areas where there is duplication.

We are investing in the development of single clinical systems across the ICS. Examples include a single pathology information system, a single maternity system and a single cancer information system which will provide richer data and further develop record sharing with people.

Kent and Medway
Integrated Care System

Chapter 9

We will provide system leadership and make the most of our collective resources.

We will achieve this through:

- championing our values
- monitoring quality and providing governance
- guiding resource allocation
- interfacing with national bodies
- building resilience and preparing for emergencies
- working with our places and neighbourhoods to align priorities and develop implementation plans.

Kent and Medway
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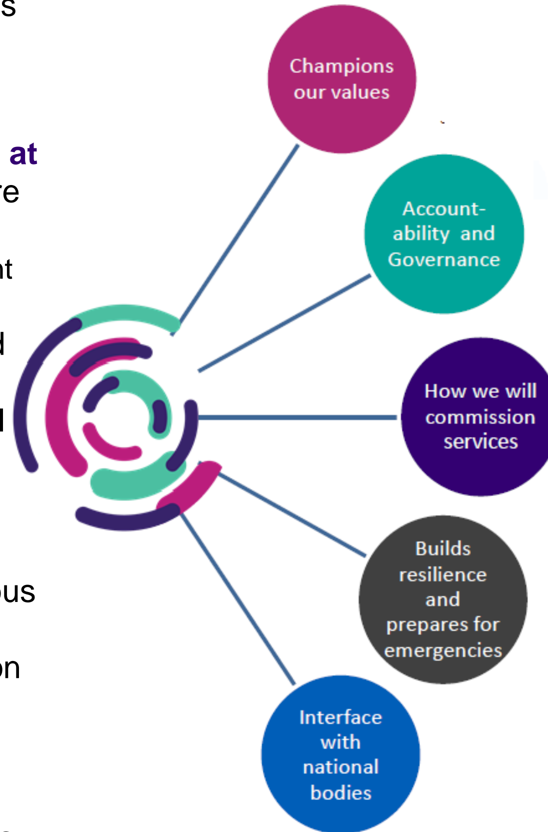
At **system level** we must focus on the complex issues that can only be dealt with by acting together. We are facing a period of significant financial challenge. We recognise the tangible patient and population benefits that can come from closer working with partners in delivery and commissioning of services.

We will work with our **health and care partnerships at place level** to ensure that priorities and ambitions are aligned and that robust implementation plans are developed with the system holding each other to account for the delivery. Organisations need to **understand each other better** so that we reduce duplication and make the most of our collective resources. Where appropriate, we will also use the tools at our disposal to pool our resources and overcome barriers to integration.

We will position voluntary, community and social enterprises (VCSE) as our strategic partners in various workstreams throughout the ICS by having an established VCSE alliance with formal agreements on how we will work together.

This strategy reflects insights from the public and the output of a Symposium held in October 2022, which had over 100 participants from across the system. As leaders, we must find ways to create space to continue to build a **culture of collaboration and trust.**



Our values act as the foundations for the way we conduct our work. We will build a culture of organisational trust and transparency and be prepared to take risks to achieve the right outcomes for our population. This extends beyond how we work together as a system but also sets out how we should interact with private businesses, voluntary organisations and the people of Kent and Medway. We will continue to build partner leadership and commit to tackling the wider determinants of health.

We must monitor progress of activity and our impact and hold each other to account for delivery on commitments. For the first time, targets will encompass combined metrics for both health and social care. We will work to develop core outcomes that will enable us to show tangible improvement. Governance will enable coordinated prioritisation and planning of activities and sharing of best practice between partners.

We will continue to listen to the voice of those with lived experience of our services, including those unable to access what they perceive they need. We are committed to increasing the resources that we can allocate and share between partners, that are jointly commissioned across health and social care. The ICB is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services. This could support new and emerging provider collaboratives and remove obstacles to operational teams working together.

We have legal duties to be prepared to respond and coordinate services in emergencies. System-wide resilience and emergency preparedness requires robust leadership and accountability. We have a robust system-level response plan and test these plans locally, regionally and nationally. Our ongoing, coordinated response to Covid-19 is led at an ICS level.

As changes take place across health and social care on a national level, the ICS will act as the voice of the people of Kent and Medway on the national stage. We will advocate on behalf of our community and influence wider policy to benefit our population.

Section 75 agreements allow us to pool budgets between local health and social care organisations and authorities.

We have agreed a new Section 75 agreement for learning disability and autism (LDA) services earlier this year, with Kent County Council, Medway Council and NHS Kent and Medway as partners in this single Section 75 arrangement, a move from the two separate ones.

As system partners, we are working to understand the impacts associated with significant housing developments, including the likely health needs and the future provision of health services. Through this process and as part of the wider healthcare infrastructure strategy, we will continue to identify infrastructure development requirements, including through developer contributions, that support the provision of additional healthcare services and healthcare facilities (including plans associated with existing facilities) for local populations.

Co-design and joined-up commissioning

The formation of our integrated care system (ICS) will transform how we commission services. Supported by legislation, we will deploy services and pathways that are tailored to specific needs and localities.

We will involve service users throughout design and seek regular feedback to respond to new demands and improve experiences. We will involve the voluntary, community and social enterprise (VCSE) sector and Healthwatch as additional important voices in the development of our services.

These services will be able to transcend health and social care for joined up, single access provision with an emphasis on staying well and prevention.

The Better Care Fund (BCF) allows spending for joined-up services that span health and social care, bringing them closer together in a more streamlined way.

Work has also commenced to review all BCF spend in Kent and Medway. We will look for opportunities for further joint working and re-working the BCF to make it fit for purpose and a transformational vehicle. The first stages of this work will be completed before 2023.

For example, in Medway, a joint commissioning management group, made up of system senior officers oversees all spends from the BCF. The partnership commissioning function ensures that health and social care are both embedded in new contracts.

Our Green Plan

Kent and Medway integrated care system (ICS) is taking the impact of climate change on health and inequalities very seriously. Partners across the system are now working together to create a coordinated plan of activity to maximise the effect of our collective action in tackling climate change. The more we do to reduce carbon emissions, improve air quality and promote biodiverse green spaces, the bigger the positive impact on our population’s health and wellbeing. Our vision is bold: It is to embed sustainability at the heart of everything we do, providing first-class patient care in the most sustainable way. Not just by choosing greener but by using less, repurposing what we use, and avoiding waste.

It is imperative that we work at pace and at scale as partners to deliver a combined approach not only to reducing our carbon footprint, but also promoting biodiversity and adapting to the changes in our climate that are already happening. We are confident that we can unite with our partners and our communities to achieve the ambitions of our green plan, and beyond.

We have responded to the NHS commitment to be the first healthcare service in the world to reach net zero on carbon emissions by 2040 by producing a five-year green plan, which we will deliver in partnership with staff, patients and suppliers.

Kent and Medway
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Playing our part as 'anchor institutions'

Our reach extends beyond how we work together as a system. The term 'anchor institutions' is used to describe large organisations, connected to their local area, that use their assets and resources to benefit the communities around them.

We have many large organisations across the ICS and all have a vital role to play in the health and wellbeing of our communities. As public sector anchor institutions in Kent and Medway, we will explore how we can make a difference directly to influence health and wellbeing in a positive way, including tackling health inequalities. For example, through:

- how we procure goods and service, using the power of our supply chains to broaden our reach
- looking after our workforce and offering training, employment, and professional development opportunities
- looking at how we use our buildings and land, e.g. ensuring that all green spaces across the ICS footprint are utilised fully for the benefits of biodiversity, the welfare of our staff and the people of Kent and Medway
- reducing our environmental impact and being leaders in achieving Net Zero
- working in partnership with other anchors
- retaining wealth in the region and driving inclusive, sustainable economic growth.

Kent and Medway
Integrated Care System

Chapter 10

What’s next? Engaging our communities on the issues that matter.

We will actively engage our communities on this strategy and our joint forward plan.

We will achieve this through:

- involving people from all walks of life to have their voice heard
- utilising multiple channels to ensure accessibility
- refreshing our strategy and developing supporting documents.

Next steps

In this document, we have laid out our interim strategy on how we will work together to improve the lives of people in Kent and Medway. We plan to publish an updated strategy in the autumn of 2023 to reflect the insights gathered from a wide range of engagement activities.

Our immediate next step is to create a plan to transform these initial ambitions into reality. This will be a five-year joint forward plan.

Medway Council is refreshing its joint local health and wellbeing strategy to be published in late 2023 and Kent County Council is developing an action plan based on the priorities set out in this strategy.

We will work to develop core outcomes that will enable us to measure success and show tangible improvement. We will then compile an annual report that will reflect on our performance and track our progress against targets.

Before the start of each financial year, we will publish a refreshed five-year plan, setting out our activities across health and social care that will work towards achieving our strategic goals. We will update our plan to celebrate our successes, refocus our efforts and respond to new challenges.

A new approach to engagement

We will not succeed unless we actively engage with and listen to the communities we serve, and people working throughout the system.

We want to:

- raise awareness of the work to improve health and care in Kent and Medway and the wider determinants of health and wellbeing
- give people the opportunity to influence decisions
- ensure insights gathered are considered in future plans and strategies.

Engagement activities will support us to identify priorities and improve the way we deliver services for local people. Formal public consultation and engagement activities will take place for Medway Council and Kent County Council and system partners to further develop and refine their strategies throughout 2023.

Collectively, we will use multiple channels to reach our audiences. We will ensure that, where possible, any engagement or involvement opportunities are accessible, locally available, allow for reasonable adjustments, and, where appropriate, provide resources and training to build capability and capacity to enable effective participation.

At times, engagement will be carried out on a system basis (for instance a programme of roadshows, surveys and online engagement platforms). At other times, health and care partnerships, which bring together partners at a place-based level, will lead more localised engagement, including through local district and borough councils and primary care networks, which will engage through their patient participation groups.

Individual partners may also deliver localised engagement activities. Partners will share the insights gathered through all engagement activities.

We will support, complement and champion this place- based and neighbourhood engagement and make sure there are mechanisms in place for local insights to be considered and inform strategies and plans.

Kent and Medway
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Have your say

We need everyone to help us do things differently. It's time to make positive, long-term change to the way we plan and deliver services so that we can make meaningful changes to the health and wellbeing of Kent and Medway residents.

We want to prevent ill-health wherever possible. This strategy outlines some of the work we are planning – we want to know what you think and your ideas.

There are lots of ways for you to have your say to help us plan for the future.

Your views will be listened to and will help shape our plans and strategies for the future.

You can share your thoughts on our strategy or on wider issues relating to health and wellbeing by registering for our online platform:

Have Your Say in Kent and Medway

www.haveyoursayinkentandmedway.co.uk/

Here you will also find out more about some of the exciting projects underway and examples of how we are demonstrating our new future.

- Alternatively, you can write to us at:

kmicb.engage@nhs.net or

The Engagement Team

Kent and Medway ICS

Kent House

81 Station Road

Ashford

TN23 1PP

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Item 5: Section 136 pathway and health-based place of safety service improvement

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 31 January 2023

Subject: Mental Health Transformation: Section 136 pathway and health-based places of safety service improvement

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Summary: This report falls under the transformation of mental health services in Kent and Medway.

The Committee has yet to determine if this workstreams' proposals constitute a substantial variation of service.

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1) Introduction

a) The Kent and Medway Integrated Commissioning Board have asked to present HOSC with proposed service improvements to the Section 136 (Mental Health Act 1983, as amended 2007) pathway and health-based places of safety (HBPoS) for the adult population of Kent and Medway.

2) Potential Substantial variation of service

a) On 10 June 2021, HOSC received a paper setting out the a programme of change for mental health and dementia services in Kent and Medway. The Committee agreed to receive updates on the progress of the overall transformation, as well as accepting individual reports on each of the workstreams at the appropriate time. This would allow the Committee to determine if each item is a substantial variation of service and proceed accordingly.

b) 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.

c) Where the Committee deems the proposed changes as not being substantial, this shall not prevent it from reviewing the proposed changes at its discretion and making reports and recommendations to the NHS.

d) Where the Committee deems the proposed changes as being substantial, the NHS must consult with it prior to a final decision being made, though the NHS always remains the decision maker.

e) Once the final decision has been reported to HOSC, the Committee shall decide if it supports the decision, does not support the decision, and/or provide comment on it. Where it does not support the decision, the Committee can refer it to the Secretary of State.

f) Medway Council's Health and Adult Social Care Overview and Scrutiny Committee (HASC) has considered the changes and determined they are not substantial.

3. Recommendation

If the proposals relating to places of safety are deemed substantial:

RECOMMENDED that:

(a) the Committee deems that proposed changes to places of safety are a substantial variation of service.

(b) NHS representatives be invited to attend this Committee and present an update at an appropriate time.

If the proposals relating to places of safety are deemed not substantial:

RECOMMENDED that:

(a) the Committee deems that proposed changes to places of safety are not a substantial variation of service.

(b) NHS representatives be invited to attend this Committee and present an update at an appropriate time.

Background Documents

Kent County Council (2021) Health Overview and Scrutiny Committee (10/06/21)
https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8501&Ver=4

Contact Details

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Kent County Council
Health Overview and Scrutiny Committee (HOSC)
31st January 2023

SECTION 136 PATHWAY AND HEALTH-BASED PLACE OF SAFETY SERVICE IMPROVEMENT

Report from: Taps Mutakati, Director of System Collaboration
NHS Kent and Medway NHS

Author: Louise Clack,
Programme Director, Urgent and Emergency Mental Health Care, Kent and Medway NHS

Summary

This report seeks to inform the HOSC of the proposed service improvement to the Section 136 (Mental Health Act 1983, as amended 2007) pathway and health-based places of safety (HBPoS) for the adult population of Kent and Medway. Section 136 of the Mental Health Act 1983 (as amended 2007) is the power that allows a police officer to detain and remove a person they believe to be mentally disordered and in need of immediate care or control to a health-based place of safety (HBPoS) for a period of up to 24 hours. A place of safety is commonly a designated assessment area/room in an NHS-provided mental health service that is staffed by a mental health nursing team. Once at a place of safety a Mental Health Act assessment is undertaken by two doctors and an approved mental health practitioner (AMHP) to determine whether or not the individual is suffering from a mental disorder and whether a period of inpatient admission is required.

In May 2022 NHS England invited integrated care systems across the country to bid for capital funding ringfenced for safety improvements to mental health urgent and emergency care pathways. A short timescale of three weeks was given for bid submission, precluding opportunities for wide reaching consultation. To help seize this funding opportunity, NHS Kent and Medway Integrated Care Board (ICB), commissioner, and Kent and Medway NHS and Social Care Partnership Trust (provider), with strategic/senior support from Kent Police, the two local authority approved mental health practitioner (AMHP) services and South East Coast Ambulance (SECAmb) NHS Trust, submitted a bid for service improvement to the Section 136 pathway and health-based place of safety, in the knowledge that a public consultation would nonetheless be required for a significant change and that comprehensive information would need to be provided to evidence the case for change and support a final decision.

Within Kent and Medway there is a very well-established joint planning structure in place with local partners with specific focus on Section 136 improvement which had produced the 2019 ‘Kent and Medway Crisis Care – Section 136 Pathway Standards and Health Based Place of Safety Specification’ based on national standards and best practice. Plans for improvements focus on areas where the Section 136

pathway and HBPoS fall short of these standards and safety specification and it was this that formed the basis of the capital bid. The service improvement objectives, which are detailed further on in this report, seek to improve the overall experience for service users for what is a difficult assessment process and include:

- decreasing the length of time individuals spend in conveyance to a HBPoS
- decreasing the length of time of Section 136 detention
- expediting the clinical assessment process
- making much needed improvements to the HBPoS physical environment and estate
- improving the recruitment and retention of the HBPoS workforce and enabling agencies to fulfil their obligations under the Section 136 pathway standards and HBPoS safety specification.

There are two distinct but related components to the proposed service improvement - changes to the current Section 136 pathway, and changes to the existing HBPoS base and estate.

A longlist of potential options (Appendix 1) was identified for the purpose of the bid which was appraised against the service improvement objectives for improving the overall care pathway experience for service users, along with practical considerations such as: achievability, affordability, availability and acceptability. A reduced number of options have been short-listed for option appraisal and at this stage it appears that the option to centralise the places of safety is preferred, which is the option used to inform the capital bid in June, which was necessary to inform the bid. Further work to appraise the short-listed options is ongoing, and preparations for a full public consultation are underway, with work on the pre-consultation business case (PCBC) also in hand.

1. Budget and policy framework

1.1. The Section 136 service improvement relates to the following national and local health and social care policy and strategy.

1.2. The 2014 *'A Safe Place to be'* 2014 Care Quality Commission's (CQC) report sets out the role of effective partnership working, inter-agency training and support in helping to reduce the use of Section 136 and, as a result, the demand for places of safety. It describes emerging evidence from innovative triage schemes that joint working between the police and health care staff to provide people in crisis with the right help and support can contribute to reducing the use of Section 136 overall. However, it is clear that there will be a continuing need for health-based places of safety to which distressed and vulnerable individuals will need to be taken by police officers and that these places must be fit-for-purpose.

1.3. The 2019 NHS England (NHSE) *'NHS Mental Health Implementation Plan'* sets out plans for delivery of a spectrum of mental health pathways, including development and provision of a whole system comprehensive 24/7 mental health urgent and emergency care pathway for people of all ages. As the mental health equivalent of an emergency service the Section 136 facility is by definition going to be used for people at a point of extreme distress, at least some of whom will be

at a very acute stage of illness, when risks to self and others are highest. This makes it critical that, in addition to an excellent clinical service, the facility used is designed appropriately, to provide a therapeutic environment and the highest safety standards. As access to the service is likely to be urgent, the facility must have sufficient capacity to deal with times of peak demand and, most importantly, the professional staff resources to effectively assess people's needs in a timely way must be available when required.

1.4. The 2019 *'Kent and Medway Crisis Care – Section 136 Pathways Standards and Health-based Place of Safety Specification'* sets out those responsibilities for each partner within the Kent and Medway integrated care system, for the delivery of a Section 136 pathway that ensures effective partnership working and communication; timely access to assessment in a therapeutic place of safety staffed by highly competent staff.

2. Background

Section 136

2.1. Section 136 of the Mental Health Act 1983 (as amended 2007) ('the Act') empowers a police officer without first obtaining a warrant to either remove a person to a place of safety or, if the person is already at a place of safety, keep them there or remove them to another place of safety for the permitted period of detention, usually 24 hours unless extended. This power can only be exercised if the police officer considers the person is suffering from a mental disorder and is in immediate need of care or control. The power may be exercised at any place other than a private dwelling.

2.2. The purpose of the detention is to enable examination by a registered medical practitioner (who for this purpose need not be approved under s.12 of the Act) and interview by an approved mental health professional (AMHP), and for the making of any necessary arrangements for the person's treatment or care.

2.3. It is for the police to determine what is a place of safety in each case, irrespective of whether that place has been designated as a place of safety in local protocols. A place of safety could be:

- a designated assessment area/room in an NHS-provided mental health service (a health-based place of safety HBPoS)
- A&E (a health-based place of safety HBPoS)
- a care home
- a police station (in very exceptional circumstances due to level of aggression and risk of violence to others)
- the individual's or someone else's home or room (with the consent of the individual and/or other people they live with)
- other suitable premises where the manager of those premises agrees.

2.4. The outcome of the examination and interview by the registered medical practitioner and AMHP could be:

- discharge from Section 136 and sent home
- voluntary admission to a mental health inpatient bed
- if supported by written recommendations in prescribed form of two registered medical practitioners one of whom must be approved under s.12 of the Act, detention under a further section of the Act and admission to a mental health inpatient bed.

2.5. In Kent and Medway, on average, 75 per cent of individuals are discharged from Section 136 (in line with the national average) and conveyed home by patient transport with mental health follow up where appropriate.

3. Kent and Medway Mental Health Urgent and Emergency Transformation Programme

3.1. The Section 136 service improvement forms part of the wider Kent and Medway mental urgent and emergency care pathway transformation, aligned with the NHS mental health implementation plan (2019) and the provision of a seamless 24/7 urgent and emergency mental health care pathway that is person-centred, socially inclusive and delivered via a blended approach of voluntary, community and social enterprise (VCSE) and secondary care. A revised pathway will offer individuals in mental health crisis viable alternatives to using emergency services and should realise a reduction in incidence of Section 136, and includes:

3.1.1. **Open access crisis (NHS 111 select option two)**
From March 2023, nationally, individuals experiencing mental health crisis will be able to dial NHS 111, select option two and speak directly to a trained mental health triage call handler (as opposed to having to follow the lengthy physical health algorithm). If an urgent secondary care response is required, a face-to-face or virtual urgent mental health assessment will take place by a trained mental health clinician within four hours.

3.1.2. **Clinical advice service for Kent Police**
Currently, Kent Police has telephone access to a trained mental health clinician via the '836 Police Advice Line' to discuss whether or not to use their powers of detention under Section 136; the mental health clinician is able to access clinical records where available and talk to the individual where appropriate. Recent investment has enabled expansion of this service. This has seen a significant reduction in the use of Section 136 over the last 24 months, with the current year being the lowest since 2018. (See Appendix 2).

