HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Thursday, 29th February, 2024

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Thursday, 29th February, 2024, at 10.00 am
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Kay Goldsmith**
Telephone: **03000 416512**

Membership

Conservative (10):	Mr P Bartlett (Chair), Mr P V Barrington-King, Sir Paul Carter, CBE, Mr N J D Chard, Mrs P T Cole, Ms S Hamilton (Vice-Chairman), Mr A Kennedy, Mr J Meade, Mrs L Parfitt-Reid and Ms L Wright
Labour (1):	Ms K Constantine
Liberal Democrat (1):	Mr R G Streatfeild, MBE
Green and Independent (1):	Mr S R Campkin
District/Borough Representatives (4):	Councillor P Cole, Councillor H Keen, Councillor S Mochrie-Cox and Councillor K Moses

UNRESTRICTED ITEMS

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

Item		Timings*
1.	Membership	
2.	Substitutes	
3.	Declarations of Interests by Members in items on the Agenda for this meeting.	
4.	Minutes from the meeting held on 7 December 2023 (Pages 1 - 12)	
5.	Revisions to the Terms of Reference of the Health Overview and Scrutiny Committee (HOSC) (Pages 13 - 26)	
6.	East Kent Hospitals - financial performance update (Pages 27 - 32)	10:10
7.	Specialist Children's Cancer Services (Pages 33 - 68)	10:30

8. Kent and Medway Children and Young People's Mental Health Services procurement (Pages 69 - 124) 10:55

9. HASU implementation (Pages 125 - 138) 11:15

10. Child and Adolescent Mental Health Services (CAMHS) tier 4 provision (Pages 139 - 144) 11:35

11. Work Programme (Pages 145 - 148)

12. Date of next programmed meeting – 23 April 2024

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

21 February 2024

KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Thursday, 7 December 2023.

PRESENT: Mr P Bartlett (Chair), Mr P V Barrington-King, Sir Paul Carter, CBE, Mr N J D Chard, Mrs P T Cole, Ms S Hamilton (Vice-Chairman), Mr A Kennedy, Mr J Meade, Mrs L Parfitt-Reid, Mr S R Campkin, Ms K Constantine, Cllr P Cole and Cllr S Mochrie-Cox

ALSO PRESENT VIRTUALLY: Mr R G Streatfeild, MBE, and Cllr H Keen

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

UNRESTRICTED ITEMS

149. Membership
(Item 1)

The Clerk noted that Sir Paul Carter had replaced Mrs Bruneau on the Committee. Mrs Wright was no longer a committee member.

150. Declarations of Interests by Members in items on the Agenda for this meeting.
(Item 3)

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

2. Cllr Mochrie-Cox declared that he was a representative of North Kent councils on the Integrated Care Partnership.

3. Cllr Cole declared he was on the West Kent and Tunbridge and Malling Integrated Care Board Partnership Forums and the West Kent Elected Members Forum.

4. Mr Chard declared that he was the Director of Engaging Kent.

5. Mr Kennedy declared that he had been appointed to the Board of Directors of The Health and Europe Centre.

151. Minutes from the meeting held on 5 October 2023
(Item 4)

RESOLVED that the minutes of the meeting held on 5 November 2023 were a correct record and they be signed by the Chair.

152. Kent and Medway cancer screening programmes
(Item 5)

Dr Faiza Khan, Consultant in Public Health Medicine, NHS England (South East) and David Selling, Head of Public Health (Kent, Surrey and Sussex), NHS England were in virtual attendance for this item.

1. Dr Khan provided a brief overview of the report including:
   1.1. There was a programme for genetic screening and additional capacity was being created in Kent and Medway to screen patients with genetic indicators such as Autoimmune lymphoproliferative syndrome (ALPS).
   1.2. Waiting times were an issue due to the increasing number of referrals, especially for colonoscopy and endoscopy, also bowel screening had been extended to younger age groups which meant that more people were being referred to the service.
   1.3. It was said that endoscopy services were particularly under pressure and work was ongoing to develop a fit test before referring to endoscopy services.

2. The Chair advised that Members could request any specific data they would like to receive via the clerk.

3. A Member raised concerns that a gender-based difference in outcomes was apparent and that without raising staffing levels the backlog would not come down.

4. Asked about the cervical screening mislabelling referred to in the report, Dr Khan said that if data such as surname or birth date was incorrect the laboratory would reject the sample. It was noted that the issue was national, and work was ongoing with the laboratories and primary care providers to minimise the instances of mislabelling and rejections. Individuals whose samples were rejected could get re-screened after 3 months. Dr Khan noted that when self-sampling is introduced it would likely reduce mislabelling errors as women would be more likely to complete their own details correctly.

5. A Member asked for further information on why cervical cancer screenings had seen a year-on-year drop over the past 10 years, while breast cancer screening had remained steady. It was noted that an uplift had been seen nationally between 2019-20 and 2021-22 but not in Kent. Dr Khan said that research had examined why cervical cancer screenings had dropped and several reasons had been identified including Covid-19, availability of screenings outside working hours, embarrassment, and lack of confidence in the sampling. It was noted that the process of screening had changed, and there was a now a two-stage process (HPV testing followed by cytology when there was a positive reading) which some women perceived as less accurate (which was not the case). Two projects were underway: the first was to offer more appointments outside of working hours and the second was researching barriers to cervical screening in the Gypsy, Roma and Traveller (GRT) communities. It was noted that the latest performance statistics (2022-2023) showed an improvement in the number of breast cancer screenings within the target timescale. Going forward staff recruitment and retention remained an issue. Mr Selling gave further details of upcoming work and research to support and encourage the uptake of cancer screenings. One such

project was increasing the use of text messages to remind women of their upcoming appointment and asking them for feedback if they failed to attend.

6. Mr Selling agreed to provide additional data in a future briefing on the forecasting and benchmarking of cancer targets against Key Performance Indicators (KPIs).

7. A Member asked about the communication process and follow-ups if individuals missed or did not respond to a breast cancer screening appointment. Dr Khan advised that smart screening was used in the breast cancer unit, which meant appointment slots were overbooked based on the probability of a number of patients not attending. Mixed appointments (fixed time versus wider time slot) were offered for convenience, and reminder texts sent out. 'Did Not Attend' (DNA) rates had reduced accordingly.

8. Mr Selling said work had been ongoing with Royal Mail to prioritise bowel screening samples sent via post and these were now being flagged as priority. The situation with delayed samples had stabilised in the last 6 months but was being closely monitored. He also noted that people were sensitive to traveling distance, and that the mobile units for breast cancer screenings reduced the risk of DNAs.

9. A Member asked for more detail on the use of text messaging, Mr Selling agreed to provide further information outside of the meeting.

10. The Chair asked for a written briefing on the outstanding questions to be provided at a future meeting.

11. RESOLVED that the Health Overview and Scrutiny Committee note the report.

153. East Kent Hospitals University NHS Foundation Trust - Maternity Services *(Item 6)*

Sarah Hayes, Chief Nursing and Midwifery Officer, Adaline Smith, Deputy Director of Midwifery and Tash Curtiss, Consultant in Obstetrics and Gynaecology were in virtual attendance for this item.

1. The guests provided an overview of the report. The Chair referenced an informal briefing held in October 2023 and noted that he had written to the Secretary of State, Victoria Atkins MP, on 14 November 2023 about capital funding constraints and would inform the committee when there was a response.
   1.1. The Singleton Midwife-led Unit at William Harvey Hospital was re-opening on 15 December 2023 after being closed for 3 years. This was a positive move for women, giving them more choice in their birthing options. All Members were invited to attend the opening with the details to be shared by the clerk. Improved facilities were also being opened for patients attending the triage service.
   1.2. A lot of work was being undertaken to listen to the views of women who would be or had already given birth at one of the East Kent Hospitals. The Maternity and Neonatal Voices Partnership alongside the Independent Senior Advocates would visit the maternity wards weekly to speak to women about their experiences.

1.3. There was a national target to reduce to stillbirth and neo-natal deaths by 50% by 2025 (from 2010 figures). East Kent had a 1.7 stillbirth rate per 1000 and 0.87 neonatal deaths per 1000.
1.4. Ms Curtiss acknowledged how well staff were working as a team, including across disciplines, and the positive effect this was having on culture. There was also increased co-production with women.

2. It was confirmed that the recently announced salary threshold for family visas did not apply to NHS workers. The committee would be updated if there were any further developments.

3. A Member asked to see more detail about stillbirths, including the role of health inequalities and variances in ethnicity data – this would be provided outside of the meeting. It was noted that such data helped the service target the most at-risk groups and drive improvements in care. Having been identified as a priority area, a Patient Voices Partnership had been appointed in East Kent to go into the community and support hard-to-reach women.

4. Asked about data on black and minority users of maternity services and the understanding of preventing any potential barriers to access, Ms Hayes said that there was work to do in this area but the data would be shared after the meeting.

5. In response to a question about training standards, Ms Hayes said that there were regular meetings with the Nursing and Midwifery Council (NMC) regarding placements. William Harvey Hospital welcomed the return of student midwives, with students from the University of Surrey on site. The chief nurses in Kent and Medway were working to re-establish links with Canterbury Christchurch University, and the progress was positive so far.

6. Much work was underway in relation to providing compassionate care. There had been a lot of positive feedback but there were still issues to be addressed. A patient experience midwife had been recruited and every woman who had used the maternity service would get a phone call 6-weeks after the birth to share their experiences. Support was in place for staff as well. The most recent Your Voice is Heard data showed that 92% of women would return to East Kent services and there would be a follow-up with those dissatisfied.

7. On governance, it was noted that there had been recommendations from the Care Quality Commission (CQC) on board oversight, which had been strengthened since. There had been a full review of governance across the department. Within the complaint response process, it was noted that families were invited to provide input on the report if one was required after an incident and face-to-face meetings were being arranged before the sending of a full written response.

RESOLVED that the Health Overview and Scrutiny Committee note the report

154. Kent and Medway People Strategy 2023 - 2028
(Item 7)

Rebecca Bradd, Chief People Officer, Kent & Medway Integrated Care Board was in attendance for this item.

1. Ms Bradd introduced and gave an overview of the report. The Kent and Medway People Strategy would complement local NHS organisation strategies, not replace them, and support the delivery of shared priorities.

2. A Member noted a lack of detail about engagement with staff, but Ms Bradd assured the Committee that there had been significant engagement with staff through the staff survey which engaged the entire workforce, as well as working groups sitting alongside the leadership team. In addition, all new starters were spoken to within their first year to understand their experiences and learn lessons to inform and prevent further instances of people leaving within their first year.

3. The Committee reflected on the cost-of-living crisis and its impact on recruitment and retention. Ms Bradd said that was recognised by the ICB as a major challenge and it was working with the Integrated Care Partnership and wider partners to develop plans. The Chair said that elected members had a role in supporting the provision of affordable housing within their divisions, and the Council had a role in ensuring the provision of quality childcare and education places. Dr Rickard (LMC) said that the GP attraction package pilot had been well received and the Committee asked for an update on this.

4. Members noted the importance of affordable housing and felt the provision of suitable housing options for the NHS workforce and other key workers needed to be a priority.

5. Dr Rickard said that Kent Local Medical Committee (LMC) data had shown that 44% of General Practices had stopped advertising vacancies due to estates and financial uncertainty. It was also noted that GPs faced difficulty in organising training for new staff. Ms Bradd said they did not hold data on primary care vacancy and turnover rates, but they had been working with local practices to understand their workforce needs. It was said that the focus had been on attraction and retention through the primary care training hub. Practices had been supported in becoming tier 2 employers and 30 practices were hiring Kent Medical School students.

6. Answering a question about staff involvement and attitudes, Ms Bradd said Trade Union representatives would be involved in the formation of local people plans. The ICB did not hold data on grievance complaints, staff disciplinaries or employment tribunals and these would be held at Trust level.

7. A Member said that there needed to be more communication with the public about the impact on GP provision of a growing population. They also felt there needed to be greater explanation of the different clinical roles on offer from surgeries. The Chair added that the NHS must be clearer on how population growth arising from new housing developments would impact their services and adequately reflect these in Local Plan discussions. Ms Bradd said she would take these points away.

8. A member sought further clarification on education and training. Ms Bradd said that the workforce already had a diverse range of skills and expertise and that

the education of new trainees would address future skills gaps (such as the use of artificial intelligence).

9. RESOLVED that the Health Overview and Scrutiny Committee note the People Strategy.

155. Maidstone and Tunbridge Wells NHS Trust - mortuary security
(Item 8)

Miles Scott, CEO Maidstone & Tunbridge Wells NHS Trust and Rachel Jones, Executive Director Strategy, Planning & Partnerships, Maidstone & Tunbridge Wells NHS Trust were in attendance for this item.

1. Mr Scott reiterated his apologies to the families affected by David Fuller's crimes and reassured the committee that support had been put in place for those families, and that the Trust's commitment to them was ongoing and open-ended. He provided an overview of the situation which lead to an independent inquiry chaired by Sir Jonathan Michael. The inquiry published its first report on 5 December 2023, looking at what happened in the mortuary at Tunbridge Wells Hospital. The second report would consider the wider implications for the NHS, public bodies and society. It was noted that the report had 17 recommendations, 16 for the Trust and 1 for Kent County Council and East Sussex County Council. Mr Scott confirmed that the Maidstone & Tunbridge Wells NHS Trust had accepted all the recommendations and that 11 had already been fully implemented, with the remaining 5 currently being worked on. All recommendations were expected to be implemented by March 2024 at which time they would return to the committee.

2. A Member asked how the Trust could foster greater professional curiosity. Mr Scott said that professional curiosity had to be part of the organisation's culture, as policies and procedures were not, in themselves, enough. Staff and managers had to be prepared to think the unthinkable.

3. A Member said there needed to be a culture where staff were encouraged to raise concerns and that the organisation would listen and investigate the concerns. Mr Scott agreed with the statement and noted that in this case no suspicions were ever raised despite numerous organisational changes and staff turnover.
4. It was asked if there could ever be adequate oversight considering the size and complexity of the Trust. Mr Scott acknowledged the concern and responded that policies and culture both needed to be right, with the leadership leading by example and engaging with staff throughout the Trust.

5. The Committee considered what could have prevented these crimes from taking place. CCTV had not originally been installed in the post mortem room so that distressing images could not be leaked. That had now been addressed, though the cameras were only pointed at fridge doors so bodies could not be removed and replaced without notice. Mr Scott did not think that Mr Fuller's contractual position with the Trust had significance because he had also committed offences whilst under the direct employment of the Trust. It was also the case that Mr Fuller had lied about having a criminal record and

once it was picked up on, no one questioned him about that. There was no evidence that any staff had raised suspicions about Mr Fuller. Mr Scott was not sure anything could have prevented Mr Fuller's crimes, and noted that such opportunistic crimes were not limited to hospital mortuaries (such points would be picked up in the second phase of the inquiry).

6. The Chair thanked Mr Scott and his team for their attendance and work on remedying the situation. The Chair said that the thoughts of the committee were with the families affected by the crimes committed at the Maidstone & Tunbridge Wells NHS Trust. The Chair invited Mr Scott to come back to the committee after the publication of the report from the second phase of the inquiry.

7. RESOLVED that the Health Overview and Scrutiny Committee note the response of the Trust to the interim inquiry report.

156. Maidstone & Tunbridge Wells Trust - Clinical Strategy - Repatriating Bariatric Care
(Item 9)

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

1. Ms Jones introduced and provided an overview of the report, which explained the repatriation of the surgical elements of bariatric care from London to Kent. It was noted that overall patient feedback had been positive with many compliments. One informal concern had been raised regarding confidentiality in the outpatient department and changes would be implemented to rectify that in early 2024.

2. A Member asked about the types of surgery delivered, including whether there would be a future switch of focus from weight loss surgeries to injectables such as Semaglutide. Ms Jones said she would respond after the meeting.

3. RESOLVED that the Health Overview and Scrutiny Committee note the report.

157. NHS Kent and Medway Community Services review and procurement
(Item 10)

Mark Atkinson, Director of system commissioning and operational planning, Kent & Medway Integrated Care Board and Ivor Duffy, Chief Finance Officer, Kent & Medway Integrated Care Board were in attendance for this item.

1. Mr Atkinson introduced the report, explaining that the ICB had reviewed procurement options for Community Services following HOSC and HASC meetings in September. It was noted that specialist commissioning support had been sought from Arden&GEM and they had also sought legal support and guidance over the decisions taken. Mr Atkinson noted the upcoming winter period, combined with industrial action, which would cause operational challenges and likely result in some operational deadlines being pushed back. The NHS Provider Selection Scheme was due to come into practice in

January 2024 which would drive commissioning projects going forward. Mr Atkinson also noted that they were working with provider Chief Executives and Ben Watts, Monitoring Officer KCC, on the statement of concern made by the HOSC Chair in October.

2. Mr Atkinson said that following the comments made at HOSC and HASC a new contract extension would be made to the three existing community providers for up to two years with a six-month break clause. The additional time would allow for harmonisation of contracts while further engagement was undertaken with providers, stakeholders and patients to develop the new models of care and ensure the right services were offered in the right locations. It was noted that due to the change in commissioning approach the contractual obligation on the providers to transform would no longer be there however the ICB were working alongside those providers to begin transformation over the coming two years as per NHS England's expectations for community services.

3. A Member welcomed the change of approach and asked that the proposals on the future service return to the committee at the appropriate time so that a new decision could be made on whether they constituted a substantial variation of service. Mr Atkinson agreed and committed to keeping the committee fully engaged. Mr Duffy said that the transformation complied with the national guidance.

4. RESOLVED that the Health Overview and Scrutiny Committee note the report and invite colleagues from the Integrated Care Board to provide an update at the appropriate time.

158. Kent and Medway children and young people's mental health services procurement
(Item 11)

Sue Mullin, Associate Director for Children's Mental Health, Kent & Medway Integrated Care Board and Jane O'Rourke, Director of Children's Services, Kent & Medway Integrated Care Board were in attendance for this item.

1. Ms O'Rourke introduced the report and provided a summary of the procurement and engagement process. She referred to a pre-engagement event (which the Chair had attended) as well as an event attended by over 200 children. The Chair asked that the entire committee be invited to a future pre-market engagement event.

2. A Member noted that there was very high demand for mental health support amongst young people and getting them the care they needed could be difficult. Ms Mullin said that the ICB were looking at alternatives to clinical support, such as commissioning a UASC youth group. There were challenges with early intervention and prevention and those services would be actively targeted going forward. Ms Mullin recognised the importance of voluntary and community groups and the 13-year commitment proposed in the paper would provide long-term support to those organisations. Reducing waiting lists would be challenging but a collaborative approach would be hugely beneficial.

3. Prevalence data showed an increase from 18% to 20% over 12 months. Prevalence was a national statistic that looked at the 'possible' and 'probable' mental health disorder rate in children aged 8-16. In recent years the rate had increased significantly and more at-risk groups were identified such as adolescent girls. Prevalence and complexity had increased since the Covid-19 pandemic.

4. A Member said that although the quality of care was good, issues remained with capacity as many young people were unable to access the care they needed. They felt there was not parity of esteem between physical and mental health.

5. A Member said that much of the support was offered through schools but there needed to be an offer outside of school and in the community as part of a long-term commitment. Ms O'Rourke noted that there were several programmes in operation outside of this procurement including the introduction of 37 Children's Care Navigators across 41 primary care networks. She acknowledged more work in the community was needed, and the ICB were working with voluntary organisations to support this. Ms Mullin noted that internationally there was a lack of understanding about children's mental health, but a 13-year offer would move away from short termism and offer stability.

6. Ms Mullin said there was a robust digital offer delivered by Kooth which was used by a large number of young people, but it was only part of a wider offer that would be tailored to young people and children.

7. A Member reflected that the message about young people's mental health needed to be balanced, and she noted that there were alternative sources of support for young people, such as music and pet therapy. Ms O'Rourke confirmed the role of Care Navigators was to support young people to the appropriate type of care. To do this, they would look for innovative solutions, perhaps by using Personal Health Budgets. She assured the Committee they were in a strong position with education.

8. It was confirmed that at a future meeting information would be provided on the level and types of need, the gap between the level of demand and the resources available and the plan to address resulting capacity issues.

9. Mr Goatham (Healthwatch) complimented the ICB team for the engagement they had undertaken. Ms Mullin confirmed that parents and carers were a part of the engagement process to design the future of the services.

10. RESOLVED that the Health Overview and Scrutiny Committee note the report and invite colleagues from NHS Kent and Medway to return to a future meeting with more detail.

159. Kent and Medway Strategic Estates Plan
(Item 12)

Mike Gilbert, Executive Director of Corporate Governance, Kent & Medway Integrated Care Board was in attendance for this item.

1. Mr Gilbert introduced the report. It was noted that the NHS had historically been poor at working with district authorities around Section 106 funding but progress had been made and a robust team was now in place which worked closely with the districts. A more strategic approach would be taken on how to use Section 106 and Community Infrastructure Levy (CIL) funding in the future to ensure estates were built in the right way.

2. Mr Gilbert confirmed that all Section 106 funding would stay in the local community from which it was generated. There had to be a consistent approach on how the funding was used going forward, and if used effectively it would reduce revenue costs for the NHS.

3. A Member asked about the £250 million maintenance backlog and the £123 million backlog in East Kent maternity services and how this would look in 5-10 years. Mr Gilbert said that Section 106 funding would not be used to fund backlog maintenance. It was noted that all providers were required to have rolling 3-year plans on how they would manage their backlog maintenance. However, funding from NHS England for backlog maintenance was not sufficient for the level of need. A prioritisation programme would be implemented to identify and channel funds to the most critical areas. Mr Gilbert said that the £250 million was unlikely to fall as the level of demand would only increase but the most critical issues would be dealt with.

4. Members spoke about the impact of new housing developments on public services.
   4.1. The planned new facility at Greenhithe was due to open in 2025 though did not yet have planning permission. Negotiations were ongoing and they were close to submitting the application.

   4.2. In Ebbsfleet, a strategic outline business case was going through the final stages of ICB approval and was due to be published in the new year, and it would set out what the requirements and gaps were. A mixture of capital and revenue funding would be available for health and community services.

5. Dr Rickard noted that the results of a recent LMC survey showed many GP practices were frustrated and confused about the complicated and protracted processes in place for GP expansion. They also reported that they were unable to access Section 106 funding and were concerned by the developments going on in their areas.

6. RESOLVED that the Health Overview and Scrutiny Committee note and the Strategic Estates Plan.

160. East Kent Transformation Programme
(Item 13)

1. The Chair provided the background to the report and the reason behind the Kent and Medway NHS Joint Overview and Scrutiny Committee's (JHOSC) decision to return formal scrutiny of future East Kent transformation proposals to Kent HOSC and Medway HASC.
2. There were no questions.

RESOLVED that the Health Overview and Scrutiny Committee:

1. Note the decision of the Kent and Medway NHS Joint Overview and Scrutiny Committee to return formal scrutiny of the East Kent Transformation of the Kent HOSC and Medway HASC.

2. That colleagues from the NHS Kent and Medway and EKHUFT be invited to return to the Committee with amended proposals once available.

161. Work Programme
(Item 14)

1. Members proposed items that the committee could consider at future meetings:
   1.1. An update from South East Coast Ambulance Service (SECAmb).
   1.2. A paper about how local NHS bodies are reducing waste and becoming greener.

2. RESOLVED that the Work Programme be noted.

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From: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 29 February 2024

Subject: Revisions to the Terms of Reference of the Health Overview and Scrutiny Committee (HOSC)

Status: Unrestricted

Future Pathway: Selection and Member Services Committee; County Council.

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1. Introduction

a) Using powers introduced by the Health and Care Act 2022, two sets of regulations were introduced by the government on 9 January 2024[1]. The cumulative impact is to:

1. Remove the power from local authority health scrutiny to refer substantial variations of service being proposed by the NHS to the Secretary of State.
2. Introduce new powers of ministerial intervention in proposed variations of service by local NHS organisations.

b) These changes came into effect on 31 January 2024. The terms of reference of the Health Overview and Scrutiny Committee (HOSC) needs to be amended to take these changes into account.

c) In addition, the government set out five principles for health overview and scrutiny committees in July 2022[2]. This provides an opportunity to incorporate these into the terms of reference (the new section 17.138).

2. Proposed Changes

a) While the power of referral has been removed, the duty on NHS organisations to consult with HOSC on substantial variations to services impacting the population of Kent remains. The powers to obtain information and have NHS officers attend meetings of HOSC remain to support the Committee in its work scrutinising the planning, provision, and operation of health services. HOSC will also continue to have a mechanism to receive referrals from Healthwatch.

b) It continues being the case that there is a requirement to form a Joint Health Overview and Scrutiny Committee (JHOSC) where more than one local authority has deemed a proposal a substantial variation of service. However, there is a

[1] The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) (Amendment and Saving Provision) Regulations 2024 and The National Health Service (Notifiable Reconfigurations and Transitional Provision) Regulations 2024.

[2] https://www.gov.uk/government/publications/health-overview-and-scrutiny-committee-principles/health-overview-and-scrutiny-committee-principles

need to amend the current generic rules on JHOSCs in the constitution to take account of the other changes (the revised sections are 17.159-161 as shown in the Appendix)

c) There is also a terms of reference in place for the occasions when a JHOSC needs to be formed with Medway Council. This will be reviewed in consultation with Medway Council and proposed changes, if necessary, will be presented at a future date.

d) Along with the changes brought by legislation, the opportunity has been taken to update a few sections of the terms of reference for clarity. The proposed changes are marked up and set out in the Appendix.

3. The Call-in Power

a) The Health and Care Act 2022 introduced a new call-in power which allows the Secretary of State to intervene in local NHS service reconfigurations at any stage. Statutory guidance has been released which covers the use of these intervention powers.[3]

b) In sum, NHS organisations are required to notify the Secretary of State when they are proposing a significant change to services. It is expected that only a small number of proposals will be subject to a ministerial call-in and possible intervention. Making a notification to the Secretary of State is the sole responsibility of the relevant NHS organisation (usually the NHS commissioner), however, the HOSC's views on whether a proposal has been judged a substantial variation of service will be taken into account by the NHS body and will be reported to the Secretary of State.

c) Under the previous regulations, it was only local authority health scrutiny committees which could make a referral to the Secretary of State. Ministerial intervention powers are different and the ability to submit call-in requests that these powers be used are open to any interested individual or organisation.

d) HOSC will be able to submit a formal call-in request. The expectation from government is that the call-in request form is only used as a last resort and only when all attempts at local resolution have failed. The revised terms of reference reflect and build on the statutory guidance to set a framework for how the Committee will approach making call-in requests so there is clarity for Members and for the NHS.

e) Where the Secretary of State is considering a call-in request, the HOSC may be asked for information. Where a decision has been made by the Secretary of State to intervene, a decision letter will be issued. This letter may require that the consultation underway with the HOSC is paused pending the outcome of the intervention. This is also covered by the draft revised terms of reference.

[3] https://www.gov.uk/government/publications/reconfiguring-nhs-services-ministerial-intervention-powers/reconfiguring-nhs-services-ministerial-intervention-powers#the-power-to-call-in-a-reconfiguration-proposal

f) It is unclear how the ministerial intervention powers will be used in practice, and what the experience of health scrutiny committees in making call-in requests will be. The terms of reference will be reviewed periodically to ensure that they remain fit for purpose and in line with any updated guidance from the government.

4. Membership and Conflicts of Interest

a) The section setting out that no HOSC member can be an Executive Member of KCC, or on the Kent Health and Wellbeing Board has been made clearer.

b) Using the examples set out in the government guidance on health scrutiny, some examples of potential conflicts of interest are set out as a reminder to members.

5. Recommendation

The Health Overview and Scrutiny Committee is asked to:

a) Discuss and Comment on the report.
b) Request that the Selection and Member Services Committee discuss the proposed changes to the terms of reference of the Health Overview and Scrutiny Committee and consider recommending to County Council that the changes be adopted.