3.1.3. **Community crisis alternatives**
There are currently five safe havens operating across Kent and Medway seven days a week between the hours of 6pm and 11pm (longer at weekends). The safe havens are delivered by VCSE providers and are based within community settings. They provide a physical and therapeutic space for individuals experiencing

psychological crisis as an alternative to presenting at A&E or being detained under Section 136.

3.1.4. **Crisis houses**
NHS Kent and Medway intends to commission two crisis houses (one in Medway and one in east Kent) for implementation in October 2023, providing individuals experiencing mental health crisis with a 24hour supervised but supportive therapeutic space as an alternative to inpatient admission to a mental health inpatient bed. Through timely crisis intervention this may help to prevent a service user having to access emergency services or provide a safe space for the service user to step down to following a Section 136 mental health assessment for example. They are designed to provide 24hour crisis support and supervision for a limited period of time and are usually delivered though the VCSE sector with positive outcomes including high levels of service user satisfaction. In addition to the important benefits for service users in crisis, a crisis house will support effective patient flow across the system.

3.1.5. **Enhanced home treatment**
Currently the crisis resolution and home treatment (CRHT) team model has two functions (i) responding to unplanned urgent assessments within four hours; and (ii) providing planned home treatment interventions as an alternative to inpatient admission. These two functions are directly opposed and present challenges to providing timely assessment and home treatment interventions to individuals in crisis, to support individuals to remain at home. The intention is to separate out the two functions and create (i) a rapid response team (a team whose sole purpose is to respond to requests for urgent mental health assessment); and (ii) an enhanced home treatment team who solely provides intensive home treatment as a viable alternative to inpatient admissions. This will support effective patient care, and also will positively impact upon time individuals spend within the HBPoS as described above.

3.1.6. **Mental health ambulance**
On behalf of the system, the Kent and Medway mental health team is working with South East Coast Ambulance Trust (SECAmb) colleagues on the development of a mental health urgent ambulance response. A bespoke mental health ambulance with a paramedic and mental health clinical crew would be able to respond urgently to SECAmb mental health related calls and assess and intervene at scene and possibly act as an alternative to detention under Section 136 or conveyance to A&E.

4. Section 136 Service – existing arrangements

4.1 There are currently five assessment spaces/rooms, provided by KMPT in Kent and Medway, spread across its three main hospital sites at Canterbury (two spaces), Maidstone (two spaces) and Dartford (one space).

4.2 Individuals detained on Section136 over the 24hour period are taken to the HBPoS with immediate availability; the geographical origin of detention does not determine the destination of HBPoS. This can result therefore in a detained individual being conveyed from a north Kent public place to an east Kent HBPoS as an example.

4.3 There are significant challenges with recruitment and retention within the HBPoS. Each facility is isolated and, as the teams are small, staff are required to work a disproportionate number of unsocial hours, which for some is not attractive. Gaps in staffing due to vacancies have to be covered by temporary agency staff or staff pulled from the local crisis resolution and home treatment (CRHT) team. The CRHT team provides home treatment as an alternative to inpatient admission; having to cover the HBPoS reduces capacity within the CRHT for the provision of home treatment and home visits have to be rescheduled or cancelled at short notice. There have been occasions when a HBPoS has been closed due to staff being unavailable.

4.4 The bulk of Section 136 detentions (25%) occur out-of-hours (5pm-9am Monday to Friday and 24/7 at weekends and on bank holidays). Out-of-hours all Kent and Medway Mental Health Act assessments are undertaken by Kent County Council approved mental health practitioners (AMHP)s, along with two doctors. The AMPH and medical resource out-of-hours is reduced, covers the entire county and often requires the need to travel between the three disparate HBPoS. This delays the Mental Health Act assessment process, resulting in individuals being detained longer than is necessary and reduced capacity within the HBPoS. Only five per cent of Mental Health Act assessments are completed within the nationally and locally recommended four hours, 17 per cent within eight hours, and 40 per cent of assessments take place after 21 hours.

4.5 The facilities predate the creation of KMPT in 2006, and struggle to meet modern and recommended standards, despite trust investment in their maintenance and updated layouts at various points over the past 20 years. Two of the three facilities do not have access to fresh air or adequate de-escalation space. Each facility has been subject to intermittent closures due to damage and repair. The capital award is extremely timely and much needed, providing a real opportunity to improve facilities as part of a wider care pathway improvement.

4.6 Temporary closures to the HBPoS result in police conveyance to A&Es as an alternative health-based place of safety. Police officers then have to remain with the detained individual in A&E until a Mental Health Act assessment has been convened. This is a drain on Kent Police resource.

5. Health-based place of safety locality activity and use

5.1. Appendix 2 provides a detailed breakdown of Section 136 Activity.

5.2. Individuals detained under Section 136 and requiring conveyance to a HBPoS, are taken to the HBPOS with immediate availability regardless of geographical origin of detention. It is not unusual therefore for an individual to be detained in the North of the County, and then conveyed to an East Kent HBPoS.

5.3. Analysis of detentions during the period June 2021 to July 2022 evidenced that 50 percent of Medway S136 detentions, 50 percent of Maidstone's and 40 percent of Swale were conveyed to the East Kent HBPoS. 45 per cent of East Kent S136s were conveyed to the Maidstone HBPoS. Centralisation of a HBPoS could, on the whole, reduce the time individuals in mental health crisis and distress spend being conveyed to a HBPoS.

6. Service improvement objectives and consideration of options

6.1. The table below is the full list of the Section 136 service improvement objectives

Number	Service improvement objective
1	To improve the quality of care for those detained under Section 136 by ensuring access to assessment in a high quality, robust and resilient physical care environment, enhancing safety for service users and staff.
2	To ensure timely access and assessment of those attending a place of safety by ensuring the availability of approved mental health practitioners (AMHPs) and Section 12 doctors.
3	To ensure timely access and assessment of those attending a place of safety by improving capacity.
4	To provide place of safety facilities which support and enable the roles of partner organisations in providing this emergency service, including the avoidance of use of A&E as an alternative HBPoS.
5	To ensure quality of care and assessment offered by clinicians to those accessing a place of safety, which meet place of safety standards.
6	To improve recruitment and retention of nursing staff in the place of safety and reduce the reliance on agency and temporary staffing.
7	To ensure that high quality clinicians are attracted to work within the service by providing a fully comprehensive range of mental health services which provide a professionally fulfilling experience of working across the whole care pathway, in particular for student medical and nursing staff.
8	To provide a place of safety service which meets the 2019 'Kent and Medway Crisis Care – Section 136 Pathways Standards and Health-based Place of Safety Specification'[3] by optimising capacity through dedication of the place of safety to Section 136 functions only.
9	To provide additional staff support to the place of safety in the event of serious behavioral incidents which threaten patient and/or staff safety.

6.2. There are two distinct components to the service improvement, obviously related, but needing to be considered separately for the purposes of appraising service improvement options. These are (i) care pathway improvement; and (ii) estates

improvement/change. Generally, this approach would not be taken; the separation has been as a result of the capital bid requirements working faster than the overall co-design which is the fundamental ambition governing this work.

6.3. **Pathway improvement**

Work is underway with service users and system partners identifying additional areas of pathway improvement and quantifying service user and partner agency benefits. In addition to improved service user experience, these will include significant savings and reduced pressure on partner agencies, for example on the amount of time that the police need to wait with patients using A&E, as well as reducing the occasional disruption that can happen within A&Es by the behaviour of a minority of those detained. A series of workshops are arranged to review data from partner agencies to improve the development of the model of care and pathway.

6.4. **Estates improvement/changes**

A number of potential estates options have been identified. The long list of options considered at the time of the bid is set out in Appendix 1 with a brief description. From this, a shortlist has been identified and these options will be subject to a detailed option appraisal. For the purpose of short-listing, each option has been considered against the service improvement objectives, plus practical considerations such as achievability, affordability, availability and acceptability. In addition, co-location with other mental health wards is important, HBPoS staff must be able to summon extra help at short notice from the staff on the wards if required. Whichever option is eventually agreed it will need to realise all of the scheme's benefits and objectives and enable individual organisations to meet the obligations under the standards set out within the 2019 'Kent and Medway Crisis Care – Section 136 Pathways Standards and Health-based Place of Safety Specification'.

6.5. At the time of the bid it was agreed by commissioners and the provider (KMPT) that Maidstone was the site which best met the criteria, and that investing in centralisation was preferred to investing in all three existing sites. Since then, bid work has been ongoing to further appraise all options and the centralised Maidstone option currently remains the preferred option. The work is not yet finished however and any preferred option for change will be consulted upon.

6.6. Having a centralised HBPoS in Maidstone will ensure that east Kent patients will not need to be conveyed further than Maidstone (to Dartford) which sometimes happens now. A centralised health-based place of safety at Maidstone will have some negative impact on residents in the furthest eastern parts of the county (whereas, Ashford, for example, is almost equidistant between Maidstone and Canterbury). Overall more Kent and Medway individuals will benefit from a centralised HBPoS at Maidstone and the consequent reduction in conveyance time. Further, the duration of time spent in the HBPoS for all (including east Kent residents) will reduce due to the efficiencies realised from the centralising of the AMPHs, HBPoS nursing team and medical team.

6.7. Maidstone is the only site that has the physical space to develop the existing HBPoS to the required national standard. The option of having a dual East and West Kent HBPoS has been retained for appraisal but will not realise all of the S136 pathway wider benefits aforementioned to the same extent. However, the on-going work is looking closely at the detailed financial and non-financial benefits and costs of each short-listed option to allow confirmation of a preferred option.

7. Demand and capacity

7.1. In considering centralisation of the service the NHS Kent and Medway and KMPT have reviewed whether the current provision of five HBPoS assessment rooms/spaces should be reviewed as part of that process, and either increased or reduced to meet demand. Appendix 2 sets out demand in terms of numbers and sources of origin of those people detained. The total average number of detentions per annum between 2018-2021 was 1,494, masking considerable fluctuations, with an increase in 2018 and a significant decrease in 2021. The reduced numbers in 2021 (which have continued to reduce this year) are attributed largely to the introduction of the 836 special advice line for police officers staffed by KMPT, and to investment in training for police officers. Given the sustained reduction in the last 18 months, increasing HBPoS capacity would not be deemed necessary.

8. Consultation

8.1. As part of the process of improving care for people removed to a place of safety pursuant to Section 136 of the Act and using our health-based places of safety, we have already been working with patients, public, partners, staff, and stakeholders to develop our plans.

8.2. Key activities have included:

- reviewing all patient and partner insights on crisis care so that we can learn from what people have already told us. This has included looking at what people told us during the Kent Listens project, Kent and Medway NHS and Social Care Partnership Trust's work with experts-by-experience, and wider engagement on transforming services
- offering one-to-one interviews or small focus group discussions with individuals and families affected to listen to existing users of services and partner agencies
- jointly developing the proposals with partners and people with lived experience through the integrated transformation programme
- listening to the views of frontline staff working in health-based places of safety
- wider engagement, led by a clinical and professional board, with psychiatrists, GPs, ambulance teams, police officers and social care staff

- joining discussions with peer support and advocacy services on potential improvements with existing service user and carer groups for those with complex emotional disorders
- reaching out to communities which are most affected through Voluntary, Community and Social Enterprise (VCSE) groups.

8.3. This is what they have told us:

- We need support and an environment with access to fresh air and the outside, a place which is well-staffed and comfortable rather than bland and municipal.
- Any new facility must be easily accessible, with transport there and back provided safely and in a timely manner, with parking for staff.
- Staff who are comforting and consistent for you to feel safe and supported.
- Sensory needs must be considered; sound should be soothing and not overwhelming, especially for those with autism.
- Activities to occupy you if there are delays, comforting food and facilities.
- Having different spaces for assessment, and sleeping, not built like a ward – purpose built and codesigned.
- Places for de-escalation and seclusion for the volatile and vulnerable, and to keep everyone safe, so that the facility doesn't close if someone is 'kicking off'.
- Carers and families can supply vital information on individuals to help with the assessment, if patient care plans could enable those close advocates to assist without breaching patient confidentiality

8.4. We will deliver a formal public consultation in line with best practice that complies with our legal requirements and duties. Our aims for the consultation are to:

- raise awareness of the plans and how people can have their say across Kent and Medway and how these views will be considered
- collect views from the full spectrum of people who may be affected – including staff, people with lived experience and their friends and families, stakeholders, and the public - gathering feedback from individuals and representatives in a sensitive and supportive way
- ensure we use a range of methods to reach different audiences including activities that target specific groups with protected characteristics and those quieter more diverse communities affected by health inequalities working closely with VCSE organisations to support their involvement in a safe and inclusive way
- explain how the proposals have been developed, what this means in practice, so people can give informed responses to the consultation
- ensure the integrity and legality of the consultation process to the best of our ability, working with both Kent and Medway's health overview and scrutiny committees
- meet or exceed our objectives and deliver our plan within the timeframe and budget allocated

- provide the ICB board with an independent report on the consultation responses to consider in decision-making, with sufficient time to give them thorough consideration
- feedback to all those who have contributed any decisions and actions agreed in a timely and consistent way using all appropriate channels.

8.5. Recognising the specialist nature of the service which affects a small number of individuals we suggest a two-month timeframe is appropriate to enable an inclusive but sensitive approach to public consultation and collating views on the best use of this capital funding opportunity to enable optimal service improvement to the Section 136 pathway and health-based place of safety and to improve the overall experience for service users for what is a difficult assessment process.

8.6. The detailed plans and objectives are set out in Appendix 3, our consultation plan.

8.7. The Section 136 service improvements affect residents and service partners in Kent and Medway therefore consideration of these proposals suggest that a Joint Health Overview and Scrutiny Committee is formed. We also recognise that council elections are due to take place and we will take account of guidance on purdah.

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

8.9. Where more than one local authority has to be consulted under these provisions those local authorities must convene a Joint Overview and Scrutiny Committee for the purposes of the consultation and only that Committee may comment.

8.10. The legislation makes provision for local authorities to report a contested substantial health service development or variation to the Secretary of State in certain circumstances, after reasonable steps have been taken locally to resolve any disagreement between the local authority and the relevant responsible person on any recommendations made by the local authority in relation to the proposal. The circumstances in which a report to the Secretary of State is permitted are where the local authority is not satisfied that consultation with the local authority on the proposed substantial health service development or variation has been adequate, in relation to content or time allowed, or where the authority considers that the proposal would not be in the interests of the health service in its area.

8.11. Revised guidance (https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf) for health service Commissioners on the NHS England assurance process for service changes was published in March 2018. The guidance states that broadly speaking, service change is any change to the provision of NHS services which involves a shift in the way front line health services are delivered, usually involving a change to the range of services available and/or the geographical location from which services are delivered. It also says that any proposed changes should be aligned to Sustainability and Transformation Partnership (STP) Plans.

8.12. The NHS England guidance acknowledges that the terms “substantial development” and “substantial variation” are not defined in the legislation. Instead commissioners and providers are encouraged to work with local authorities to determine whether the change proposed is substantial thereby triggering a statutory requirement to consult with Overview and Scrutiny.

8.13. The NHS England guidance also states that public consultation, by commissioners and providers is usually required when the requirement to consult a local authority is triggered under the regulations because the proposal under consideration would involve a substantial change to NHS services.

8.14. However, public consultation may not be required in every case, sometimes public engagement and involvement will be sufficient. The guidance says a decision around this should be made alongside the local authority.

8.15. Government Guidance on Local Authority Health Scrutiny says that constructive dialogue with health scrutiny when communicating on timescales for comments or decisions in relation to substantial developments or variations should help ensure that timescales are realistic and achievable. In addition, the Guidance says “it sensible for health scrutiny to be able to receive details about the outcome of public consultation before it makes its response so that the response can be informed by patient and public opinion”.

9. Recommendations

9.1. Members are asked to:

a) Comment on the proposals to improve the mental health urgent and emergency care pathway and support the plan for a two month public consultation period.

b) Decide whether the proposals constitute a substantial variation in the provision of health services in Kent.

9.2. This report requests HOSC note the information about improving the mental health urgent and emergency care pathway and support the plan to go to public consultation. Recognising the specialist nature of the service which affects a small number of individuals we suggest a two-month timeframe is appropriate to enable an inclusive but sensitive approach to public consultation and collating

views on the best use of this capital funding opportunity to enable optimal service improvement to the Section 136 pathway and health-based place of safety and to improve the overall experience for service users for what is a difficult assessment process.

Lead officer contact

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Appendices

Appendix 1 Health-based Place of Safety - Long List of Options
Appendix 2: Section 136 Activity Report
Appendix 3: Consultation Plan

Background papers

Kent and Medway Crisis Care – Section 136 Pathway Standards and Health Based Place of Safety Specification https://democracy.medway.gov.uk

Care Quality Commission (2014) 'A safe space to be' *https://www.cqc.org.uk/node/1496*

NHS England (NHSE) 2019 'NHS Mental Health Implementation Plan'
https://www.longtermplan.nhs.uk

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APPENDIX 1

Section 136 Pathway and Health Based Places of Safety Service Improvement

Long List of Options

Option Appraisal Utilisation of Capital Funding		
Option	Description	Long list Appraisal
Option 1 Option 2	Do nothing Do minimum - Refurbish each existing HBPOS to meet minimum standards	Rejected – meets none of the objectives Retained - Meets some objectives in a limited way – retained for baseline purposes
Option 3a-c	Reduce to two sites instead of three and refurbish to meet all standards 3a) EK HBPOS and WK HBPOS only 3b) EK HBPOS and Dartford HBPOS only 3c) WKHBPOS and Dartford HBPOS only	Retained for appraisal Rejected – meets some objectives only in a limited way
Option 4 Option 5a-c	Relocate to new facilities on DGH sites Centralise HBPOS on one of the Trust's 3 hospital sites 5a) St Martins, Canterbury	Rejected - Unavailable, unaffordable, no co-location with mental health services, unlikely to be agreed by DGH. Rejected - There are more 136 detentions in North and West Kent. EK is not central within Kent and this will have an adverse impact upon individuals outside of East Kent. The existing HBPOS in East Kent cannot be extended due to insufficient space. There is no other suitable available space. EK of all areas is most difficult to recruit to. There will be a significant overall increase in Travel/Transport costs and conveyance time. Unavailable, likely to be unaffordable (if new build), unacceptable to significant population.
	5b) Maidstone site, Hermitage Lane	Retained. Most central site so most accessible location in general, although will impact upon 50% of East Kent detentions. Which will increase conveyance time for a cohort of individuals. Potential for increased travel and transport costs incurred by Kent Police and SECAMB are mitigated for by the decrease in travel and transport costs for Medway/DGS and West Kent Patients currently conveyed to East Kent. There is sufficient space on the current HBPOS site to extend. The Maidstone site

		hosts, and is planned to host more, county-wide mental health services
	5c) Little Brook Hospital, Dartford	Rejected – very poor location for rest of county, no space available, significant increases in costs of transport/travel and conveyance time for West Kent and East Kent individuals. Dartford has the second lowest rate of 136 detention. Unavailable, likely to be unaffordable (if new build), unacceptable to significant population.
Option 6	New site	Rejected – No sites identified, no co-location with mental health services, land cost likely to make unaffordable. Unavailable and unachievable in timeframes.
Option 7	Other KMPT hospital sites (QEQM, Medway Hospital)	Rejected - Insufficient mental health services to co-locate with. Unavailable, unachievable, unaffordable (acquisition of land) and, in the case of QEQM, unacceptable location on fringe of county (as for Dartford above)
Option 8	Peripatetic, community-based service	Rejected – not viable without HBPoS

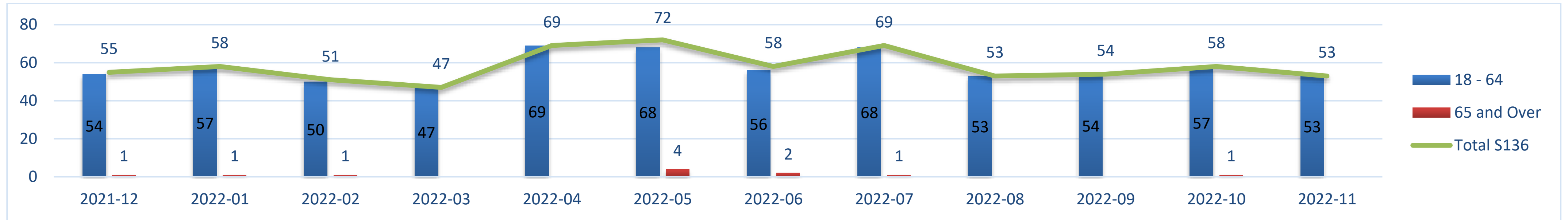
Kent and Medway NHS
NHS and Social Care Partnership Trust

Report Lead	Cheryl Lee
Report author	Sharon Jullings
Report Date	12th December 2022