6. Background Documents

Department of Health and Social Care, Guidance – Local authority health scrutiny, as updated 9 January 2024: https://www.gov.uk/government/publications/advice-to-local-authorities-on-scrutinising-health-services/local-authority-health-scrutiny

Department of Health and Social Care, Statutory guidance – Reconfiguring NHS services – ministerial intervention powers, as published 9 January 2024: https://www.gov.uk/government/publications/reconfiguring-nhs-services-ministerial-intervention-powers

Department of Health and Social Care, Guidance – Health overview and scrutiny committee principles, as published 29 July 2022: https://www.gov.uk/government/publications/health-overview-and-scrutiny-committee-principles/health-overview-and-scrutiny-committee-principles

The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, https://www.legislation.gov.uk/uksi/2013/218/contents/made

The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) (Amendment and Saving Provision) Regulations 2024, https://www.legislation.gov.uk/uksi/2024/16/contents/made

The National Health Service (Notifiable Reconfigurations and Transitional Provision) Regulations 2024, https://www.legislation.gov.uk/uksi/2024/15/contents/made

7. Report Author and Relevant Director

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Health Overview and Scrutiny Committee (HOSC) – **PROPOSED NEW TERMS OF REFERENCE**

17.133 Membership: 13 Members; plus, Borough/District Council representatives: 4.

17.134 None of the following may be a Member of HOSC, or any Sub-Committee or Task and Finish Group of it:

(a) An Executive Member of Kent County Council.
(b) A member of the Kent Health and Wellbeing Board.
(c) A member of any Joint Health and Wellbeing Board on which Kent County Council is represented.

17.135 The membership exclusions set out in 17.134 also apply to any Joint Health Overview and Scrutiny Committee established with any other authority or authorities.

17.136 Where there is a risk of a member of the Committee having a conflict of interest, the appropriate rules and guidance must be followed. Examples of potential conflicts of interest include the member being:

(a) An employee of an NHS body.
(b) A member or non-executive director of an NHS body.
(c) An executive member of another local authority.
(d) An employee or board member of an organisation commissioned by an NHS body or local authority to provide services.

17.137 This Committee reviews and scrutinises matters relating to the planning, provision and operation of health services in Kent through exercising the powers conferred on Kent County Council under Section 244 of the National Health Service Act 2006 (as amended)and operates according to Part 4 of The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 (as amended). The Committee may consider and scrutinise the work of the Health and Wellbeing Board where relevant.

17.138 The Committee will work with the NHS and other local system partners in accordance with the following principles:

(a) Outcome focused.
(b) Balanced.
(c) Inclusive.
(d) Collaborative.
(e) Evidence informed.

17.139 This Committee is responsible for setting its own work programme, giving due regard to the requests of commissioners and providers of health services to bring an item to the Committee's attention, as well as taking into account the referral of issues by Healthwatch and other third parties.

17.140 This Committee cannot consider or handle individual complaints relating to health services. Individuals will be asked to use the complaints process of the relevant organisation.

17.141 Task and Finish Groups may be established with the approval of the Committee, in order to consider issues in more depth and can include elected representatives from KCC or Borough/City/District Councils in Kent who are not members of the Committee. Task and Finish Groups cannot exercise any formal health scrutiny powers.

17.142 Commissioners and providers of local health services are required to provide the Committee with such information as it may reasonably require in order to discharge its relevant functions.

17.143 The Committee may require any member or employee of a local health service commissioner or provider to appear before the Committee to answer such questions as are necessary for discharging its relevant functions.

17.144 Nothing in 17.142-143 requires the provision of any information where the disclosure is prohibited under any enactment or where a living individual would be identifiable, subject to Section 26 of the 2013 Regulations.

17.145 Healthwatch shall have the right to refer issues to the Committee:

HOSC: Healthwatch

(a) Issues referred by Healthwatch will receive an acknowledgment within 20 working days and Healthwatch will be kept informed of any actions taken.

(b) Where the Committee includes an item on its agenda as a result of a referral from Healthwatch, a representative from Healthwatch is entitled to address the Committee.

Reports and Recommendations

17.146 The Committee may make evidence-based reports and recommendations to relevant NHS bodies and require a response within 28 days, or longer at the Committee's discretion. The following information will be included in a report or accompanying any recommendations:

(a) An explanation of the matter reviewed or scrutinised.
(b) A summary of the evidence considered.
(c) A list of the participants involved in the review or scrutiny.
(d) An explanation of any recommendations on the matter reviewed or scrutinised.

Substantial Variations of Service

17.147 NHS commissioners and providers are required to consult with the HOSC on proposed substantial variations of services affecting the population of the area. Exclusions from the definition of 'substantial variations of service are set out at 17.151-152.

17.148 The Committee will determine whether any given proposal, or element thereof, constitutes a substantial variation of service and so requires consultation with the Committee. The Committee's decision will be based on information provided by the relevant NHS organisations.

17.149 Once the Committee has deemed a proposal a substantial variation of service, the NHS shall consult with the Committee prior to the final decision being made by the NHS. A timetable for consultation will be agreed between the Committee and NHS, with the NHS informing the Committee of the date on which they intend to make their final decision.

17.150 In considering substantial variations of service, the Committee will take into account the resource envelope within which the relevant NHS organisations operate and will therefore take into account the effect of the proposals on the sustainability of services, as well as on their quality and safety. The NHS must take the comments of the Committee into account when making its final decision.

17.151 The NHS is not required to consult with the Committee where the NHS has acted because of a risk to patient safety or to ensure the welfare of patients or staff. Where this has been the case, the Committee shall be informed as soon as possible.

17.152 In addition, the designation of 'substantial variation of service' will not apply in the following circumstances:

(a) Establishment, dissolution, or change to the constitution, of an NHS Trust or Integrated Care Board. However, any consequential service variation may be determined a 'substantial variation of service' in line with usual Committee practice.

(b) Any proposals contained in a Trust Special Administrator's report or draft report and any recommendations made under a health special administration order.

Call-in Requests

17.153 Schedule 10A to the NHS Act 2006 provides call-in powers to allow the Secretary of State to intervene in NHS service reconfigurations at any stage. Individuals and organisations, including this Committee, may submit requests that the Secretary of State exercise these powers of intervention in a specific reconfiguration.

17.154 This Committee will not submit, or support, a call-in request until it has determined that all attempts to resolve its concerns about the reconfiguration

with the NHS locally have been exhausted. Where a call-in request is made by this Committee, evidence of these attempts will be provided.

17.155 Any call-in request by this Committee will be submitted in accordance with the requirements set by the Secretary of State, with the content of any request agreed by the Committee.

17.156 The Committee will give the relevant NHS organisations a minimum of 15 days notice that the Committee will be meeting to determine whether or not to submit a call-in request.

17.157 A call-in intervention will commence when the Secretary of State issues a direction letter to the relevant NHS organisations. Where the direction letter relates to a substantial variation of service which is under review by this Committee under 17.147, the consultation will pause if required by the letter.

17.158 Notwithstanding 17.157, when there is a call-in, the relevant NHS bodies may provide the Committee with information to allow the Committee to make representations to the Secretary of State on the proposal which is the subject of the intervention.

Joint Health Overview and Scrutiny Committees (JHOSCs)

Joint Health Overview and Scrutiny Committees (JHOSCs)

17.159 Where the relevant Overview and Scrutiny Committee of more than one authority has determined the same proposal(s) to be a substantial variation of service, this will entail the establishment of a Joint Health Overview and Scrutiny Committee (JHOSC). A Kent and Medway JHOSC has been established on a permanent basis to meet when required (19.38-47).

17.160 Where a JHOSC has been established, the Kent HOSC is deemed to have delegated its function to scrutinise the specific proposal(s) to the JHOSC. The formal powers of HOSC as set out at 17.142-144 are also delegated in connection with the proposal. However, with the agreement of the relevant NHS organisation(s), the HOSC may continue to receive updates while the JHOSC undertakes its review.

17.161 At any stage during its review, and at its conclusion, the JHOSC may make reports and recommendations to the authorities represented on the JHOSC. These recommendations will be reported to a meeting of the Kent HOSC. The Kent HOSC is not required to accept these recommendations but may do so.

*Health Overview and Scrutiny Committee (HOSC) – **CURRENT TERMS OF REFERENCE***

17.133 Membership: 13 Members; plus, Borough/District Council representatives: 4.

17.134 No Executive Member, Member of the Kent Health and Wellbeing Board or the Kent and Medway Joint Health and Wellbeing Board shall be a Member of this Committee, or of any Sub-Committee or Informal Member Group of it, or of any Joint Health Overview and Scrutiny Committee established with any other authority or authorities.

17.135 This Committee reviews and scrutinises matters relating to the planning, provision and operation of health services in Kent through exercising the powers conferred on Kent County Council under Section 244 of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) and operates according to Part 4 of The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

17.136 This Committee is responsible for setting its own work programme, giving due regard to the requests of commissioners and providers of health services to bring an item to the Committee's attention, as well as taking into account the referral of issues by Healthwatch and other third parties.

17.137 This Committee cannot consider individual complaints relating to health services.

17.138 Informal Member Groups may be established with the approval of the Committee, in order to consider issues in more depth and can include elected representatives from KCC or Borough/City/District Councils in Kent who are not members of the Committee. Informal Member Groups cannot exercise any formal health scrutiny powers.

17.139 Commissioners and providers of local health services are required to provide the Committee with such information as it may reasonably require in order to discharge its relevant functions.

17.140 The Committee may require any member or employee of a local health service commissioner or provider to appear before the Committee to answer such questions as are necessary for discharging its relevant functions.

17.141 Nothing in 17.139-140 requires the provision of any information where the disclosure is prohibited under any enactment or where a living individual would be identifiable, subject to Section 26 of the 2013 Regulations.

17.142 Healthwatch shall have the right to refer issues to the Committee.

HOSC: Healthwatch

17.143 Issues referred by Healthwatch will receive an acknowledgment within 20 working days and Healthwatch will be kept informed of any actions taken.

17.144 Where the Committee includes an item on its agenda as a result of a referral from Healthwatch, a representative from Healthwatch is entitled to address the Committee.

17.145 The Committee may make evidence-based reports and recommendations to relevant NHS bodies and require a response within 28 days, or longer at the Committee's discretion.

17.146 NHS commissioners and providers are required to consult with the HOSC on potential substantial variations of services affecting the population of the area covered by the Committee unless 17.147 applies.

HOSC: Substantial Variations of Services

17.147 The exception referred to in 17.146 is where the NHS has acted because of a risk to patient safety or to ensure the welfare of patients or staff. Where this has been the case, the Committee shall be informed as soon as possible.

17.148 The Committee will determine whether any given proposal, or element thereof, constitutes a substantial variation of service. However, the designation of 'substantial variation of service' will not apply in the following circumstances:

(f) Establishment, dissolution, or change to the constitution, of an NHS Trust or Clinical Commissioning Group. However, any consequential service variation may be determined a 'substantial variation of service' in line with usual Committee practice.

(g) Any proposals contained in a Trust Special Administrator's report or draft report and any recommendations made under a health special administration order.

17.149 Where the Committee has decided a proposal does not constitute a substantial variation of service it retains the ability to review the proposed change and can make reports and recommendations on the matter to the relevant health commissioner or provider. Where the NHS changes the proposal, the Committee may reconsider whether or not it deems the proposal a substantial variation of service.

17.150 Once the Committee has deemed a proposal a substantial variation of service, the NHS shall consult with the Committee prior to the final decision being made by the NHS. The NHS always remains the decision-maker though must take comments of the Committee into account.

17.151 When the NHS has determined when it will make a final decision on the proposal for a substantial variation of service, this date shall be communicated to the Committee. Sufficient time shall be allowed by the NHS for the Committee to make comments on the proposed decision ahead of this date unless 17.147 applies.

17.152 The final decision referred to in 17.151 is to be formally presented at a meeting of the Committee as soon as is practical after it has been taken by the NHS. The Committee will determine its response to the decision and may support the decision, not support the decision, and/or comment on the decision.

17.153 Where the Committee does not support the decision at the meeting referred to in 17.152, the Committee may consider referral to the Secretary of State but cannot make a final decision on referral at this meeting. No referral may be proceeded with unless the Committee agrees at this meeting which of the grounds in 17.154 provisionally apply and agrees the reasons why.

17.154 A substantial variation of service may only be referred to the Secretary of State for Health and Social Care where one of the following applies:

(a) The consultation with the Committee on the proposal is deemed to have been inadequate in relation to content or time allowed,

(b) The reasons given for not consulting with the Committee on a proposal are inadequate, or

(c) The proposal is not considered to be in the interests of the health services of the area.

17.155 In the event of a decision by the Committee under 17.153 that one or more of the grounds for referral set out in 17.154 provisionally apply:

(a) The decision of the Committee made at the meeting held under 17.152 must be communicated to the NHS in writing as soon as possible after the meeting to allow the NHS time to consider and respond to the decision of the Committee.

(b) The Committee shall inform the NHS of the date when it will meet to make a final determination as to whether or not to refer the substantial variation of service to the Secretary of State in line with regulations within eight working days of the meeting held under 17.152. This meeting of final determination shall be held as soon as practicable, subject to a minimum of twenty working days after the meeting held under 17.152.

17.156 All practical steps shall be taken by the NHS and Committee to come to an agreement between the meeting held under 17.152 and the one at which the Committee will make a final determination on referral, the date for which is set under 17.155(b).

17.157 Prior to any final determination on referral, the Committee shall consider the NHS response to the reasons set out under 17.153 at the meeting arranged under 17.155(b) along with the results on any other discussions between the Committee and NHS that may have taken place. The Committee will then make a final determination as to whether or not the matter is to be referred to the Secretary of State and may only do so when the Committee is satisfied the requirements of 17.154 and 17.158 apply.

17.158 Where the Committee makes a final determination to refer, the following apply:

(a) Any referral to the Secretary of State shall be accompanied by full evidence of the case for referral.

(b) 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.

(c) 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.

17.159 Where the Committee makes a final determination not to refer, the following apply:

(a) The HOSC can request updates on implementation of the service change, along with a response to any comments made in the Committee's final determination.

(b) Where the NHS makes significant changes to the decision presented to the Committee at the meeting of final determination, the Committee has the ability to deem this a substantial variation of service and require formal consultation with the Committee.

Joint Health Overview and Scrutiny Committees (JHOSCs)

Joint Health Overview and Scrutiny Committees (JHOSCs)

17.160 Where the relevant Overview and Scrutiny Committee of more than one authority has determined the same proposal(s) to be a substantial variation of service, this will entail the establishment of a Joint Health Overview and Scrutiny Committee (JHOSC). A Kent and Medway JHOSC has been established on a permanent basis to meet when required (19.38-47).

17.161 Where a JHOSC has been established, the Kent HOSC is deemed to have delegated its function to scrutinise the specific proposal(s) to the JHOSC until it has concluded its consideration and made any recommendations to the authorities represented on the JHOSC. These recommendations will be

reported to a meeting of the Kent HOSC. The Kent HOSC is not required to accept these recommendations but may do so.

17.162 The Kent HOSC at no time delegates the power of referral to any JHOSC.

17.163 Following the conclusion of the work of the JHOSC on a given proposal, the HOSC will make a final determination in line with the procedure set out in 17.152-159. No decision to refer may be made at the first meeting of the HOSC when the outcome of the JHOSC is considered as this will be the first occasion the HOSC has been able to consider the proposal formally and the NHS must be able to respond fully to any comments made by the HOSC.

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Item 6: East Kent Hospitals financial performance

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 29 February 2024

Subject: East Kent Hospitals financial performance

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by East Kent Hospitals University NHS Foundation Trust (EKHUFT).

It provides background information which may prove useful to Members.

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1) Introduction

a. HOSC has a remit to scrutinise the planning, provision and operation of health services in Kent – this may include scrutinising the finances of local health services. Representatives from East Kent Hospitals University NHS Foundation Trust (EKHUFT) have been invited to attend today's meeting to answer questions about the financial position of the Trust.

2) Background

a. At its meeting on 7 November 2023, the Kent and Medway Integrated Care Board ('ICB') received an update on the local NHS system's financial position. The update reported an adverse achievement of Year to Date (YTD) efficiency savings along with an increased deficit (£75.1m) compared to budget (£35.3m). A key risk was identified as the deficit increase at East Kent Hospitals University NHS Foundation Trust (EKHUFT).

b. At the end of month 5, the Trust were reporting an outturn deficit of £120m if no corrective action was taken. £7m savings had been made against the total £40m set out in the Cost Improvement Programme (CIP).

c. On 6 November 2023, Tim Glenn was seconded to the Trust as the Chief Finance Officer on a one-year secondment from Royal Papworth Hospital NHS Foundation Trust where he was Chief Finance Officer and Deputy Chief Executive.

3) A (very) brief overview of NHS finances

a. NHS providers such as EKHUFT receive revenue income from several sources, including (but not limited to) contractual income from the Integrated Care Board for commissioned services; grant funding; NHS England; and charges such as car parking and catering. Foundation Trusts also have the power to enter into commercial ventures such as providing support services through subsidiary companies.

b. Capital expenditure is funded through the sale of assets, DHSC financing, leases and donations/ grants. [capital funding will not be featured in the Trust's report]

c. An NHS foundation trust's chief executive is their accounting officer. This statutory role is accountable to Parliament.

d. All NHS organisations must produce an annual budget, setting out the expected income and expenditure of their planned activities. Foundation trusts do not have a specific statutory duty to break even (i.e., to not spend more than they receive) but they must remain solvent.

e. Integrated Care Boards (ICBs) are statutory bodies that are responsible to NHS England. As well as developing a plan to meet the needs of the local population, ICBs are responsible for allocating resources to deliver those plans. They do that by commissioning services from providers and paying them for that work.

4) Possible lines of inquiry

a. Members may wish to explore the following areas during their scrutiny:

i. What areas are driving the overspend?

ii. What action is being taken to reduce the deficit and achieve savings?

iii. How will service delivery be affected? Are efficiency savings across all areas of service delivery or specific areas? How are these efficiency savings monitored for progress?

iv. What happens if the Trust does end the year with a substantial deficit?

v. How is the Trust working with the ICB and other local partners to improve its finances?

5) Recommendation

a. RECOMMENDED that the Committee consider and note the report.

Background Documents

NHS Kent and Medway Board (2023) '*Finance update November 2023 item 13 (7/11/23)*' https://www.kentandmedway.icb.nhs.uk/application/files/8616/9901/8718/Agenda_and_papers_for_ICB_Board_-_7_November.pdf

Healthcare Financial Management Association (HFMA) (2023) HFMA introductory guide to NHS finance_October 2023.pdf

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East Kent Hospitals University NHS Foundation Trust

East Kent Hospitals Update for Health Overview and Scrutiny Committee
Financial Performance Update: February 2024

1. Purpose

1.1 To provide an update to HOSC on the Trust's financial recovery plan and Cost improvement programme for the next financial year.

2. Background

2.1. East Kent Hospitals University NHS Foundation Trust (EKHUFT) has five hospitals: three Acute Hospital sites (William Harvey, Ashford; Queen Elizabeth The Queen Mother, Margate; Kent and Canterbury, Canterbury), two Community Hospitals (Buckland Hospital, Dover; Royal Victoria, Folkestone), and a number of community clinics including an Outpatient diagnostic centre (Estuary View, Whitstable).

2.1. The Trust receives the majority of its funding to provide patient care from its commissioners NHS Kent and Medway and for some specialist services from NHS England. This is separate from capital funding which is required for managing the trust's estate.

2.2. During the Covid-19 pandemic, the usual financial arrangements within the NHS were suspended and the Government provided emergency funds to support the response to it. The NHS has reintroduced pre-pandemic financial arrangements which include the requirement to meet agreed end of year targets and deliver a cost improvement programme.

2.3. The Trust has historically struggled to meet its end of year financial targets. This is not where we want to be and is not acceptable for our patients, staff or the public. The Board is focussed on a long-term plan of stabilising the organisation's finances, embedding best practice in financial management and having sustainable cost improvement plans which also improve patient care and experience. To do this the Trust has the help of an experienced interim finance director and a package of support funded by NHS England.

3. Financial performance in 2023/24

3.1. The Trust's original financial plan for 2023/24 was to deliver a £72m deficit. The Trust was not meeting this target and brought in a number of measures to address this growing deficit including an independent detailed analysis of its cost pressures, processes and cost improvement plans.

3.2. At the February Board meeting, a forecast year end deficit of £117.4m was agreed. This forecast was discussed and has been acknowledged by NHS England.

3.3. This forecast position includes £13.1m of improvements made to the Trust's underlying run rate, which is a stretching savings target to deliver in three months. The Trust has cost pressures associated with treating more patients over winter (£3.5m), the financial impact of industrial action (£1.9m), additional costs required to manage the Trust's endoscopy backlog (£1.9m), and other risks that impact the Trust's year end position (£2.0m).

We care

3.4. At the end of month nine, the Trust's deficit was £84m, which is in line with the agreed end of year forecast.

3.5. This is a significant deficit, however, the measures the Trust is taking, for example on controlling agency spend and vacancies are starting to show some early signs of improvement. For example, spend on pay in December was £49.9m), the lowest it has been since April 2023.

3.6. Whilst we expect pay to have increased in January due to the impact of industrial action, pay spend in both November (£50.9m) and October (£50.4m) was less than the average monthly spend (£51.4m) in the first six months of the current financial year, showing the start of a trend of financial improvement at the Trust.

4. Cost Improvement Plan for 2024/25

4.1. Tackling our financial performance, reducing our deficit and increasing cost savings whilst improving the services we provide, have been identified among the priorities for the Board for the coming year. This includes a necessarily ambitious target of £49m of cost improvements to deliver next year. Cost improvement projects will be signed off before the end of this financial year, to enable full delivery in 2024/25, and undergo quality impact assessments to safeguard patient care and outcomes.

4.2. The Trust wide Cost Improvement Programme (CIP) is an annual process for identifying potential cost efficiency projects across all services. Staff engagement is integral to this work.

4.3. The Trust's focus on reducing waiting lists and improving performance has a positive impact on its finances as well as on patient experience. For example, making sure our theatres are used effectively so we can operate on more patients and patients are not staying in hospital when they no longer need to be there, which also reduces a patient's risk of becoming less mobile or acquiring infection.

4.4. We also need to work within our planned workforce numbers. For example, the February Board heard how staff had managed to not have any patients being cared for in the emergency department corridor. Not only is this better for patients, it saves money because we do not need to bring in high cost agency staff to care for patients in those areas.

4.5. One of the key drivers of the underlying deficit, was a significant increase in bank (£20m) & agency (£17m) staff, despite also significantly increasing substantive staff by 1,649 Full Time Equivalent (FTE) (£164m). We are reviewing how we are using our workforce to ensure that staff are in the right place and we are not using high-cost agency staff unless necessary. We have also introduced a non-pay panel to scrutinise purchases and ensure we are getting best value for money.

5. Working with health and social care partners

5.1. We are working with our partners within the Kent and Medway Integrated Care System to improve patient care. We still have too many patients remaining in hospital who no longer need acute hospital care which is not good for patients and has a significant financial impact as we need to staff escalation areas and it limits our ability to create "flow" through the hospital.

5.2. We need to ensure that patients are being cared for in the right place, which means doing everything we can to stop patients from being delayed in leaving hospital but also by working with our partners to increase options for out of hospital care.

5.3. We acknowledge that the forecast deficit figure is not acceptable and there still remains much more the Trust needs to do to tackle this and look ahead to the next financial year, with the primary focus on providing the best care for our patients.

6. Recommendation

It is recommended that the Committee consider and note the report.

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Item 7: Children Cancer Services – Principal Treatment Centre

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 29 February 2024

Subject: Specialist Children's Cancer Services

Summary: This report invites the Health Overview and Scrutiny Committee to receive an update on the Children's Cancer Services proposals following the public consultation. HOSC has determined the changes do not constitute a substantial variation of service for the residents of Kent.

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1) Introduction

a) NHS England is responsible for commissioning specialist services, including children's cancer services for those aged 0-15 years. Care is provided from one of 19 Principal Treatment Centres (PTC) across the UK.

b) In London and the South East (Kent, Medway, Surrey, Sussex, south east and south west London) a joint PTC is provided by The Royal Marsden NHS Foundation Trust and St George's University Hospitals NHS Foundation Trust. The PTC receives around 400 referrals per year, 107 of which were from Kent and Medway (in 2019/20).

c) A new national service specification was published in November 2021 and requires PTCs to be delivered on a site with a Paediatric Intensive Care Unit (PICUs). The Royal Marsden Hospital (Sutton Site) does not have a PICU, and their Trust decided to withdraw from the contract. Therefore, NHS England had to undertake an options appraisal on a shortlist of possible sites for a new service that complies with the specification.

2) Previous visits to HOSC

a) HOSC received a paper at their meeting 31 January 2023 setting out the proposals for change and being informed the shortlisted options were St George's University Hospital and Guy's and St Thomas' at Evelina Children's Hospital. Following discussion, Members agreed that the proposals did not constitute a substantial variation of service.

b) Key discussion points at the meeting were:

i) Centralisation of care on a single site would lead to better care, compliance with the standards, fewer treatment transfers and improved development opportunities for staff.

ii) Current treatment required travel to London, as would the new service.

iii) Shared care units allowed patients to access some elements of their care closer to home.

iv) Charities were represented on the stakeholder group.

v) Members raised concerns about travel and accessibility and suggested the commissioner approach Transport for London to see whether there was scope for patients to be exempt from charges.

b) The Chair summarised the discussion, highlighting that service provision was expected to be the same albeit from a different site, still in London. Just over 100 children per year would be affected, and the re-location would result in less transfers between multiple sites. Some engagement had commenced, and more was due to take place. For those reasons he proposed the change was not substantial but invited NHS England back to present the results of the consultation.

c) A public consultation ran from Tuesday 26th September to Monday 18th December 2023. HOSC members were kept informed via email updates. A decision is expected to be taken in spring 2024.

d) A representative from NHSE has been invited to present an update on the proposals for children's cancer services Principal Treatment Centre following the conclusion of a public consultation.

3) Recommendation

RECOMMENDED that the Committee note the report.

Background Documents

Kent County Council (2023), Health Overview and Scrutiny Committee (31/01/2023) https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=9051&Ver=4

NHS England (2023) Proposals for the future location of very specialist cancer treatment services for children living in south London and much of south east England, https://www.transformationpartners.nhs.uk/childrenscancercentre/

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Proposals for the future location of very specialist cancer treatment services for children in south London and much of south east England

End of Public Consultation Update

Kent HOSC

29 February 2024

Presentation

Introduction

We are here today to share information about the key findings of our public consultation; our priorities for this next phase; to gather your views and answer your questions.

Agenda:

- Recap of the process thus far
- End of public consultation update
- Decision-making process update
- Next steps

We hope that the Committee finds this session helpful - we welcome any questions.

For more information, see our consultation website

Background and context

- Specialist children's cancer services in England are led and coordinated by Principal Treatment Centres.
- The service for children living in Brighton and Hove, East Sussex, Kent, Medway, south London and most of Surrey is provided in partnership between The Royal Marsden NHS Foundation Trust at its site in Sutton, and St George's Hospital in Tooting, south west London.
- The service they provide is safe and high quality - but they are not all on the same site as a children's intensive care unit.
- The current Principal Treatment Centre does not and cannot comply which means very specialist cancer services currently provided on The Royal Marsden site need to move.
- The consultation helped us to understand the impact of implementing either of the two options being considered for the future location of the Principal Treatment Centre as well as the impact of moving conventional radiotherapy from The Royal Marsden to University College Hospital.

Radiotherapy

Both options in our consultation propose that children's conventional radiotherapy moves from The Royal Marsden to University College Hospital in central London.

Why things need to change

1. Hospital transfers of very sick children for intensive care add risks and stress
2. The intensive care team is not currently able to provide face to face advice on the care of children on the cancer ward
3. There is a need to improve children and families' experience when patients require intensive care and other specialist children's services
4. National clinical requirements for Principal Treatment Centres are set by NHS England. They say very specialist cancer treatment services for children – like those at The Royal Marsden – MUST be on the same site as a level 3 children's intensive care unit and other specialist children's services. This is non-negotiable.
5. Although it offers a wide range of innovative treatments, the current Principal Treatment Centre is excluded from giving a specific type of new treatment, and others expected in the future

Shortlisted options

Over the past three years, we have engaged widely with patients, families, staff, cancer charities, patient groups, cancer specialists and health and care partners across the catchment area, to find out what is important to them about these services and to get their input into our process.

We followed a best practice approach to identifying the possible ways the Principal Treatment Centre could be provided in the future. We identified 'fixed points' and 'hurdle criteria' which were applied to a long list of eight possible solutions. This resulted in two potential locations for the future centre:

- **Evelina London Children's Hospital in Lambeth, south east London, run by Guy's and St Thomas' NHS Foundation Trust** with conventional radiotherapy services at University College Hospital

- **St George's Hospital, in Tooting, south west London, run by St George's University Hospitals NHS Foundation Trust** with conventional radiotherapy services at University College Hospital.

Both locations deliver outstanding rated children's services, and both could deliver a future Principal Treatment Centre that meets the service specification.

- Both propose that conventional radiotherapy services for children currently provided at The Royal Marsden move to **University College Hospital,** meaning that all radiotherapy services for children in south London would be provided there in the future, instead of only some, as now.

**Under both options children would continue to travel for some specialist cancer services because of the specific expertise hospitals have in these areas and interdependencies with others services. A range of these services were considered 'fixed-points' and were not part of the public consultation. Further detail available in our consultation document, available on our website here*

Evelina London Proposal

- Purpose-built specialist children's hospital. All staff are experts in children's healthcare
- Is a specialist children's heart and kidney centre
- Runs the retrieval service which transfers seriously ill children, including those with cancer
- A children's intensive care unit with capacity for 30-beds. Two of these beds are expected to be needed for children with cancer
- In 2019/20, treated almost 120,000 young patients living in Kent, Medway, south London, Surrey and Sussex
- Does not currently provide the Principal Treatment Centre or surgery to remove tumors. It has a team of 54 surgeons with wide ranging expertise and would work with them, and others to create a team to undertake this surgery if it became the future centre
- Has more than 70 staff working on more than 180 national or international research projects in child health
- Guy's and St Thomas NHS Foundation Trust, which runs Evelina London, attracted more than £25 million of funding for research staff in 2019/20.

If the future Principal Treatment Centre was at Evelina London, it would have:

- A new children's cancer inpatient ward in Evelina London's main children's hospital building
- A dedicated children's cancer day-case unit and a dedicated outpatient space for children with cancer next to other facilities for children. Diagnostic services in the children's hospital building
- Outdoor spaces on site and at a park directly opposite the hospital
- Intensive care, cancer surgery and all other expert care provided on-site, other than services which are not changing, radiotherapy (proposed to be provided at University College Hospital) and neurosurgery which would continue to be at King's College Hospital and St George's.

- Guy's and St Thomas' would offer parking for children and families accessing children's cancer care. They would be able to reimburse parking, and support parents of children with cancer to access reimbursement for ULEZ and congestion zone charges.
- Guy's and St Thomas' has a dedicated patient transport team.
- Evelina London's volunteers would support families as mobility assistants, especially families with disabilities. There would also be a volunteer driver scheme.

**Further detail available in our consultation document, page 44-45*

St George's Proposal

- A large teaching hospital. Provides specialist services for adults and children
- Provides all the intensive care, most cancer surgery, and other specialist children's services for the current Principal Treatment Centre, which it provides in partnership with The Royal Marsden
- Has a 14-bed children's intensive care unit. Two of these beds, like now, are expected to be needed for children with cancer
- In 2019/20 treated almost 60,000 young patients mainly living in south west London, Surrey and Sussex
- 25 years experience of caring for children with cancer
- All children's service staff are experts in children's healthcare
- Provides neurosurgery alongside King's College Hospital
- Has 25 children's researchers and a good track record in national and international research
- St George's University Hospitals NHS Foundation Trust, which runs St George's Hospital, attracted £8.2 million of funding for research staff in 2019/20.

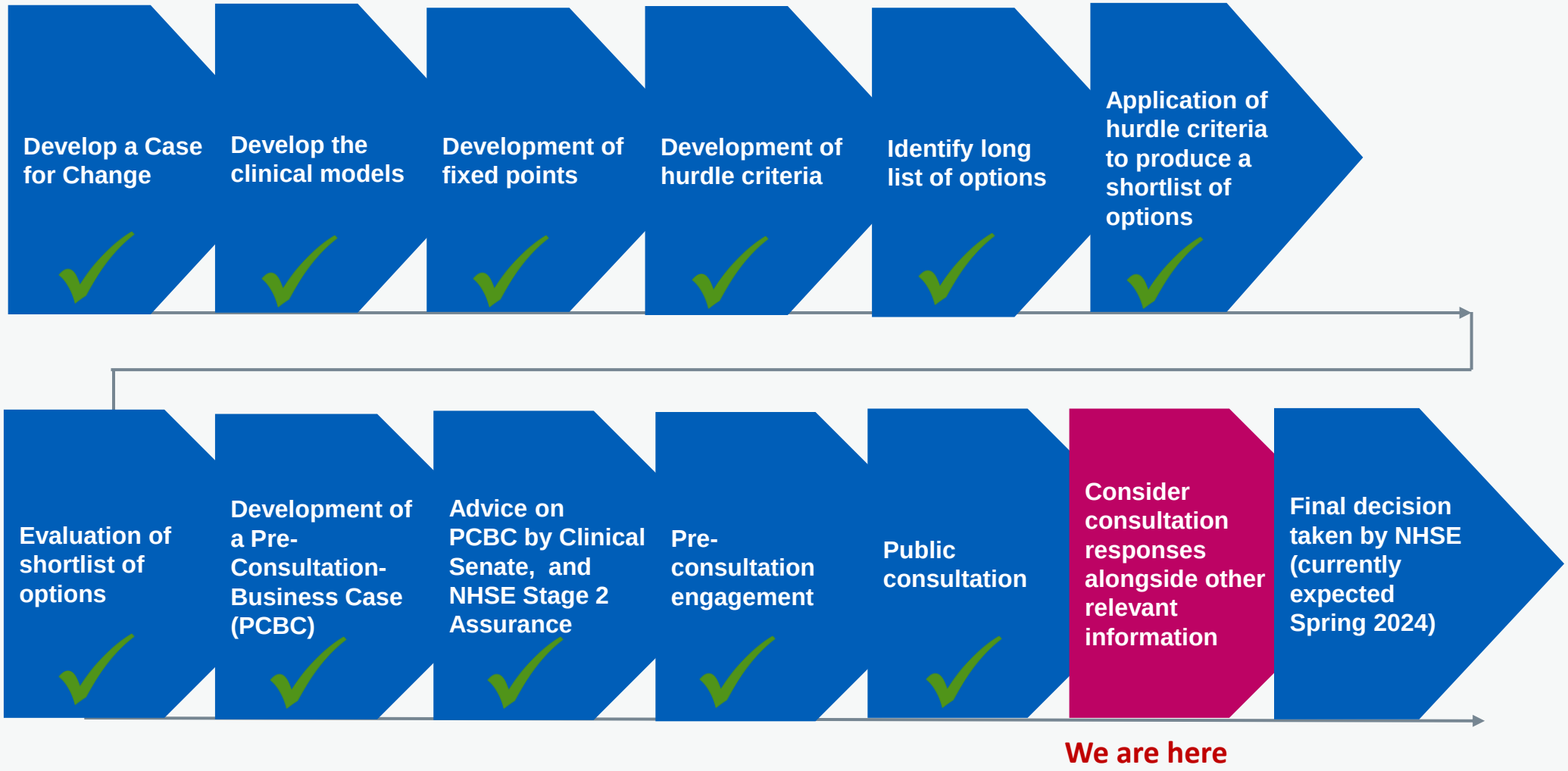
If the future Principal Treatment Centre was at St George's, it would have:

- A new children's cancer centre in a converted wing of the hospital with its own entrance
- Dedicated outpatient clinics and day case treatments including chemotherapy and minor operations in the cancer centre, with diagnostic services close by
- Dedicated garden space which could be closed off to other patients and visitors.
- Intensive care, cancer surgery and all other expert care provided on-site, other than services which are not changing, radiotherapy (proposed to be provided at University College Hospital), and specialist heart and kidney services which would continue to be at Evelina London.

- St George's would offer parking for children and families accessing children's cancer care. They would be able to reimburse parking, and support parents of children with cancer to access reimbursement for ULEZ charges.
- St George's has a dedicated patient transport team.
- St George's helps families with travel arrangements for appointments and to make the journey home by taxi or patient transport after a hospital stay.

**Further detail available in our consultation document, page 46-47*

The formal reconfiguration process



Public Consultation: Tuesday 26th September – midnight Monday 18th December 2023

- A range of documents were made available from the start of consultation to support the public, including staff and patients, to consider the two options. NHS England led communication and engagement activity throughout the consultation period supported by specialists.

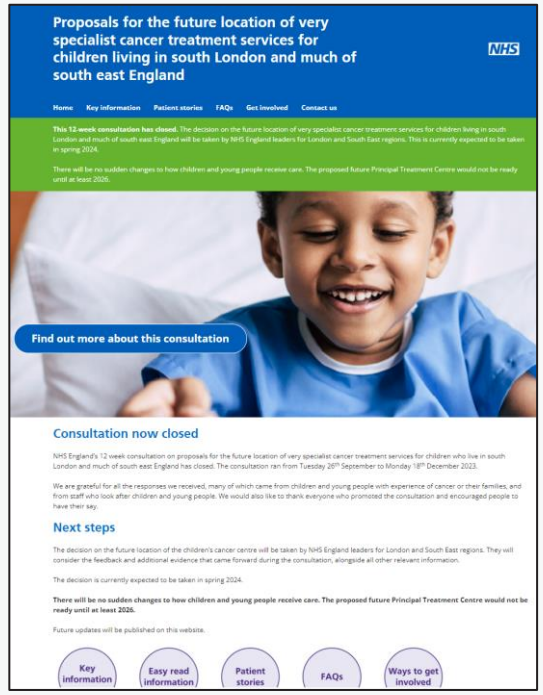
- As we launched the public consultation, we were clear that we wanted to use it as an opportunity to:

  - Listen, acknowledge and understand the feedback to support decision-makers to determine the best decision for the future of this service
  - Ascertain a thorough understanding of what a wide range of people think about the proposals – both strengths and challenges
  - Gather insights to support the design of any mitigating actions to address concerns and issues

- We remain open-minded about both options.

- We believe that the consultation has been fair, robust and comprehensive. We are grateful for all the responses received, many of which came from children and young people with experience of cancer or their families, and from staff who look after children and young people.

- The consultation responses have been analysed by an independent external organisation and written up in a report that has now been published on our website.



Consultation website snapshot

End of Public Consultation Update

Public Consultation activity – a summary

Communications activity included:

These activities were supported by our partners including the Trusts involved and Integrated Care System colleagues.

- Letters directly to patients, distributed by Trusts on our behalf and shared by the Facebook group run by parents
- Animation subtitled in different languages
- Printed posters and documents at hospitals
- Briefing and FAQs for staff to help them answer families' questions
- Toolkits for partners to raise awareness through their networks
- Media release and media interviews
- Content on social media including Facebook campaign
- Meetings to brief stakeholders about the consultation
- Proactive phone calls to organisations

Engagement activity included:

Some of these activities were supported by specialist organisations commissioned by NHS England.

- Community focus groups
- Play specialist sessions on wards
- Public listening events
- Joining community events with people representing equalities groups
- 1:1 interviews
- Site visits to spend time in outpatient areas
- Focus groups with staff and other stakeholders
- Meetings with wider clinical colleagues, MPs, Overview and Scrutiny Committee leads

Key Stakeholders

The consultation was open to all. However, there were a number of specific stakeholder groups that the consultation targeted. It was important that these groups were represented in the consultation feedback. The level of engagement of these groups was tracked and activity modified to maximise opportunity for their engagement. Following the mid-point we took a number of actions to gather feedback from stakeholders who we had heard less from at that point.

Groups directly impacted	Other key stakeholder groups:	Communities with specific protected characteristics*:
• Children and young people with cancer or who have experienced cancer (and their families) • Clinical and non-clinical NHS staff from The Royal Marsden, St George's Hospital, Evelina London Children's Hospital	• Other clinical and non-clinical NHS staff with an interest in the service, including staff of children's cancer shared care units • Professional bodies, specialist children's cancer charities and research organisations • Children, young people, and their families with related experience • Members of the public and public representatives	• People from ethnic minorities • Families with poor literacy skills and/or language barriers • People with autism • People with physical disabilities • People literacy skills and/or language barriers • People with mental health issues • Families with caring responsibilities • Looked after children and young people • Families experiencing financial difficulties or who live in the most deprived areas**

*List does not reflect all protected characteristics rather those identified as likely to be more/most impacted.
**While not a group protected by equality legislation, families experiencing financial difficulties or who live in the most deprived areas were identified by the interim Integrated Impact Assessment as potentially experiencing a greater impact, and so were also included as a priority group.

Explain's Independent Consultation Report – Summary*

** Please note that the content of the following slides is extracted from the independent consultation report produced by Explain Research. These are extracts only and do not reflect all findings from the full report (available on our website).*

Consultation report: responses & reach

The consultation has captured feedback from a diverse range of people across stakeholder types, ages, ethnicities, socio-economic groups, and geographical areas within the catchment area for the future Principal Treatment Centre.

2,669 **Formal responses to consultation ***

604,895 **Prompts to organisations and individuals to share their views****

Consultation survey

- **1,763 survey responses** of which:
  - 319 from affected staff working within the PTC
  - 233 from children, young people (CYP) and their families/carers

Face-to-Face engagement

- **831 people** reached through face-to face activities across **115 engagement sessions**
- **144 people** were children, young people, their families and staff currently experiencing/working in the PTC - engaged over **58 community sessions**
- **309 people were from equalities groups** highlighted in the early equalities impact assessment - engaged over **25 community sessions**

Other feedback

- **45 official organisational responses**
- **30 emails/ telephone calls** from a range of stakeholders (e.g. members of the public, charity and community organisations, research/academic staff, NHS staff, councillors)

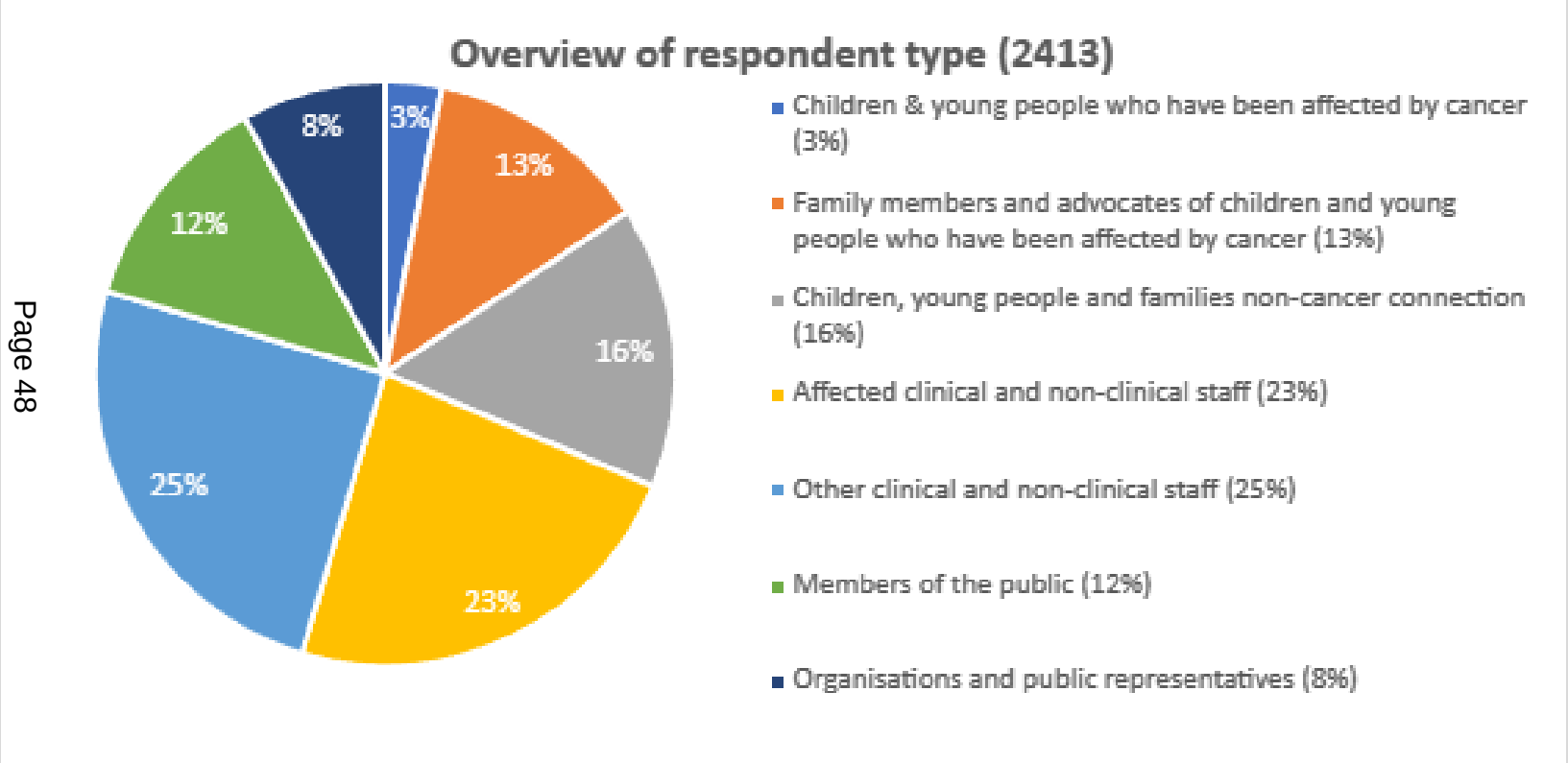
Alongside the consultation a group of parents also launched a petition:

Petition

- #HeartheMarsdenKids campaign: 10,394 signatures / 304 written comments

* Comprised of 1,763 survey responses, 831 individuals through face-to-face work, 45 official organisational responses, 30 emails/telephone calls
** Comprised of social media reach, email distribution, social media campaign views

Overall reach: respondents to the consultation



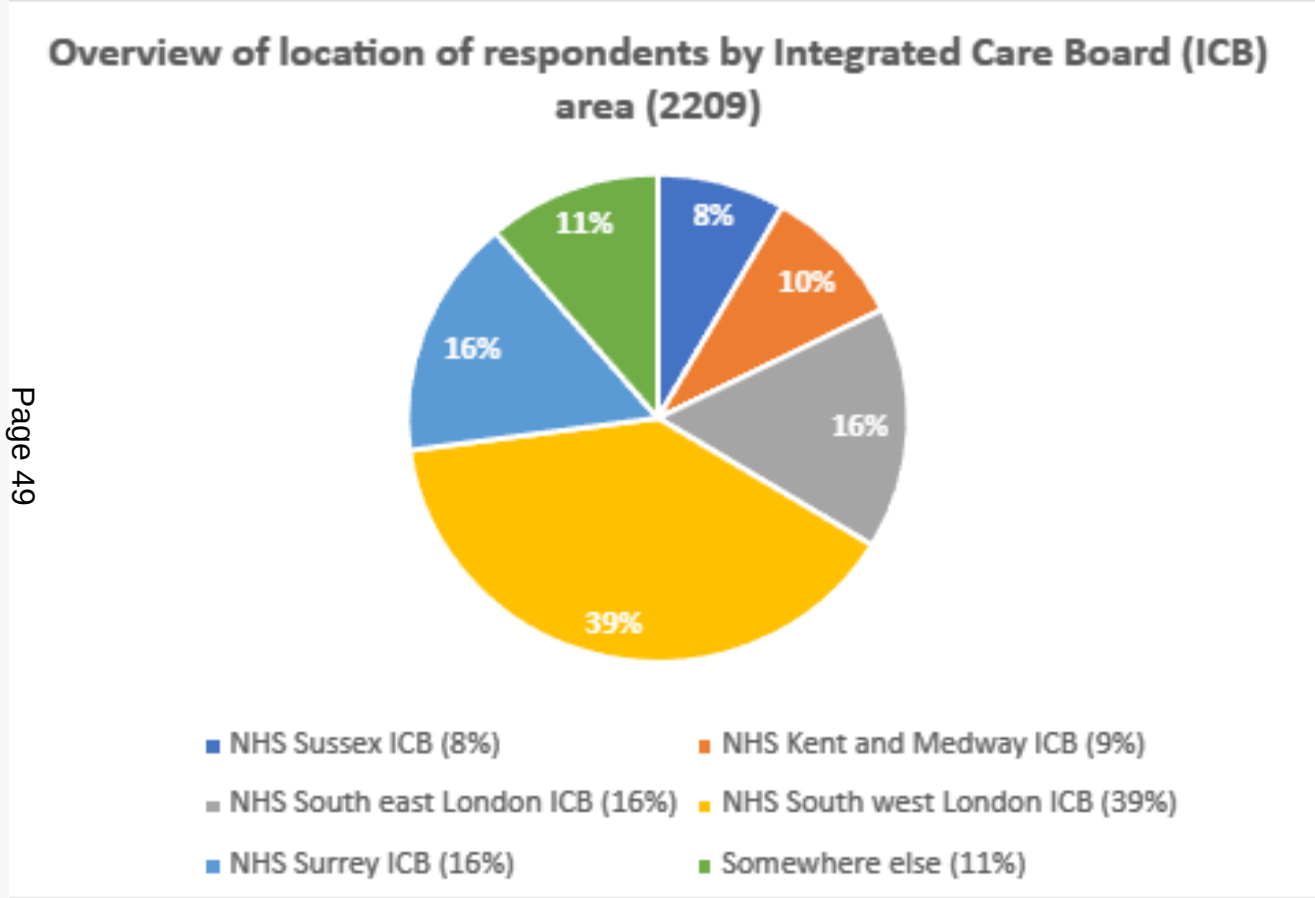
Summary

- **Good reach to affected and other clinical and non-clinical staff** working in children's cancer or wider services (RMH: 155; St George's: 216)
- Although many opportunities were given, response rates from children and young people who have been affected by cancer were lower than hoped. 13% **of responses came from parents and/or advocates for this group.**
- **Significant response from those without direct experience of cancer services**

Overview of respondent type: across all engagement methods. (Base number of 2413 reflects number of respondents that disclosed their stakeholder type.)

Extract: Explain Consultation Report - Executive Summary. Note 'affected staff' defined as staff at the hospitals where the PTC is currently, or could be.

Overall reach: geographical location



Overview of responses across all engagement methods and respondent types. (Base number of 2209 reflects number of respondents who disclosed their location).

Please note, due to rounding, percentages in the chart do not total 100%

Summary

- The **greatest response was from those in the NHS South West London ICB area**, of whom most were staff and members of the public
- **Good reach into NHS Surrey, NHS South East London and NHS Sussex ICB areas** – when comparing this to the proportion of recipients of the current service across those geographies
- **The lowest response rate was from NHS Sussex ICB area**
- When looking at the numbers of children and young people and their families/ advocates with experience of cancer services, **geographical reach is more representative of the patient cohort of the current Principal Treatment Centre**

NHS Kent and Medway ICB: Demographic we heard from

A breakdown of the questionnaire feedback from respondents living in the NHS Kent and Medway ICB area.

- 110 responses to the questionnaire (6.4% of the total) were from people living in the NHS Kent and Medway ICB area. Almost a third of these responses (32.7%) were from family members of children with cancer - a higher proportion than the other ICB areas.
- Of those Kent and Medway respondents who provided their demographic details:
  - more than a fifth were from ethnic groups other than white (21.8%)
  - almost two-thirds were female (65.5%)
  - more than half were aged 41-65 (59.1%).
  - 10% were disabled
  - almost 70% were from socio-economic groups ABC1 (69.1%)
  - 13.2% were receiving additional income support - more than the other ICB areas.

Note: Socio-economic group ABC1 reflects A (higher, managerial, administrative and professional occupations) B (Intermediate managerial, administrative and professional) and C1 (Supervisory, clerical & junior managerial, administrative, professional occupations)

Overall reach: summary of strengths and gaps

Key demographic strengths of the consultation

- **Ethnicity:** broadly reflective of the population across Integrated Care Board regions with 70% being from white ethnicities and 23% from ethnic minority communities (excluding white minorities)
- **Patient cohort:** Children and young people in the consultation are broadly representative of the wider patient cohort in terms of Integrated Care Board region and socio-economic group/deprivation levels.
- **Staff:** The consultation heard from 81% of The Royal Marsden staff and 52% of St George's staff currently working as part of/within the Principal Treatment Centre.

Key demographic gaps of the consultation

- **Age:** most respondents were aged 41-65 (51%), compared to 32% of members of the public across the catchment area. Younger ages were significantly underrepresented with around 10% of consultation responses from young people and children under 18 years of age compared to around 22% of the catchment population.
- **SEG:** around 91% of total respondents were from socio-economic groups ABC1 compared to around 66% from across Integrated Care Board regions. As well as this, only 9% of respondents were from SEG C2DE compared to around 37% of the wider population across the catchment area.
- **Gender:** 67% of overall responses were from females compared to only 52% of the population across Integrated Care Board regions.

Note: Socio-economic group ABC1 reflects A (higher, managerial, administrative and professional occupations) B (Intermediate managerial, administrative and professional) and C1 (Supervisory, clerical & junior managerial, administrative, professional occupations)
Extract: Explain Consultation Report - Executive Summary

Consultation report: Feedback on attributes people said they would value in the future PTC

When thinking about the future Principal Treatment Centre, respondents shared key attributes that they would value:

Survey responses highlighted:

- The provision of all or most specialisms and services needed for children's cancer care on a single site, such as surgery, neurosurgery, radiotherapy, children's intensive care unit, and health and kidney care*
- Specialist knowledge of and experience in children's cancer care
- A convenient location, particularly in terms of access by car
- Strong research facilities and track record

Other suggestions:

- Child-friendly hospital, with bright and colourful spaces and spacious facilities that cater to children's needs (such as age-appropriate play and education spaces, only for children with cancer)
- Preservation of the welcoming, family-friendly and homely environment of The Royal Marsden
- Personalised care for the child
- Ensuite accommodation, with space for at least one parent to stay overnight
- If there are wards, there is no mixing of different ages of children
- Spaces to accept visitors, especially siblings and other family members
- Good hospital food, catering for the child's needs, preferences, and tastes
- Family accommodation nearby
- Private facilities for parents, such as working showers and comfortable beds. Kitchen facilities, including space to store food and cook meals were also important
- Access to outdoor spaces that are dedicated to children with cancer
- Cancer charities have their own spaces and rooms in the ward to provide family support
- Lifts instead of stairs, with priority given to sick children
- Good signage
- Staff to help you to navigate hospital spaces, make introductions, make you feel welcome, explain what is happening and when; staff knowing your name; people who make an effort to listen
- Plenty of free parking spaces close to the hospital
- Good network of communication between Principal Treatment Centre, children's cancer shared care units, community nursing teams, and GPs.
- Good communication of key information when a child first becomes a patient of the Principal Treatment Centre; easily digestible information and guidance
- Good communication with the Principal Treatment Centre; so they answer your call first time you ring.

Consultation report: Feedback for the *Evelina* option

Some feedback on the Evelina London option from the consultation report is summarised below. **More detail is included in the consultation report.**

Strengths raised

- It is a purpose-built children's hospital, which is child-focused, with good facilities
- It provides other important specialisms that children with cancer often need, including heart and kidney care
- It has a large children's intensive care unit with the perception that this would mean that there would be capacity for intensive care for children with cancer, if needed
- The perception it has excellent research infrastructure and expertise, with a strong track record of research. It has a good research proposition, in virtue of its membership of Guy's and St Thomas' NHS Foundation Trust and links to King's College London
- It has good public transport links given its location in central London for both families and staff
- It is well-located for access to local amenities, such as shops and recreational spaces
- It is located close to University College Hospital if a child or young person needed to travel for radiotherapy
- There is family accommodation nearby.