Measure 1: Section 136 by Age Range per Month

Age	2021-12	2022-01	2022-02	2022-03	2022-04	2022-05	2022-06	2022-07	2022-08	2022-09	2022-10	2022-11	Total
18 - 64	54	57	50	47	69	68	56	68	53	54	57	53	686
65 and Over	1	1	1			4	2	1			1		11
Total S136	**55**	**58**	**51**	**47**	**69**	**72**	**58**	**69**	**53**	**54**	**58**	**53**	**697**

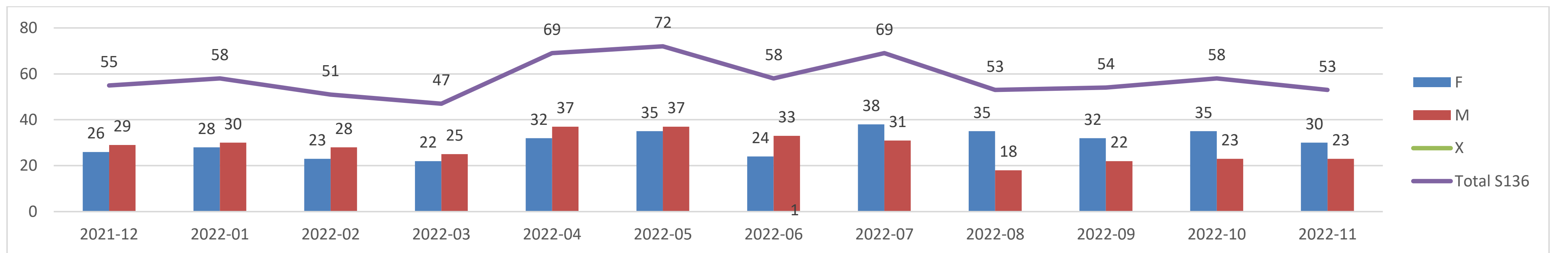
Age %	2021-12	2022-01	2022-02	2022-03	2022-04	2022-05	2022-06	2022-07	2022-08	2022-09	2022-10	2022-11	Average
18 - 64	98.2%	98.3%	98.0%	100.0%	100.0%	94.4%	96.6%	98.6%	100.0%	100.0%	98.3%	100.0%	98.4%
65 and Over	1.8%	1.7%	2.0%	0.0%	0.0%	5.6%	3.4%	1.4%	0.0%	0.0%	1.7%	0.0%	1.6%
Total S136	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**



Measure 2a: Section 136 by Gender per Month

Gender	2021-12	2022-01	2022-02	2022-03	2022-04	2022-05	2022-06	2022-07	2022-08	2022-09	2022-10	2022-11	Total
F	26	28	23	22	32	35	24	38	35	32	35	30	360
M	29	30	28	25	37	37	33	31	18	22	23	23	336
X							1						1
Total S136	**55**	**58**	**51**	**47**	**69**	**72**	**58**	**69**	**53**	**54**	**58**	**53**	**697**

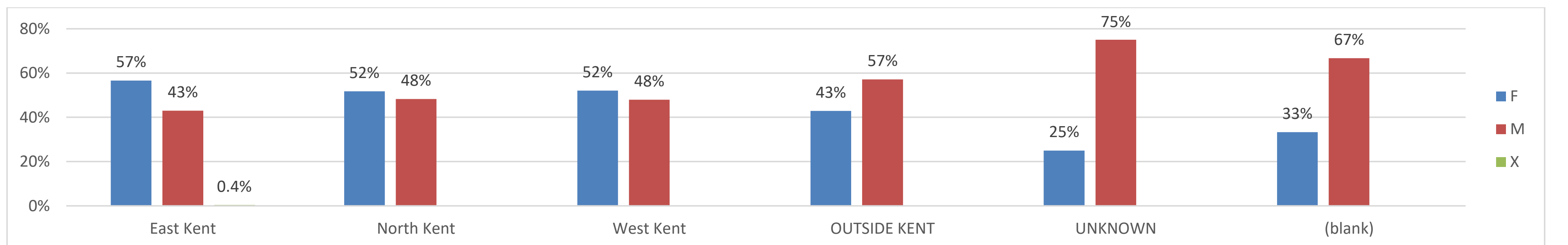
% Gender	2021-12	2022-01	2022-02	2022-03	2022-04	2022-05	2022-06	2022-07	2022-08	2022-09	2022-10	2022-11	Average
F	47.3%	48.3%	45.1%	46.8%	46.4%	48.6%	41.4%	55.1%	66.0%	59.3%	60.3%	56.6%	51.6%
M	52.7%	51.7%	54.9%	53.2%	53.6%	51.4%	56.9%	44.9%	34.0%	40.7%	39.7%	43.4%	48.2%
X	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
Total S136	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**



Measure 2b: Section 136 by Gender per CCG Area

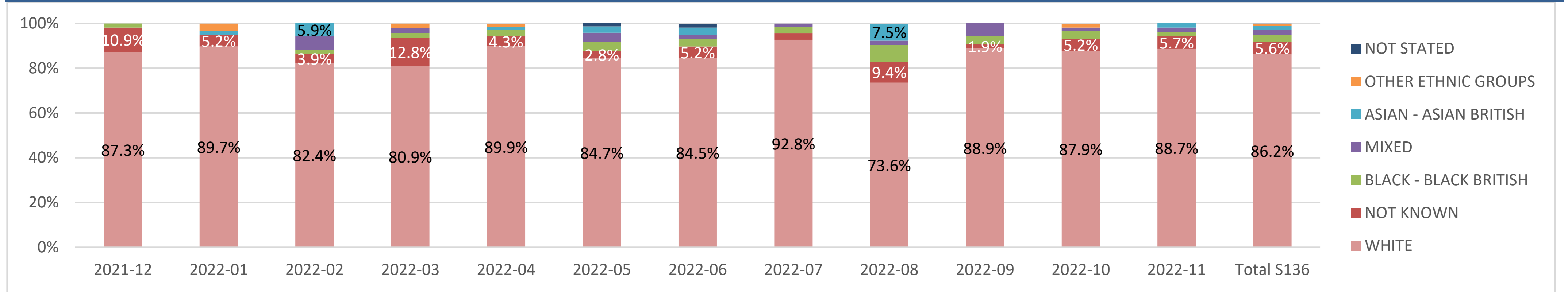
Gender/CCG	East Kent	North Kent	West Kent	OUTSIDE KENT	UNKNOWN	(blank)	Total S136
F	138	124	61	30	5	2	360
M	105	116	56	40	15	4	336
X	1						1
Total S136	**244**	**240**	**117**	**70**	**20**	**6**	**697**

% Gender/CCG	East Kent	North Kent	West Kent	OUTSIDE KENT	UNKNOWN	(blank)	Average
F	56.6%	51.7%	52.1%	42.9%	25.0%	33.3%	51.6%
M	43.0%	48.3%	47.9%	57.1%	75.0%	66.7%	48.2%
X	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
Total S136	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**



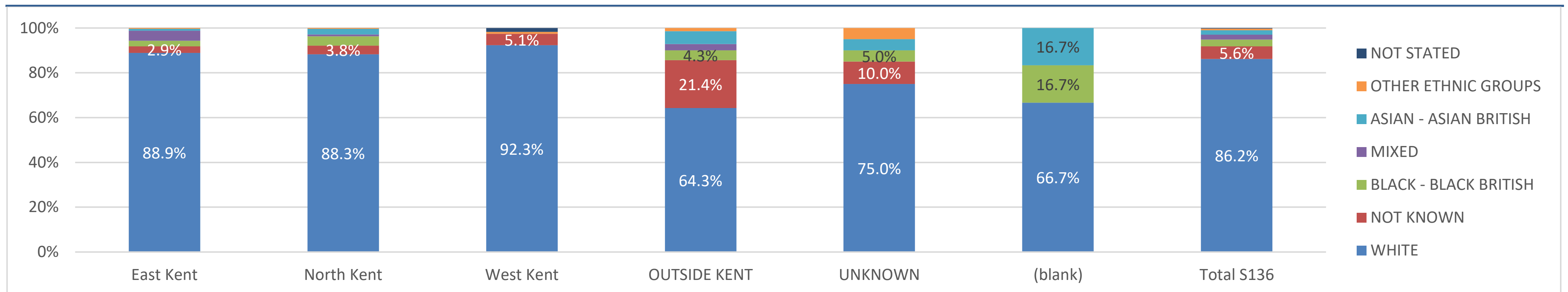
Measure 3a: Section 136 by Ethnicity NHS Group per Month

Ethnicity/Month	2021-12	2022-01	2022-02	2022-03	2022-04	2022-05	2022-06	2022-07	2022-08	2022-09	2022-10	2022-11	Total
WHITE	48	52	42	38	62	61	49	64	39	48	51	47	601
NOT KNOWN	6	3	2	6	3	2	3	2	5	1	3	3	39
BLACK - BLACK BRITISH	1		1	1	2	3	2	2	4	2	2	1	21
MIXED			3	1		3	1	1	1	3	1	1	15
ASIAN - ASIAN BRITISH		1	3		1	2	2		4			1	14
OTHER ETHNIC GROUPS		2		1	1						1		5
NOT STATED						1	1						2
Total S136	**55**	**58**	**51**	**47**	**69**	**72**	**58**	**69**	**53**	**54**	**58**	**53**	**697**



Measure 3b: Section 136 by Ethnicity NHS Group per CCG Area

Ethnicity/CCG	East Kent	North Kent	West Kent	OUTSIDE KENT	UNKNOWN	(blank)	Total S136
ASIAN - ASIAN BRITISH	2	6		4	1	1	14
BLACK - BLACK BRITISH	6	10		3	1	1	21
MIXED	11	2		2			15
NOT KNOWN	7	9	6	15	2		39
NOT STATED			2				2
OTHER ETHNIC GROUPS	1	1	1	1	1		5
WHITE	217	212	108	45	15	4	601
Total S136	**244**	**240**	**117**	**70**	**20**	**6**	**697**

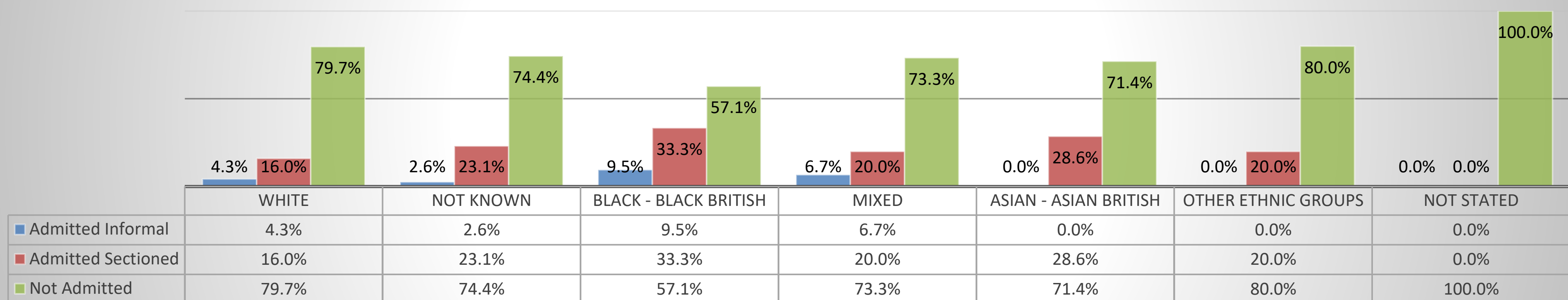


Measure 3c: Section 136 by Specified Ethnicity Category per Month (3+ S136 episodes over report duration)

Specified Ethnicity	2021-12	2022-01	2022-02	2022-03	2022-04	2022-05	2022-06	2022-07	2022-08	2022-09	2022-10	2022-11	Total
White - British	40	46	36	35	57	51	41	58	38	48	45	42	**537**
Unable to Request (Not Known)	5		1	3	3	1	1	2	4		2	3	**25**
White - English	4	1	2	1	2	6	3	1			2	1	**23**
White - Any other background	2	2	1	2	2	1	3	1			1	2	**17**
Not Requested (Not Known)	1	3	1	3		1	2		1	1	1		**14**
Black or Black British - African	1				1	1	2	1	2	1	2	1	**12**
Asian or Asian British - Indian		1	1		1	1			3			1	**8**
Mixed - White & Black Caribbean				1		2		1		3		1	**8**
White - Irish						2	1	2				1	**6**
White - Other European			1				1	1			1	1	**5**
Black or Black British - Any other			1		1	1				1			**4**
White - Polish	1	2							1				**4**
Mixed - White & Black African			1			1			1		1		**4**
Black or Black British - Caribbean						1		1	1				**3**
Asian or Asian British - Any other							2		1				**3**

Measure 3d: Section 136 Outcome by Ethnicity December 2021 to November 2022 inc

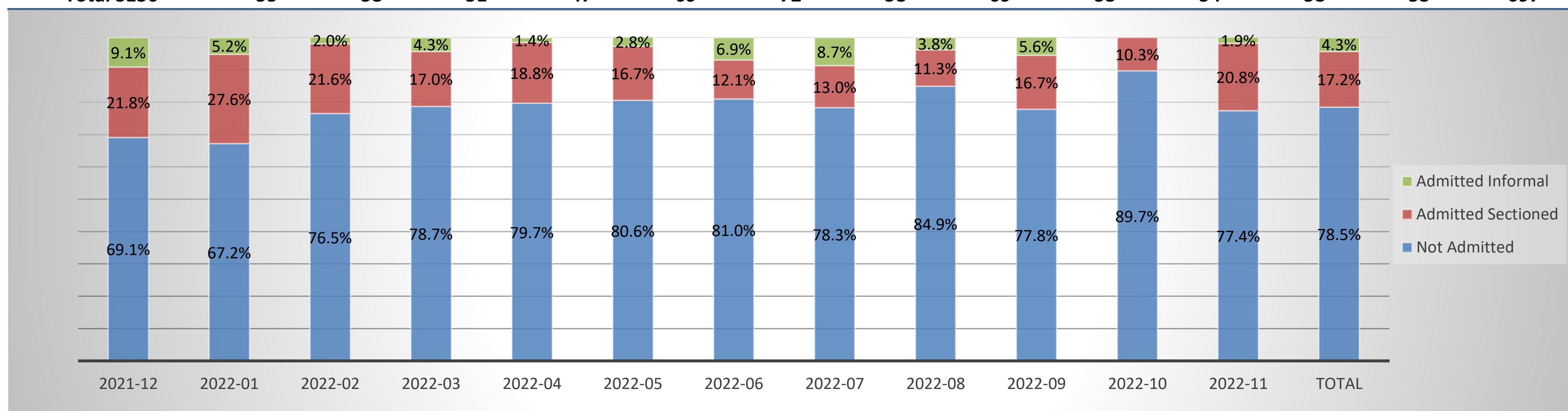
Outcome/Ethnicity	Admitted Informal	Admitted Sectioned	Not Admitted	Total
WHITE	26	96	479	**601**
NOT KNOWN	1	9	29	**39**
BLACK - BLACK BRITISH	2	7	12	**21**
MIXED	1	3	11	**15**
ASIAN - ASIAN BRITISH		4	10	**14**
OTHER ETHNIC GROUPS		1	4	**5**
NOT STATED			2	**2**
Total S136	**30**	**120**	**547**	**697**



	WHITE	NOT KNOWN	BLACK - BLACK BRITISH	MIXED	ASIAN - ASIAN BRITISH	OTHER ETHNIC GROUPS	NOT STATED
Admitted Informal	4.3%	2.6%	9.5%	6.7%	0.0%	0.0%	0.0%
Admitted Sectioned	16.0%	23.1%	33.3%	20.0%	28.6%	20.0%	0.0%
Not Admitted	79.7%	74.4%	57.1%	73.3%	71.4%	80.0%	100.0%

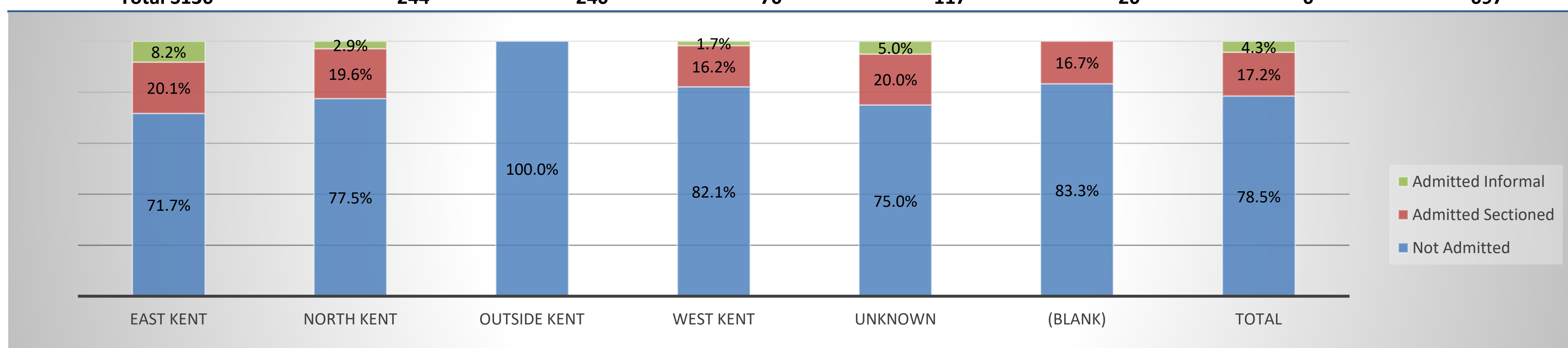
Measure 4a: Section 136 by Outcome per Month:

Outcome	2021-12	2022-01	2022-02	2022-03	2022-04	2022-05	2022-06	2022-07	2022-08	2022-09	2022-10	2022-11	Total
Not Admitted	38	39	39	37	55	58	47	54	45	42	52	41	547
Admitted Sectioned	12	16	11	8	13	12	7	9	6	9	6	11	120
Admitted Informal	5	3	1	2	1	2	4	6	2	3		1	30
Total S136	**55**	**58**	**51**	**47**	**69**	**72**	**58**	**69**	**53**	**54**	**58**	**53**	**697**



Measure 4b: Section 136 by Outcome and Locality (Dec 2021 to Nov 2022 inc)

Outcome by Locality	East Kent	North Kent	OUTSIDE KENT	West Kent	UNKNOWN	(blank)	Total
Not Admitted	175	186	70	96	15	5	**547**
Admitted Sectioned	49	47		19	4	1	**120**
Admitted Informal	20	7		2	1		**30**
Total S136	**244**	**240**	**70**	**117**	**20**	**6**	**697**



Measure 4c: Section 136 Other Specific Outcomes:

Specific Outcomes	2021-12	2022-01	2022-02	2022-03	2022-04	2022-05	2022-06	2022-07	2022-08	2022-09	2022-10	2022-11	Total
Not Admitted	16	18	14	9	15	14	17	23	15	11	17	10	**179**
CMHT	6	13	6	10	15	8	13	10	11	6	18	10	**126**
Admitted Sectioned	12	16	11	8	13	12	7	9	6	9	6	11	**120**
CRHT	7	4	9	8	14	17	10	11	5	15	8	11	**119**
Acute OT	2	2	3	3	3	8	2	3	5	5	4	3	**43**
Admitted Informal	5	3	1	2	1	2	5	6	2	3		1	**31**
Liaison Psychiatry	1		1	2	6	6	2	1	3	2	1	1	**26**
UMHH	3	1	3	1		1		2	1				**12**
Patient Flow	1			1		2			2	1	2	2	**11**
CJLaDS	1		1	3	2			1			2		**10**
CED Crisis Group		1	2			1		1		1		2	**8**
Personality Disorder							1		1	1		1	**4**
PICU Outreach								2					**2**
MHLD Combined									1				**1**
Early Intervention Service									1				**1**
Physiotherapy						1							**1**
Open Dialogue Service												1	**1**
Primary Care MH							1						**1**
Psychological Therapies	1												**1**
Total S136	**55**	**58**	**51**	**47**	**69**	**72**	**58**	**69**	**53**	**54**	**58**	**53**	**697**

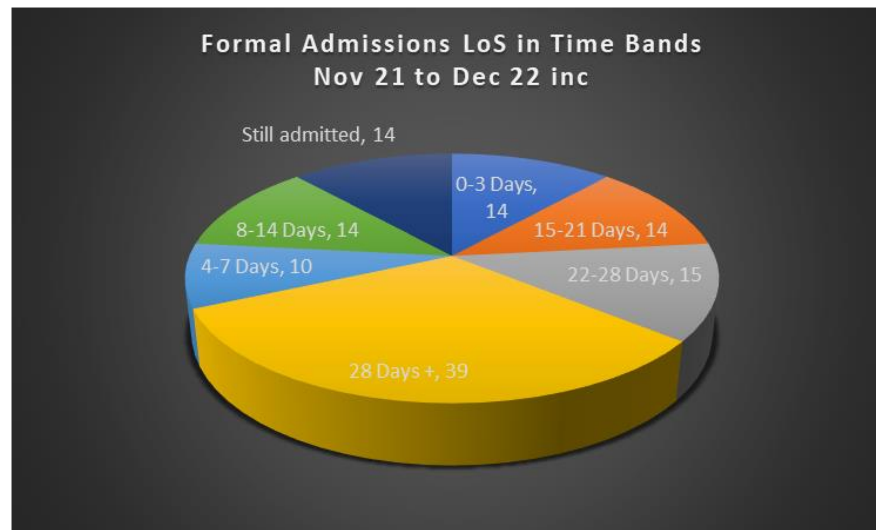
Source: BI Lined Reports/ S136 monthly performance MASTERFILE 24 hours

Measure 5a: Informal Admissions Length of Stay in Time Bands

Informal LoS	2021-12	2022-01	2022-02	2022-03	2022-04	2022-05	2022-06	2022-07	2022-08	2022-09	2022-11	Total
0-3 Days	1	2						2	1			**6**
15-21 Days	1											**1**
22-28 Days										2		**2**
28 Days +				1			2	2		1		**6**
4-7 Days	3	1	1					2	1			**8**
8-14 Days				1	1	2	2				1	**7**
Total Informal	**5**	**3**	**1**	**2**	**1**	**2**	**4**	**6**	**2**	**3**	**1**	**30**

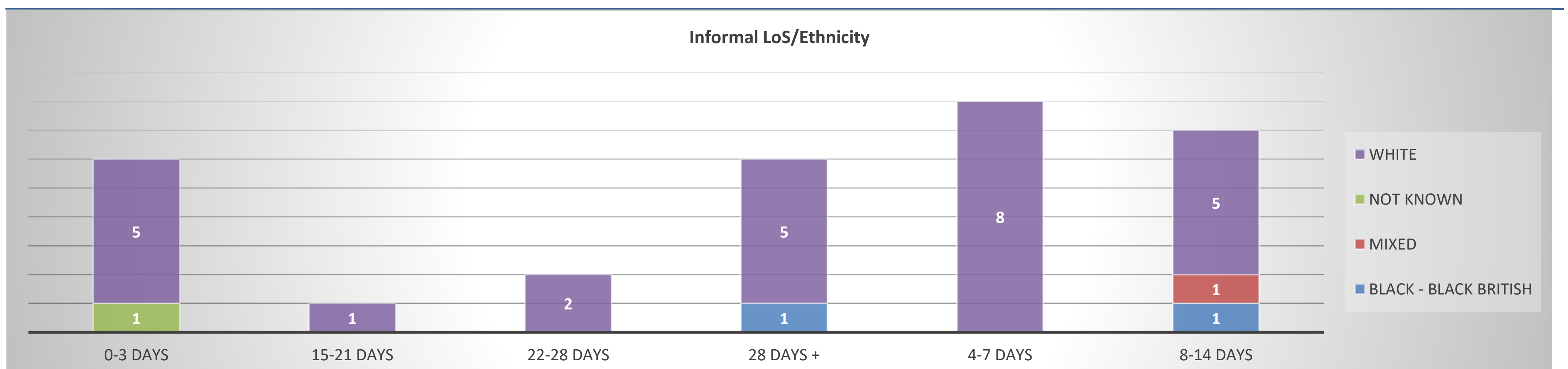
Measure 5b: Formal Admissions Length of Stay in Time Bands

Formal LoS	2021-12	2022-01	2022-02	2022-03	2022-04	2022-05	2022-06	2022-07	2022-08	2022-09	2022-10	2022-11	Total
0-3 Days	2	4	1		2			1	1		2	1	**14**
15-21 Days	1		1	1	5	1	1	1		1		2	**14**
22-28 Days	2	1	2	3		1	3			2		1	**15**
28 Days +	4	7	4	2	4	8	1	4		4	1		**39**
4-7 Days	1	1	2		1		1	1			2	1	**10**
8-14 Days	2	2		2	1	2			3	1		1	**14**
Still admitted		1	1				1	2	2	1	1	5	**14**
Total Formal	**12**	**16**	**11**	**8**	**13**	**12**	**7**	**9**	**6**	**9**	**6**	**11**	**120**



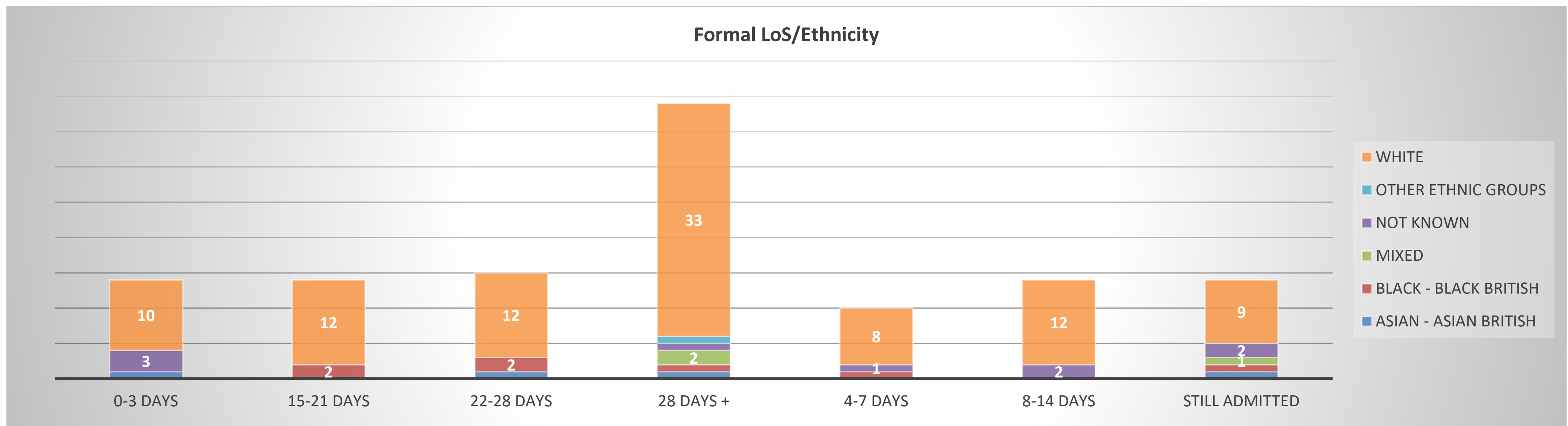
Measure 5c: Ethnicity of Informal Admissions Length of Stay in Time Bands (Dec 2021 to Nov 2022 inc)

	0-3 Days	15-21 Days	22-28 Days	28 Days +	4-7 Days	8-14 Days	Total
BLACK - BLACK BRITISH				1		1	**2**
MIXED						1	**1**
NOT KNOWN	1						**1**
WHITE	5	1	2	5	8	5	**26**
Total Informal	**6**	**1**	**2**	**6**	**8**	**7**	**30**



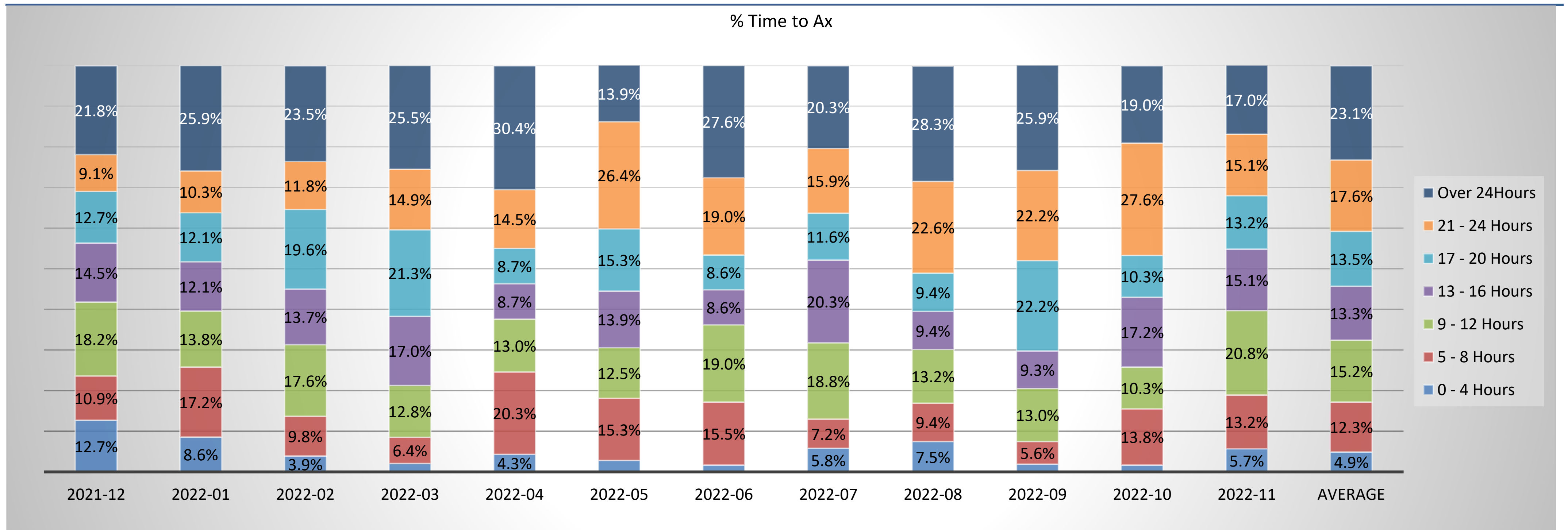
Measure 5d: Ethnicity of Formal Admissions Length of Stay in Time Bands (Dec 2021 to Nov 2022 inc)

Formal Admissions	0-3 Days	15-21 Days	22-28 Days	28 Days +	4-7 Days	8-14 Days	Still admitted	Total
ASIAN - ASIAN BRITISH	1		1	1			1	**4**
BLACK - BLACK BRITISH		2	2	1	1		1	**7**
MIXED				2			1	**3**
NOT KNOWN	3			1	1	2	2	**9**
OTHER ETHNIC GROUPS				1				**1**
WHITE	10	12	12	33	8	12	9	**96**
Total Formal	**14**	**14**	**15**	**39**	**10**	**14**	**14**	**120**

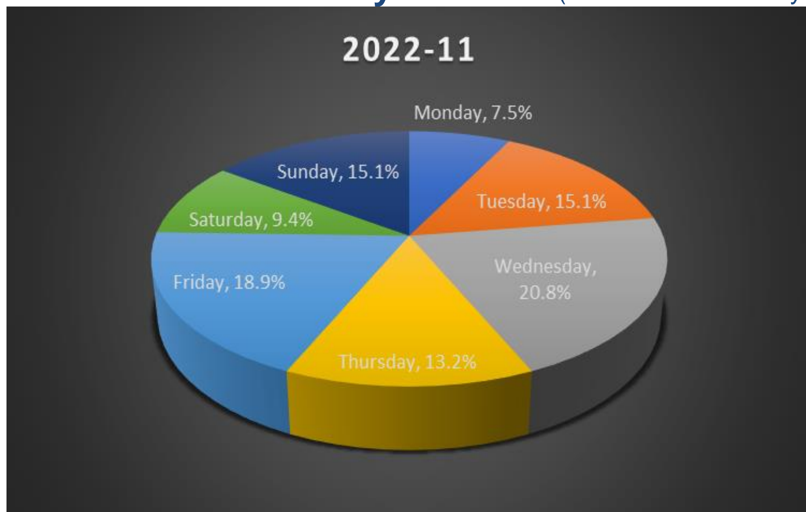


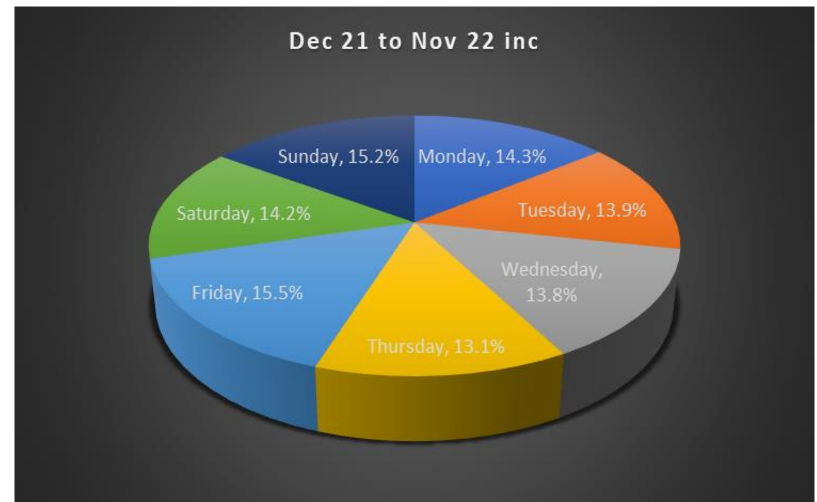
Measure 6: Section 136 Time Frame Assessment

Time to Ax	2021-12	2022-01	2022-02	2022-03	2022-04	2022-05	2022-06	2022-07	2022-08	2022-09	2022-10	2022-11	Total
0 - 4 Hours	7	5	2	1	3	2	1	4	4	1	1	3	**34**
5 - 8 Hours	6	10	5	3	14	11	9	5	5	3	8	7	**86**
9 - 12 Hours	10	8	9	6	9	9	11	13	7	7	6	11	**106**
13 - 16 Hours	8	7	7	8	6	10	5	14	5	5	10	8	**93**
17 - 20 Hours	7	7	10	10	6	11	5	8	5	12	6	7	**94**
21 - 24 Hours	5	6	6	7	10	19	11	11	12	12	16	8	**123**
Over 24Hours	12	15	12	12	21	10	16	14	15	14	11	9	**161**
Total	**55**	**58**	**51**	**47**	**69**	**72**	**58**	**69**	**53**	**54**	**58**	**53**	**697**

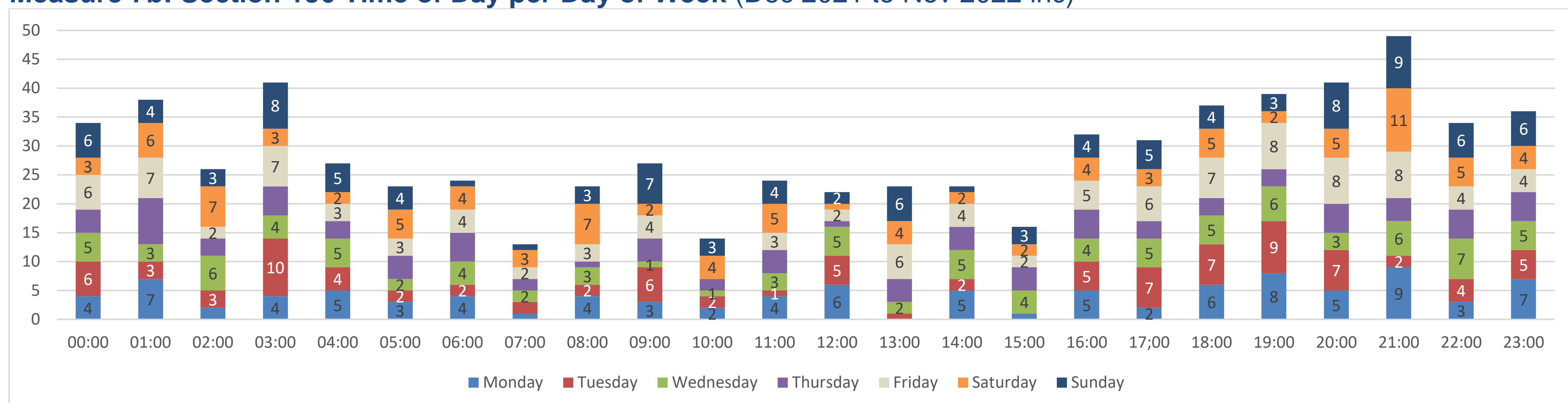


Measure 7a: Section 136 Day of Week (current month and yearly average)



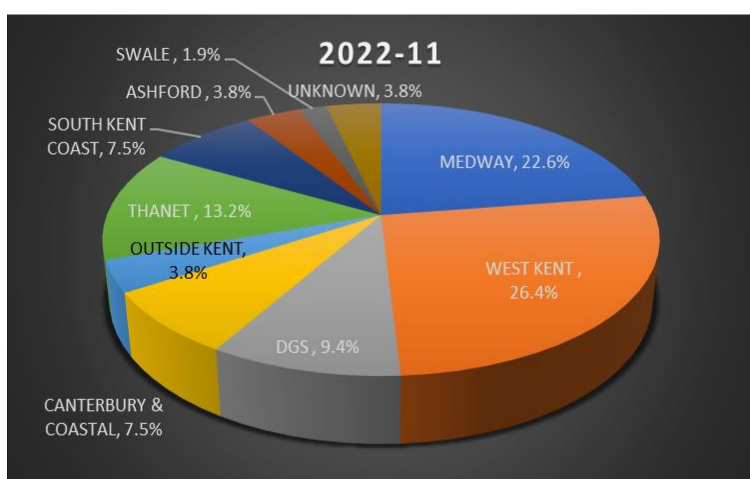


Measure 7b: Section 136 Time of Day per Day of Week (Dec 2021 to Nov 2022 inc)



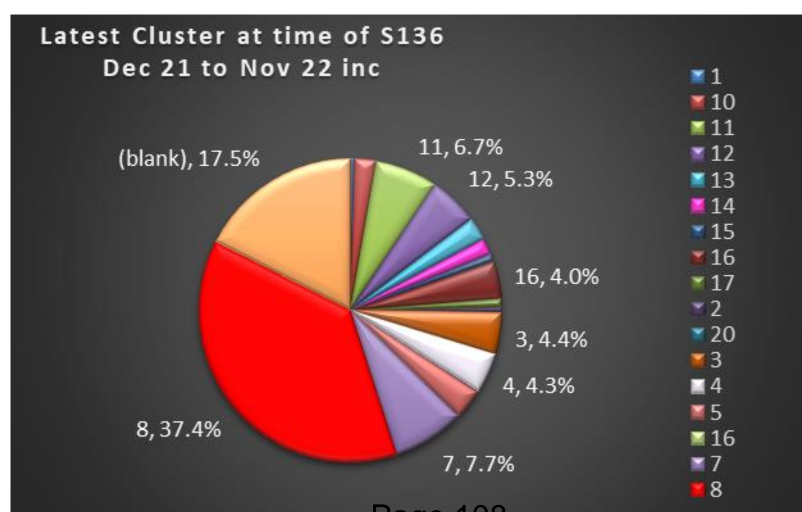
Measure 8: Section 136 by Month and Sub CCG

	2021-12	2022-01	2022-02	2022-03	2022-04	2022-05	2022-06	2022-07	2022-08	2022-09	2022-10	2022-11	Total
MEDWAY	7	8	7	9	17	15	12	11	9	11	13	12	131
WEST KENT	10	9	12	9	7	15	11	14	2	6	8	14	117
DGS	5	5	5	8	5	6	7	11	7	5	2	5	71
CANTERBURY & COASTAL	12	10	3	5	4	8	3	2	5	6	9	4	71
OUTSIDE KENT	7	5	6	4	9	6	3	4	9	8	7	2	70
THANET	3	8	5	2	7	2	8	8	7	3	4	7	64
SOUTH KENT COAST	5	7	4	2	10	10	3	5	3	4	5	4	62
ASHFORD	4	2	2	4	6	2	4	5	6	8	2	2	47
SWALE	1	4	6	2	2	7	2	5	3	2	3	1	38
UNKNOWN	1		1		2	1	1	4	2	1	5	2	20
(blank)				2			4						6
Total	**55**	**58**	**51**	**47**	**69**	**72**	**58**	**69**	**53**	**54**	**58**	**53**	**697**



Measure 9: Latest Cluster at Time of S136 per month

	2021-12	2022-01	2022-02	2022-03	2022-04	2022-05	2022-06	2022-07	2022-08	2022-09	2022-10	2022-11	Total
1 - Common MH Problems (Low Severity) (12wks)				2							1		**3**
10 - First Episode Psychosis (12mths)	2		1	2	1	2	1	2	2	1	1	1	**16**
11 - Ongoing Recurrent Psychosis (Low Symptoms) (12mths)	2	8	4	6	4	5	3	5	2	3	3	2	**47**
12 - Ongoing or Recurrent Psychosis (High Disability) (12mths)	2	1	3	3	6	4	3	5	3	1	3	3	**37**
13 - Ongoing or Recurrent Psychosis (High Symptoms & Disability) (12mths)	2	2	2	1	3	1			2	2	1	1	**17**
14 - Psychotic Crisis (4wks)	1	1	1			1	1	1	2	3		1	**12**
15 - Severe Psychotic Depression (4wks)		2		1		1	1					1	**6**
16 - Dual Diagnosis (6mths)	2	1	3	2	3	2	4	2	2	3		4	**28**
17 - Psychosis & Affective Disorder (Difficult to Engage) (6mths)	1		1	1		1				1		1	**6**
2 Common MH Problems (Low Severity with Greater Need) (15wks)	1		1								1		**3**
20 - Cognitive Impairment or Dementia (High Need) (6mths)		1											**1**
3 - Non-Psychotic (Moderate Severity) (6mths)		1	2	2	4	2	2	6	1	2	4	5	**31**
4 - Non-Psychotic (Severe) (6mths)	4	2		1	4	5	2	3	3	3		3	**30**
5 - Non-Psychotic Disorders (Very Severe) (6 mths)	6	2	1	1	2	2	1	1	1	2	1	2	**22**
6 - Non-Psychotic Disorder of Over-Valued Ideas (6mths)								1					**1**
7 - Enduring Non-Psychotic Disorders (High Disability) (12mths)	6	4	1	1	7	8	4	7	6	3	5	2	**54**
8 - Non-Psychotic Chaotic & Challenging Disorders (12mths)	14	20	19	16	24	28	26	27	19	20	27	21	**261**
(blank)	12	13	12	8	11	10	10	9	10	10	11	6	**122**
Total S136	**55**	**58**	**51**	**47**	**69**	**72**	**58**	**69**	**53**	**54**	**58**	**53**	**697**



Source: BI Lined Reports/ S136 monthly performance MASTERFILE 24 hours

Measure 9: Patients with 4+ S136s including the S136 Outcome in 6-month period:

	2022-06	2022-07	2022-08	2022-09	2022-10	2022-11	Total S136 Interventions
Patient 1		**1**		**1**	**4**	**1**	**7**
Not Admitted		1		1	4	1	7
Patient 2					**3**	**2**	**5**
Not Admitted					3	2	5
Patient 3		**1**	**1**	**1**		**2**	**5**
Not Admitted		1	1	1		2	5
Patient 4	**2**	**1**			**1**	**1**	**5**
Not Admitted	2	1			1	1	5
Patient 5	**2**		**1**		**1**		**4**
Not Admitted	2		1		1		4
Patient 6	**1**	**1**	**2**				**4**
Not Admitted	1	1	2				4

NB: RIO numbers are available for audit purposes

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NHS
Kent and Medway

Communications and engagement consultation plan

for Improving health based places of safety, as part of the transformation of mental health urgent and emergency care.