Challenges raised

- It has a lack of experience and expertise in children's cancer care and treating children's cancer
- It does not provide neurosurgery
- Whilst it conducts a wide range of research, it does not conduct research in paediatric cancer, which leads to concerns about the continued provision of children's clinical cancer trials
- It is perceived that it may face significant recruitment issues as it would be heavily reliant on retaining experienced staff from The Royal Marsden
- There is the possibility that staff would not want to work in and travel to central London, given the lack of financial incentive and the potential detrimental impact on family life
- It would be difficult for families to access Evelina London by car, which is a preferred method of transport. It would be costly and time consuming for families to travel to Evelina London, acknowledging schemes to reimburse congestion charges and Ultra Low Emission Zone
- Family accommodation at Evelina London considered not being close to the hospital. Eligibility for and the availability of accommodation may not be guaranteed and has not been confirmed at this stage

Extract: Explain Consultation Report - Executive Summary

Consultation report: Staff feedback for the *Evelina* option

In addition, NHS staff highlighted the additional feedback. More detail is included in the consultation report.

Strengths [also] raised by staff

- Staff at Evelina London already work with some children with cancer and children's cancer services through their existing work
- It has existing links with many different healthcare providers in the catchment area, including King's College Hospital and hospitals which also provide children's cancer shared care units
- It has links to adult cancer services through Guy's and St Thomas' NHS Foundation Trust - Guy's Hospital has an adult cancer centre and Experimental Centre for Cancer Medicine
- It uses the same IT system for patient records as The Royal Marsden, which would help with a smooth transition of the Principal Treatment Centre
- It is considered by some staff to be a good place to work.

Challenges [also] raised by staff

- Recruitment to Evelina London could have a potential negative impact on the recruitment and retention of staff for other nearby NHS services, due to competing demand
- Due to the proposed layout of the service across different buildings, it would operate a distributed workflow, with staff working in different areas across the hospital, which could compromise communication between team members and care for some patients.
- There is a perception that Evelina London lacks space to take on the service.

Extract: Explain Consultation Report - Executive Summary

Consultation report: Feedback for the *St George's* option

Some feedback on the St George's option from the consultation report is summarised below. **More detail is included in the consultation report.**

Strengths raised

- It is part of a well-established Principal Treatment Centre, with services and pathways already in place
- It has existing links with The Royal Marsden, which were viewed as beneficial for transitioning the Principal Treatment Centre
- Some neurosurgery is offered on site and a well-established children's cancer surgery service
- It would offer a separate unit, which was considered important to make it more child friendly and minimise infection risk when mixing with other patients and visitors
- Easy to access by car
- Lots of private rooms with ensuite facilities
- Family accommodation nearby
- It is already known and familiar to some families, meaning the continuity of care would be maintained for those families when the transition happens.

Challenges raised

- Reflections on the current estate, which was described in some feedback as being outdated, with facilities considered to be poor, was a cause for concern when thinking about the ability of St George's to accommodate the future Principal Treatment Centre
- There is perceived to be a lack of privacy on the ward and in other parts of the hospital where adults are also being cared for
- It feels busy and chaotic, particularly given the delivery of adult healthcare services there; and there is a perception that this poses an infection risk
- Some key specialisms are missing, such as specialist heart and kidney care
- There is a perception that children would not be prioritised on surgery lists, because of treatment of trauma patients
- There is a perception that the research proposition is not strong, with lack of experience in running clinical trials for children with cancer
- It would be difficult for families to access, including by car. It would be costly and time consuming for families to travel. There is not enough family accommodation
- There is a perceived lack of recreational facilities and activities, both indoor and outdoor, suitable for children and young people receiving treatment for cancer.

Extract: Explain Consultation Report - Executive Summary

Consultation report: Staff feedback for the *St George's* option

In addition, NHS staff highlighted the additional feedback. More detail is included in the consultation report.

+ Strengths [also] raised by staff

- There were no additional strengths identified by clinical and non-clinical staff; feedback was consistent across all stakeholder groups.

− Challenges [also] raised by staff

- There are perceived financial constraints at St George's Hospital, which could make the transition to the Principal Treatment Centre a risk for its future
- Disentangling existing relationships to set up the new Principal Treatment Centre could be challenging, for example, if key people had different views on what should be done
- It does not use the same IT system for patient records as The Royal Marsden, which could have a negative effect on the transition of the Principal Treatment Centre.

Extract: Explain Consultation Report - Executive Summary

Consultation report: Feedback for Radiotherapy proposal

Outline of feedback on proposals for conventional radiotherapy. **More detail is included in the consultation report.**

Strengths raised

- There are benefits associated with consolidating radiotherapy expertise and services in one location
- Existing knowledge and experience of staff at University College Hospital
- Other treatments available there e.g. proton beam therapy

Challenges raised

- The transport of very sick children, into central London, to receive treatment
- Some families would face longer journey times to University College Hospital to receive radiotherapy treatment, particularly when compared to The Royal Marsden
- The capacity and resourcing of University College Hospital to take on the service on behalf of the Principal Treatment Centre
- The loss of resilience in having a single radiotherapy site across London and much of the south east
- The potential negative experience of disjointed care, with the need to travel to a different hospital to receive radiotherapy treatment.

Extract: Explain Consultation Report - Executive Summary

Consultation report: Challenges affecting both proposals

More detail is included in the consultation report.

Challenges affecting both proposals

- Neither option could offer a ‘single-site’ solution, including where all neurosurgery, specialist heart and kidney services, and radiotherapy could be co-located at the Principal Treatment Centre
- Concern that the quality of personalised care and specialist skills and services of The Royal Marsden could be lost, including the dedicated spaces of the Oak Centre. This related to both staff expertise and experience and the attributes of the healthcare spaces at The Royal Marsden (Oak Centre, Maggie’s Centre)
- Concern that the excellent research infrastructure and expertise of The Royal Marsden could be lost, including the loss of access to children’s cancer clinical trials (which could be a temporary loss as the move happens, or longer- term loss if the move has a detrimental impact on the ability of the Principal Treatment Centre to secure future research funding)
- Both options could be costly, at a time when financial resource is perceived to be stretched in the NHS
- Both would need more parking spaces and more parent accommodation
- Suggestion that children receiving cancer treatment should use public transport to travel to Evelina London and St George’s was considered at odds with advice that parents and family advocates have received in the past
- Staff recruitment and retention, given the wider issue of staff recruitment in the NHS, as well as the London-based locations of both Evelina London and St George’s Hospital
- Potential detrimental effect on the resilience of the current service at The Royal Marsden due the potential for staffing losses, such as early retirement
- Potential negative impact on The Royal Marsden’s teenage and young adults (TYA) service.

Extract: Explain Consultation Report - Executive Summary

Other ideas put forwards

A range of other ideas were put forward; including some alternative proposals. This included:

- A **risk-adapted model that retains the Principal Treatment Centre at The Royal Marsden and St George's.** This proposes that services continue to be provided at The Royal Marsden with patients who, upon diagnosis are deemed likely to require intensive care receiving their care at St George's.

- A **3-stage solution**, which involves:
  - adoption of the risk-adapted model outlined above, then
  - adopt new technologies to support a hub and spoke model by which intensivists based at a 'hub' can support 'spoke' services; with a trial at The Royal Marsden and
  - the building of a new children's specialised services hospital at a South Thames location.

- **Utilisation of the new hospital to be built in Sutton, next to The Royal Marsden**, by including a level 3 children's intensive care unit

In the questionnaire, there was a final question asking for any other thoughts or ideas. The top three themes were:

- **Selecting St George's as the Principal Treatment Centre** (16% of questionnaire responses to this question).
  - Most respondents who left comments of this nature were affected staff (31%), closely followed by other clinical and non-clinical staff (22%), with these respondents most likely to come from the South West London ICB area (56%)

- **Keeping the Principal Treatment Centre at The Royal Marsden** (15% of questionnaire responses to this question).
  - Most comments making this point were left by affected children or affected family members or advocates for children, with many referencing how children are comfortable or familiar with the current hospital setting, as well as the expertise and high standard of care they have received or are receiving from The Royal Marsden

- **The importance of listening to feedback from staff and patients** (8% of questionnaire responses to this question).
  - The meaning of this varied across comments, with some stating that NHS England (London and South East regions) must choose the proposal which best addresses the needs of those they considered most important, the patients and staff, while others considered that if they focused on the needs of patients and staff, they would not move the services at all.

Extract: Explain Consultation Report - Executive Summary

Case for change

Through the public consultation, many respondents took the opportunity to voice their opinion about the case for change.

Support for the case for change

- This was found in the formal responses submitted by organisations (including Children's Cancer and Leukaemia Group, Children's Hospital Alliance, Great Ormond Street Hospital, Guy's and St Thomas' NHS Foundation Trust, Royal College of Paediatrics and Child Health, and South Thames Paediatric Network,) as well as feedback left by clinicians in the questionnaire, during focus groups, and in emails.
- Some family members and advocates also support the case for change.
- Some of those with lived experiences of children's intensive care unit transfers involving their child or close relative shared details of this, calling for the change to be made to improve patient safety and patient experience, in line with the national service specification.

Challenges raised

- There was feedback from some parents, carers, and advocates who thought that the change should not happen in the first place – with some calling on NHS England to rethink the move (such as keeping the Principal Treatment Centre at The Royal Marsden) and consider alternative proposals (often because the proposals from Evelina London and St George's did not appear, for them, to guarantee the experience, expertise, quality of care, and research capability of The Royal Marsden).
- It is also noted here that the #HeartheMarsdenKidsCampaign, a petition calling on the NHS to reconsider the move, reflects wider opposition to the consultation.

Extract: Explain Consultation Report - Executive Summary

Criticism of consultation

Although not a key theme, some respondents across the stakeholder groups and the catchment area expressed criticism of the consultation. This feedback focused on:	How NHS England will continue to address the concerns raised by respondents
- The perception that the consultation was biased or the result already decided, because Evelina London had been identified as the preferred option	It is established law that it is appropriate for public consultations to put forward a preferred option, along with the evidence to support this in the consultation materials. This does not impact our ability to maintain an open mind as to the right final decision for the benefit of patients. A decision on the future location of services has not been made. It is currently expected that NHS England leaders will take a decision in Spring 2024; in taking a decision they will consider all relevant information including feedback from the public consultation. They will also have regard to their statutory functions and Triple Aim duties.
- A feeling from a few parents, carers, and advocates that their feedback has not been listened to (during pre-consultation) - A feeling of doubt from some parents, carers, and members of staff that their feedback could actually affect the decision-making process	Our pre-consultation engagement ran from April to August 2023 and involved a range of activities. In total, we had 739 responses to this phase of engagement, which included 27 engagement sessions, 313 responses to online surveys and seven ward visits. This feedback has been listened to and helped to shape our approach to consultation. Further detail in our pre-consultation report here. All feedback from the consultation will be considered and will inform the decision-making business case. Much of the feedback will also be valuable to informing the Implementation phase.
- The perception that there was a lack of financial detail, and financial scrutiny, associated with the proposals.	In line with formal NHS processes, it was determined that both proposals were affordable in revenue and capital terms ahead of public consultation. The pre-consultation business case contained appropriate financial information and further financial detail will be included in the decision-making business case.

Extract: Explain Consultation Report - Executive Summary with commentary from NHS England

Suggestions to address challenges

Across engagement activities, people were asked to provide suggestions to minimise or reduce any negative effects of the service change.

Suggestions are really valuable and will be used by NHS England and other stakeholders to support our ongoing work.

Access to healthcare

1. Improvement of children's cancer care closer to home
2. Working together with the team that manages POSCUs

Travel

1. Improvement to the provision of effective and free hospital transport; expending eligibility criteria for this
2. Dedicated parking spaces
3. Reimbursing travel costs/charges for all visitors to child in hospital
4. Supporting families with travel costs in advance of travel
5. Support with flexible appointment times and overnight accommodation

Facilities

1. Outdoor spaces dedicated to children cancer patients
2. Guaranteed parental accommodation on or very close to the Principal Treatment Centre
3. Dedicated, separate entrance to the Principal Treatment Centre

Research

1. Using The Royal Marsden @ model to safeguard continuity of research and funding

Staffing

1. Using The Royal Marsden @ model to support staff retention and recruitment
2. Implementing a staff retention package for staff who move to the new Principal Treatment Centre, specifically relating to costs
3. Flexible working contracts
4. Assurances to staff that their role is safeguarded

Extract: Explain Consultation Report - Executive Summary (summary from)

Kent and Medway: consultation feedback

Good points for options

Evelina London: specialist children's hospital, provides holistic services, has a good children's intensive care unit

St George's Hospital: good level of experience, well connected (for example with The Royal Marsden), accessible when driving

Radiotherapy: good idea; good to centralise services and expertise.

Potential challenges for options

Evelina London: accessibility including location in central London, car/parking issues, far to travel to

St George's Hospital: accessibility issues including via travel generally, accessibility issues via public transport, and accessibility issues via car/parking

Radiotherapy: too far, should be on the same site as the Principal Treatment Centre.

What is important to people

Travel priorities: parking on site, family accommodation nearby, public transport available nearby

Support and information priorities: understanding impact on any ongoing research trials, understanding which staff will still be part of ongoing care, reassurances about how and when the move will happen

NB. This slide reflects feedback that was most prominent in survey responses from people who identified that they live within this Integrated Care Board (ICB) area (as set out in the relevant chapter of the independent Consultation Report prepared by Explain Research

Decision-making Process

Consideration of themes

Activity is underway within NHS England to consider themes from the consultation feedback, including (but not limited to):

- Consider all feedback received including new information, discuss mitigations and develop recommendations
- Requesting supplementary information from Trusts where applicable
- Continued work on reviewing the risks and mitigations in relation to both options

Decision on the future location of the children's cancer centre

Who

The decision will be taken by NHS England leaders for London and South East regions.

How

NHS England leaders will take a decision on which option will give them the greatest confidence it will deliver the best quality care for children with cancer in the future. They will look at all evidence available to them, i.e. clinical evidence, workforce and estates information, and the integrated impact assessment etc., including feedback from the public consultation. They will also have regard to their statutory functions and Triple Aim duties.

When

The decision on the future location of the Principal Treatment Centre including the proposed location for conventional radiotherapy, is currently expected to be taken in Spring 2024. The decision-making meeting will be held in public. Details of the meeting will be shared in due course.

Our focus after decision-making

- Once the decision is made, we will work closely with staff in the current service, patients and their families, all the Trusts involved, the cancer network, the Institute of Cancer Research, and other partners to ensure that the move to the future site, wherever it is, is as smooth as possible. All staff involved in the service would have the opportunity to be part of this work. Patients and parents will also be able to help design the new service – the team running the future centre would make sure that people from different groups and communities have the chance to get involved.

- There will be no sudden changes. Services would not move until at least 2026. We expect all the preparations for the future Principal Treatment Centre to take place within two and a half years.

During this time, we will focus on ensuring a smooth transition. Areas of focus include:

- planning and undertaking building work to refurbish existing space for the future centre,
- developing and implementing detailed action plans to address concerns around travel and access
- maintaining the current levels of research activity,
- supporting as many staff as possible from the current service to move to the future centre,
- developing clear patient and family information on the new services, how and when to access them as part of the implementation plan
- putting everything in place for a safe, smooth transfer of patient care.

For more information – please visit our website here

We welcome any questions you may have.

Thank you for your time and we look forward to receiving your formal consultation response

Item 8: Kent and Medway children and young people's mental health services procurement

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 29 February 2024

Subject: Kent and Medway children and young people's mental health services procurement

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

The Committee has yet to determine if the changes represent a substantial variation of service.

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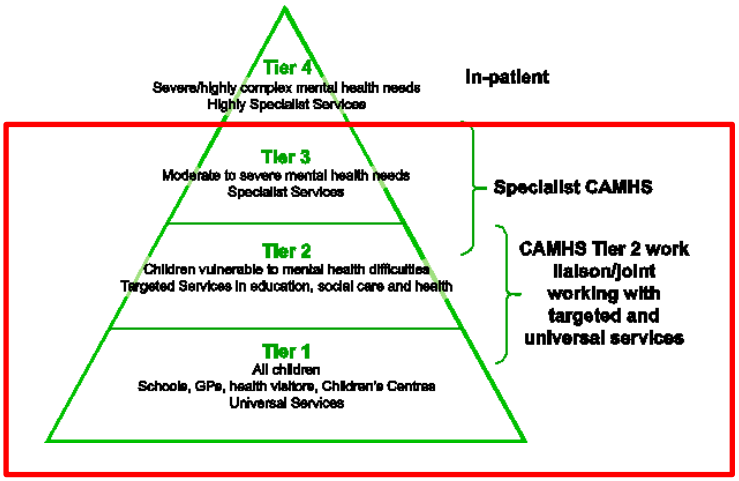
1) Introduction

a) Children and young people's mental health services (CYPMHS) is an umbrella term covering a wide range of services commissioned by the NHS and local government. The diagram below helps explain the four-tiered provision of the overall service.[1] NHS England commission tier 4 services and the Integrated Care Board (ICB) Commission tier 1-3 services.



b) NHS Kent & Medway ("the ICB") has an annual budget of £37m to deliver mental health services for children and young people in Kent and Medway. They do this by commissioning a range of services from providers across the NHS, local authority and voluntary, community and social enterprise sector. Services are delivered across primary care, schools, community groups, digitally and within specialist clinical settings. All the contracts with current service providers are due to expire by 31 August 2025.

[1] 1 Parliament (2014) CAMHS as a whole system, https://publications.parliament.uk/pa/cm201415/cmselect/cmhealth/342/34206.htm#note29

c) In Kent and Medway, service tiers 1-2 are a combination of commissioning by the ICB, Local Authority, Primary Care Networks and schools and provided by a range of organisations. Tier 3 is commissioned by the ICB, with North East London Foundation Trust (NELFT) as the provider.

2) Previous visits to Kent's HOSC

a) Representatives from the ICB attended HOSC on 7 December 2023 to provide an overview of the upcoming procurement exercise. The procurement presents an opportunity to commission modernised services and support implementation of the Local Transformation Plan as well as outcomes in the Integrated Care Strategy.

b) New contracts will be awarded on a 13-year basis, providing stability and security in the delivery of services. The ICB is working with stakeholders to develop what future services will look like. HOSC members attended a workshop led by the ICB on 8 February 2024.

c) Children and Young People's mental health services have been a focus of HOSC for a number of years. These proposals sit against a backdrop of increasing challenges across the sector, including increasing demand for crisis services, increasing complexity of cases, increased levels of anxiety, growing waiting times, and workforce challenges.

d) The ICB have been invited to attend today's meeting and provide an update on the procurement plan so that HOSC can decide if the proposals constitute a substantial variation of service. HOSC is asked to scrutinise the procurement of CYPMHS tiers 1-3.

3) Recommendation

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

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

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

If the proposals relating to the ICB's procurement of CYPMHS are deemed substantial:

Item 8: Kent and Medway children and young people's mental health services procurement

RECOMMENDED that:

(a) the Committee deems that the procurement of CYPMHS in Kent and Medway is 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 the ICB's procurement of CYPMHS are not deemed substantial:

RECOMMENDED that:

(a) the Committee deems that the procurement of CYPMHS in Kent and Medway is 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 (2023) *'Health Overview and Scrutiny Committee (7/12/23)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=9319&Ver=4

Kent County Council (2022) *'Health Overview and Scrutiny Committee (11/05/22)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8763&Ver=4

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Children and young people's mental health future contracts: Update report for Health Overview and Scrutiny Committee

1 Introduction

1.1 About this report

This report provides the Health Overview and Scrutiny Committee with a detailed update from NHS Kent and Medway Integrated Care Board (NHSKM) on future contracts for children and young people's mental health services in Kent and Medway.

The report and appendices describes the following:

- current service provision, including population demographics and need
- engagement activity with stakeholders, including children and young people, and the key themes emerging that have informed the proposed future contracts
- the contracting approach, including finances and contract management approach and anticipated benefits
- timeline and next steps to implement future contracts.

Our (NHSKM) contracting approach set out in this paper is aligned to the ongoing implementation of our Local Transformation Plan[1].

The approach described in this paper will deliver more effective management of children and young people's mental health contracts, without needing to make changes to current pathways or the clinical interventions offered. The new approach will deliver stability and sustainability in children and young people's mental health services and address some of the key challenges we currently face. This will in turn, and most importantly, improve care and outcomes for children and young people.

1.2 Development and implementation of future contracts

All NHSKM children and young people's mental health contracts with current providers of services in Kent and Medway are due to expire by the end of August 2025. This presents an opportunity to streamline contracting arrangements and reduce the number of existing contracts whilst maintaining the same level of investment and service provision.

The new contracts will deliver NICE-compliant interventions and pathways for children and young people, as services do currently. There will be the same (or greater) capacity in the system, and the services that children, young people and families rely on, will continue to be provided. Through the new contracts, providers will be required to embed a culture of collaboration, so that the workforce is better connected, better able to target help at the right time to help prevent children and young people becoming seriously unwell, and able to provide specialist care when needed.

[1] Children, young people and young adults' emotional wellbeing and mental health :: Kent & Medway ICS (kmhealthandcare.uk)

1.3 Our strategy for children and young people's mental health services in Kent and Medway

The NHS Long Term Plan[2] sets out the priorities for expanding children and young people's mental health services. It aims to widen access to services closer to home, reduce unnecessary delays and deliver specialist mental healthcare, which is based on a clearer understanding of young people's needs and provided in ways that work better for them. Achievements against the NHS Long Term Plan can be found in Appendix A.

There is still work to do to achieve our ambition of improved emotional wellbeing and mental health outcomes for children and young people. By focusing on workforce, increasing support to trusted adults, and ensuring that services are more collegiate, we will improve the offer to children, young people and families in Kent and Medway.

1.4 Work to date

As part of the preparation phase of the procurement process, we have undertaken a range of engagement activity with children, young people, families and carers, professionals and providers. This work is set out in more detail in Section 4. We have also established a clinical reference group to ensure that future contracts meet the clinal standards required for future children and young people's mental health services in Kent and Medway. This is described further in Section 5 of this report. We have also reviewed existing provision, along with current best practice, national guidance and legislation, and demand and capacity.

2 Current services and existing contracting arrangements

2.1 Demographics and service demand

There are 353,707 under 18s in Kent and, based on local authority data, it is expected that there will be no significant change in this population over the next 10 years.

The national prevalence of mental health disorders in children and young people has increased by 7.8 percentage points between 2017 and 2023 but is starting to plateau (19.0% in 2022 to 20.3% in 2023).

This means that there are currently an estimated 49,181 children and young people with a probable mental health disorder in Kent.

This figure is borne out by the demand and activity in our current services across Kent:

- Number of accepted referrals to current NHS commissioned services: **35,727**[3] in the last 12 months
- Number of contacts with current NHS commissioned services: **146,000 contacts** in the last 12 months
- Number of accepted referrals to current NHS commissioned specialist services: **13,083** in the last 12 months

[2] https://www.longtermplan.nhs.uk/

[3] Noting that many children and young people access wellbeing and mental health interventions outside of NHS commissioned services, such as school counselling services and voluntary sector providers.

- Number of under 18s on an NHS commissioned services caseload at any time: **4,150 mental health plus 9,300 neurodevelopment**
- Number of under 18s waiting for specialist mental health services (Dec-23): **1,059 (221 waiting over 18 weeks)**

Waiting times for children and young people's mental health services are often thought to be much longer than they are. This is because the waits for neurodevelopment assessments (autism and ADHD) are often reported as mental health waits.

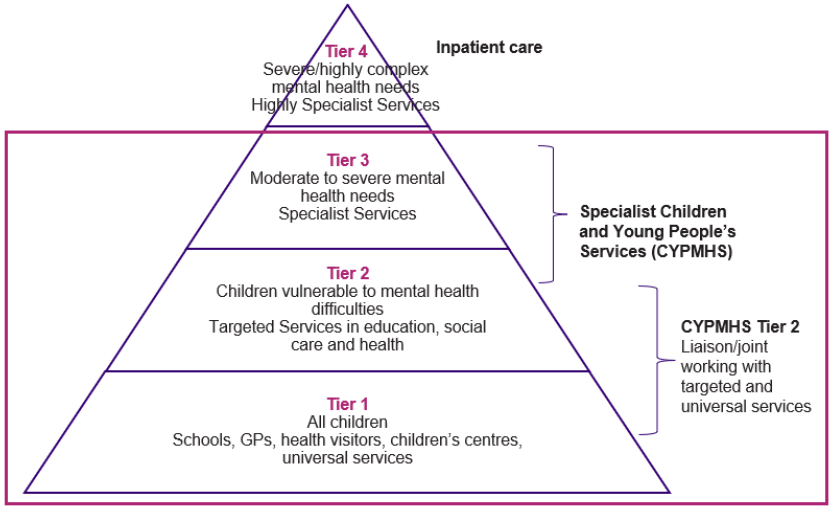
Overall, our specialist teams are seeing most children and young people in under 18 weeks (81% are waiting under 18 weeks from referral to treatment), however, this varies quite widely across Kent and Medway, with some areas having more children waiting over 18 weeks for treatment while other areas have no waiters.

Please see Appendix B for further detail on the current population need and demand for services.

2.2 Overview of services

Children and young people's mental health services (CYPMHS) is an umbrella term covering a wide range of services commissioned by the NHS. We commission a range of services from providers across the NHS, local authority and VCSE. Services are delivered across primary care, education settings, community groups, digitally and within specialist clinical settings.

Traditionally CYPMHS have been thought of in 'tiers', as shown in the diagram below.[4]



Traditional 'tiers' of care

NHS England commission Tier 4 services and NHSKM commission Tier 3 services (with North East London NHS Foundation Trust (NELFT) as the current provider). In Kent and Medway, Tiers 1-2 are a combination of services commissioning by NHSKM, local authority, primary care networks and education settings, and are provided by a range of organisations. A large

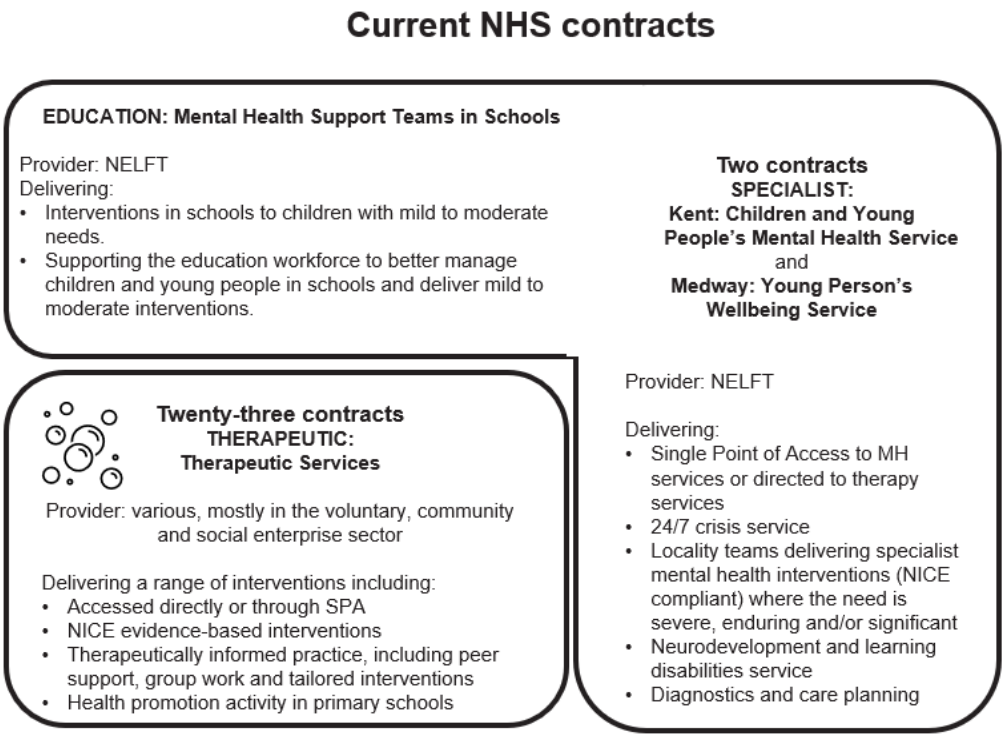
[4] Parliament (2014) CAMHS as a whole system, https://publications.parliament.uk/pa/cm201415/cmselect/cmhealth/342/34206.htm#note29

proportion of Tier 2 interventions, such as counselling, are commissioned by education settings and Public Health.

Services in Kent and Medway have implemented the i-THRIVE Framework which recognises that the needs of children and young people can and do change, and that services need to be flexible and tailored to meet the needs of the individual.

NHSKM have over 25 contracts for children and young people's mental health, with all contracts having been commissioned between 2016 and present. The largest growth area of investment has been for the crisis pathway and Mental Health Support Teams in the specialist contract and smaller contracts in the therapeutic and VCSE.

A high-level summary of current contracts is shown in the diagram below:



Current Kent and Medway children and young people's mental health services contracts

Appendix C provides full details of all our current services and contracts.

3 Current challenges

While more than 33,000 children and young people in Kent and Medway receive mental health support from a range of NHS commissioned services annually, there are several challenges within the system that impact on quality of care and responsiveness such as increased demand, increased acuity, reducing workforce and emergence of new vulnerable groups and presentations. Most contracts were set-up prior to Covid and, as the impact of Covid on mental health continues to emerge, services are adapting well to meet the need, within the constraints of their specification and financial envelope.

Some of the key challenges we face include:

- **Increasing complexity and seriousness of mental health needs children and young people have.** Children and young people have been presenting with more complex needs across all pathways from early intervention to acute and urgent care. In Kent and Medway, increased investment and multi-agency focus on the crisis and urgent pathway has seen a positive reduction in children and young people spending unnecessary time in hospital or inpatient care.

- **Challenges in recruitment and retention of specialist mental health professionals**. There are challenges nationally regarding recruitment and retention of the workforce, exacerbated by our proximity to London. One of the most significant challenges is the lack of stability in the VCSE, due to short-term or reducing contracts, which disables providers and individuals to build capacity and take risks in entering emerging areas of workforce development, skill and competency.

- **National and local financial challenges.** Early intervention, social and environmental support has reduced in recent years. The consequence of this reduction in investment and services directly impacts children and young people and stimulates increased demand for specialist mental health services.

4 Engagement: what we have done and what we have heard

We have a strong track record in Kent and Medway of engaging with those who use our children and young people's mental health services. Our engagement and lived experience leads ensure that a wide range of engagement takes place on a regular basis. This work is part of our 'business as usual' and provides a strong foundation on which we can build when specific programmes of work, like the new contract arrangements, need and want to draw on engagement insights and mobilise additional activity designed to support the development of services.

We continue to work with children, families, partners and stakeholders to develop services that focus on specialist mental health, therapeutic earlier support and mental health support in education settings. Last year we reviewed all the evidence we had gathered over the previous 18 months, over 60 reports featuring the experience and views of thousands of children and young people and their families.

We also worked throughout the summer and autumn, at events, summer activities and groups and meetings to actively engage 487 children, young people and young adults, carers and staff, resulting in 981 written contributions, one poem, one drawing, five podcasts, and ten short films.

Using a variety of media, channels, and events we contacted over 100,000 people and cascaded the information through various newsletters and networks. The views and insights provided by this work and the feedback from our clinical reference group and providers has informed the future contracts.

See Appendix D for a comprehensive summary of the engagement work that has taken place to date.

5 Future contracts and contract management

The new contracting arrangements will address the challenges of workforce and responsiveness of services through greater coordination of provision and practitioners for the benefit of children and their families. Streamlining and entwining contracts and specifications to ensure appropriate and adequate service delivery is intended to increase access and availability of services and reduce waiting times for specialist mental health services whilst improving navigation and patient experience. Evidence of system coordination has seen sustainable and positive impacts in Medway and within the crisis and complex pathway across Medway and Kent.

Children and young people will access future services through the same processes as now, whereby children and families will be able to directly refer into therapeutic services and access specialist mental health services through a single point of access that uses a shared telephone number and referral form. Education settings and primary care will be able to refer as they do now. In addition, they will have more opportunities to speak to clinical experts through a consultation phone line and networking events.

Alongside engagement with children, young people, families and carers, professionals and providers, and the market engagement activity, the clinical reference group (CRG), comprised of children and young people's mental health specialists, has reviewed and assessed the new contract proposal to ensure the implementation of:

- evidence-based and appropriate clinical care
- child and family-led design
- whole system approach which values the VCSE sector as key partners
- holistic and early intervention approaches
- evidence-based, i-THRIVE and trauma informed interventions.

5.1 Future contracts

The future contracts for children and young people's mental health will be similar to the current arrangements. The new contracts will not see a reduction in NHS investment, expected volumes of activity, or changes to clinical pathways or clinical interventions. The future contracts would deliver the following components:

Children and Young People's Mental Health: Education

This contract will predominately deliver the national Mental Health Support Teams programme, supporting children and young people in identified education settings by providing low to moderate interventions for emotional wellbeing needs. In addition, the contract would support the educational workforce to better support children and young people with mental health/emotional wellbeing needs so that all education settings, including academies, can access information and advice as required.

The new contract would see growth of the Kent and Medway contract value from £6m to £9m by 2028 due to the national investment into this programme increasing.

Children and Young People's Mental Health: Therapeutic

This contract will provide brief interventions to children and young people with mental health/emotional wellbeing needs, with a focus on creative therapies and therapeutically informed practice.

This contract will enable a number of future providers to collaborate under one contract, thereby reducing the current 23 contracts into one partnership contract which would function on a Health Care Partnership (HCP) footprint. Additionally, there would be a small grants innovation funding function and personal health budgets, to ensure responsive and localised support for children and young people.

Children and Young People's Mental Health: Specialist services

This contract will provide evidence-based interventions for children and young people with moderate to severe mental health/emotional wellbeing needs.

This contract will be on an Integrated Care System (ICS) footprint and have increased capacity to deliver advice and consultation to partners including primary care and education settings.

Contract length

The three contracts would each be awarded for a ten-year term with an option to extend by a further three years. This 'contract for a generation' approach will build stability of service and enable workforce stability and growth. Feedback from the market, particularly the VCSE and private sector, confirms that longer-term contracting is essential to grow capacity and competency within the workforce, with the example of similar models of long-term connected contracts and delivery operating in Surrey ICB.

5.2 Contract management and review

Contracts will be awarded at the same time (March 2025). A six-month joint mobilisation period across all three contracts will take place between March and August 2025. All contracts will be contract-managed by NHS Kent and Medway. They will have regular service reviews built in at fixed points (Years 1-3; Years 4-6; Years 7-9; Years 10-12) to: review progress in the previous three years; agree to any changes to future delivery based on learning from previous years; and consider any legislation/guidance that has been introduced or is due to be introduced that may impact on service delivery.

5.3 Partnership working across contracts

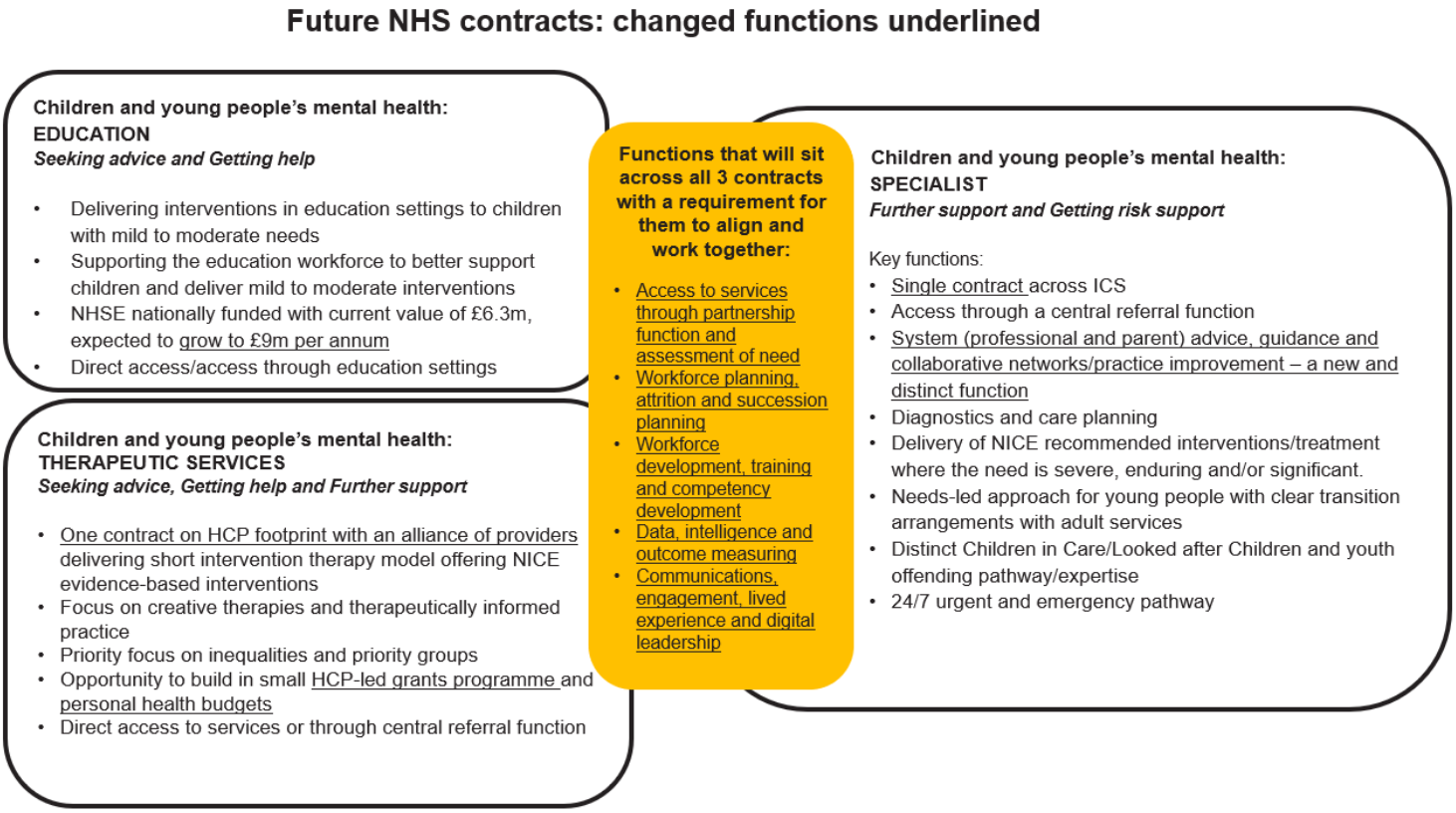
The three proposed contracts would work in partnership to ensure that children and young people across Kent and Medway are able to seek appropriate support for their mental health and emotional wellbeing in a timely manner. The aim of this approach is to ensure a higher volume of early intervention, preventative services and early support are readily available and accessible and to reduce the referrals and waiting times within specialist mental health services.

There would be new requirements within all three contracts for providers to work together to deliver:

- partnership arrangements to support rapid assessment of need and navigation to the most clinically appropriate service

- a workforce plan that address recruitment, retention, attrition and succession planning between specialisms and contracts
- shared workforce training and competency development within the future providers and a responsibility to support the wider workforce to develop their competencies and confidence
- shared data, intelligence and outcome measures to measure impact
- shared approach to communications, engagement, lived experience and digital leadership.

The diagram below provides further detail on the proposed new contracting arrangements:



Proposed new contracting arrangements for Kent and Medway children and young people's mental health services

6 Impact and benefits

Having delivered a children and young people's mental health transformation programme that has seen benefits outlined in Section 1.3, we need to ensure that we continue to bring improvements to the system through the new contracting arrangements. The impact of the proposed future offer would be to:

- reduce the current children and young people's mental health contracts from 24 to three
- reduce inequity caused by historic commissioning arrangements
- create an environment of stability with long-term contracting, particularly within the therapeutic sector
- deliver an integrated approach with partners to improve outcomes for children and families
- give professionals and parents access to advice, guidance and collaborative networks/practice improvement (a new and distinct function)
- use the i-THRIVE Framework to implement shared language to describe and navigate the information and support on offer
- enable training, workforce development and networks for all adults to support their understanding of children and young people's mental health
- provide an 'innovation fund' to grow new ideas and approaches at place, and personal health budgets to holistically support children and young people.

All contracts would:

- share KPIs and outcomes
- share a communications and engagement strategy and delivery plan
- employ lived experience leads and implement the Lived Experience Framework (currently in development)
- work together to mobilise at the same time
- work together to explore opportunities to develop one record system in the longer term.

The new contracts will contribute to the ICS strategy priorities as shared in the previous HOSC briefing in December 2023.

7 Workforce

The children's mental health recruitment issues that are seen nationally are especially felt within Kent and Medway due to the proximity to London where staff can earn higher salaries. The geography of the county is varied: some areas are highly populated while other areas are rural. The county is mostly bordered by the coast, meaning there are fewer opportunities for staff to move or work in Kent and Medway from neighbouring counties.

Under our proposed new approach, future providers would be required to work together, with the Royal Colleges, NHS England's national mental health team, medical school, colleges and universities to develop long-term strategies to attract and grow a workforce made up of the current children and young people of Kent and Medway. The future contracts will embed the system enablers

that have been put in place through the children and young people's mental health transformation work which are outlined in the following sub-sections.

8 Summary of key risks

There are a number of risks associated with a procurement of this scale.

The high-level risks at time of writing (February 2024) can be summarised as follows:

- **The future market:** The market profile, their appetite and capacity to engage with a procurement process is not fully known until the procurement process commences. To mitigate as much risk as possible, we have undertaken market engagement and offered two opportunities for potential providers to engage in contract design sessions. There will be one further formal market event on 20 March 2024, and every provider will be offered an individual session to follow-up to try to stimulate as much interest as possible.
- **Impact on services and workforce:** Changes to contracts and services can cause concern within the workforce and this can impact service delivery and in turn children and young people's experience. We intend to mitigate the risk through open and regular communications with the current service providers to ensure that they are aware of the process that is being undertaken and timescales.
- **Increased demand through changes to system investmen**t: Changes to the availability of funding both nationally and locally will impact the level of support and interventions available to families, education setting and the wider provider sector. The concern is that with reducing health promotion, earlier intervention, social and resilience support, there will be an even greater demand for children and young people's mental health services. Close working with national and local partners to understand where changes to investment may be made and an assessment of impact will support planning and risk mitigation.

9 Finance

In 2023/24, NHS Kent and Medway's budget for children and young people's mental health provision totalled £37.857m, of which £31.807m (83%) was utilised for provision in Kent.

Kent County Council contributes £1.267m annually to the specialist service's mental health contract which ensures fast-tracked assessments for Kent Looked after Children, provision to support children who display harmful sexual behaviours and some support for children in pupil referral units. Kent County Council do not intend to continue with investment into the future contracts. We plan to mitigate the impact of the reduced investment through efficiency and prioritising future children's mental health investment from NHS England.

NHS Kent and Medway has established that the proposed total financial envelope for the three 13-year contracts is £501.452m (values based on 2023/24 contract prices with no uplifts or pay assumptions included).

Contract values will be largely in proportion with the current values, with the most significant investment in the Specialist contract. Contract values will be finalised and released with the service specifications once completed.

10 Timeline and next steps

The procurement timeline enables alignment between NHS Kent and Medway's Community Services' transformation year and the six-month mobilisation period for the future children and young people's mental health contracts (from April 2025 to September 2025), as well as the 2025/26 school academic year. Next steps and indicative timeline are as follows:

- Service specifications will be finalised in April 2024 once the comprehensive programme of engagement concludes (including formal market engagement and relevant scrutiny committees), and all feedback has been reviewed and cross-referenced
- The Invitation To Tender will be published in early June 2024
- Bids will be evaluated between July – September 2024, noting that children and young people will be part of the evaluation panel
- Providers will be notified of outcome by December 2024
- Contracts will be awarded in March 2025
- Mobilisation will take place for all new contracts between March – August 2025
- New services will go live on 1st September 2025.

11 Conclusion

This paper has outlined in detail the rationale for a new contracting approach for children and young people's mental health services in Kent and Medway. It has set out the challenges we currently face, and what we have heard, through our engagement activity, is important to children, young people, families and carers, professionals and providers of services. We have described how our proposed new contracting approach is in step with our transformation programme and impacts that have been delivered so far, and how it has been designed to address both the current challenges and consider the feedback we have heard from engagement activity.

The proposed new contracting approach will help us deliver improved care but does not represent a change to clinical pathways, our clinical model, or clinical interventions offered.

The approach described will help to improve the stability and sustainability of services, through better contracts and closer alignment across providers to support partnership working. This in turn helps to address the challenges we face around workforce and an increased need for services, and most importantly will deliver benefits for children and young people.

Report author: Sue Mullin, Associate Director, NHS Kent and Medway suemullin@nhs.net

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Long Term Plan achievements so far: Kent

- Increasing access to services: 35,727 referrals were accepted to current commissioned children and young people's mental health services in 2022/23[1]
- Rolling out nationally funded Mental Health Support Teams to 50% of the school population, which includes academies (known locally as Emotional Wellbeing Teams)
- Developing mental health practitioner and navigator/social prescribing roles in primary care
- Significant and consistent reduction in the number of children and young people in acute hospitals and those needing Tier 4 inpatient care
- Achieving national eating disorders standards of 95% of urgent cases being seen within one week of referral and maintenance of that standard during Covid
- Implementing a new transition framework and structure to support children moving into adulthood
- Implementing i-THRIVE and trauma informed approaches to support children and young people's needs being met early and appropriately
- A 45% reduction in the number of children and young people waiting more than 18 weeks for mental health services since July 2023
- Embedding children and young people's lived experience, participation and voice in our strategy, policies, workforce, service design and delivery

Working with the voluntary, community and social enterprise sector (VCSE) to develop workforce competencies and support evidence-based and innovative practice.

[1] Data for 2022/23 was sourced from the Mental Health Services Data Set. In previous years, local access to the national MHSDS was unavailable due to it not being set up within a local data warehouse. Also, not all commissioned providers were submitting to the MHSDS. External support was contracted to both work with providers to enable submissions and to ensure analysts could access robust and processed MHSDS locally. This process was started in started in mid-2021 and therefore 2021/22 data is incomplete.

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NHS
Kent and Medway

Children and Young People's Mental Health and Emotional Well-Being Dynamic Activity Overview

NHS
Kent and Medway

Contents

Aims

The aim of this document is to provide NHS Kent and Medway Children's Commissioning Team with data and intelligence to support the procurement of children and young people's

mental health services. It will provide an overview of demography and prevalence and explore current service use and potential future service use. Cohorts of children and young people who may be more vulnerable to mental ill health will also be considered. This document sits alongside documents such as the 2017 Kent Public Health Observatory needs assessment[1] and the Kent and Medway Local Transformation Plan[2].

This document will be a dynamic report and may change over time as additional data sources become available, additional analytics capacity becomes available and as we learn more about what will be most beneficial to the CYP of Kent and Medway, and their families and / or carers. The data presented in this report will be, at times, flawed, uncertain, proximate and sparse (FUPS); however, as Wolpert and Rutter[3] argue, FUPS data can be very useful as a starting point for conversation and decision making, and form a great foundation on which to build.

This report will be primarily utilised by the ICB's children's commissioning team; however, will also be externally facing to ensure transparency in our decision making.

[1] Emotional-and-mental-Health-Needs-Assessment-for-Children-.pdf (kpho.org.uk) [accessed 31st January 2024]
[2] Children, young people and young adults' emotional wellbeing and mental health :: Kent & Medway ICS (kmhealthandcare.uk) [accessed 31st January 2024]
[3] Wolpert, M., Rutter, H. Using flawed, uncertain, proximate and sparse (FUPS) data in the context of complexity: learning from the case of child mental health. BMC Med 16, 82 (2018). https://doi.org/10.1186/s12916-018-1079-6

Methodology

Some criteria were agreed at the beginning of producing this document that will underpin the whole report.

Age groups

The following age groups will be used, where possible (dependent on data sources):

- Under 5s (0 to 4 years of age inclusive)
- Primary school (5 to 10 years of age inclusive)
- Secondary school (11 to 17 years of age inclusive)

Some data will be presented for 18-24 year old as some mental health and emotional wellbeing services span the 0-24 population.

Geographies

Where possible, data will be presented in the following geographic Health Care Partnership (HCP) areas:

- East Kent
- West Kent
- North Kent
- Medway and Swale

Due to commissioning arrangements for children's services, data will also be presented by the following geographical regions:

- Kent and Medway
- Kent
- Medway

Demographics

There were 428,229 children and young people aged under the age of 18 registered to Kent and Medway GP practices as of December 2023.

However, given the geographical size of Kent and Medway, healthcare services are generally managed locally by Health Care Partnerships (HCPs). Each HCP covers distinctly different populations sizes, socio-economic factors and ethnicity.

Area	Dec 2023 Registered Population
Kent & Medway	428229
Kent	353707
Medway	74522
DGS HCP	67883
East Kent HCP	144530
Medway & Swale HCP	99800
West Kent HCP	116016

Source: Dec-23 GP Registration

Population forecasts (using a Local Authority forecasting tool that reflects expected birth rates, migration, and housing developments) shows that the population is set to rise over the next 10 years by approximately 4% to 445,368. However, this growth is not uniform across Kent and Medway. The table below shows variations in that expected growth across Health Care Partnership areas, with Medway showing a slightly increased growth rate of 7.7% and East Kent at 2.8%.

Population Forecasts for Children & Young People aged 0-17 years and registered to Kent & Medway GP Practices

Area	Dec 2023 Registered Population	Forecast Population 2026	Forecast Population 2028	Forecast Population 2030	Forecast Population 2033	Forecast 10yr change %
Kent & Medway	428229	437377	440761	442128	445368	4.0%
Kent	353707	360650	362932	363527	365114	3.2%
Medway	74522	76727	77829	78601	80254	7.7%
DGS HCP	67883	69908	70741	70622	70622	4.0%
East Kent HCP	144530	147499	148039	148174	148578	2.8%
Medway & Swale HCP	99800	102128	103098	103679	105134	5.3%
West Kent HCP	116016	118114	118752	119026	120485	3.9%

Source: Dec-23 GP Registration - KCC Forecast Toolkit

There are further nuances to the figures presented for the 0-17 population, with percentage increases and decreases within specific age groups. Forecast show that much of the rise in

the under 18 population is in the number of under 4s, with a predicted rise of 10.5% across Kent and Medway. Again, there a local variation in predicted growth ranging from just 4% in Dartford, Gravesham and Swanley to 14% in Medway. The detail of this rises can be seen in the table below.

Population Forecasts for Children & Young People aged 0-4 years and registered to Kent & Medway GP Practices

Area	Dec 2023 Registered Population	Forecast Population 2026	Forecast Population 2028	Forecast Population 2030	Forecast Population 2033	Forecast 10yr change %
Kent & Medway	101815	104336	106475	108901	112510	10.5%
Kent	83693	85699	87324	89234	91814	9.7%
Medway	18122	18637	19152	19666	20696	14.2%
DGS HCP	17212	17212	17440	17554	17896	4.0%
East Kent HCP	33126	34538	35180	35822	36721	10.9%
Medway & Swale HCP	24325	24786	25339	25984	27089	11.4%
West Kent HCP	27152	27857	28386	28915	29797	9.7%

Source: Dec-23 GP Registration - KCC Forecast Toolkit

The age group with the lowest projected rise in size is the 5 to10 year old (primary school age) cohort with forecast ranging from a fall of -1.5% in Dartford, Gravesham and Swanley to just 2.6% increase in Medway. Across Kent and Medway the population change over the 10 year period is just 0.05%.

Population Forecasts for Children & Young People aged 5-10 years and registered to Kent & Medway GP Practices

Area	Dec 2023 Registered Population	Forecast Population 2026	Forecast Population 2028	Forecast Population 2030	Forecast Population 2033	Forecast 10yr change %
Kent & Medway	145,490	120,594	142,483	142,804	145,562	0.0%
Kent	119,625	118,041	116,951	117,050	119,031	-0.5%
Medway	25,865	2,553	25,532	25,754	26,531	2.6%
DGS HCP	23,352	23,471	23,233	22,995	22,995	-1.5%
East Kent HCP	48,057	47,125	46,726	47,258	48,190	0.3%
Medway & Swale HCP	34,710	34,612	34,022	34,120	34,907	0.6%
West Kent HCP	39,371	38,822	38,547	38,547	39,463	0.2%

Source: Dec-23 GP Registration - KCC Forecast Toolkit

Prevalence of probable mental health disorders (see next section) shows that the age group with the highest prevalence are those aged 11 and 17 years. Within this age group the 10 year forecast across Kent and Medway is 3.3% (0.2% in east Kent to 7.9% in Medway). It is also notable that this is the only age cohort that set to rise over the next five years but then fall slightly over the subsequent five years.

Population Forecasts for Children & Young People aged 11-17 years and registered to Kent & Medway GP Practices

Area	Dec 2023 Registered Population	Forecast Population 2026	Forecast Population 2028	Forecast Population 2030	Forecast Population 2033	Forecast 10yr change %
Kent & Medway	180,924	189,134	191,875	190,239	186,979	3.3%
Kent	150,389	156,884	158,710	157,188	154,042	2.4%
Medway	30,535	32,250	33,165	33,051	32,937	7.9%
DGS HCP	27,319	29,148	29,880	30,002	29,636	8.5%
East Kent HCP	63,347	66,010	66,290	65,169	63,487	0.2%
Medway & Swale HCP	40,765	42,744	43,733	43,436	43,041	5.6%
West Kent HCP	49,493	51,439	51,903	51,625	50,605	2.2%

Source: Dec-23 GP Registration - KCC Forecast Toolkit

It should be noted that as the ICB are proposing a ten-year contract; reliability of projected data decreases over time. Therefore, flexibility will be built into the contracts to allow for this, and demand will be monitored over time and compared with any projections made. It is anticipated that there will be a few reviews over the lifetime on the contract, rather than producing unreliable projections now and trying to make a provider(s) deliver to them.

The population that is projected to grow the most over the next 10 years is for those aged 18 to 24 years with a forecast rise of 24.7% (18% in West Kent to 30.7% in Medway).

Population Forecasts for Children & Young People aged 18-24 years and registered to Kent & Medway GP Practices

Area	Dec 2023 Registered Population	Forecast Population 2026	Forecast Population 2028	Forecast Population 2030	Forecast Population 2033	Forecast 10yr change %
Kent & Medway	148631	161,594	172,322	182,205	185,306	24.7%
Kent	123768	134,223	142,988	150,908	152,809	23.5%
Medway	24863	27,371	29,334	31,297	32,496	30.7%
DGS HCP	20687	22,320	24,089	25,450	26,403	27.6%
East Kent HCP	60808	68,346	72,618	76,136	75,256	23.8%
Medway & Swale HCP	32912	35,753	38,299	40,748	42,120	28.0%
West Kent HCP	34224	35,034	36,857	38,780	40,401	18.0%

Source: Dec-23 GP Registration - KCC Forecast Toolkit

Socio-economic levels vary from locations that are in the 10% most deprived nationally (parts of Swale, Thanet, Medway, Folkestone and Hythe) to those in the 10% least deprived (Sevenoaks, Tunbridge Wells, Tonbridge). The association between deprivation and poor mental health is well documented[4]. It should also be noted that there is relative deprivation within all local authorities, which can also have a significant impact on wellbeing[5].