December 2022

Key contacts

Communications and engagement lead	***Sara Warner Engagement lead Julia Walsh Communications lead***
Programme lead(s)	***Taps Mutakati, Louise Clack***
Approval of plan	***NHS Kent and Medway***

Date	**Version**	**Revisions made**	**Author**
August 5	**Draft 1**		**Sara Warner**
October 10	**Revision to back grd/context**		**Sara Warner**
December 9	**Comms and Engagement working group**		**Sara Warner**

Introduction

NHS Kent and Medway is working with system partners, to improve the mental health urgent and emergency care (MHUEC) pathway and is currently focusing on developing proposals to improve the health based places of safety (HBPoS) and the section 136 service.

The health-based places of safety assessment suites are currently on three KMPT sites (Maidstone, Canterbury and Dartford) and the Trust struggles to provide a consistently good service which meet national standards, due to challenges with staffing and facilities. Staff teams are small and relatively isolated, with unattractive shift patterns and unsocial working hours. Due to the geography and resource levels, there can be minimal on-site support for staff at times. People placed under a section 136 need a full mental health assessment (MHA) with an Approved Mental Health Professional (AMHP) and two Section 12 Doctors. With a limited numbers of Approved Mental Health Professionals (AMHPs) and Section 12 Doctors covering three sites, coordination of assessments can be challenging.

Plus, the facilities are no longer fit for purpose, despite investment in their maintenance and updated layouts over the years, all Kent and Medway NHS and Social Care Partnership Trust's (KMPT's) Section 136 suite health-based places of safety, struggle to meet standards for Section 136 health-based places of safety. There is inadequate space for assessment teams. One suite does not have access to seclusion and the other two share seclusion facilities with inpatient services, which is against guidance from the Care Quality Commission (CQC).

These persistent challenges have a negative impact on people experiencing a crisis, lengthening the time taken to assess people and get them the support they need. At times, wider service provision and/or clinical pressures require the temporary change of use of some of the existing Section 136 suites, which impacts on capacity and the ability of to meet Section 136 standards. The Section 136 suite health-based places of safety can also be unavailable due to damage. These challenges lead to people being taken to emergency departments (EDs) temporarily, where it may have an adverse effect on their welfare due to the busy nature of EDs. As well as having an impact on other emergency support services such as: community crisis service, police, emergency departments, and ambulances. At a time when individuals' need an urgent assessment and possibly treatment, when they are often at a point of extreme distress, and some of whom will be at a very acute stage of illness, when risks to self and others are highest.

Currently around 1,500 people per annum will go through this section 136 assessment process to decide what type of support they require, although recent improvements are reducing the numbers. Some people will always require emergency support, out of those people detained for assessment, approximately 20 per cent will need hospital care, whilst the others may receive referral to community-based support and return home with the support of patient transport.

As this is a crisis service when people are at their most vulnerable, it works closely in partnership with other emergency services such as the police, ambulance service, Emergency departments (A&E) as well as Psychiatric support services in hospitals and the community. It deeply affects the individuals involved and often their family, friends and care givers.

BACKGROUND

NHSE have made capital funding available to all Integrated Care Systems, specifically ringfenced for improvements to Mental Health Urgent and Emergency Care to enhance patient safety. The Kent and Medway ICS successfully bid for capital funding to improve the Section 136 Pathway and Health Based Place of Safety (HBPOS) provision. This scheme forms part of the wider Kent and Medway Mental Health Urgent and Emergency Care Transformation Programme (MHUEC), which will provide a clearly defined

improved pathway and increased menu of interventions for individuals who are experiencing Mental Health Crisis.

The Transformation Programme is co-produced with Lived Experts and System Partners and will provide a range of mental health services that are person centred and socially inclusive, delivered via a blended approach of VSCE and Secondary Care. This improved MH UEC Pathway and increased range of community crisis alternatives will offer individuals experiencing a crisis viable alternatives to using NHS Emergency Services and can potentially result in a reduction in incidence of detention under Section 136 of the Mental Health Act (1983).

Included within the MHUEC Programme:-

Open Access Crisis (NHS 111 select 2)

From March 2023 nationally, individuals experiencing mental health crisis will be able to dial NHS 111 and select option two, to speak directly to a trained mental health triage call handler. From there, if an urgent secondary care response is required the call handler will arrange for a face to face or virtual urgent mental health assessment to take place by a trained mental health clinician. Other health care professionals will also be able to directly access the specialist MH call handler. An expected outcome from implementation of this service is a reduction in the use of emergency services (SECAmb, ED presentation, police calls)

Training and support for partner agencies, Kent Police have telephone access to a trained mental health clinician via the '836 Police Advice Line'. Police use this professional advice line to discuss whether or not to use their powers of detention under S136; the mental health clinician is able to access clinical records where available and talk to the individual where appropriate. This has seen a significant reduction in the use of S136 over the last 24 months, with August 2022 being the lowest rate in 6 years. Recent investment into this service has enabled expansion of this service.

Alternative sources of support for those people in Crisis

1, There are currently five **Safe Havens** operating across Kent and Medway 7 days a week between the hours of 1800hrs-2300hrs (longer at weekends). The safe havens are delivered by VCSE providers and are based in community settings. They provide a physical and therapeutic space for individuals experiencing psychological crisis as an alternative to presenting at an emergency department or being detained on S136.

The transformation programme is looking at ways to improve the overall model through a recent series of workshops with lived experience experts and partner organisations (Kent Police, SECAmb, Acute Trusts, KMPT etc.) to understand low usage and consider solutions. This winter a revised model is to be piloted for evaluation, with two of the safe havens being co-located on hospital sites, and the remaining three to have clinical staff input. These changes should make them a more recognisable part of the pathway used by partner agencies and individuals.

2, Crisis House(s): Crisis Houses provide individuals with an alternative to admission to a mental health acute inpatient bed; they are designed to provide 24hr crisis support and supervision for a limited period of time and are usually delivered though the VCSE sector at a considerably reduced cost yet with positive outcomes including high levels of service user satisfaction. The ICB and KMPT are jointly leading a workstream on alternatives to inpatient admission, with the intention to commission a Crisis House(s) using Mental Health Investment Standards for implementation in October 2023.

Within Kent and Medway 50 per cent of adult's hospitalised are discharged in eight days or less (with a significant proportion being discharged within 72hrs or less). The 50 per cent of individuals discharged within eight days or less, commonly present for admission in an acute psychological or emotional crisis.

3, Enhanced Home Treatment: The Crisis Resolution and Home Treatment Teams (CRHT) within KMPT are being reviewed. The CRHT team has two main functions (i) Responding to unplanned urgent assessments within four hrs; and (ii) Providing planned home treatment interventions as an alternative to inpatient admission. The intention is to improve the team's functionality by focusing on the two functions and creating two teams:

a) a rapid response team (RRT) (whose sole purpose is to respond to requests for urgent mental health assessment);

b) and an enhanced home treatment team who sole purpose is to provide intensive home treatment as a viable alternative to inpatient admission.

This will support effective patient flow, which in turn will positively impact upon the options for people in crisis and improve the treatment choices for assessed in the HBPoS.

4, Mental health ambulance

Development of a bespoke mental health urgent response vehicle with a paramedic and mental health clinician crew, who would be able to respond urgently to Southeast Coast Ambulance (SECAmb) mental health calls, for example by police when considering Section 136, and assess and intervene at scene as an alternative to Section 136 or being taken to a hospital emergency department.

Pre-consultation Engagement

As part of the process of improving care for people placed under a Section 136 order and using our health-based places of safety, we have already been working with patients, public, partners, staff and stakeholders. Feedback to date has informed the development of these proposals.

Key activities have included:

- Reviewing all patient and partner insights on crisis care so that we can learn from what people have already told us. This has included looking what people told us during Kent Listens, Kent and Medway NHS and Social Care Partnership Trust's (KMPT's) work with Experts-by-Experience, and wider engagement on transforming services
- Offering one-to-one interviews or small focus group discussions with individuals and families affected to listen to existing users of services and partner agencies
- Jointly developing the proposals with partners and people of lived experience through the integrated transformation programme
- Listening to the views of frontline staff working in health-based places of safety
- Wider engagement, led by a clinical and professional board, with psychiatrists, GPs, ambulance teams, police officers and social care staff
- Joining discussions with peer support and advocacy services on potential improvements with existing service user and carer groups for those with complex emotional disorders,
- Reaching out to communities which are most affected through Voluntary, Community and Social Enterprise (VCSE) groups.

This is what they have told us is:

- We need support and an environment with access to fresh air and the outside, a place which is well-staffed and comfortable rather than bland and municipal.
- Any new facility must be easily accessible, with transport there and back provided safely and in a timely manner, with parking for staff.
- Staff, who are comforting and consistent for you to feel safe and supported
- Sensory needs' must be considered, sound should be soothing and not over whelming, especially for those with autism.
- Activities to occupy you if there are delays, comforting food and facilities.
- Having different spaces for assessment, and sleeping, not built like a ward – purpose built and codesigned
- Places for de-escalation and seclusion for the volatile and vulnerable, and to keep everyone safe, so that the facility doesn't close if someone is 'kicking off'.
- Carers and families can supply vital information on individuals to help with the assessment, if patient care plans could enable those close advocates to assist without breaching patient confidentiality

Consultation process

Statutory duties and legislation

This plan sets out the approach to a formal consultation on proposal(s) to centralise the section 136 assessment service, improving care for people at this most vulnerable time, making the service swifter, better, and more resilient. To support this aim we propose building a new purpose-built facility with five assessment suites which fulfil national standards and offer a better safer environment for patients.

It has been informed by best practice principles and guidelines from NHS England and NHS Improvement[1], the Cabinet Office[2], the Consultation In[3]stitute and Healthwatch. We are also building on the experience and feedback from previous engagement and consultation programmes in Kent and Medway and from our pre-consultation engagement work.

[1] B1762-Guidance-on-Working-in-Partnership-with-People-and-Communities-2.docx (live.com)

[2] National Government Consultation Principles (1).docx (publishing.service.gov.uk)

[3] The Consultation Charter - The 7 Best Practice Principles — The Consultation Institute

Guiding Principles

NHS Kent and Medway

NHS Kent and Medway is working with system partners to support the people of Kent and Medway to lead healthier lives for longer. We see our future as one where we collaborate with the people of Kent and Medway to create thriving communities that are amongst the healthiest in England. We want to be known for the quality and safety of our services but also as an influential partner in our communities.

To do this, we will strive to have a deep understanding and connection with the people and communities we serve and actively involve them to co-produce and shape improvements to local services. By working with, listening to and acting on feedback from people and communities, NHS Kent and Medway, together with health and care partners in the integrated care system, can:

- support people to sustain and improve their health and wellbeing
- involve people and communities in developing plans and priorities
- continually improve the way we deliver our services
- address health inequalities by working with our people and communities where inequalities exist to co-produce solutions
- work with wider partners to create holistic services and pathways across organisational and sector boundaries that best serve the whole person or community.

When planning service change it is best to be:

Accountable and Transparent

The NHS Constitution states: 'The system of responsibility and accountability for taking decisions in the NHS should be transparent and clear to the public, patients and staff.' Organisations should be able to explain to people how decisions are made in relation to any proposal – and how their views have been taken onboard. Transparent decision-making, with people and communities involved in governance, helps make the NHS accountable to communities. Engaging meaningfully with local communities build public confidence and support as well as being able to demonstrate public support for proposals.

Improve quality of care by working with people, partners and communities

Partnership approaches mean that services can be designed and delivered more appropriately, because they are personalised to meet the needs and preferences of local people. Without insight from people who use, or may not use, services, it is impossible to raise the overall quality of services. It also improves safety, by ensuring people have a voice to raise problems which can be addressed early and consistently.

This makes for better decision-making

We view the world through our own lens and that brings its own judgements and biases. Business cases and decision-making are improved when insight from local people is used alongside financial and clinical information to inform the case for change. Their insight can add practical weight and context to statistical data, and fill gaps through local intelligence and knowledge. Challenge from outside voices can promote innovative thinking which can lead to new solutions that would not have been considered had the decision only been made internally.

Length of consultation

We propose the consultation is for 8 weeks, as this is one small yet significant part of the MHUEC pathway with relatively few people (1,500) per year affected, which is a small proportion of population, and the

Kent and Medway

specialist nature of service. This transformation programme is being undertaken throughout with our partners and experts by experience.

Also, the specialist nature of service means this should be handled sensitively so that people can share their experiences and opinions without fear, or anxiety in safe and confidential ways. Offering people a range of ways to contribute without a focus on loud public meetings, but quieter conversations with individuals, or smaller discussions in safe places.

Aims

We will deliver a formal public consultation in line with best practice that complies with our legal requirements and duties.

Our aims for the consultation are to:

- raise awareness of the public consultation and how to contribute across Kent and Medway
- collect views from the full spectrum of people who may be affected – including staff, people with lived experience and their friends and families, stakeholders, and the public - gathering feedback from individuals and representatives
- ensure we use a range of methods to reach different audiences including activities that target specific groups with protected characteristics and those quieter more diverse communities affected by health inequalities
- explain how the proposals have been developed, what this means in practice, so people can give informed responses to the consultation
- ensure the integrity and legality of the consultation process to the best of our ability, working with both Kent and Medway's Health Overview and Scrutiny committees
- meet or exceed our objectives and deliver our plan within the timeframe and budget allocated
- provide the ICB governing body with an independent report on the consultation responses to consider in decision-making, with sufficient time to give them thorough consideration.
- Feedback to all those who have contributed any decisions and actions agree in a timely and consistent way using all appropriate channels

SMART objectives

Specific, measurable, achievable, realistic, and time-bound (SMART) objectives are key to ensuring that communications and engagement activity can be accurately assessed and measured. This is particularly important within the context of consultation activity where the results of our work will inform the development of the decision-making business case and play an integral part in the assurance process.

The quality of feedback to our consultation is important alongside the quantity. It is important that we seek and get a broad, representative, and diverse range of views to give rich insights to support our decision-making. If we set our targets for reach too high, we will need to use a lot more resource to generate higher response numbers in the limited timeframe of the consultation, which may not then result in a very different outcome or feedback.

Smart objective	Measure of success
Raising awareness through opportunities to see or hear about the consultation* - informing a minimum of 90,000 (approximately 5 per cent of Kent and Medway population due to specialist nature of service) about the proposals during the consultation period	To be achieved through multiple channels and activities: dedicated website space for consultation information and associated case for change, advertising and publicity (radio, newspaper and online) and posters etc. in local communities in addition to more personalised and interactive engagement including evaluation of social media, research, face-to-face and virtual events, focus groups etc
Target for active and direct engagements – 500 people (reflecting numbers affected per annum, due to the specialist nature of the service).	To be achieved through mailings to staff, stakeholder patient and carer distribution lists, meetings and events, social media interactions, discussions in safe places, focus groups, targeted outreach work etc.
Target for responses – 250 separate responses to the consultation (approximately half the population identified above, recognising the specialist nature of the service).	Collecting responses to the consultation including consultation questionnaire, focus groups, emails, social media interactions, phone calls, letters, comments at events etc.
Outreach to those identified in EIA, run one or two focus groups with each identified cohort, or 1 to 1 interviews to give choice to individuals (People with complex emotional disorders, younger adults, BAME, homeless, people with dual diagnosis). 6-8 people in each focus group.	Measured by the number of people attending the focus groups multiplied by number of cohorts identified in EIA.
NB Recognising specialist nature of service make sure that people with lived experience have choices and can contribute in a variety of safe and anonymous ways and make sure that information and processes overcome barriers and a variety of formats is	Taking advice from KMPT and people with lived experience to enable a range of means to take place.
Patients, and families affected all those individuals affected by service and their families/carers have already had the opportunity to be part of developing proposals and can also respond to the consultation. They will have a choice of one-to-one private interview, joining a focus group, attending community based discussions or completing the consultation questionnaire, or responding to the consultation in another way by email, letter, or phone. In addition, working in partnership with KMPT we will attend at least one	Using a variety of appropriate channels (letters, newsletters, media publicity as set detailed within this plan) to ensure affected individuals, and/or their families/carers can respond to the consultation. We will achieve direct engagement with affected patients and their families and working with our partners will involve representative groups of people with lived experience of services and their families. Assessment will be based on the opportunities to engage, and responses received.

Audiences

Stakeholder mapping

family/carer support group and at least one patient group – *which reflects the cohort of patients* with experience of crisis care and section 136.	
Discussions in safe places we propose 8 small scale listening events hosted by VCS partners across the geography of Kent and Medway to enable communities to contribute in safe and sensitive way with trusted organisations	20 people maximum in smaller hosted safe community led discussions. 160 people across four place-based geographies
Attending public events possibly as roadshow/manned exhibitions working in partnership with community safety partners: police, LAs, SECamb and recognising aligned pieces of work such as transformation of community mental health services and Integrated care Strategy. **Hold a survey** with Kent and Medway citizen panel (representative sample of Kent and Medway population)	To make sure public have a direct ways to contribute in person, as well as a remote ways through online survey. At least 100 people take part Citizen panel provides demographic sample of public to contribute their views
Attend stakeholder meetings: many partners have their own meetings which we can attend to brief people and raise awareness of the consultation and the issues involved, sharing information and evidence e.g. Healthwatch, LAs, HCPs, VCS networks, staff networks, etc	Attend as many meetings as possible within 8 week consultation period depending on number of invites/service issues. Measured by spread and range of invitations. Many stakeholders will have been involved in the pre-consultation engagement and we will make sure we keep them are briefed throughout
Staff and clinical engagement we will attend staff network, team meetings and offer drop-in sessions and online surveys so that everyone has a range of ways to contribute.	All affected staff will have the opportunity to access information about the consultation, complete the consultation questionnaire and/or join one of two staff workshops during the consultation period. Measured by numbers taking part.
Independent analysis of the responses received, to ensure transparency we will commission an independent organisation to analyse and report on the responses received.	Report received from independent experts provides an overview on whether SMART objectives have been met, as well as an analysis of the responses received.
Budget we will achieve this within the agreed funding for operational costs.	TBC once amount is agreed/identified.

Kent and Medway

This consultation plan describes the formal consultation that NHS Kent and Medway and its partners are required to undertake with relevant local authorities under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 (see Appendix A). We will formally consult our local authorities partners via the Kent and Medway health overview and scrutiny committees, or as a JHOSC subject to their approval, as this is a substantial variation to service affecting the population in both counties in line with our legal duties.

This plan sets out the additional, complementary, and public-facing activity that we will undertake to elicit responses and promote engagement and involvement during the consultation period. Through our pre-consultation engagement work we have identified and worked with a range of audiences and stakeholders. We have grouped our stakeholders into 7 categories with detailed sub-groups within each category:

People and communities served	**Staff across partnerships**
• people with lived experience, loved ones, unpaid carers, • Residents in Kent and Medway • KMPT/EK360 patients, service users, carers and volunteers • Patient and carer support groups • Resident, voluntary, community and local business groups • Healthwatch in both Kent and Medway • Those diverse communities affected e.g., personality disorders, those with complex mental health disorders, younger adults, people who are homeless, or people with addictions. • Protected characteristic groups (under equalities legislation) including age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, pregnancy and maternity • Advocacy and peers support groups • VCS groups and networks • ICB local health network patient and community engagement groups • GP patient participation groups • NHS providers patient governors and membership	• KMPT (particularly section 136 staff, 12 doctors including staff side and trade unions) • Local clinical, nursing and AHP leads • Provider trusts – East Kent University NHS Hospitals Foundation Trust Medway NHS Foundation Trust, Medway Community Health CIC, Maidstone and Tunbridge Wells NHS Trust, Dartford and Gravesham NHS Trust, Kent Community Health Foundation NHS Trust, HCRG care group • Southeast Coast Ambulance Service NHS Foundation Trust • Kent Police • Kent and Medway ICB • Dartford, Gravesham and Swanley; east Kent; Medway and Swale; and west Kent HCPs – stakeholders • General practice (including primary care network clinical directors and primary care teams) • Medway Council and Kent County Council (including social care and public health teams)
System leaders	Clinical and Professional bodies
• MHLDA partnership and • Kent and Medway ICB governing body (including as decision-makers for this consultation) • Kent and Medway NHS and Social Care Partnership Trust Board • K&M ICP • Dartford, Gravesham and Swanley; east Kent; Medway and Swale; and west Kent HCPs	• MHLDA clinical and professional board Southeast Clinical Senate • K&M local medical and pharmacy committees, • The Royal College of Psychiatrists • The Royal College of Physicians • KSS Academic Health Science Network

• Medway and Kent Health and Wellbeing Boards • Medway and Kent Council executive teams • PARTNER leadership – police/Ambulance	
Regulators/assurance	**Elected Officials**
• Department for Health and Social Care • NHS England and NHS Improvement • Care Quality Commission • Healthwatch Medway, Healthwatch Kent • Medway HASC, Kent HOSC	MPs, Kent Council and Medway Council District and Parish councils

Consultation activities and materials

At the core of our consultation will be a consultation document which clearly lays out the basis on which we are consulting, the background to the consultation, a summary of the data upon which options have been developed and what the proposals/options are, with signposting to more detailed technical information if needed. This document will be presented in plain language, which is easy to understand by the public, we will seek feedback and will promote the various methods by which people can take part in the consultation and contribute their experiences and views.

The consultation document associated materials and consultation questionnaire will be published on a dedicated section of the K&M ICB website. This will be clearly signposted from the ICB home page and system partner websites. It will host general information about the programme and consultation, as well as the case for change; meeting papers and other key decision documents; providing the evidence and data used to inform the design of proposals and decisions, etc.

A sensitive animation will be produced to introduce the service and explain when and how section 136 may be required so that individual stories and community concerns can be set within a clear framework without stigma.

Accessibility

We will ensure that we target, and cater for, groups and individuals with additional requirements, or those responding on behalf of another individual, and those who are less familiar with the subject matter. To best meet the needs of people with additional requirements we will:

- Produce documents in plain English
- Produce our consultation document in accessible formats, such as Easy Read, and in different print formats on request e.g. large print, audio, or foreign language translation, or braille etc.
- Telephone and Freepost contact details: to support open and accessible communications, the engagement team will be accessible via telephone, email, and post. This will give people the opportunity to give feedback in the way they prefer and is inclusive.

Throughout the consultation period we will receive regular response monitoring reports from the independent agency analysing the consultation. We will monitor this information closely to identify any

demographic trends which may indicate a need to adapt our approach regarding consultation activity. An example would be under representation from a particular demographic group or geographic area, particularly where there is a demonstrable disproportionate impact upon individuals within that group.

Media approach

We will work with the media on a proactive and reactive basis – updating them with key updates and milestones and responding to any of their enquiries as they arise.

We will promote consultation events and opportunities through the local news media, social media, and all our established newsletters, bulletins and communication channels. We will also work with the local press (print, online and radio) to further amplify messages about the consultation and encourage involvement. We will provide clinical spokespeople wherever possible to explain the reasons for change and our proposals, recognising that people have high levels of confidence and trust in clinicians and health professionals.

Specific handling plans will be created for any significant milestones during the consultation, including in each case: key messages, detailed questions and answers and sequenced information cascades to staff, key stakeholders and the media. We will keep a record of which outlets have been approached and will also consider arrangements to offer interviews and photograph/filming opportunities in response to requests.

Detailed plans will be put in place to cover the launch, mid-point and close of the consultation with proactive communications with all our stakeholders. An animation will help to set the context and describe the specialist nature of the service. This will be supplemented with learning from people with lived experience and partner case studies where appropriate to illustrate the case for change and the expected benefits of the proposals developed.

An efficient and effective approvals process will be important in terms of reacting quickly to requests for information/responses, rebutting any inaccurate media articles, and signing off any new content to respond to issues and themes as they develop through the consultation. To facilitate this, we will develop and agree a media handling protocol that will ensure all partner organisations are able to respond and react appropriately to queries from the media.

We will evaluate all media coverage to assess its effectiveness, and the inclusion of our key messages, adapting our approach as appropriate.

Impact of consultation on outcomes and decision-making

A public consultation is not a referendum. What we seek from the consultation responses, is to fully understand the impacts (positive and negative) that people believe the proposals will have.
As well as understanding what people might like about our proposals, we will want to understand how any negative impacts might be mitigated, and provide an opportunity for any additional evidence, data or alternative proposals and solutions to be put forward that would support improving the quality of care, and our case for change. Feedback will be used to shape the final proposals and allow us to consider mitigating actions for concerns that are raised.

Consultation responses will be used alongside a range of other evidence gathered as part of the decision-making process (including clinical, financial, workforce, estate, travel time evidence etc) and any other relevant information which may become available before a final decision. Consultation responses will be used to:

- help decide if the proposed option is taken forward
- identify if changes are needed to help develop the option taken forward

- identify actions to progress opportunities to improve / mitigate concerns raised.

This decision-making process will comply with the NHS England guidance ‘*Planning and Delivering Service Changes for Patients*’.

After the consultation has closed, and the independent report analysing responses has been carefully considered by NHS Kent and Medway, the consultation team will publish formal response and activity reports for the public consultation.

Resourcing plan

To deliver an effective best practice consultation we will commit sufficient resources, including internal staff, specific expertise from external agencies, and a non-pay budget for a range of essential expenditure.

An effective consultation will produce rich feedback and insights to improve the overall quality of decision-making and service design, and in turn, the quality of people’s outcomes and experience in the future. This approach will not only make sure we meet our statutory duties around involvement and consultation, it will also help mitigate the risk of successful legal or other challenge to the consultation process at a later stage, which then incurs further cost and time delays.

It is important to note that consultations can be challenged on process as well as the final proposal and the decision taken, which can lead to long delays, potential re-consultation and increased costs. Most importantly, successful challenge to a programme such as this also has opportunity costs for patients and our partner agencies in delaying improvements to services.

Action plan

Kent and Medway NHS

Public Information and Engagement Project Plan	Owner	October	November	December	January	February	March	April
Stakeholder mapping to identify involvement levels	SW C&E group							
Briefing to MP's	ICB							
Draft consultation plan	SW							
Review of all existing engagement and feedback	SW/BWS							
Comms and Engagement working group	SW							
General Con doc, FAQs and glossary	Comms/JW							
Review and consult on evidence from engagement/focus groups								
Development of key comms messages and narrative	Julia W							
Preparation and commission of animation to promote consultation and share info	JuliaW/ML							
Briefing papers for HOSC/HASC	Louise Clack/SW							
Collateral production and distribution	JW/C&E group							
Stakeholder communications to support distribution of collateral	JW							
Stakeholder engagement	LC/?							
Engage with people with lived experience	CT/LC/SW/BWS							
Briefing/Focus group/discussions GPs	SW/LC							
Press releases	JW							
Internal briefing and engagement of staff								
Partner staff focus groups	VF/LC/SW							

Design survey questions	SW C&E group							
Stakeholder workshops	LC/VF							
Engagement letters sent to specific staff	KMPT							
Working groups with clinical and professional board to discuss/develop plans	LC/SW							
Staff Newsletters/internal channels	ICB/KMPT Partners?							
Website project page set up and approved	Julia W/SW C&E working group							
Engagement focus groups with CED	SW/BWS							
Briefing and arrangements with VCS groups	BWS/SW							
Commission Independent analysts	SW							
Design brief for documents and social media	JW							
Letters to stakeholders re consultation	ICB							
Consultation materials distributed	ICB							
Consultation launch	20 February							
Coordinated messages to all staff and stakeholders								
VCS engagement events								
Attending public events/other people activities								

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Item 6: Specialist Children's Cancer Services

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 31 January 2023

Subject: Specialist Children's Cancer Services

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

It provides background information which may prove useful to Members.

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1) Introduction

a) In late November 2022, Chris Streather, Regional Medical Director and Janet Meek, Regional Director of Direct Commissioning at NHS England wrote to the Chair of HOSC regarding changes to children's specialist cancer services.

b) They have asked to present to the Committee today to explain the background and set out the proposals.

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 deems the proposed changes as not being substantial, this shall not prevent it from reviewing the proposed changes at its discretion and making reports and recommendations to the NHS.

c) Where the Committee deems the proposed changes as being substantial, the NHS must consult with it prior to a final decision being made, though the NHS always remains the decision maker.

d) Once the final decision has been reported to HOSC, the Committee shall decide if it supports the decision, does not support the decision, and/or provide comment on it. Where it does not support the decision, the Committee can refer it to the Secretary of State.

e) The commissioned services are accessed by patients across South London and South East England, therefore NHS England will be presenting the changes to a number of health overview and scrutiny committees. If more than one committee determines the changes as substantial, then it will be necessary to establish a Joint HOSC.

3. Recommendation

If the proposals relating to children's cancer services are deemed substantial:

RECOMMENDED that:

(a) the Committee deems that proposed changes to children's cancer services are a substantial variation of service.

(b) NHS representatives be invited to attend this Committee and present an update at an appropriate time.

If the proposals relating to children's cancer services are deemed not substantial:

RECOMMENDED that:

(a) the Committee deems that proposed changes to children's cancer services are not a substantial variation of service.

(b) NHS 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 England London

Changes to children's specialised cancer services Principle Treatment Centre Programme – South London & South East England

Kent HOSC

January 2023

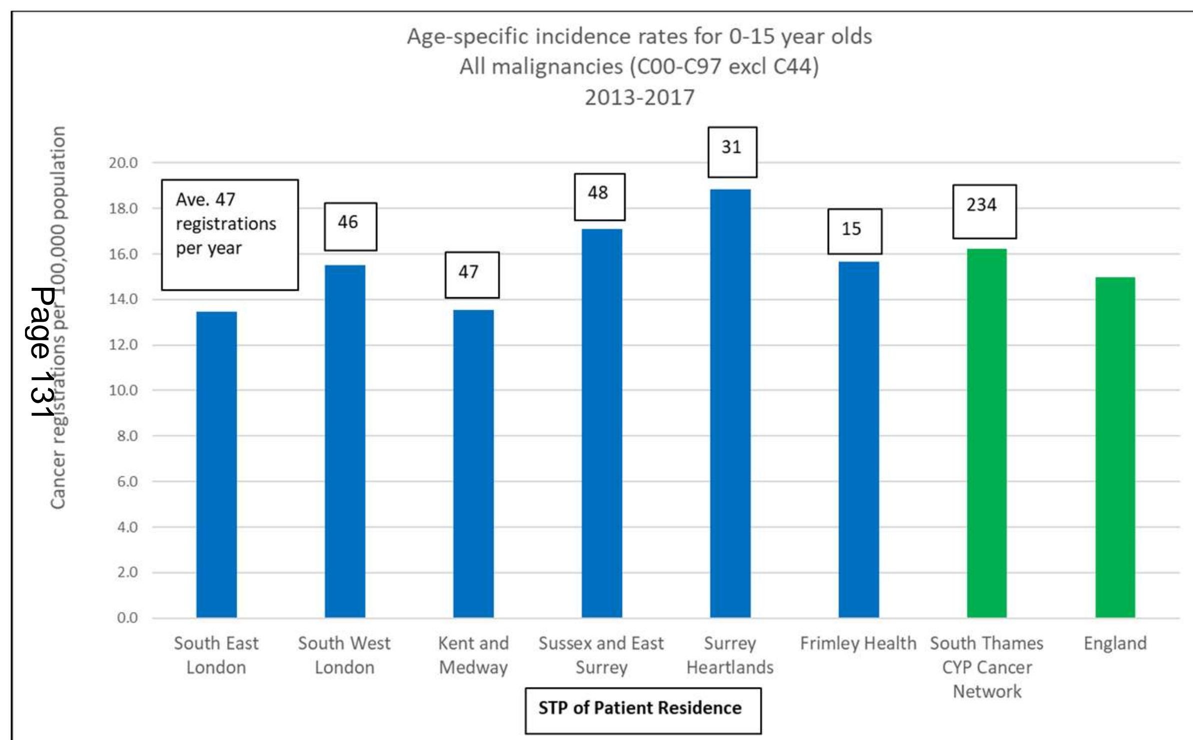
Purpose of the discussion

NHS England London

- Explain how Children's Cancer services are currently organised and which services are in scope for this service change
- Explain why changes to the current service provision is required i.e. the case for change
- Describe the implications for people from Kent
- Describe the work of the programme to date
- Demonstrate how we have already been engaging to support our thinking
- Outline the broad timeline we are working to
- Discuss next steps – developing a JOSC for this service change

The South Thames Children's Cancer Network: incidence by area of residence

NHS England London



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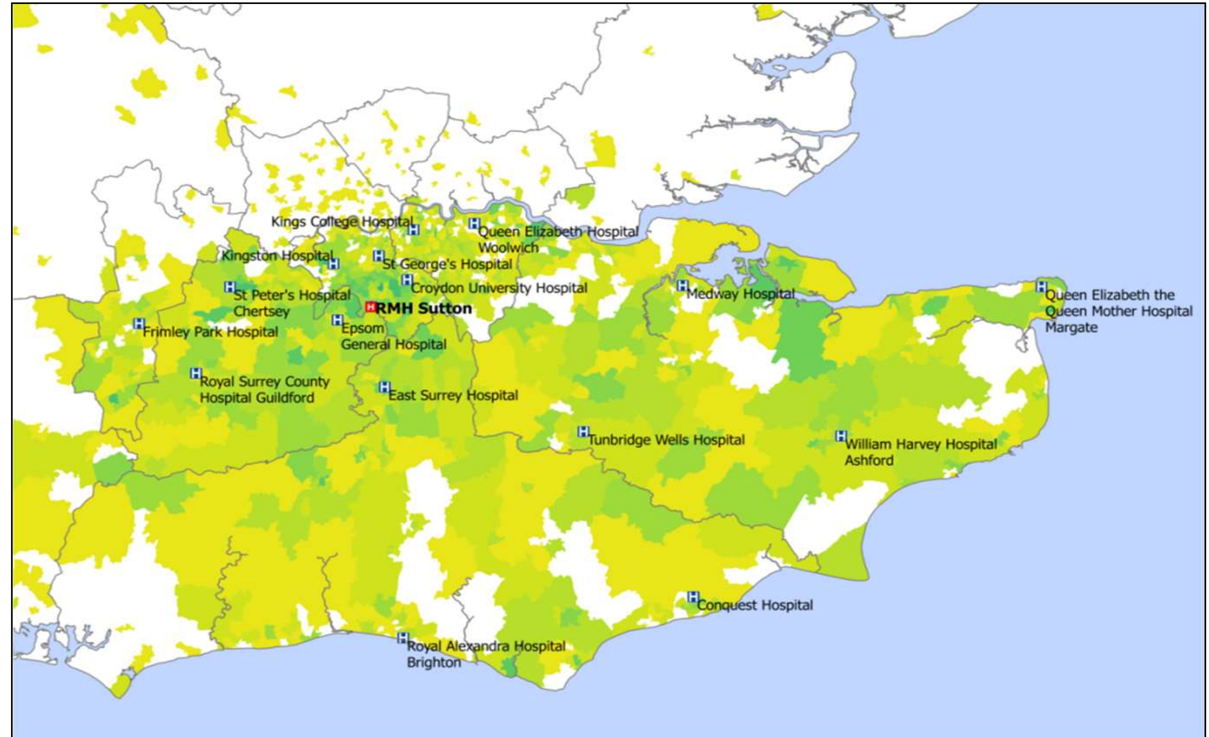
Childhood cancer is relatively rare, and on average 1,400 children (ages 0-15) are diagnosed with cancer in England per year. Most cancers affecting children are different than those affecting adults (e.g. occur in different parts of the body and respond differently to treatments).

The age-specific incidence rates for childhood cancer do not vary significantly across the network and are similar to England. On average there are around 234 new cancer registrations per year amongst residents of the South Thames Cancer Network.

Different cancer types are more common at different ages, with leukaemia being most common in under five year olds, CNS tumours being the most common cancer in those aged 10-14 years, and lymphomas and carcinomas increasing with age

About the programme – the current service

- NHS England is **responsible** for commissioning specialist services, including **children's cancer services for those aged 0-15 years**
- In England on average **1,400 children (under 15 years) are diagnosed with cancer every year** – meaning **very small numbers** of children need to access these services
- **All children and young people** in the UK who are diagnosed with cancer are treated in **one of 19 Principal Treatment Centres (PTCs)** which are responsible for coordinating and delivering care
- Currently, the joint PTC in this area (**The Royal Marsden NHS Foundation Trust and St George's University Hospitals NHS Foundation Trust**) covers; **Kent and Medway, Surrey, Sussex, south east and south west London.** This PTC received **c400 referrals** per year and has an **active caseload of c1500 patients.**
- **Paediatric Oncology Shared Care services (POSCUs)** allow children and young people with cancer to be treated closer to home so that families do not need to travel long distances to the nearest PTC for some procedures. The map shows the POSCU's associated with the joint PTC in London



Paediatric Oncology Shared Care services associated with the joint PTC run by The Royal Marsden NHS Foundation Trust and St George's University Hospitals NHS Foundation Trust in London.

In 2019/20 **107 children from across Kent and Medway** accessed the joint PTC. Numbers from other areas are similar.

The current principal treatment service in south London

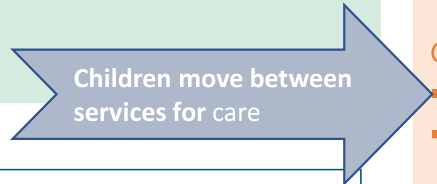
NHS England London

South Thames Joint PTC (Children aged 1-15 years): **c400 referrals per annum**
Active caseload of c1500 patients

The Royal Marsden (RM) - primarily oncology, chemotherapy radiotherapy & bone marrow transplant

INPATIENT
- Inpatients (18 beds of which 75% used by -16s, c470 admissions pa).
- Palliative care (c100 palliative and symptom patients per year)

AMBULATORY
- Outpatients (c5,800 attendances pa)
- Chemotherapy (c3,600 attendances pa)
- Radiotherapy (c800 treatments pa)
- Imaging & nuclear medicine (3,700 images pa)
- Day case treatment/procedures (1,800 procedures pa)



- Almost all specialist ambulatory cancer care is provided at RM
- Other providers, in particular KCH (for neurosurgery and liver) and GOSH/UCLH (for under 1s) play significant role

St George's Hospital (SGUH) - primarily surgery & critical care

INPATIENT
- PICU (c65 admissions pa, average 1.5 beds)
- Inpatients (4 beds, c135 admissions pa).

PROCEDURES
- Biopsies (c45 pa)
- Line insertion / removal (c190 pa)
- Surgery incl. neuro-surgery and tumour resections (c20 pa)

OTHER
- Neuro-rehab
- Specialist paeds including gastroenterology, neurology, dental, bronchoscopy/respiratory, infectious diseases, gynae, urology, Max Fax, plastics

Other specialist centres providing/supporting cancer care for South patients.

Kings College Hospital (KCH)
- Provides ⅔ of all neuro-surgery
- All liver surgery
- Endocrine & ophthalmology OPD

GOSH/UCLH PTC
- All children aged under 1
- CAR-T therapy
- Some surgical procedures

Evelina London (GSTT)
- Cardiology service, including echo cardiograms as part of cancer care, and renal.

RNOH – bone sarcoma
Barts - retinoblastoma

Other key providers:

Epsom & St Helier
- Ophthalmology OPD (c40 referrals pa)
- Endocrine OPD
- Audiology OPD (c70 patients pa)

Oxford/Hammersmith
- Fertility services

NHS England London

Children accessing inpatient PTC cancer care

Activity at RM and SGUH (2019/20) for those aged 0-15

Overall inpatient activity

In 19/20, 88% of a total 536 children using the RM/SGUH PTC for inpatient care and 91% of all inpatient activity related to children came from five main areas.