[4] NHS England, 2022, CYPMH survey, https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2022-follow-up-to-the-2017-survey/part-5-social-and-economic-context [accessed 12th February 2024]

[5] Chen, X, 2015, Relative deprivation and individual well-being, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5638129/#:~:text=Relative%20deprivation%20has%20been%20shown,rights%20such%20as%20health%20status. [accessed 12th February 2024]

Ethnicity in Kent and Medway also shows variation with higher percentages of Black and Minority Ethnic populations in Dartford (34%) and Gravesham (30%) than is seen in Dover (8%).

Ethnic breakdown for 0-17 yr olds across Kent & Medway - Census 2021

	Asian, Asian British	Black, Black British	Mixed	Other	White
Ashford	6%	4%	5%	1%	84%
Canterbury	6%	5%	6%	2%	81%
Dartford	11%	14%	6%	2%	66%
Dover	3%	1%	3%	1%	92%
Folkestone and Hythe	5%	1%	4%	1%	89%
Gravesham	12%	9%	6%	3%	70%
Maidstone	5%	3%	5%	1%	86%
Medway	6%	8%	6%	2%	78%
Sevenoaks	3%	2%	6%	1%	88%
Swale	1%	3%	4%	1%	91%
Thanet	3%	1%	5%	2%	89%
Tonbridge and Malling	3%	1%	5%	1%	90%
Tunbridge Wells	5%	1%	6%	1%	87%
Kent & Medway	5%	4%	5%	1%	83%

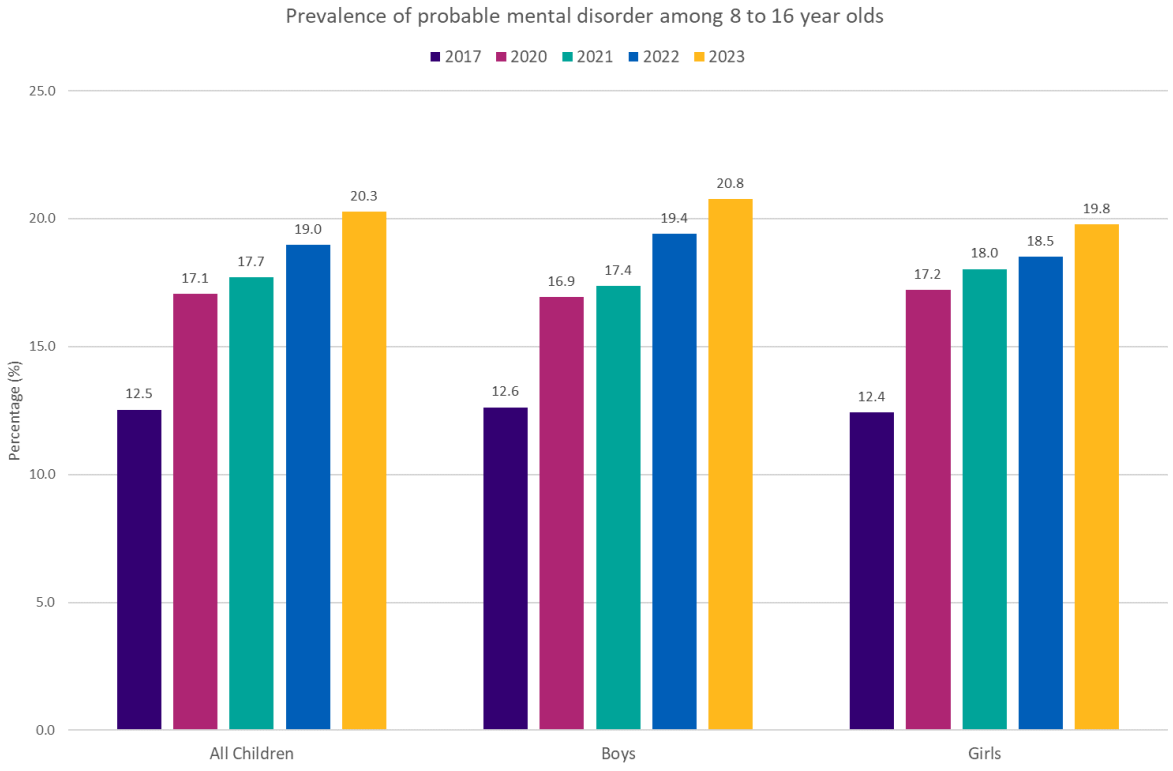
Prevalence

NHS England[6] have conducted a series of surveys investigating the mental health of CYP nationally. The first survey was conducted in 2017 and there have been four subsequent follow-up surveys, or waves: in 2020 (wave 1), 2021 (wave 2), 2022 (wave 3) and 2023 (wave 4).

This report will focus on some of the key findings from the 2023 follow up, as well as making some comparisons to 2017, where possible, to look at changes over time. The 2017 survey included CYP as young as age 2; however, these CYP have now grown up and so the 2023 wave 4 follow-up includes 2,370 CYP aged between 8 and 25 years who took part in the MHCYP 2017.

The survey focusses on mental health as well as household circumstances and experiences of education and services and of life in families and communities. Further analyses of the prevalence surveys can be found in the appendix one.

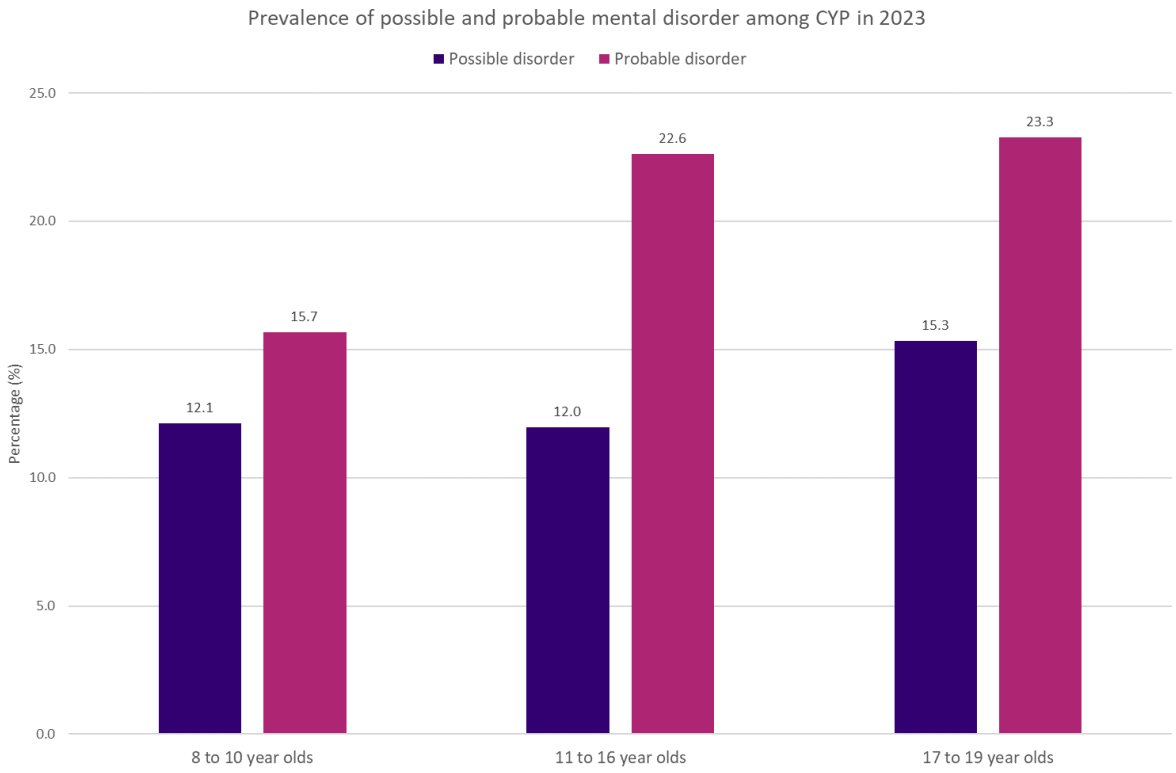
CYP completed the Strengths and Difficulties Questionnaire (SDQ)[7], a validated tool that can be used to assess different aspects of mental health, including problems with emotions, behaviour and hyperactivity. Based on this, responses were then categorised into 'probably', 'possibly' or 'unlikely' to have a mental health condition. The likelihood of those who 'probably' or 'possibly' have a mental health condition accessing services is unknown, so we have assumed that those with a 'probable' mental health condition will be those who need to access services.



In 2023, one in five (20.3%) children aged 8 to 16 years old had a probable mental health disorder, an increase from 12.5% in 2017. There was a considerable increase to 17.1% in

[6] NHS England, 2023, https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2023-wave-4-follow-up [accessed 3rd January 2024]
[7] Strengths and Difficulties Questionnaire, https://vimeo.com/888036265, [accessed 3rd January 2024, from 06:25 minutes]

2020 but since then rates of probable mental disorder have remained relatively stable in all age groups between 2022 and 2023. The Health Foundation published informative data regarding the impact of covid-19 on CYP's mental health and the subsequent increase in demand for services[8].



The percentage of CYP with a possible mental disorder remains consistent for 8 to 10 year olds and 11 to 16 year olds (approximately 12%) but increased to 15.3% among 17 to 19 year olds. The prevalence of probable mental disorder increased with age from 15.7% among 8 to 10 year olds to 22.6% among 11 to 16 year olds. It then remained fairly stable (23.3%) among 17 to 19 year olds.

Applying these national prevalence statistics to the Kent and Medway populations suggests that 100,463 CYP aged 5 to 17 years old may have a mental disorder. Of these, 59,362 CYP have a probable mental disorder and 41,101 have a possible mental disorder. The table below shows the age and gender breakdown of the estimated number of CYP with probable or possible mental disorders, based on 2023 registered populations.

[8] The Health Foundation, Covid-19 and the road ahead, 2022, https://www.health.org.uk/news-and-comment/charts-and-infographics/children-and-young-people-s-mental-health [accessed 8th January 2024]

	Estimated prevalence	Probable mental disorder			Possible mental disorder			Any mental disorder		
		Male	Female	Persons	Male	Female	Persons	Male	Female	Persons
Kent and Medway	5-7 year olds	4,219	2,447	6,698	6,195	3,431	9,677	10,414	5,877	16,375
	8-10 year olds	6,693	4,887	11,580	6,295	2,654	8,951	12,987	7,541	20,531
	11-16 year olds	17,908	17,363	35,273	9,118	9,521	18,643	27,026	26,884	53,916
	17 year olds	1,994	3,799	5,812	1,900	1,929	3,830	3,893	5,728	9,641
	5-17 year olds	**30,813**	**28,495**	**59,362**	**23,508**	**17,535**	**41,101**	**54,321**	**46,030**	**100,463**
Dartford and Gravesham	5-7 year olds	687	391	1,081	1,009	549	1,562	1,695	940	2,643
	8-10 year olds	1,051	794	1,849	988	431	1,429	2,039	1,225	3,278
	11-16 year olds	2,719	2,648	5,368	1,385	1,452	2,837	4,104	4,101	8,205
	17 year olds	279	560	835	266	285	550	545	845	1,385
	5-17 year olds	**4,736**	**4,394**	**9,132**	**3,647**	**2,716**	**6,378**	**8,383**	**7,110**	**15,510**
West Kent HCP	5-7 year olds	1,131	670	1,815	1,661	940	2,622	2,792	1,610	4,437
	8-10 year olds	1,819	1,313	3,130	1,711	713	2,419	3,530	2,026	5,549
	11-16 year olds	4,904	4,747	9,651	2,497	2,603	5,101	7,401	7,350	14,752
	17 year olds	546	1,035	1,588	520	525	1,046	1,066	1,560	2,634
	5-17 year olds	**8,400**	**7,765**	**16,183**	**6,389**	**4,781**	**11,189**	**14,789**	**12,546**	**27,372**
East Kent HCP	5-7 year olds	1,390	800	2,199	2,041	1,122	3,177	3,430	1,923	5,376
	8-10 year olds	2,229	1,620	3,848	2,096	880	2,974	4,325	2,499	6,822
	11-16 year olds	6,251	6,026	12,278	3,183	3,304	6,489	9,434	9,330	18,767
	17 year olds	734	1,357	2,109	700	689	1,390	1,434	2,046	3,499
	5-17 year olds	**10,604**	**9,803**	**20,433**	**8,020**	**5,995**	**14,030**	**18,623**	**15,798**	**34,464**
Medway and Swale HCP	5-7 year olds	1,011	585	1,603	1,485	820	2,316	2,496	1,405	3,919
	8-10 year olds	1,594	1,160	2,754	1,499	630	2,129	3,093	1,790	4,882
	11-16 year olds	4,034	3,942	7,976	2,054	2,162	4,216	6,088	6,104	12,192
	17 year olds	434	847	1,280	414	430	844	848	1,277	2,124
	5-17 year olds	**7,073**	**6,534**	**13,613**	**5,452**	**4,042**	**9,504**	**12,525**	**10,576**	**23,117**
Kent	5-7 year olds	3,469	2,009	5,505	5,095	2,818	7,954	8,564	4,827	13,458
	8-10 year olds	5,507	4,018	9,525	5,179	2,182	7,362	10,686	6,200	16,887
	11-16 year olds	14,893	14,401	29,297	7,583	7,897	15,484	22,476	22,298	44,781
	17 year olds	1,673	3,158	4,855	1,594	1,603	3,199	3,267	4,761	8,054

	5-17 year olds	**25,542**	**23,587**	**49,181**	**19,452**	**14,501**	**33,999**	**44,994**	**38,088**	**83,180**
Medway	5-7 year olds	749	437	1,193	1,100	613	1,724	1,850	1,050	2,917
	8-10 year olds	1,186	869	2,055	1,115	472	1,588	2,301	1,340	3,643
	11-16 year olds	3,015	2,962	5,976	1,535	1,624	3,159	4,550	4,586	9,135
	17 year olds	321	641	957	306	325	631	626	966	1,588
	5-17 year olds	**5,271**	**4,908**	**10,181**	**4,056**	**3,034**	**7,101**	**9,327**	**7,942**	**17,282**

Notes	5-7 year olds	Based on 2020 5 to 10 year olds prevalence
	8-10 year olds (2023)	Based on 2023 prevalence
	11-16 year olds (2023)	Based on 2023 prevalence
	17 year olds (2023 17-19 year olds)	Based on 2023 17 to 19 year olds prevalence
	5-17 year olds	

Projected forwards, it is estimated that by 2028, 61,500 CYP aged 5-17 will have a probable mental disorder and an additional 42,143 CYP a possible mental disorder. This is based on the 2023 prevalence remaining constant (as it has remained relatively steady between 2022 and 2023); however, it is likely that the prevalence may still increase.

Pre-school prevalence

The 2017 CYP MH survey included analyses regarding CYP aged 2 to 4, presented as experimental data[9]. It was reported that 5.5% of CYP aged 2-4 years of age had a mental disorder, shown in the table below.

Specific mental disorder	Prevalence (%)
Oppositional defiant disorder	1.9
Pervasive development disorder / Autism spectrum disorder	1.4
Feeding disorder	0.8
Sleeping disorder	1.3
Elimination (toileting) disorder	0.2

These conditions would fall outside of the service being commissioned, so 2- to 4-year-olds will be not be a focus of analyses within this report.

[9] NHS England, 2017, https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017 [accessed 8th January 2024]

Current Demand

This section of this report outlines the current demand on our commissioned services. It starts by discussing the national target for the number of CYP accessing our services then provides an overview of the Mental Health Services Dataset, which is the source of the data for the current demand section.

Following this, the activity within different mental health services is outlined; focussing on inpatient, specialist mental health services, non-specialist mental health services, and non-NHS commissioned services.

Activity related to Mental Health Support Teams (MHSTs), Crisis and Neurodiverse services is detailed with the supporting appendix two.

NHS England's Access Target

The Five Year Forward View for Mental Health (FYFVMH) gave Clinical Commissioning Groups (CCGs) targets for the number of CYP accessing mental health services from 2016/17. The NHS Long Term Plan built upon the FYFVMH commitment to increase access so that by 2023/34, an additional 345,000 children and young people nationally have access to support from an NHS funded service or school- or college-based Mental Health Support Team (MHST).

This support may involve immediate advice, support, or a brief intervention, help to access another more appropriate service, the start of a longer-term intervention or agreement about a patient care plan, or the start of a specialist assessment that may take longer. The new access metric was defined as children and young people receiving one contact with services. In 2023/24, our Kent and Medway target was to enable 33,598 children and young people aged under 18 to access support (one contact or more) from services. This target is being kept consistent for 2024/25.

Mental health services dataset

To measure performance against the access target, and other metrics, providers are required to submit to the mental health services dataset (MHSDS)[10]. The MHSDS is held by NHS England, and is a patient level, output based, secondary uses data set which aims to deliver robust, comprehensive, nationally consistent and comparable person-based information regarding children, young people and adults who are in contact with services for mental health and wellbeing, Learning Disability, autism or other neurodevelopmental conditions needs. All activity relating to patients of any age who receive care for a suspected or diagnosed mental health and wellbeing need, Learning Disability, autism or other neurodevelopmental conditions is within scope of the MHSDS.

It is mandatory for any relevant service in receipt of NHS funding (wholly or partially) to submit data to the MHSDS, and optional for services not in receipt of NHS funding. Where services are not in receipt of NHS funding, it may be a contractual requirement to submit data to the MHSDS. As a minimum, providers must submit the relevant data to contribute towards NHS England's monitoring metrics, which vary according to services delivered.

Locally, we can access pseudonymised data from the MHSDS and use MHSDS data to look at current service use. An alternative would be to use local provider reported data (e.g. performance reporting); however, all providers should submit data to the MHSDS in the

[10] Mental Health Services Data Set (MHSDS) - NHS Digital [accessed 31st January 2024]

same format and it should have greater coverage. There are shortfalls of the MHSDS data; for example, some providers do not code geography within their submission; however, as with all FUPS data, it is a good starting point.

The current provider landscape is articulated in the Kent and Medway Local Transformation Plan[11].

Inpatient services

Tier 4 inpatient mental health services are commissioned by NHS England via provider collaboratives[12]. There is a provision of 9 long stay and 3 short stay beds children and young people's inpatient beds within the Kent and Medway Adolescent Hospital. There are Kent and Medway CYP who are placed out of area.

Over the 12 months period up to August 2023 there were 20 new admissions to KMAH and 30 new admissions to inpatient beds outside of Kent.

Specialist mental health services

Activity

An overview of specialist activity is presented in appendix two, the following is a summary of the key findings from that analysis.

There were 15,897 referrals into specialist services in the 12-month period April 2022 to March 2023. These exclude referrals to Mental Health Support Teams, Eating Disorders, Crisis and Neuro Development related (referrals for assessment, etc). In total there were 17,851 open referrals (as some were received prior to April 2022). These referrals generated a total of 104,064 contacts (a contact is defined as an interaction with the service, be that face to face, in a group or via video call, or messaging service) for children and young people aged under 18.

The 11- to 17-year-old age group accounted for 80% of referrals and 91% of all contacts. The gender split for referrals for under 11s was slightly higher for males (59%) but changed to a higher percentage for females in the 11- to 17-year-old cohort (61%).

A similar pattern was seen in the contacts data with males having more contacts in the under 11s age cohort (61%) and females in the 11- to 17-year-old cohort (64%).

The referral rate (per 1,000 CYP) was highest in the East Kent HCP and Medway and Swale HCP areas. Contacts rates were also highest in East Kent HCP area.

The primary reasons for referral into a specialist service across Kent and Medway were highest for depression, self-harm behaviours and anxiety. These three conditions also saw the most contacts within specialist services, with self-harm being the highest.

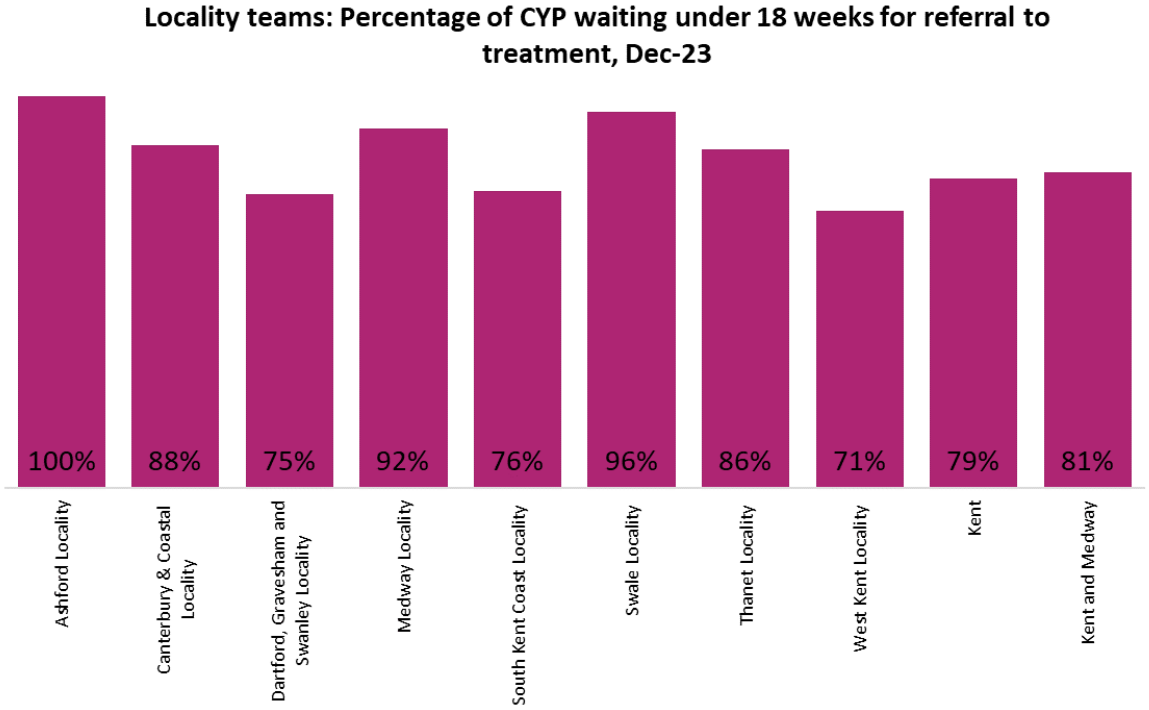
Together, depression and/or anxiety account for 48% of referrals and 40% of contacts.

Waiting Lists for specialist service

Further analysis shows that approximately 13% of CYP referred for depression and/or anxiety also have a referral for a further specialist condition within the same year.

[11] Summary of Kent and Medway children, young people and young adults emotional wellbeing and mental health Local Transformation Plan 2021 (kmhealthandcare.uk) [accessed 31st January 2024]
[12] NHS England » NHS-Led Provider Collaboratives: specialised mental health, learning disability and autism services [accessed 31st January 2024]

As of December 2023, specialist teams are generally meeting demand, with 81% of CYP waiting under 18 weeks for referral to treatment. This varies across Kent and Medway, with high percentages of CYP waiting under 18 weeks in Ashford (100%) and Swale (96%). Dartford, Gravesham and Swanley (75%) and West Kent (71%) have higher percentages of CYP waiting over 18 weeks.



The table below shows the number of CYP waiting in total, and the number of CYP waiting over 18 weeks from referral to treatment, as at December 2023.

Locality team area	Total CYP waiting	CYP waiting over 18 weeks
Ashford	64	0
Canterbury & Coastal	161	20
Dartford, Gravesham and Swanley	161	40
Medway	132	11
South Kent Coast	132	32
Swale	49	2
Thanet	110	15
West Kent	382	112
Kent	1059	221
Kent and Medway	1191	232

Non-specialist mental health services

Activity

An overview of non-specialist activity is presented in appendix two, the following is summary of the key findings from that analysis.

There was a total of 12,667 referrals to non-specialist services in the period April 2022 to March 2023. These referrals generated 33,972 contacts with those services.

11- to 17-year-olds accounted for a 89% of all non-specialist referrals. Females were 2.8 times more likely to have a referral than males.

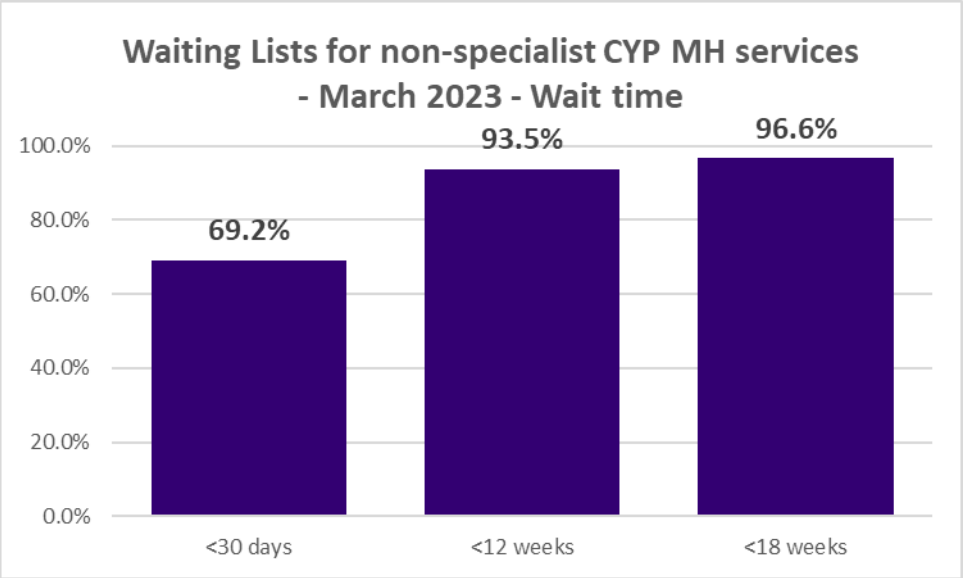
Analyses of geographical area was not possible to due to the poor recording of GP practice code or resident postcode (which are used to link the activity with an area). Only 28% of referrals could be allocated to HCP areas.

There were also poor completion rates for primary reason for referral. There are some tables presented in appendix two in relation to referral reason but they should be treated with caution due to the data quality.

The majority (72%) of the non-specialist service activity is allocated to KOOTH (an online emotional well-being support service).

Waiting list for non-specialist services

Waiting lists for non-specialist services are managed within each of the provider organisations. For the online emotional well-being support service (KOOTH), there is no waiting list and this accounts for 72% of the activity. Of the remaining referrals, 97% are seen within 18 weeks.



For an overview of Mental Health Support Team, Crisis and Neurodiverse referrals in terms of age/gender and geography please refer to appendix two.

Non-NHS commissioned services

CYP also access mental health support through other sources; for example, non NHS funded charitable sector services, KCC funded services, education funded services or privately. It is not possible to access data to understand the demand on these services, or the quantify the number of CYP accessing support via these services.

However, data is available in some cases – for example KCC's emotional wellbeing service delivered by KCHFT received 6,500 referrals. KCHFT have reported that referrals have been increasing in recent months and have seen a 34% increase in referrals over the last six months of 2023.

Activity delivered through Mental Health Support Teams (MHST)[13] is currently delivered by NELFT and provide in schools. By wave 12 in 2026, 60% of Kent and Medway pupils will have access to an MHST. An overview of this activity can be found in appendix two.

[13] NELFT Mental Health Support Teams, https://www.nelft.nhs.uk/kent-and-medway-mental-health-support-teams/ [accessed 3rd January 2024]

Future model: Specialist service and Therapeutic Alliance balance

The proposed model for the mental health services across Kent and Medway includes a specialist service and a therapeutic alliance service. Information regarding the proposals is available via the NHS Kent and Medway children's commissioning team.

We have used existing data from our provider's submissions to the Mental Health Services Dataset (MHSDS) for 2022/23 to estimate the amount of activity in both the specialist and Therapeutic Alliance services. More detailed information on the methodology for this is included in the appendix three, but broadly referrals with a primary referral reason of anxiety, depression and relationship difficulties are moved from specialist services to sit within a Therapeutic Alliance.

The table below shows the current split between CYP being referred to specialist and other NHS commissioned (therapeutic alliance) services, based approximately on 2022/23 primary reasons for referral.