SW London:
111 children
21% of children
23% of activity

SE London:
92 children
17% of children
17% of activity

Kent and Medway
107 children:
20% of children
21% of activity

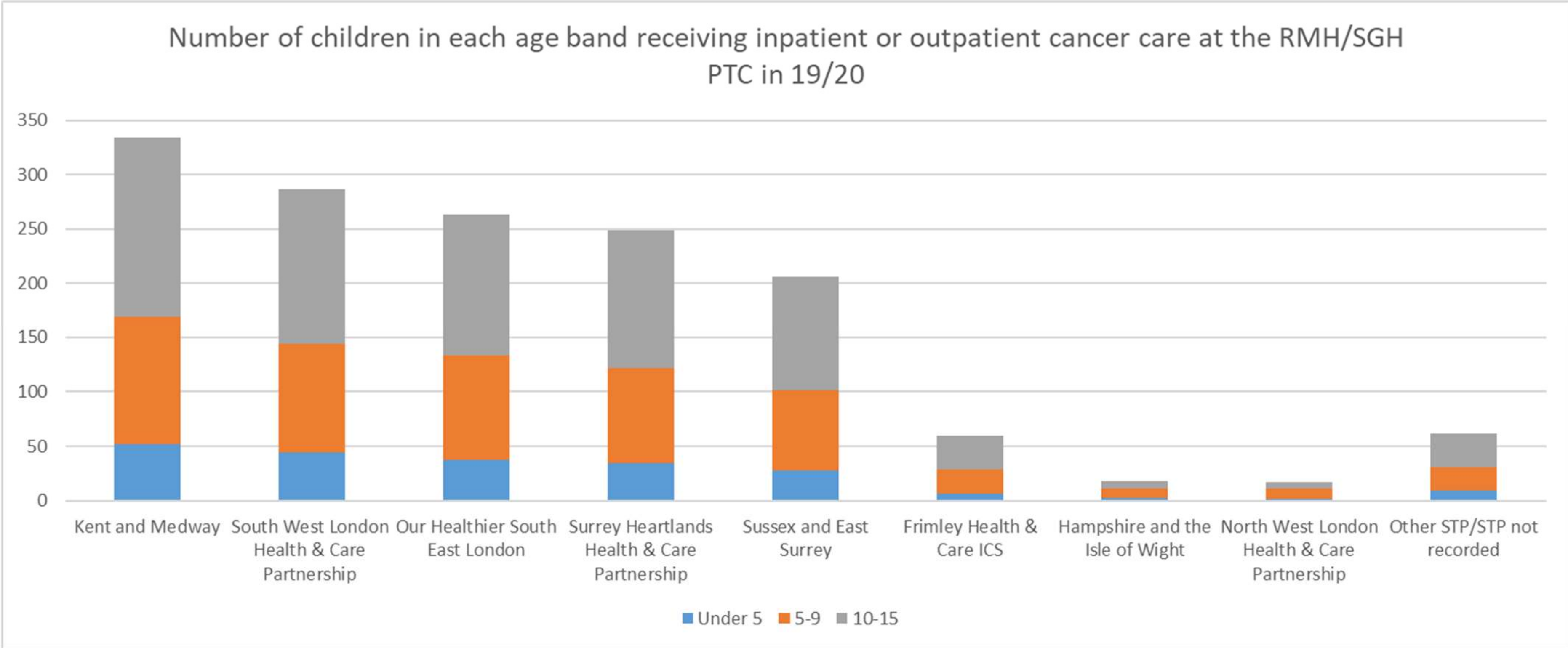
Surrey:
97 Children
18% of children
17% of activity

Sussex:
76 children
14% children 16% of activity

All children accessing PTC cancer care

Activity at RMH and SGUH (2019/20) for those aged 0-15

In 19/20, there were almost 1,400 children aged 0-15 who accessed paediatric cancer care as either an inpatient or outpatient at the primary treatment centre provided by The Royal Marsden and St George's. 210 of these children were aged under 5, 526 aged 5-9 and 737 aged 10-15.



NHS England London

A new national service specification for PTCs

- Children in the UK currently receive some of the best cancer care in the world, utilising cutting-edge treatments and technology. Following a number of reviews of services nationally, NHS England has worked with professionals and patients and consulted the public on a new set of service specifications which set out how services should be organised in the future. These have been published and are available here. In particular they wanted to:
  - **Improve integration** between different children's cancer services;
  - **Improve experience of care**
  - **Improve participation** in **clinical trials**
  - Tackle variation, ensuring that patients got the **same high quality care, regardless of where they were treated**

- Standards for Principal Treatment Centres were developed by clinicians, patients, families and providers to ensure that wherever children and young people receive specialist cancer services, it would be the same excellent care across the country from diagnosis to management and follow-up of cancer

- The outcomes of the 2019 consultation on the standards was reflected in a new service specification for PTCs (published here in November 2021) which includes ***a requirement*** **for Principal Treatment Centres to be delivered on site with Paediatric Intensive Care Units**, alongside paediatric surgery, radiology, haematology and paediatric anaesthetics, with ideally a range of other specialist children's services too**.**

- These specifications set out how services should be provided in future and meet the highest safety considerations, as well as ensuring that services are able to meet the needs of new technologies and treatments.

Changes are needed to meet the new service specification

NHS England London

- London has internationally renowned paediatric cancer services – **the new specification helps strengthen them even further** by creating future facing services able to excel in new treatments modalities making the need for an on-site PICU is even more necessary

- The **Royal Marsden NHS Foundation Trust currently provide high quality and safe specialist children's cancer services on behalf of London and the south east. The research undertaken by the RMH is outstanding.**

- The current PTC is provided across The Royal Marsden (Sutton site) and St George's University Hospital NHS Foundation Trust, **but there is no PICU at The Royal Marsden (Sutton site**) meaning the PTC does not comply with the new specification

- Professor Nicholas van As, Medical Director for The Royal Marsden NHS Foundation Trust, has said recently: "it is not economic to provide PICU services with a highly specialised workforce at a greater number of locations including The Royal Marsden, Sutton. Given this decision, The Royal Marsden will not be bidding to remain a PTC but will work in partnership for the benefit of children with either St George's Hospital, our existing partner, or Evelina London Children's Hospital."

- The programme is in the process of undertaking an **options appraisal process** on a shortlist of options, in order that services can be **relocated to comply with the new specification.**

Though the number of children, young people, families and carers using these services is very small, what is provided is vital and specialist care. Therefore, our Programme Board feels that any changes to these services would be significant and we are planning for a formal consultation.

What are the expected benefits of any change?

NHS England London

A service ready for the future

With paediatric intensive care available on the same site as the principal treatment centre for children's cancer, the service will be ready to deliver new types of care, such as immunotherapies to very sick children.

More care delivered on a single site

We wont address all of the service fragmentation in London, but we do want to maximise the number of other specialist children's services delivered on the same site as the PTC, meaning that children will be able to receive care from clinicians skilled in a wider range of specialist care for children. This will not just mean that treatment transfers are reduced, but coordinated holistic care is also increased.

Good treatment for staff

We aim to match and ideally improve on the current training and support offer to staff.

Compliance with the national service specification

The service specification includes standards which are in place to ensure all children receive the best possible care. Compliance in itself should be seen as a very positive step.

Fewer treatment transfers

Streamlining access to critical care will happen immediately once the PTC is on the same site as a PICU. This will remove the need for emergency transfers. Availability of a wider range of clinical specialties on the same site as the PTC should also reduce the limited number of other transfers that also occur currently. Care models that reduce transfers further will be one of the evaluation criteria.

Although The Royal Marsden/St Georges service is safe and offers excellent care, all treatment transfers carry risk, and the aim should be to minimise these where possible.

Managing Risks during the transition

We are assessing the two short-listed options against four key criteria:

- Clinical
- Research
- Patient and Carer Experience
- Enabling support (workforce, capacity, resilience

We aim, by taking this approach, to protect what is excellent in the current service, including research, and build on this for the future. We will work with all parties to ensure the benefits of this change are realised.

Work to date

Work has recently restarted on the programme, following a pause due to COVID

NHS England London

A developing governance structure

- Formal programme board – membership includes tertiary trusts in south London providing specialist children's care, the south east and south west London ICBs, NHS England London and south east regions
- Clinical advisory group
- Communications working group
- Patient and stakeholder advisory group
- Children and young people (CYP) sub-group

Understanding impacts

- Early engagement work undertaken with parents, carers and children and young people
- Development of equalities impact assessment
- Development of a travel analysis

Planning for consultation

- Planning an inclusive and proportionate consultation
- Working with charities and trusts to explore how we can better reach CYP
- Beginning to map organisations and channels in all geographies to make best use of existing relationships

Options appraisal process

- Working with current and potential providers to understand solutions to meet the service specification
- Long list of options developed
- Evaluation criteria created with input from experts including clinicians, parents and carers
- Initial shortlisting undertaken resulting in, a **short list of two options.** With either option, services would cease at The Royal Marsden.
  - St George's University Hospitals, the partner provider with The Royal Marsden of the current children's cancer PTC; and
  - Guys and St. Thomas' NHS Foundation Trust's Evelina children's hospital, the largest specialist centre serving south London and the south east of England.
- Further work from November to January to **evaluate both solutions and arrive at a preferred option**

Assurance

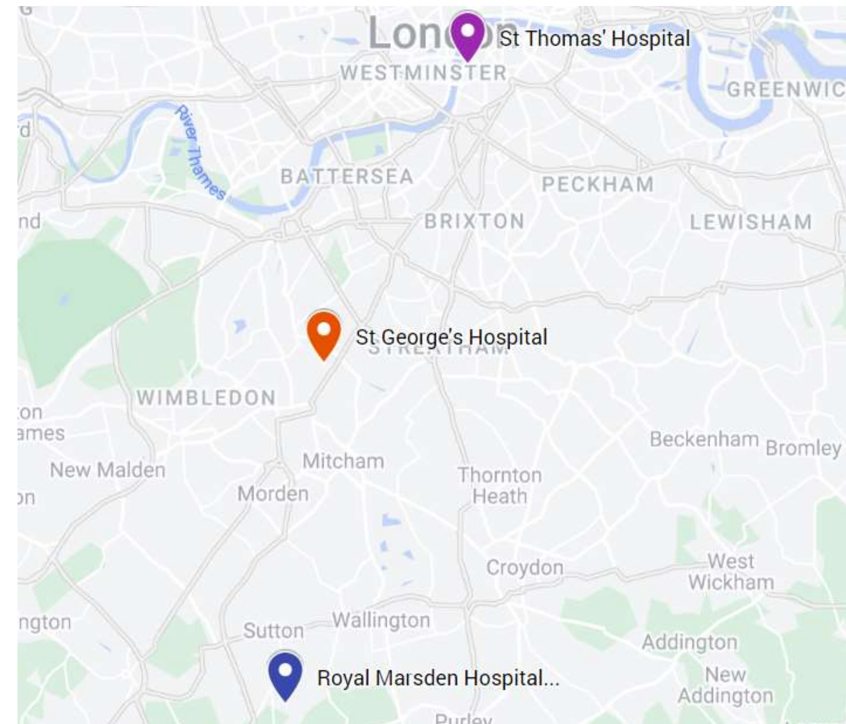
- Working with London and south east region Clinical Senates to provide further expert clinical appraisal
- Undertaking NHS England assurance
- Early conversations with affected OSCs

The picture in Kent and Medway

NHS England London

Potential impacts

- In 2019/20 **107 children and young people from across Kent (96) and Medway (11)** accessed the service - which is similar to numbers from other areas accessing the same service
- Any changes proposed are unlikely to be implemented until 2026, following consultation
- Both options being considered still require travel into London and mean services will cease at the Royal Marsden Hospital
- St. Georges option means travel to the St. Georges Hospital site in Tooting (see map opposite)
- Evelina London option means travelling to St. Thomas' Hospital site near Waterloo (see map opposite)



Map depicting where services may be provided in future (St. Georges Hospital or Evelina London) and where they are currently provided (St. Georges Hospital and the Royal Marsden)

Involvement in the programme

- Involvement from ICBs, Trusts and the Children and young peoples cancer network in our governance
- As we begin planning for consultation we are working to ensure we are connected with charities and local groups working with children and young people with cancer in Kent and Medway

Children who use this PTC come from a broad geography and therefore **we will want to engage all OSCs likely to be affected** as we plan for consultation. We want to discuss with you **the most time and resource efficient way** to do this.

Engagement to date: working with children, young people and parents/carers across London and the south east

NHS England London

During our early engagement, between September 2020 and March 2021 we had :

- **Six meetings** with the stakeholder group, involving 17 parents - who input to discuss engagement plans, options development, domain and sub-criteria content and weightings
- Approximately **62 contacts** with parents/carers /caregivers, which were a combination of meetings, individual conversations with parents (telephone or virtual) and email contacts - to support their participation and engagement
- **208** survey and interview responses to an externally commissioned survey - to understand what was important to children and young people around children's cancer services
- **50** survey responses from the stakeholder group and current inpatients – feeding back around the sub-criteria scoring for the patient experience domain

Engagement was paused until spring 2022 due to COVID pressures.

New activity since autumn 2022:

- Supported a **panel of parents to participate in the options appraisal process**, developing and scoring the patient experience domain.
- **Re-established the stakeholder group**, in November 2022, **to support us as we develop our consultation plan**. This group includes parents, carers and organisations that provide support across London and the south east.
- Started a **children and young people's sub-group**, in January 2023, to support us to understand how we can better engage with CYP as we plan and undertake wider engagement work

How engagement has made a difference

NHS England London

Feedback from children, young people and parents/ carers during this early phase of engagement has already influenced a number of important aspects of the programme. Below is a snapshot.

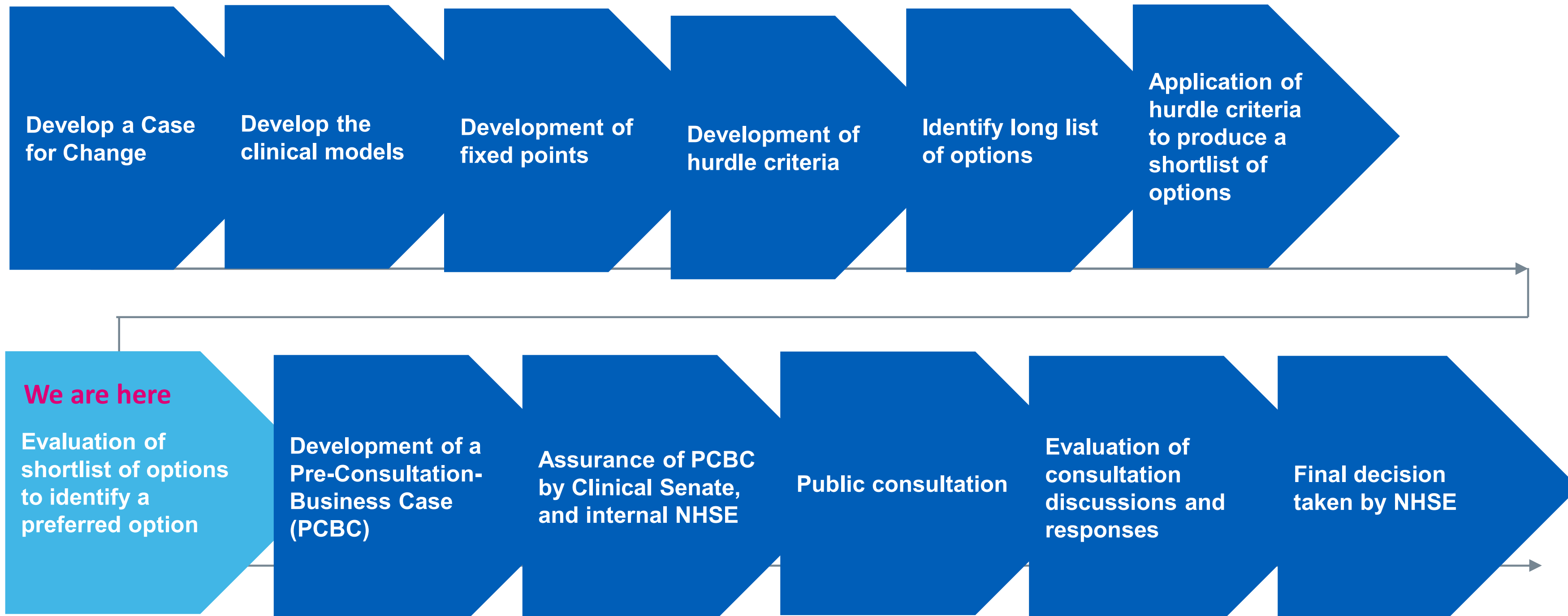
Supporting communications and engagement planning

- Informing frequently asked questions.
- Designing and agreeing the Association for Young People's Healthy survey (AHYP) questions to ensure they were accessible.
- The stakeholder group recommended wider engagement with current service users, which has been undertaken by providers and fed into the options appraisal process.

Options development

- Feedback from the stakeholder group and AYHP survey provided feedback on current patient experience and what was important, from their perspective, in terms of the service.
- As a result of feedback, several changes and additions were made to the patient experience domain criteria.
- Current service users on wards were surveyed to understand what good looks like in several areas of the sub-criteria.

Where we are in the formal reconfiguration process



Programme timeline/ expected milestones

NHS England London

January - June

- Options appraisal concluded
- Planning for consultation
- Development of Pre Consultation Business Case
- Development of Equalities Impact Assessment
- Meeting with Clinical Senate
- **Meeting with OSCs/JOSCs**
- Commissioning of expert organisation(s) to support engagement
- Preparing consultation materials and questions

June - September

- **Expect to launch and conduct consultation**
- Equalities Impact Assessment updated
- Conduct mid-point review

September - December

- Consultation feedback analysed and outcome report prepared
- Programme Board considers feedback ahead of decision making
- Decision Making Business Case Prepared
- Decision confirmed and communicated – consultation respondents notified
- Begin planning to implement decision

Working with you going forwards

NHS England London

In November, we started a cycle of early conversations with OSC Chairs from all areas to brief them on the programme and discuss how we best work together. We understand that guidance suggests forming a JOSC in these circumstances, but that this requires significant time and energy – especially as this programme involves inner and outer London OSCs (Kent and Medway, Surrey, Sussex and south east and south west London.

We would want to engage with you **at several key points** in the process, including at least one meeting before, during and after consultation to:

- Brief all members about the programme and impact in their area
- Present and discuss plans for consultation and seek feedback
- Share key documents like the pre-consultation business case and consultation materials
- Share the outcome of the consultation and the decision
- Share plans for implementation and the impact this may have on each area

Our proposed approach to engage with you

We will be engaging with each of the affected OSCs/ JOSCs to understand if they believe the changes are substantial for their residents. If more than one committee agrees the changes are substantial, then there will need to be a Joint HOSC. We would like to explore whether there is the opportunity for regional JHOSCs to scrutinise the consultation outcomes and form a view as to whether to recommend referral to the Secretary of State.

We believe this will enable:

- Early engagement with OSCs to happen so that members are briefed and can be involved in conversations about planned activities in their local area
- Understanding of whether individual areas feel the change is substantial and how they would like to be involved/ engaged throughout the process
- Enable enough time for the practicalities of a JOSC to be worked through so that a group could be properly constituted
- A balance between understanding local concerns and preferences and having a shared conversation
- Everyone to have an equal voice

Discussion and next steps

NHS England London

Discussion questions:

- Do you, as a committee, view this change as **substantial**?
- If you do not think it is substantial, how would you like us to engage with you moving forward?
- If you think it is substantial, what further information would be helpful at this time?

Should more than one overview and scrutiny committee call the proposal substantial, we will work with the relevant Committee chairs and officers to determine the most practical way of coordinating a Joint HOSC.

Next steps:

- Agreeing arrangements for engagement and working together moving forward
- Meetings with other OSCs involved to understand their views
- Background work with democratic services teams to take forward feedback from today's session

Item 7: Vascular Services

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 31 January 2023

Subject: Vascular Services (East Kent and Medway)

Summary: This report invites the Health Overview and Scrutiny Committee to consider the recommendation from the Kent and Medway Joint Health Overview and Scrutiny Committee (JHOSC) in relation to Vascular Services.

NHS England are establishing an inpatient vascular services centre at Kent & Canterbury Hospital, with outpatient services delivered at other hospital sites. The JHOSC are supportive of the decision.

The Committee is being asked, in light of the recommendation from the JHOSC, to respond to the NHS decision.

---

1. Introduction

1.1. Vascular disease affects veins and arteries. The services under consideration are specialised and therefore commissioned by NHS England closely supported by the Kent and Medway ICB.

1.2. In East Kent and Medway, vascular inpatient services are currently provided by two NHS Trusts: Medway NHS Foundation Trust (MFT) and East Kent Hospitals University NHS Foundation Trust (EKHUFT) at their Kent and Canterbury Hospital site. Medway Hospital has experienced a number of challenges around staffing and service sustainability, and since January 2020 their Abdominal Aortic Aneurysm (AAA) elective and emergency services have been taking place at the Kent and Canterbury Hospital.

1.3. The national recommendation is that vascular services are organised into a “hub and spoke” model, allowing patients access to a wide range of services locally but with arterial and emergency work centralised at a centre of excellence. Dedicated vascular centres allow for higher volumes of activity and are evidenced to deliver better patient outcomes.