Area	Specialist Services Referrals	Other NHS Commissioned Services Referrals	Total referrals	Percentage referrals to Specialist	Percentage referrals to Other
Kent & Medway	**15,897**	**12,677**	**28,574**	**55.6%**	**44.4%**
Kent	13,083	10,372	23,455	55.1%	44.9%
Medway	2,574	1,600	4,174	61.7%	38.3%
East Kent HCP	6,494	5,095	11,589	56.0%	44.0%
Dartford, Gravesham & Swanley HCP	1,900	1,573	3,473	54.7%	45.3%
Medway & Swale HCP	3,730	2,592	6,322	59.0%	41.0%
West Kent HCP	3,533	3,058	6,591	53.6%	46.4%
Unknown Area	240	224	464	51.7%	48.3%

Excludes: MHSTs, Eating Disorders, Crisis and Neurodiverse referrals

Source: MHSDS

For the purposes of this table, all NELFT activity has been included in the specialist column; however, this may not be the case in practice. KMPT data and MCH data (not including their ND activity) also contribute towards the specialist service figures. Activity that is coded as anxiety, depression or relationship difficulties but is currently seen in NELFT is coded as specialist currently as they are a specialist service provider.

We have then modelled this analysis via a range of options, looking at different splits in demand between specialist and a proposed therapeutic alliance. The following percentages, if anxiety, depression and relationship difficulties were removed from the specialist services and moved into the therapeutic alliance: 100%, 80%, 50% and 30%.

Scenario one: Referrals breakdown assuming 100% of anxiety, depression and relationship difficulties are removed from Specialist services and instead referred into the therapeutic alliance.

Area	Specialist Services Referrals	Other NHS Commissioned Services Referrals	Total referrals	Percentage referrals to Specialist	Percentage referrals to Other
Kent & Medway	**6,908**	**21,666**	**28,574**	**24.2%**	**75.8%**
Kent	5,536	17,919	23,455	23.1%	76.9%
Medway	1,218	2,956	4,174	29.2%	70.8%
East Kent HCP	2,795	8,794	11,589	24.1%	75.9%
Dartford, Gravesham & Swanley HCP	763	2,710	3,473	22.0%	78.0%
Medway & Swale HCP	1,754	4,568	6,322	27.7%	72.3%
West Kent HCP	1,442	5,149	6,591	21.9%	78.1%
Unknown Area	154	310	464	33.2%	66.8%

Excludes: MHSTs, Eating Disorders, Crisis and Neurodiverse referrals

Source: MHSDS

Scenario two: Referrals breakdown assuming 80% of anxiety, depression and relationship difficulties are removed from Specialist services and instead referred into the therapeutic alliance.

Area	Specialist Services Referrals	Other NHS Commissioned Services Referrals	Total referrals	Percentage referrals to Specialist	Percentage referrals to Other
Kent & Medway	**8,706**	**19,868**	**28,574**	**30.5%**	**69.5%**
Kent	7,045	16,410	23,455	29.5%	70.5%
Medway	1,489	2,685	4,174	35.7%	64.3%
East Kent HCP	3,535	8,054	11,589	30.5%	69.5%
Dartford, Gravesham & Swanley HCP	990	2,483	3,473	28.5%	71.5%
Medway & Swale HCP	2,149	4,173	6,322	34.0%	66.0%
West Kent HCP	1,860	4,731	6,591	28.2%	71.8%
Unknown Area	171	293	464	36.9%	63.1%

Excludes: MHSTs, Eating Disorders, Crisis and Neurodiverse referrals

Source: MHSDS

Scenario three: Referrals breakdown assuming 50% of anxiety, depression and relationship difficulties are removed from Specialist services and instead referred into the therapeutic alliance.

Area	Specialist Services Referrals	Other NHS Commissioned Services Referrals	Total referrals	Percentage referrals to Specialist	Percentage referrals to Other
Kent & Medway	**11,403**	**17,172**	**28,574**	**39.9%**	**60.1%**
Kent	9,310	14,145	23,455	39.1%	60.9%
Medway	1,896	2,278	4,174	45.4%	54.6%
East Kent HCP	4,645	6,944	11,589	40.1%	59.9%
Dartford, Gravesham & Swanley HCP	1,332	2,142	3,473	38.3%	61.7%
Medway & Swale HCP	2,742	3,580	6,322	43.4%	56.6%
West Kent HCP	2,488	4,103	6,591	37.7%	62.3%
Unknown Area	197	267	464	42.5%	57.5%

Excludes: MHSTs, Eating Disorders, Crisis and Neurodiverse referrals

Source: MHSDS

Scenario four: Referrals breakdown assuming 30% of anxiety, depression and relationship difficulties are removed from Specialist services and instead referred into the therapeutic alliance.

Area	Specialist Services Referrals	Other NHS Commissioned Services Referrals	Total referrals	Percentage referrals to Specialist	Percentage referrals to Other
Kent & Medway	**13,200**	**15,374**	**28,574**	**46.2%**	**53.8%**
Kent	10,819	12,636	23,455	46.1%	53.9%
Medway	2,167	2,007	4,174	51.9%	48.1%
East Kent HCP	5,384	6,205	11,589	46.5%	53.5%
Dartford, Gravesham & Swanley HCP	1,559	1,915	3,473	44.9%	55.1%
Medway & Swale HCP	3,137	3,185	6,322	49.6%	50.4%
West Kent HCP	2,906	3,685	6,591	44.1%	55.9%
Unknown Area	214	250	464	46.2%	53.8%

Excludes: MHSTs, Eating Disorders, Crisis and Neurodiverse referrals

Source: MHSDS

An alternative way to look at demand could be to consider the number of contacts with MH services. The table below shows the number of contacts in 2022/23 with Kent and Medway NHS commissioned mental health services.

Area	Specialist Services Contacts	Other NHS Commissioned Services Contacts	Total Contacts	Percentage Contacts to Specialist	Percentage Contacts to Other
Kent & Medway	**104,064**	**33,972**	**138,036**	**75.4%**	**24.6%**
Kent	86,626	23,330	109,956	78.8%	21.2%
Medway	15,484	2,306	17,790	87.0%	13.0%
East Kent HCP	44,392	10,427	54,819	81.0%	19.0%
Dartford, Gravesham & Swanley HCP	11,642	2,733	14,375	81.0%	19.0%
Medway & Swale HCP	23,451	6,744	30,195	77.7%	22.3%
West Kent HCP	22,625	5,732	28,357	79.8%	20.2%
Unknown Area	1,954	8,184	10,138	19.3%	80.7%

Excludes: MHSTs, Eating Disorders, Crisis and Neurodiverse Contacts

Source: MHSDS

These data have been aligned to specialist or other NHS commissioned services in the same way as the referrals data. We have also then modelled this via a range of options, looking at different splits in demand between specialist and therapeutic alliance. The following percentages if anxiety, depression, and relationship difficulties were removed from the specialist services and into the therapeutic alliance: 100%, 80% and 50%.

Scenario one: Contacts breakdown assuming 100% of anxiety, depression and relationship difficulties activity is removed from Specialist services into the therapeutic alliance.

Area	Specialist Services Contacts	Other NHS Commissioned Services Contacts	Total Contacts	Percentage Contacts to Specialist	Percentage Contacts to Other
Kent & Medway	**68,753**	**69,283**	**138,036**	**24.2%**	**75.8%**
Kent	56,569	53,387	109,956	23.1%	76.9%
Medway	10,617	7,173	17,790	29.2%	70.8%
East Kent HCP	30,499	24,320	54,819	24.1%	75.9%
Dartford, Gravesham & Swanley HCP	7,278	7,097	14,375	22.0%	78.0%
Medway & Swale HCP	16,341	13,854	30,195	27.7%	72.3%
West Kent HCP	13,068	15,289	28,357	21.9%	78.1%
Unknown Area	1,547	8,591	10,138	33.2%	66.8%

Excludes: MHSTs, Eating Disorders, Crisis and Neurodiverse Contacts

Source: MHSDS

Scenario two: Contacts breakdown assuming 80% of anxiety, depression and relationship difficulties activity is removed from Specialist services into the therapeutic alliance.

Area	Specialist Services Contacts	Other NHS Commissioned Services Contacts	Total Contacts	Percentage Contacts to Specialist	Percentage Contacts to Other
Kent & Medway	**75,815**	**62,221**	**138,036**	**30.5%**	**69.5%**
Kent	62,580	47,375	109,956	29.5%	70.5%
Medway	11,590	6,199	17,790	35.7%	64.3%
East Kent HCP	33,278	21,541	54,819	30.5%	69.5%
Dartford, Gravesham & Swanley HCP	8,151	6,224	14,375	28.5%	71.5%
Medway & Swale HCP	17,763	12,432	30,195	34.0%	66.0%
West Kent HCP	14,979	13,378	28,357	28.2%	71.8%
Unknown Area	1,628	8,510	10,138	36.9%	63.1%

Excludes: MHSTs, Eating Disorders, Crisis and Neurodiverse Contacts

Source: MHSDS

Scenario three: Contacts breakdown assuming 50% of anxiety, depression and relationship difficulties activity is removed from Specialist services into the therapeutic alliance.

Area	Specialist Services Contacts	Other NHS Commissioned Services Contacts	Total Contacts	Percentage Contacts to Specialist	Percentage Contacts to Other
Kent & Medway	**86,409**	**51,628**	**138,036**	**39.9%**	**60.1%**
Kent	71,598	38,358	109,956	39.1%	60.9%
Medway	13,051	4,739	17,790	45.4%	54.6%
East Kent HCP	37,446	17,373	54,819	40.1%	59.9%
Dartford, Gravesham & Swanley HCP	9,460	4,915	14,375	38.3%	61.7%
Medway & Swale HCP	19,896	10,299	30,195	43.4%	56.6%
West Kent HCP	17,847	10,511	28,357	37.7%	62.3%
Unknown Area	1,751	8,388	10,138	42.5%	57.5%

Excludes: MHSTs, Eating Disorders, Crisis and Neurodiverse Contacts

Source: MHSDS

Scenario four: Contacts breakdown assuming 30% of anxiety, depression and relationship difficulties activity is removed from Specialist services into the therapeutic alliance.

Area	Specialist Services Contacts	Other NHS Commissioned Services Contacts	Total Contacts	Percentage Contacts to Specialist	Percentage Contacts to Other
Kent & Medway	**93,471**	**44,565**	**138,036**	**67.7%**	**32.3%**
Kent	77,609	32,347	109,956	70.6%	29.4%
Medway	14,024	3,766	17,790	78.8%	21.2%
East Kent HCP	40,224	14,594	54,819	73.4%	26.6%
Dartford, Gravesham & Swanley HCP	10,333	4,042	14,375	71.9%	28.1%
Medway & Swale HCP	21,318	8,877	30,195	70.6%	29.4%
West Kent HCP	19,758	8,599	28,357	69.7%	30.3%
Unknown Area	1,832	8,306	10,138	18.1%	81.9%

Excludes: MHSTs, Eating Disorders, Crisis and Neurodiverse Contacts

Source: MHSDS

Vulnerable groups

There are several cohorts of CYP who may have both higher risk of mental illness as well as additional challenges regarding access to services. The following section of this document explores some of these cohorts.

Adverse Childhood Experiences

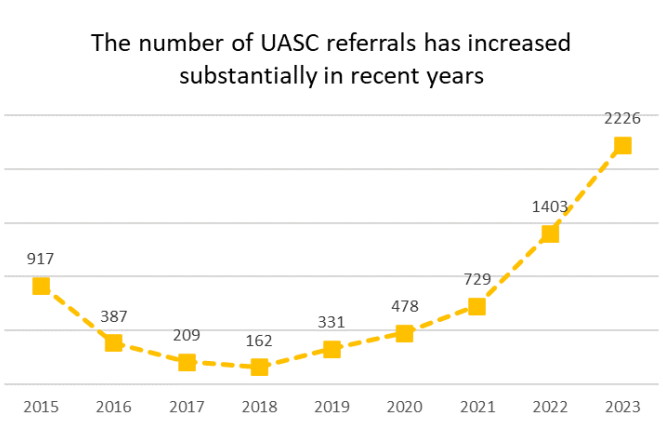
Adverse Childhood Experiences (ACEs) are potentially traumatic events that occur in childhood. Toxic stress from ACEs can change brain development and affect how the body responds to stress. ACEs are linked to chronic health problems, mental illness, and substance misuse in adulthood[14]. Whilst 61% of adults had experienced at least one ACE and 16% had experienced four or more types of ACEs, CYP known to social services are more likely to have experienced ACEs than the general population.

Unaccompanied Asylum-Seeking Children

Unaccompanied Asylum-Seeking Children in our care have been exposed to trauma in multiple ways; the reasons for leaving their country of origin, during their journey and the trauma of being within the UK. Underpinning these traumas is also the abrupt and traumatic separation, loss and grief for their significant attachment figures.

A Health Needs Assessment[15] conducted in 2016 referenced research that 48% of UASC met diagnostic criteria for a mental illness, the most common diagnoses being Post-Traumatic Stress Disorder (PTSD), major depressive disorder, general anxiety disorder and agoraphobia.

Delayed presentations of mental illness are also recognised and may affect up to 1 in 5 unaccompanied children. This may be because young people are reluctant to discuss their symptoms due to shame or guilt, or due to cultural differences in interpretation of symptoms of mental illness. Survivors of torture may prioritise focusing on their basic needs, such as stable accommodation, before being willing to discuss their experiences. Therefore, reassessment and ongoing surveillance for signs of mental illness is required.

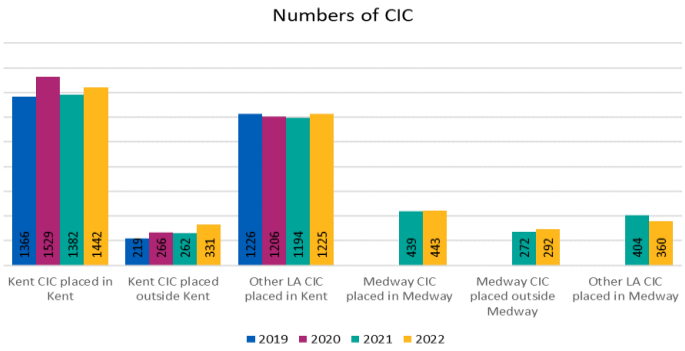


Kent tends to have higher numbers of UASC than other areas due to its geographical location; however, CYP can be placed outside of the Local Authority. In December 2023, there were 1,604 UASC aged 25 and under in Kent, consistent with the number in the previous year (1,602 in December 2022)[16]. In 2022, Medway had 20 UASC placed into the Unitary Authority[17]. If 48% of UASC meet the diagnostic criteria for a mental illness, then this would equate to approximately 800 UASC across Kent and Medway. Further area specific breakdown within Kent and Medway is not available.

[14] Centers for Disease Control and Prevention, [accessed 24th January]
[15] https://www.kpho.org.uk/__data/assets/pdf_file/0011/58088/Unaccompanied-children-HNA.pdf [accessed 19th January 2024]
[16] KCC MIU
[17] Medway Council

Children in care

Due to their experiences both before and during care, children in care (CIC) are at much greater risk of poor mental health than their peers. Research suggests that around 45% of children in care have a diagnosable mental health disorder, and up to 70%-80% have recognisable mental health concerns[18].



Sources: KCC & Medway council

The numbers in the CIC chart cannot be summed to form a Kent and Medway CIC total figure as some children may be double counted across Kent and Medway. However, research suggests approximately 2,000 CIC in Kent and Medway may have a diagnosable mental health disorder.

Further information on demographical breakdown of CIC is available in the annual reports for the Looked After Children's team.

Request for support proceeding to Children's Social Work Services[19]

4.9% of Kent pupils had a request for support proceeding to children's social work services. Applied to the Kent and Medway school aged population, approximately 13,500 may have a request for support proceeding to children's social work services. This could be approximately 2,500 in Medway and 11,000 in Kent.

Child protection act

0.6% of Kent pupils were under the child protection act. Applied to the Kent and Medway school aged population, approximately 1,700 may be under the child protection act. This could be approximately 300 in Medway and 1,400 in Kent.

Children in Need

1.6% of Kent pupils were classified as children in need. Applied to the Kent and Medway school aged population, approximately 4,400 may be classified as children in need. This could be approximately 800 in Medway and 3,600 in Kent.

Adoption

Most CYP who are adopted from care have suffered adverse childhood experiences[20]. They are at higher risk of poor mental health than the general population. Among adoptees, research showed that mental health had not improved four years after adoption. Problems increased with the number of adverse childhood experiences CYP had before adoption. Adopted children are more likely to have symptoms of post-traumatic stress than the general population.

[18] https://www.nice.org.uk/guidance/ng205/evidence/f-interventions-to-promote-physical-mental-and-emotional-health-and-wellbeing-of-lookedafter-children-young-people-and-care-leavers-pdf-333471052728 [accessed 19th January]
[19] Kent Children's Integrated dataset [accessed 22nd January 2024]
[20] https://evidence.nihr.ac.uk/collection/adverse-childhood-experiences-what-support-do-young-people-need/ [accessed 22nd January 2024]

Care leavers

A care leaver is a young person aged 16-25 who has spent time in care. This might be foster care or residential care[21]. KCC and Medway Council have provided separate data.

Barnado's[22] conducted research in 2017 which showed that 46% care leavers had mental health needs and one in four young people had faced a mental health crisis since leaving care. 65% of care leavers identified as having mental health needs were not currently receiving any statutory service, but just over half (54%) of those identified as having mental health needs were receiving some informal support with their mental health. 9% of those identified as having mental health needs were on the waiting list to receive support from statutory services.

Local Authority/District	Count (October 2022)	Possible MH needs
Kent Local Authority Area	1373	632
Ashford	126	58
Canterbury	314	144
Dartford	72	33
Dover	77	35
Folkestone and Hythe	100	46
Gravesham	163	75
Maidstone	171	79
Sevenoaks	21	10
Swale	115	53
Thanet	155	71
Tonbridge and Malling	37	17
Tunbridge Wells	22	10
Medway	136	63
Other Local Authority (excluding Medway)	456	210
No current address recorded	105	48

As at October 2022 in Medway, there were 149 care leavers aged under 21 and 32 aged 21 and above who were receiving support via an allocated PA. A further 205 care leavers did not have an allocated PA. In Medway this would equate to approximately 83 care leavers with a PA who have mental health needs and 94 without an allocated PA who have mental health needs.

Young carers

One in three young carers (38%) reported having a mental health problem[23]. The 2021 census[24] collected data regarding the number of unpaid carers, shown in the table below alongside the potential number with mental health problems.

District	Number of unpaid carers	Percentage of unpaid carers in population	Potential number with a mental health problem

[21] Barnado's, Young people leaving care | Barnardo's (barnardos.org.uk) [accessed 13th February 2024]
[22] Barnado's, 2017, Neglected Minds, neglected-minds.pdf (barnardos.org.uk) [accessed 13th February 2024]
[23] https://carers.org/downloads/resources-pdfs/young-adult-carers-at-school.pdf [accessed 21st January 2024]
[24] Office for National Statistics

	Age 5 to 17	Age 18 to 24	Age 5 to 17	Age 18 to 24	Age 5 to 17	Age 18 to 24
Ashford	980	980	2.3%	5.4%	372	372
Canterbury	940	1615	2.2%	3.5%	357	614
Dartford	580	760	1.4%	5.0%	220	289
Dover	840	1060	2.4%	7.1%	319	403
Folkestone and Hythe	810	865	2.6%	6.1%	308	329
Gravesham	570	845	1.6%	5.4%	217	321
Maidstone	990	1180	1.8%	5.0%	376	448
Medway	1260	2340	1.4%	5.3%	479	889
Sevenoaks	590	630	1.5%	4.5%	224	239
Swale	1155	1280	2.4%	5.9%	439	486
Thanet	780	1180	1.9%	6.4%	296	448
Tonbridge and Malling	885	860	2.0%	5.2%	336	327
Tunbridge Wells	670	650	1.7%	4.8%	255	247
Kent and Medway	11050	14245	1.9%	5.2%	4199	5413

Neurodiversity

The national prevalence suggests that 1.76% (7,537 children) of the Kent and Medway population are autistic, though recent research suggests this could be as high as 2.94% (12,590 children).

Area	U18 population	Lower estimate (1.59%)	National estimate (1.76%)	Upper estimate (2.94%)
Kent and Medway	428,229	6,809	7,537	12,590
Kent	353,707	5,624	6,225	10,399
Medway	74,522	1,185	1,312	2,191
DGS HCP	67,883	1,079	1,195	1,996
East Kent HCP	144,530	2,298	2,544	4,249
Medway and Swale HCP	99,800	1,587	1,756	2,934
West Kent HCP	116,016	1,845	2,042	3,411

Source: registered population December 2023, NHS England and O'Nions et al (2023)

Autistic children are 28 times more likely to attempt suicide and on study reported that 15% of autistic children had suicidal thoughts compared to 0.5% of typically developing children[25].

Learning Disability

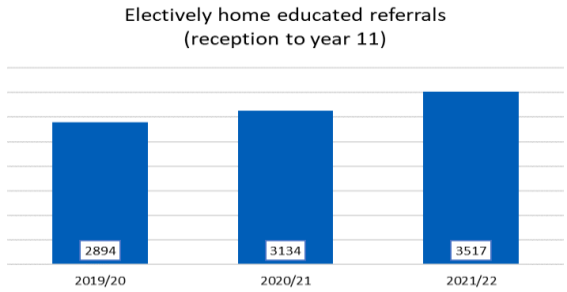
904 CYP aged 14- and 17- years old are on the Quality Outcomes Framework register for a Learning Disability[26]. There are many reasons why people with a learning disability are more likely to experience poor mental health; for example, biology and genetics may increase vulnerability to mental health problems, a higher incidence of negative life events, access to fewer resources and coping skills and the impact of other people's attitudes[27].

Some studies suggest the rate of mental health problems in people with a learning disability is double that of the general population, and the estimated prevalence of mental health disorders range from 15-52%, depending on the diagnostic criteria used. This would give a

[25] Government Events, 2022, High Suicide Rates among Neurodiverse Individuals: Why it matters and what can be done about it, https://www.governmentevents.co.uk/high-suicide-rates-among-neurodiverse-individuals-why-it-matters-and-what-can-be-done-about-it/ [accessed 13th February 2024]
[26] Learning Disability dashboard, NHS Future Collaboration website
[27] Mencap, Learning Disability and Mental Health - Mental Health Research | Mencap, [accessed 24th February 2024]

range of between 136 and 471 CYP aged between 14 and 17 years old with a Learning Disability and mental health need.

Electively Home Educated



In 2021/22, 3,517 referrals were received for Electively Home Educated pupils. This number had increased between 2019/20; however, the impact of Covid-19 would still have been having an impact.

Data provided by Kent schools' reports health and emotional health issues as the main reason that parents advise schools of when they remove their CYP from a school roll to home educate. This was cited for 30.1% of new notifications in the academic year 2021-2022[28].

It is known that children with a probable mental disorder were twice as likely to have missed more than 15 days of school (18.2%) as those unlikely to have a mental disorder (8.8%)[29].

Lesbian, gay, bi-sexual and queer young people

In Queer Futures survey[30] of 789 LGBTQ+ CYP aged 13 to 25, 88.8% of participants had harmed themselves in some way, while 97.8% had experienced suicidal thoughts or feelings. 58% of the sample had planned or attempted suicide at some point.

Almost three quarters of participants (74.1%) indicated that not being able to talk about their feelings and emotions (in relation to their mental health, sexuality and gender identity) strongly influenced their self-harm and suicidal feelings.

According to the Census 2021 there are approximately 2,896 16- and 17-year-olds are LGBTQ+ in Kent, and a further 588 in Medway.

Gender diverse

Trans respondents (36%) were much more likely than cisgender respondents (21%) to have accessed mental health services[31]. Trans respondents (14%) were also more likely than cisgender respondents (7%) to have tried to access mental health services without success. There were 115 17-year-olds and 155 under 16s on the Tavistock waiting list at the end of 2023 (no further geographical breakdown available).

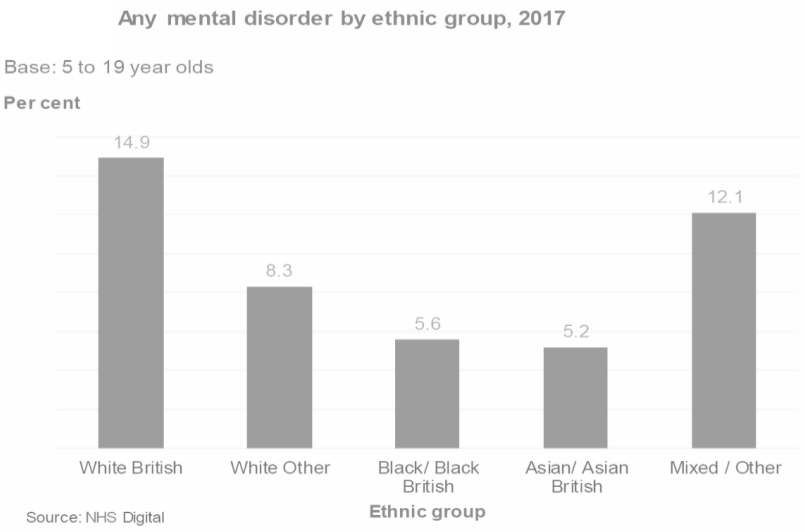
Youth Offending

Ethnicity

Prevalence rates for the general population have increased since 2017; however, it is likely that the relative levels of mental disorder between the different ethnic groups have remained

[28] KCC MIU
[29] Source: CYP MH survey 2021 [accessed 22nd January]
[30] https://www.queerfutures.co.uk/wp-content/uploads/2016/06/Queer-Futures-Final-Report.pdf [accessed 19th January 2024]
[31] https://assets.publishing.service.gov.uk/media/5b3b2d1eed915d33e245fbe3/LGBT-survey-research-report.pdf [accessed 19th January 2024]

similar. CYP of white British ethnicity had highest levels of mental disorder, followed by individuals of mixed or other ethnicity[32].



Profound inequalities exist for people from ethnic minority groups in terms of access to treatment, experience of care and quality of outcomes. Black people are over four times more likely to be detained under the act and over ten times more likely to be subject to a community treatment order[33].

CYP from Mixed-race and Asian backgrounds were less likely to measurably improve than not change after treatment compared to White British CYP. This could be due to stigma or the confounding variable of socio-economic status[34].

Data regarding ethnicity is available in the demogrpahics section of this document.

[32] CYP MH survey 2017 [accessed 19th January]
[33] https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act [accessed 22nd January]
[34] https://link.springer.com/article/10.1007/s00787-023-02233-5 [accessed 19th January]

Appendices

Appendix one

Further analyses of the 2023 CYP MH survey conducted by NHS England.

Appendix two

Appendix two provides and overview of current CYP mental health specialist and other mental and emotional well-being service activity.

Appendix three

To split activity into specialist and therapeutic service models, the following methodology was used. Data were extracted from the Mental Health Services Dataset[35], for all activity in 2022/23. Data coded for Mental Health Support Teams in the 'service or team type referred' to were excluded.

Activity was then split into specialist services and other NHS services according to the primary referral reason. Eating disorder activity was excluded as this contract is commissioned separately. Activity related to neurodiversity was excluded as this will largely relate to referrals for diagnostic assessments. Crisis activity was also excluded. For the records coded as unknown primary referral reason:

- VSCE unknown records were included in the other NHS services data
- MCH unknown records were assumed to be their neurodiverse activity as specialist services were coded.