1.4. The current solution is an interim one. The permanent location of the main hub will be determined through the East Kent Transformation Programme. However, this major programme, which is designing changes to a wide range of acute NHS services in east Kent, is unlikely to be completed within the next 8 to 10 years.

1.5. The new model of care will see a single hub for specialised inpatient vascular surgery on the Kent and Canterbury Hospital site. Outpatient services will continue to be delivered at QEQM, William Harvey, Buckland Hospital and

Medway Hospital. EKHUFT's Vascular network team will also provide outpatient vascular services and some vascular diagnostic services at Maidstone Hospital, Maidstone, and Sheppey Hospital.

2. Scrutiny

2.1. In 2015 Kent County Council's Health Overview and Scrutiny Committee and Medway Council's Health and Adult Social Care Overview and Scrutiny Committee determined that changes being proposed by NHS England to Vascular Services in East Kent and Medway amounted to a proposal for a substantial variation to the health service across both areas.

2.2. In line with regulations, formal scrutiny passed to the Kent and Medway NHS Joint Overview and Scrutiny Committee who have received updates since that time.

2.3. In addition to extensive engagement work, a formal public consultation ran from 1 February – 15 March 2022. This was a separate process to the NHS' engagement with health scrutiny. Responses were broadly in favour of the proposal, but key areas of concern were around travel and transport to the Kent and Canterbury Hospital, particularly for visitors of patients. A public meeting has since been held to find ways of mitigating those concerns.

2.4. There will be workforce changes to support the new model of care, and the Vascular Team at Medway Hospital will be formally consulted about the changes and offered the opportunity to transfer their employment to EKHUFT.

2.5. Specialist Commissioning at NHS England and the Kent and Medway Integrated Care Board (ICB) considered the Decision-Making Business Case on 14 September 2022 and 1 November 2022 respectively and made their final decision. Boards at Medway Foundation Trust and East Kent Hospitals University NHS Foundation Trust also considered the decision during November. The decision was to support the DMBC and locate (in the medium term) the inpatient vascular hub at Kent and Canterbury Hospital.

2.6. On 6 December 2022 the JHOSC met to consider the decision of NHS England. The draft minutes are attached to this report, and the Committee agreed the following:

RESOLVED that

i) the Committee supports the decision of the Kent and Medway Integrated Care Board (ICB) and Specialist Commissioning at NHS England regarding the interim solution for the delivery of vascular services in East Kent and Medway.

ii) the relevant NHS bodies be asked to consider that the TUPE consultation is carried out according to statute whilst taking into account industrial action.

3. Next Steps

3.1. In line with its Terms of Reference, the Kent and Medway JHOSC considered whether to recommend to the Medway HASC and Kent HOSC that the decision of NHS England on 14 September 2022 should be referred to the Secretary of State.

3.2. The decision of the JHOSC was not to recommend referral, as is set out above (2.6). As the power of referral was not delegated to the JHOSC, the Kent HOSC is able to determine its response to this recommendation.

3.3. As set out in KCC's Constitution, a substantial variation of service may only be referred to the Secretary of State for Health where one of the following applies:

i) The consultation with the HOSC on the proposal is deemed to have been inadequate in relation to content or time allowed;
ii) The reasons given for not consulting with the HOSC on a proposal are inadequate; or
iii) The proposal is not considered to be in the interests of the health service of the area.

3.4. If HOSC does not feel that any of these apply to the matter under discussion, it cannot make a legitimate referral. It can still monitor the implementation of the service and make comments and recommendations directly to the relevant NHS organisations at any time.

3.5. If HOSC does feel that one of these applies, it cannot make a final determination on referral at this meeting. The Constitution sets out that the proposer of the substantial variation of service shall be informed of the date on which HOSC intends to make a determination on referring an issue to the Secretary of State for Health.

3.6. Any referral to the Secretary of State must contain the following:

i) The full evidence of the case for referral.

ii) Evidence that all other options for resolution have been explored must be included along with all additional requirements for the submission of a referral required by legislation and statutory guidance.

iii) Where the referral is on the grounds that the Committee believes the proposal is not in the interests of the health service of the area, a summary of the evidence considered must be provided, including any evidence of the effect or potential effect of the proposal on the sustainability or otherwise of the health service of the area.

3.7. Prior to making any referral to the Secretary of State, the Committee would need to be assured that all the above could be supplied.

3.8. Whilst a decision to refer cannot be made at this meeting, a decision to support the decision of NHS England, or support with qualifications and/or comments can be made at this meeting.

4. Further information

4.1. NHS England – Consultation on specialised vascular services in Kent and Medway: https://www.england.nhs.uk/south-east/our-work/info-professionals/spec-comm/consultation-on-specialised-vascular-services-in-kent-and-medway/

5. Recommendation

The Committee is asked to consider the decision of NHS England Specialised Commissioning on 14 September 2022 and take one of the following actions:

(a) Endorse the recommendation of the JHOSC and support the decision of NHS England about the medium-term model of care for vascular services in East Kent and Medway.

(b) Specify concerns that the Committee has with the decision of NHS England and invite the NHS to a future meeting of the Committee where their response to these concerns will be considered ahead of a final determination by the Committee as to whether or not to refer the decision of NHS England to the Secretary of State for one of the reasons set out in 3.3.

Background Documents

Kent County Council (2022) *'Kent and Medway NHS Joint Overview and Scrutiny Committee (06/12/22)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=757&MId=9188&Ver=4

Kent and Medway NHS Joint Overview and Scrutiny Committee – meeting agendas and papers: https://democracy.kent.gov.uk/ieListMeetings.aspx?CId=757&Year=0

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KENT AND MEDWAY NHS JOINT OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Kent and Medway NHS Joint Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Tuesday, 6 December 2022.

PRESENT: Mr P Bartlett (Chairman), Cllr D Wildey (Vice-Chairman) and Mr N J D Chard

PRESENT VIRTUALLY: Ms K Constantine, Ms S Hamilton

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

UNRESTRICTED ITEMS

57. Declaration of interests by Members in items on the Agenda for this meeting
(Item 2)

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

58. Minutes from the meeting held on 26 April 2022
(Item 3)

RESOLVED that the minutes from the meeting held on 26 April 2022 were a correct record and they be signed by the Chair.

59. Specialist Vascular Services Review
(Item 4)

Present for this item: Su Woollard, Transformation Delivery Manager (Vascular), NHS England, Dr Christopher Tibbs, Medical Director, NHS England, Simon Brooks-Sykes, Associate Director Strategy and Population Health, K&M NHS, Tracy Rouse, Director Strategic Change and Population Health, K&M NHS, Nicky Bentley, Director of Strategy and Business Development, EKHUFT, Tom Lovegrove-Bacon, Senior Strategic Development Manager, EKHUFT
Virtually present for this item: Dr Alison Davis, Chief Medical Officer, Medway NHS Foundation Trust and Sabahat Hasson, Communication and Engagement Lead, NHS England.

1. The Chair welcomed the guests and asked them to introduce themselves. The Committee then turned to questions.

2. A Member asked whether outcomes had improved since elective and emergency services for Abdominal Aortic Aneurysm (AAA) had moved to Kent and Canterbury Hospital in January 2020. Dr Tibbs explained that there had not been enough patients treated to adequately respond, but they were

confident that the service had improved as evidenced by a reduced length of stay, a reduced number of people on call, and efficiencies.

3. A Member asked how the consultation process had engaged with hard-to-reach groups, such as the Gypsy, Roma and Traveller (GRT) community. Mr Brooks-Sykes summarised the types of consultation methods used during the 6-week period. These included online surveys, written information, focus groups and workshops. Professional support was provided by an independent organisation who helped reach a diverse range of people, including those who had accessed vascular and related services in the past. One to one interviews had also been conducted along with two focus groups.

4. Dr Davis gave an example of a direct action that had occurred as a consequence of concerns raised during the public consultation. Transport had been raised as a concern which led to a patient transport group being established for patients and families.

5. The Committee asked to be provided with a copy of the Equality Impact Assessment (EqIA).

6. Ms Hasson confirmed a list of the communities and organisations engaged during the public consultation were detailed in the consultation report.*

7. A Member was concerned about the timing of the staff consultation, to be held 12 December – 10 January 2023, and questioned whether it should be delayed until later in January. Dr Davis provided assurance that staff had been engaged throughout the journey and were aware, and supportive, of the plans.

8. Medway Foundation Trust was gathering information to understand which staff would be affected by the TUPE process. NHS colleagues were united in their conviction that any further delay would not be welcomed by staff. In addition, Dr Tibbs explained that Medway Hospital's Vascular services had been unsustainable for some time and any further delay would require additional locum staff to maintain a required level of service.

9. A Member raised concerns around the impact of industrial action and bank holidays on the statutory timetable for staff consultation. Dr Davis explained the Trust would take into account how industrial action would effect employees and that it would be carried out in a kind and respectful way. She also confirmed that bank holidays were not included in the statutory period, and that the Trust would absolutely meet its statutory duties.

10. The Chair echoed the requirement for the staff consultation and TUPE process to follow the legislation in relation to the impact of industrial action.

11. Dr Davis confirmed not all Medway staff would be affected by the move as some services were staying at the Medway site. She also said there would be wider opportunities once the centre of excellence was established.

12. A Member voiced their concern about a further service being reduced at Medway Hospital but felt that it was the right move for Vascular services. They also welcomed the comprehensive consultation that had been undertaken.

13. Dr Davis confirmed that patients taken care of under a network benefited from better outcomes. Data would be collected, benchmarks compared, and best practice shared to evidence the improved quality of service.

RESOLVED that

i) the Committee supports the decision of the Kent and Medway Integrated Care Board (ICB) and Specialist Commissioning at NHS England regarding the interim solution for the delivery of vascular services in East Kent and Medway

ii) the relevant NHS bodies be asked to consider that the TUPE consultation is carried out according to statute whilst taking into account industrial action

**post meeting note*: A list of stakeholder and community organisations contacted is listed in Appendix 7 of the attached document: [Vascular - Consultation report - Appendices.pdf (kent.gov.uk)]

Item 8: CAMHS Tier 4 provision at Cygnet Hospital, Godden Green

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 31 January 2023

Subject: CAMHS Tier 4 provision

Summary: This report invites the Health Overview and Scrutiny Committee to consider the response provided by NHS England (NHSE) Direct Specialised Commissioning and the Kent and Sussex CAMHS Provider Collaborative to questions raised at the last meeting.

It is a written response only and no guests will be present to speak on this item.

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1) Introduction

a) Since late 2020, HOSC has received updates about Children and Adolescent Mental Health Services (CAMHS) tier 4 provision following the closure of Cygnet Hospital, near Sevenoaks following a serious incident. Specialised tier 4 provision is commissioned by NHS England.

b) In July 2022 a written report on the closure was presented to HOSC following conclusion of the investigation. Members had questions around the delivery of tier 4 CAMHS provision, which NHS England responded to with a written update on 30 November 2022. Members sought further clarification, to which NHS England (NHSE) Direct Specialised Commissioning and the Kent and Sussex CAMHS Provider Collaborative have provided the attached written response. Unfortunately, no representatives were available to speak on the item.

c) The questions were:

i. What areas were covered by the 186 CAMHS tier 4 beds in the South East region?

ii. Did the 186 include the removal of the 20 beds taken out of service at St Mary Cray?

iii. What was the breakdown of tier 4 beds by county and how many were vacant?

iv. Why were the additional 6 beds at Kent and Medway Adolescent Hospital (KMAH) still not available?

v. Was it accurate that there was an eating disorders day clinic at Haywards Heath but it was almost impossible to get there by public transport?

2. Recommendation

RECOMMENDED that the Committee consider and note the response and invite the NHS to attend with an update at an appropriate time.

Background Documents

Kent County Council (2020) *'Health Overview and Scrutiny Committee (24/11/20)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8498&Ver=4

Kent County Council (2022) *'Health Overview and Scrutiny Committee (7/7/22)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8969&Ver=4

Kent County Council (2022) *'Health Overview and Scrutiny Committee (30/11/22)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=9048&Ver=4

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CAMHS T4 Provider Collaborative
Kent and Sussex

Health and Scrutiny Oversight Committee Report 31st January 2023

Update on CAMHS Tier 4 (specialist inpatient /day patient and alternatives to admission) Provider Collaborative

1. Context

Sussex Partnership NHS Foundation Trust (SPFT) is the lead provider of the Kent and Sussex Provider Collaborative for Child and Adolescent Mental Health (CAMHS) Tier 4 Services. The Provider Collaborative is delegated by NHSE to commission CAMHS inpatient beds for children and young people from Kent and Sussex The Provider Collaborative (PC) operated in shadow form from October 2020 until going live on 1st October 2021.

The current CAMHS Tier 4 services commissioned in the Provider Collaborative network are:

- KMAH – a CAMHS General Adolescent Unit (GAU) located in Staplehurst, Kent that currently provides 11 beds and is managed within the Crisis and Home Treatment (CREST) care pathway. There is also a Health Based Place of Safety on site where young people can be detained under S136 of the mental health act.
- Chalkhill– a CAMHS General Adolescent Unit (GAU) located in Haywards Heath, Sussex that is commissioned to provide 16 beds and where there is also a Health Based Place of Safety.
- Elysium Brighton and Hove - a CAMHS Specialist Eating Disorder Service (SEDU) that provides 16 beds.

2. Purpose of Update Report

This update paper is in response to further questions raised within HOSC at the meeting in November 2022 on discussion of a written response provided to this meeting authored by Andrew Sutherland, Head of Quality Specialised Commissioning Mental Health, Health and Justice, Acute - South East Region NHS England & NHS Improvement

3. Background

The Provider Collaborative enables a more collaborative and joined-up approach to commissioning and associated service delivery through admissions and discharge planning, increasing the likelihood of patients getting access to appropriate services that best suit their needs at the earliest possible opportunity including accessing appropriate community treatment rather than going into hospital if it's not needed.

As a partnership we have formed a Clinical Activity Panel (CAP) and Single Point of Access (SPA) for CAMHS Tier 4 services. The CAP consists of senior clinicians, managers from Tier 4 in-patient services /crisis teams and specialist community CAMHS / Eating disorder services and senior representatives from social care nominated directly by the respective Directors of Children's Services. By bringing together clinical and operational experts we are ensuring that clinical decisions are made by the most appropriate people to better

NELFT NHS Foundation Trust   Elysium Healthcare   NHS Sussex Partnership NHS Foundation Trust

enhance patient care. The CAP operates across Kent and Sussex to ensure there is a shared understanding of demand across the footprint of the PC and to be able to oversee flow into the units across the area.
The SPA operates a full bed or day service finding and gatekeeping function. This allows a better grip of the cohort and releases clinical capacity in teams who were previously bed searching. Case Managers oversee all young people who are referred for admission and those in units as well as unit quality assurance working with the PC Quality and Safeguarding Leads.

4. Service developments

1) 3 Additional General Acute beds at Kent and Medway Adolescent Hospital and the addition of 3 short stay beds. The short stay beds allow for a seamless pathway from crisis to inpatient and back to home as these will fall under the enhanced treatment pathway so they remain with their teams.
Progress to date:
The unit at KMAH has been redeveloped to increase the overall number of bedrooms as per the plans above. The physical works are now complete to add 3 new beds and 3 new crisis (72 hour) beds and a high dependency area to manage children and young people needing specific support off the main ward area . The completion of the work was significantly delayed due to access to construction materials in particular ligature safe doors. This was a consequence of Covid and the impact of the changes in the relationship with the European Union.
However, in November 2022 it was identified there are further essential estates works needed in the existing bedroom corridor because of health and safety issues. It has therefore been necessary to undertake further works to rebuild walls in bedrooms to ensure they are more resistant to damage and to replace windows with integral blinds to reduce ligature risk. During these works the unit has to limit the overall bed numbers to 9 to enable works to be completed safely and to limit the impact on the young people. This is regrettable but the works are clearly needed to ensure the safety of the young people and to limit the risk of them being able to harm themselves.
The overall refurbishment, which will lead to the full 17 bed capacity is due to be completed at the end of February. Recruitment is underway for additional staffing to support the new beds but this is in the context of overall NHS national workforce challenges.
NELFT has also continued the improvement to the environment in KMAH since taking on the service including completion of a sensory room, reconfiguration of the space to enable quieter areas and to ensure the nurses station is partitioned to avoid inappropriate access by young people. This will ensure the environment is of higher quality to support the young people who are admitted.
NELFT are ensuring the community crisis and home treatment (CREST) team can proactively support young people to avoid admissions where possible. The Provider Collaborative and NELFT are working together to ensure the flow through the unit supports young people to be admitted for as short a period as possible and to enable admission and discharges to be smooth.

2) Day hospital for Sussex for young people with Eating Disorders.
This unit opened at the end of October 2022. The building works were delayed due to the lack of

availability of construction workers and materials. Due to its location it is true to say that this is likely to be accessed predominantly by young people in Sussex. However, the Kent and Medway all age eating disorder pathway is highly effective at supporting young people to remain well in their community and there has been a significant reduction over time in referrals for admission which is really positive. As a CAMHS inpatient Provider Collaborative we continue to review opportunities to develop alternatives to admission in Kent and Medway and to work with the Integrated Care Board to consider how we can work together to enhance the overall pathways of care for children and young people in Kent and Medway.

3) There was initial allocation of revenue by NHSE to fund the development of a Psychiatric Intensive Care Unit in Kent and Sussex but due to a lack of identified capital this scheme is not currently progressing. The Provider Collaborative does not hold a capital budget as this is delegated to the Integrated Care Systems in Sussex and Kent and Medway.

Alison Nuttall
Provider Collaborative Programme Director for Kent and Sussex CAMHS Tier 4 Services and Adult Eating Disorders.

Gill Burns Children's Services Director NELFT

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Item 9: Work Programme 2023

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 31 January 2023

Subject: Work Programme 2023

Summary: This report gives details of the proposed work programme for the Health Overview and Scrutiny Committee.

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1. Introduction

a) The proposed Work Programme has been compiled from actions arising from previous meetings and from topics identified by Committee Members and the NHS.

b) HOSC is responsible for setting its own work programme, giving due regard to the requests of commissioners and providers of health services, as well as the referral of issues by Healthwatch and other third parties.

c) The HOSC will not consider individual complaints relating to health services. All individual complaints about a service provided by the NHS should be directed to the NHS body concerned.

d) The HOSC is requested to consider and note the items within the proposed Work Programme and to suggest any additional topics to be considered for inclusion on the agenda of future meetings.

2. Recommendation

The Health Overview and Scrutiny Committee is asked to consider and note the report.

Background Documents

None

Contact Details

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Work Programme - Health Overview and Scrutiny Committee

1. Items scheduled for upcoming meetings

28 March 2023		
Item	**Item background**	**Substantial Variation?**
Maidstone & Tunbridge Wells NHS Trust - Clinical Strategy Overview	To receive updates on the Trust's clinical strategy and determine on an individual basis if the workstreams constitute a substantial variation of service. The following items have been to the Committee and not deemed to be substantial: Cardiology Services, Digestive Diseases Unit.	TBC
Edenbridge Health and Wellbeing Centre	To receive an update from KCHFT on provision of the service.	-
Integrated Care Board – update on first 6 months	To receive an update on the early stages of ICB implementation.	-
Urgent Care Review Programme - Swale	Following the meeting on 2 March 2022, the Chair invited future updates on the transformations and related public communications.	No

2. Items yet to be scheduled

Item	Item Background	Substantial Variation?
Burns service review	To receive information about a review of burns services by NHS England Specialised Commissioning	TBC
Podiatry Services	To receive an update on the service following its relocation.	No
Maidstone and Tunbridge Wells NHS Trust - Mortuary Security	To receive the Trust's reaction to Sir Jonathan Michael's report following its publication.	No

Transforming mental health and dementia services in Kent and Medway	To receive information about the various workstreams under this strategy.	TBC
Ophthalmology Services (Dartford, Gravesham, Swanley)	To receive updates about the long term provision of the service.	No
Capital investment at QEQM Hospital Maternity Unit	Member's have asked to receive information about future capital investment in the maternity ward.	-
HASU implementation	To receive updates on the implementation of Hyper Acute Stroke Units.	-
Nurse recruitment	Members have asked to be kept informed on the progress with recruitment and retention of nurses in the acute sector.	-
Delayed discharges from acute hospitals	Members have asked to understand what action is being taken locally to combat delayed discharges from hospitals.	-
Orthotic Services and Neurological Rehabilitation	To receive information on the provision of these services in Kent for adolescents. (This was a member request).	-
School immunisation amongst the Gypsy, Roma and Traveller communities	To understand the outcomes of a project by KCHFT to increase vaccine uptake and reducing inequalities amongst the GRT community.	

3. Items that have been declared a substantial variation of service and are under consideration by a joint committee

Kent and Medway Joint Health Overview and Scrutiny Committee NEXT MEETING: TBC		
Item	**Item Background**	**Substantial Variation?**
Transforming Health and Care in East Kent	Re-configuration of acute services in the East Kent area	Yes