Specialist

01 - First Episode Psychosis
02 - Ongoing or Recurrent Psychosis
03 - Bipolar disorder
06 - Obsessive compulsive disorder
07 - Phobias
08 - Organic brain disorder
09 - Drug and alcohol difficulties
10 - Unexplained physical symptoms
11 - Post-traumatic stress disorder
13 - Perinatal mental health issues
14 - Personality disorders
15 - Self harm behaviours
16 - Conduct disorders
20 - Gender Discomfort issues
21 - Attachment difficulties
22 - Self - care issues
23 - Adjustment to health issues

Therapeutic Alliance

[35] Mental Health Services Dataset, accessed via the Kent and Medway Data Warehouse in December 2023, more information available on https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set

04 - Depression
05 - Anxiety
19 - Relationship difficulties

Neurodiversity related

24 - Neurodevelopmental Conditions, excluding Autism Spectrum Disorder
25 - Suspected Autism Spectrum Disorder
26 - Diagnosed Autism Spectrum Disorder
30 - Behaviours that challenge due to a Learning Disability

12 - Eating disorders

12 - Eating disorders

17 – Unknown Code Description

17 - Unknown Code Description

18 - In crisis

18 - In crisis

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Appendix B: Current commissioned children's mental health provision for Kent's children

NHS Kent and Medway funds a number of mental health services for Kent's children. NHS England requires NHS-funded providers to submit activity data to the Mental Health Services Data Set for patients of any age who receive care for a suspected or diagnosed mental health and wellbeing need, learning disability, autism, or other neurodevelopmental conditions*. There were 35,727 accepted referrals to NHS-commissioned children and young people's mental health services for Kent in 2022/23.

The following sub-sections provide details of some services delivered within Kent that are funded by NHS Kent and Medway.

1.1.1 Health promotion activity and resilience building initiatives (Thriving)

- Fantastic FRED: this primary school wellbeing mobile theatre groups was accessed by over 100,000 primary children in Kent's primary and special schools.
- Shooting Stars: our current primary school wellbeing mobile theatre groups has been accessed by approximately 31,000 primary children in the past 12 months in Kent's primary and special schools.
- During children and young people's mental health voice week (2-11February) NHS Kent and Medway with their local authority partners promoted the animation feeding back on CYP views shared through collective social media and newsletter channels as well as taking part in celebration activities at Dover and Thanet Speak out groups, Whitstable youth hub and the Kent Youth hub and Medway council's celebration event at the corn exchange.
- 12 district-level children's mental health networks on a termly basis to support schools to support children.
- Websites, leaflets, participation, lived experience and bespoke workforce development programmes.
- National and local campaigns and programmes to increase access to information, advice, and support.
- Support for parents and carers through a range of interventions in partnership with local authorities through maternity and early year services.

1.1.2 Early intervention, targeted interventions (Seeking advice and Getting help)

In the past 12 months:

- Around 40,000 Kent children aged between 5 – 15 in selected education settings have received an intervention or attended whole-setting activities delivered by a Mental Health Support Team.
- 765 Kent children and young people aged between 13 – 25 have received a self-harm and risk-taking reduction programme called the Mind and Body programme.
- 2,197 Kent children aged between 10 – 25 have received digital counselling called Kooth from Kooth plc.
- Around 600 Kent young adults aged 18+ have received digital counselling called Qwell from Kooth plc (please note: service went live in September 2023).
- 198 Kent children and young people aged between 3.5 – 25 have received specialist bereavement support.
- 745 children and young people in Kent on the Complex and Crisis pathway have received support from the Therapeutically Informed Family Support Service.
- 173 children and young people in Kent have received support from The BeYou Project, which provides peer support and meet-ups for LGBT+ children and young people.
- A number of smaller contracts that specifically target and support unaccompanied children have operated across Kent.

A much wider workforce exists that is funded through primary care (navigators and social prescribing), school and college funded counselling and therapy services, local authority/public health funded counselling services, school nursing, education psychology, youth work and voluntary sector projects funded by grants and national funding bodies.

1.1.3 Specialist mental health (Further support)

North East London NHS Foundation Trust (NELFT), is the incumbent provider of Kent's Children and Young People's Mental Health Service, which is a specialist mental health service.

As part of this contract, NELFT delivers a Single Point of Access, Crisis and Home Treatment Team, Neurodevelopment and Learning Disability Service, and locality mental health teams that cover: Maidstone, Tonbridge, Dartford, Ashford, Thanet, Swale, Canterbury and South Kent. The service supports children and young people with low mood, depression, severe anxiety, self-harm, conduct and behaviour, tics and Tourettes, suicidal thoughts.

In the past 12 months, NELFT have seen 12,144 children and young people in their specialist mental health service and have provided ADHD and autism diagnostic assessments to 2,072 children and young people.

NELFT also deliver the All Age Eating Disorder Service (Please note: this service is not in scope for this procurement).

1.1.4 Acute and inpatient care (Getting risk support)

Inpatient care/ Tier 4: Adolescent hospital units provide support when a child or young person is detained under the Mental Health Act for assessment and treatment of severe mental health conditions. Kent and Medway Adolescent Hospital is commissioned by Sussex Partnership Trust who host the regional provider collaborative for Kent, Medway, and Sussex footprints. Kent and Medway's Health-based place of safety (known as a Section 136 suite) is located within the Kent and Adolescent Hospital.

Forensic CAMHS: This service supports children and young people presenting with severe disorders of conduct and emotion, neurodevelopmental or serious mental health problems. NHS England commissions this service.

All acute hospitals in Kent have paediatric mental health liaison nurses to support emergency departments and wards.

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Appendix D

Have Your Say survey

An online survey was hosted on NHS Kent and Medway's 'Have Your Say' platform between July and October 2023. A detailed report on the methodology and outputs of the survey is available on request.

The survey was promoted to children, young people, families, carers and health professionals in a number of ways, summarised in the table below.

Channel	Activity	Reach	Engagement
Newsletters, bulletins, emails	Articles in 5 Integrated Care Boards (ICB) bulletins/updates or newsletters, likewise in KCC, Medway Council newsletters and bulletins, and cascade emails sent to staff, stakeholders/partners and public	18,592 people	235 engagements (e.g. links clicked in newsletters etc)
Professional networks	Briefing and materials were shared with a range of professional networks for onward cascade to colleagues, parents, schools etc.	700+ people	We asked colleagues and stakeholders to cascade to their networks, however we cannot track numbers of those who received/opened emails
Summer activities, schools and events	Our council partners in KCC and Medway Council cascaded the information and promoted ways to be involved during their summer activities, at youth/family events and children and young people's conferences	9,567 people	
Social media	Paid for and organic posts across NHS, local authority and provider/partner organisations social media channels including Facebook, Instagram, X (formerly Twitter) and LinkedIn	80,000+ people	300+ direct engagements (e.g. likes, comments and shares)
Face-to-face participation activities	In addition to promoting the survey, a number of targeted face-to-face participation events were held aligned to the Have Your Say survey, a Young Adults' conference, as well as smaller face to face activities	N/A	250 children, young people and adults attending the 'Big Conversation'; 90 young people attended the Young Adults' conference; 200 across other events

In addition to feedback gathered at the face-to-face participation events described above, we received 981 written responses to the survey, plus 1 poem, 1 drawing, 5 podcasts, and 10 short films.

A summary of the key themes from the feedback is below, with further detail available in the Have Your Say report embedded above.

- Access to services: People want easier and faster access to mental health services, with clear pathways to access support, more capacity, funding and staff to enable the system to meet demand and to reduce waiting times for services.
- Person-centred care: Services should be person-centred with support tailored to individual needs, flexible and innovative, and take a holistic approach, involving coordinated efforts between professionals, education settings, and families. Emphasis on early intervention and support for children with mental health issues.
- Collaboration and communication: There is a need for better system working, with collaboration between different services, education settings, and GPs and improved communication with those who use services.

Wider engagement activity and feedback from those who use services

Between January 2022 and October 2023, we collated a huge range of insights from direct engagement events and activities, and from informal feedback from those who use our services. This evidence-base represents feedback from thousands of people who use or rely on our services.

These insights were reviewed by an independent communications and engagement agency who developed a detailed report on the key themes emerging from the activity. The report is available on request.

This review identified three thematic headings:

- Service provision: feedback on the way in which services are provided, the range of services available, their ease of access, capacity, waiting times and opportunities to be involved in service design.
- Experience of services: feedback on the value and impact of positive interactions with professionals (and the negative impact of poor interactions) and the need for a person-centred and holistic approach.
- Outcomes/benefits: feedback on what children and young people consider to be the most important benefits of receiving support from mental health and wellbeing services, for example reducing isolation and building confidence.

Stakeholder engagement

Since establishing the procurement programme, we have regularly engaged with key stakeholders to ensure that the views of those impacted, those with expertise, and those with responsibility for scrutiny inform our work. In summary we have:

- involved 63 partners and expert advisors (covering quality, safeguarding, workforce, finance, public health, contracting, governance, comms and engagement, participation, and lived experience)
- established a clinical reference group of 8 mental health professionals, plus 2 trainee GPs
- held two pre-procurement market engagement events (see Section 4.4 below) involving 34 provider organisations including NHS Trusts, VCSE sector organisations, and the independent sector
- provided written updates and held workshops with overview and scrutiny colleagues in Kent and Medway.

Market engagement events

Two pre-procurement market engagement events have taken place, one in November 2023 and one in February 2024. The events brought together key partners in the Kent and Medway children's mental health and emotional wellbeing provider landscape to understand the procurement process and the emerging outline plans, and a detailed discussion about potential contract models. In total 34 organisations attended the events and most key stakeholders from across the system were represented.

Detailed reports on these workshops are available on request.

In summary, participants provided feedback on the importance of:

- getting the contract/structure right in order to foster shared responsibility for children and young people
- good communication, cooperation, and coordination between organisations and listening to and involving stakeholders
- strong and trusting relationships between services and workforces, and a positive culture
- understanding demand and building enough flexibility into the contracts to respond to changing demands
- workforce development and training and having the right resources in the right place
- supporting families/carers to support children and young people
- robust data/information sharing systems
- learning from examples elsewhere.

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Item 9: Reconfiguration of Acute Stroke Services

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 29 February 2024

Subject: HASU Implementation

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

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1) Introduction

a) The Kent and Medway Integrated Care Board is establishing three Hyper Acute Stroke Services (HASUs) to serve Kent and Medway. These will be located in Maidstone, Ashford and Dartford.

b) The implementation follows a long period of planning, consultation, and challenges. A summary timeline was set out in a paper to HOSC in January 2022.

c) HOSC received a written update on the implementation of the HASUs on 5 October 2023. The update included:

i) The go-live dates for the units at Dartford and Maidstone would be on or soon after 1 April 2024 following the completion of phase 1 capital works. Go-live dates would be dependent on recruitment with business cases for the additional staff to be approved by December 2023.

ii) The East Kent Hospitals University NHS Foundation Trust (EKHUFT) scheme was being developed as a second phase due to capital constraints. Work was focussed on preparing for procurement.

iii) There had been an improvement in SSNAP ratings due to the consolidation of the workforce onto three sites as well as the standardisation processes in the acute part of the pathway. Dartford in particular had improved from a ‘D’ rating in April 2021 to a ‘B’ in October 2021.

d) The Committee requested assurance that hospitals actively take part in the collection of SNAPP data. They also wanted to understand the reasons behind the delay in the rollout at William Harvey Hospital.

e) HOSC also received updates on implementation of the HASUs on 26 January 2022 and 30 November 2022. Updates included:

i) Three travel advisory groups were to be re-established, which would listen to the concerns of patients and families and put strategies in place to address these concerns.

ii) Within six months of HASUs being operational, the expectation was that each of the three units would be A rated (this would be evident after 9 months due to a 3-month lag in data, so December 2023).

iii) The use of telemedicine had reduced the number of non-stroke patients being sent to a stroke unit which had resulted in improved patient flow.

iv) 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.

v) During the covid pandemic, stroke services in east Kent relocated to Kent and Canterbury Hospital (KCH) to free up acute capacity for Covid-19 patients. KCH does not have an A&E department, and therefore it was not expected that the services would remain on that site because SSNAP audit data evidenced improved outcomes when a HASU was co-located with an A&E. The expected dependencies were being looked at by a national team.

f) NHS Kent and Medway will be in attendance at the meeting to provide a further update and answer questions.

2) Recommendation

RECOMMENDED that the Committee note the report.

Background Documents

Kent County Council (2022) Health Overview and Scrutiny Committee (26/01/2022), https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=8761&Ver=4

Kent County Council (2022) Health Overview and Scrutiny Committee (30/11/2022), https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=9048&Ver=4

Kent County Council (2023) Health Overview and Scrutiny Committee (05/10/2023) https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=9318&Ver=4

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Transformation of stroke services in Kent and Medway

Purpose of briefing

The purpose of this briefing is to update the Kent Health and Overview Scrutiny Committee (HOSC) on the transformation of stroke services in Kent and Medway.

Background on the reconfiguration of acute stroke services

The Kent and Medway Stroke Review was commissioned in 2014 in response to concerns by Kent and Medway Clinical Commissioning Groups (CCGs) about the performance and sustainability of hospital stroke services across all units in Kent and Medway. The CCGs and hospital trusts were tasked with developing proposals to improve outcomes for patients, reducing deaths and disability.

The review recommended a model of care involving specialist stroke services consolidated at three hospitals, each with a hyper-acute stroke unit (HASU) and an acute stroke unit (ASU), to ensure rapid access to specialist staff, equipment, and imaging to improve quality and outcomes for patients.

HASUs enable patients to have rapid access to the right skills and equipment and be treated 24/7 on a dedicated stroke unit, staffed by specialist teams. Following a stroke, a patient will be taken directly to a HASU where they will receive dedicated expert care, including immediate assessment, access to a CT scan and clot-busting drugs (if appropriate) within 30 minutes of arrival at the hospital.

ASUs are for subsequent (after 72 hours) hospital care. These units offer ongoing specialist care with seven-day therapies services (physiotherapy, occupational therapy, speech and language therapy and dietetics input) and effective multi-disciplinary team (MDT) working.

Public consultation on the proposal was undertaken in 2018 and the decision to establish HASU/ASUs in Dartford, Maidstone and Ashford was made the following year. Following a review into the decision-making process, the Secretary of State granted approval to proceed in November 2021.

Since the NHS decision in 2019, there have been three emergency temporary changes to stroke services in Kent and Medway:

- Tunbridge Wells Hospital stroke service transferred to Maidstone Hospital in September 2019 due to staffing challenges.
- In April 2020, in response to Covid, East Kent Hospitals University Foundation Trust (EKHUFT) transferred its stroke services at William Harvey Hospital (WHH) and Queen Elizabeth the Queen Mother Hospital (QEQM) to the Kent and Canterbury Hospital (K&C). The stroke service remains at Canterbury at this time.
- Medway Hospital stroke service closed in July 2020 due to staffing challenges. The majority of stroke patients that would previously have gone to Medway Hospital are now going to Maidstone Hospital with a small number going to Darent Valley Hospital.

The programme will be delivered in two phases with Dartford and Maidstone going live in 2024 and East Kent as soon as the works are complete. Business cases for the associated works and staffing for Phase 1 were agreed by NHS Kent and Medway in January 2024.

Progress to date

Details of the planned timescales for developing the three HASUs in Kent and Medway are shown in **Table 1**:

Table 1: Timescales for developing the three HASUs

Site	Works	Completion of capital works (as confirmed by Trusts)
Dartford Darent Valley Hospital (DVH)	Refurbishment of existing and additional space	June 2024
Maidstone Maidstone Hospital (MGH)	Refurbishment of existing and additional space	March 2024
Ashford William Harvey Hospital (WHH)	Extension and refurbishment	To be confirmed

The reconfiguration is being funded by the Kent and Medway health system from the capital allocation over a multi-year period. Monies to commence the capital works were released early to accelerate progress.

Phase 1 capital works are nearing completion at Dartford (June 2024) and Maidstone (end March 2024). The go-live dates for these units will be dependent on recruitment of the additional staff to deliver the new model of care. Posts will be filled from April 2024.

The East Kent scheme is being delivered as a second phase.

Activity review

The original activity assumptions outlined in the outline business case (OBC) were agreed in December 2017. The consolidation of stroke services onto three sites through the temporary moves has provided the opportunity to evaluate the original activity assumptions.

In 2022 the Clinical Effectiveness Group (CEG) undertook a review of the clinical model and activity assumptions within the OBC to ensure they remain robust.

The review considered the original assumptions around the proportion of activity which would flow from Medway to Dartford and Maidstone. It was apparent that the activity that transferred from Medway was higher than modelled. In addition, Maidstone had received a greater proportion of the activity than originally anticipated, with 85% of the activity transferring to Maidstone instead of the 80% assumed.

The review concluded that the three-year average activity used within the original modelling should be rolled forward to 2019-2021. In addition, it was agreed that the 2020 activity should be adjusted to reflect the national drop in stroke incidence during the start of the covid pandemic (11% from April to June 2020).

The 2019-2021 three-year average primary stroke activity at each of the three sites is detailed in **Table *2***.

Table 2: Revised inpatient activity figures

	Avg 2019-2021			
	DGT	EKHUFT	MTW	Total
Stroke activity	807	1,267	1,148	3,222
TIA	81	127	115	323
Mimics	186	291	264	741

Bexley activity

The Kent and Medway catchment area will alter following the establishment of a HASU at Dartford as it will be quicker for Bexley patients to access the stroke service at DVH.

The 2022 activity review included updating the travel time analysis of the South East London area. A modelling exercise was undertaken to look at the shortest travel time from each Lower Super Output Area (LSOA[1]) in SE London to local HASUs. The sites reviewed were DVH in Dartford, Princess Royal University Hospital (PRUH) in Orpington and Kings College Hospital in Denmark Hill. The outcome of the updated travel time analysis was in line with the 2017 analysis.

It has been agreed that:

- The pathway for patients with a suspected stroke in Greenwich, Lewisham and Bromley remains unchanged, and patients from these populations will continue to be cared for at a London site
- Patients in Bexley currently treated at Kings College Hospital in Denmark Hill will continue to be treated at this site as it is hypothesised that the primary reason for these patients being treated there is not travel time
- 100% of Bexley patients currently seen in DVH and PRUH will be included in the scope for the Kent and Medway catchment area.

Impact of the updated inpatient activity

The impact of the updated activity means that a further 13 beds are required across Kent and Medway than that previously agreed. The greatest impact on bed numbers is at MTW which has increased to 49 beds. Bed numbers at DGT remain the same following a reduction in the activity that will transfer from Bexley.

Table 3: Impact of the updated bed model

	DGT			MTW			EKHUFT			K&M		
	HASU	ASU	Total	HASU	ASU	Total	HASU	ASU	Total	HASU	ASU	Total
Activity refresh	10	24	**34**	14	35	**49**	15	39	**54**	39	98	**137**
Activity in OBC	10	24	**34**	11	27	**38**	15	37	**52**	36	88	**124**
Increase	0	0	**0**	3	8	**11**	0	2	**2**	3	10	**13**

[1] An LSOA is a geographical area. LSOAs were designed to improve the reporting of small area statistics in England and Wales. They have a minimum population of 1,000 and mean population of 1,500. Each postcode in the UK can be mapped to an LSOA.

Impact on workforce

As part of the reconfiguration of acute stroke services in Kent and Medway, significant investment in the workforce has been agreed to support the new units. The model requires staffing 24 hours a day, seven days a week by a multidisciplinary team of medical, nursing and allied health professionals, as well as effective management and support teams.

In 2020, DGT and MTW received investment for the additional activity resulting from the withdrawal of the stroke service in Medway. The staffing gap to HASU levels at the two sites reduced as a result. There is a total gap of 81.76 whole time equivalents (wte) across the staff groups between the three providers (DGT 22.13wte, MTW 22.6wte and EKHUFT 37.27wte). The bulk of the posts required are registered nurses and therapists.

Each provider has developed detailed recruitment plans to fill the posts. Plans include employing 'grow your own' strategies' through career progression and development, local and international recruitment and collaborating with local universities.

Phase 2: East Kent

Establishment of the unit in East Kent was scheduled for March 2026; however, the scheme is delayed, and this timeline is no longer achievable.

In December 2023, the ICB Acute Stroke Reconfiguration Steering Group agreed to undertake a gateway review of the Phase 2 programme to gain assurance on the delivery of the East Kent scheme. The gateway review formed a formal governance step focussed on the project management of the scheme. The review was undertaken based on information provided by EKHUFT.

The objectives of the review were:

- To review the current delivery strategy
- To ascertain the funding requirement and affordability of the scheme
- To ensure the scheme remains value for money.

Outcome of the gateway review

The group concluded that there had not been sufficient progress to be assured on the development of the East Kent scheme. In the absence of confirmed solution, confirmed costs for the programme and no confirmed timeline for delivery of the works, the group could not recommend funding early recruitment to HASU/ASU staffing levels at this stage.

Simultaneous recruitment across all three units had been agreed by the Joint Committee of CCGs in 2019 to mitigate the risks of the phased implementation of the programme. The ICB continues to be committed to the development of the East Kent HASU but is unable to provide any additional funding until further assurance on the delivery of the scheme is received.

Next steps

A recovery plan is now required to support delivery of the East Kent scheme to meet the conditions of the gateway review. The ICB will work with EKHUFT to address the key challenges and develop the plan. Current works on the scheme will cease until the recovery plan is agreed.

Feedback on the outcome of the gateway review has been shared by the ICB with EKHUFT to support development of the recovery plan. Details of the plan, including a revised timeline for go-live of the unit will be provided to members of HOSC once EKHUFT have provided sufficient plans to pass the gateway.

Sentinel Stroke National Audit Programme (SSNAP)

Data is collected on individual trust performance by the Sentinel Stroke National Audit Programme (SSNAP), which is a national healthcare quality improvement programme based at King's College London. SSNAP measures the quality and organisation of stroke care in the NHS and is the single source of stroke data in England.

Data from Stroke Sentinel National Audit Programme (SSNAP) in **Table 4** demonstrates the improvement across provider organisations following the temporary consolidation of services. Further improvements are anticipated following the implementation of the three HASUs.

Table 4: SSNAP ratings pre and post consolidation of stroke units

Hospital	Dec 16 - Mar 17	April - Jul 17	Aug - Nov 17	Dec17 - Mar 18	Apr - Jun 18	Jul - Sep 18	Oct - Dec 18	Jan - Mar 19	Apr - Jun 19	Jul - Sep 19	Oct - Dec 19	Jan - Mar 20	April - Jun 20	Jul - Sep 20	Oct - Dec 20	Jan - Mar 21	April - Jun 21	Jul - Sep 21	Oct - Dec 21	Jan - Mar 22	April - Jun 22	Jul - Sep 22	Oct - Dec 22	Jan - Mar 23	April - Jun 23	Jul - Sept 23
DVH	D	D	D	E	D	D	D	D	C	D	D	D		C			D	C	B	B	B	B	C	C	B	B
QEQM	D	C	D	D	D	D	D	D	D	C	D	D														
WHH	C	B	B	B	B	C	C	D	D	C	D	D														
K&C														A			A	A	A	B	B	B	A	A	A	A
MGH	A	A	B	B	B	B	A	A	B	B	C	D		A			A	A	B	B	B	A	B	A	A	A
TWH	C	C	C	C	C	B	C	B	C	C																
MMH	D	D	D	E	E	E	E	D	D	D	E	E														

Temporary emergency service transfer

Clinical audit was suspended for the duration of this quarter.

The ISDN is focused on making continual improvement across all aspects of the stroke pathway. Positively, there has already been improvement in SSNAP ratings related to the consolidation of the workforce onto three sites and the standardisation processes

in the acute part of the pathway. Scores reduced over the winter period due to operational pressures but have since increased.

Table 5: SSNAP key indicators July – Sept 2023

Indicator	National	Kent & Medway	DGT	EKHUFT	MTW
% of patients scanned within 1 hours of clock start	59.3	76.1	66.2	95.6	70.1
Median time between clock start and scan (hours:mins)	0:43	0:24	0:41	0:15	0:31
% of patients directly admitted to a stroke unit within 4 hours of clock start	49.5	71.3	49.2	84.9	79.8
% of all stroke patients given thrombolysis (all stroke types)	11.4	13.0	15.4	14.3	12.5
% of patients who were thrombolysed within 1 hour of clock start	61.0	73.0	60.0	80.6	72.7
% of patients assessed by a stroke specialist consultant physician within 24h of clock start	84.0	91.4	92.3	98.8	96.2

SSNAP review

The SSNAP dataset is being revised to better reflect updated clinical standards (National Clinical Guideline for Stroke April 2023, and NICE guidelines October 2023). Changes to SSNAP included separating the inpatient, community and six-month assessment datasets to reflect the differences in care delivered in these periods. These changes will provide clearer and more appropriate community indicators, enabling further improvement opportunities.

The changes will come into effect from July 2024, with the first report published in December 2024. Scoring on the new measures will not start until July 2025 to give teams time to adapt to the new dataset.

At a national level, discussions are ongoing with stroke service providers across the country regarding the development of a reporting mechanism to enable a pathway view. This would enable the ability to assess the impact of the pre-hospital pathway

on outcomes. Work is also ongoing nationally to ensure the reporting of outcomes by locality as well as by provider.

Clinical improvements in East Kent:

The stroke team is committed to delivering further improvements in stroke care and improving outcomes along with patient and carer experience. The temporary consolidation of services on one site ahead of the move to WHH has contributed to the significant improvements in processes of care and outcomes in East Kent, such as:

- Significant reduction in door to scan times. Nationally only 59.36% of patients are scanned within an hour, compared to 95.6% at EKHUFT, with a median scan time of 15 minutes compared to 43 minutes nationally (SSNAP July – Sept 2023).
- Significant reduction in adjusted mortality. This is now the lowest in the South East and second lowest nationally.
- EKHUFT, in partnership with SECAmb, developed telemedicine triage of patients by the stroke medical team prior to the patient being conveyed to hospital. The result of the triage is that the patient is directed to the most appropriate care pathway, such as the Stroke Unit, Emergency Department, TIA clinic or follow up by GP without need for hospital attendance.
- New assessment and triage arrangements within the UTC at K&C has resulted in an improvement in door to needle time for thrombolysis in ischemic stroke. The median time is 41 minutes from clock start to thrombolysis compared to 53 minutes nationally (SSNAP July – Sept 2023).

The planned move to WHH will build on these improvements further by ensuring compliance with the national standards and align with the DMBC recommendations i.e. co-located with an Emergency Department.

Kent and Medway Integrated Stroke Delivery Network (ISDN)

The ISDN was established in Kent and Medway in 2021 following the introduction of the National Stroke Service Model (2021). The aim of the ISDN is to bring people and organisations together to deliver the best possible care for their population. ISDNs include providers and commissioners of services across the whole stroke pathway. ISDNs are responsible for designing and delivering optimal stroke pathways, which will ensure that more people who experience a stroke receive high-quality specialist care, from pre-hospital, through to ESD, community specialist stroke-skilled rehabilitation and life after stroke.

Key ambitions

- Best practice personalised stroke pathways configured and managed from pre-hospital care onward, including ambulance, thrombectomy, ESD and six-month reviews, and then building to cover the entire pathway from prevention through to life after stroke.
- A flexible, future-proofed competency-based stroke workforce, supported by a skills and capabilities framework and toolkit.
- A comprehensive dataset that meets the needs of clinicians, commissioners and patients in capturing care quality and outcomes.

The ISDN has recently refreshed its infrastructure to reflect the maturing needs of the network. New clinical leadership has been appointed and the network is now led by Dr Peter Maskell, Medical Director of West Kent Health and Care Partnership (HCP). The new infrastructure removes duplication, creates clear programmes of work linked to the network's priorities and strengthens the patient voice through the Carer and Patient Advisory Group (CPAG). The revised infrastructure is currently being rolled out and has received a positive response.

ISDN programme of work

Transient ischaemic attack (TIA) seven-day services

The development of seven-day TIA services is an ISDN priority. Scoping work has recently begun to identify the workforce and diagnostic capacity and investment that will be required. This will determine the timeline of the improvement work as there is likely to be workforce constraints. The ISDN will build upon the workforce plan associated with the HASU/ASU reconfiguration. There will also be interdependencies and potential opportunities associated with the development of the Community Diagnostic Centres across Kent and Medway.

Early supported discharge (ESD) and rehabilitation

As a result of the emergency temporary changes to the acute stroke services detailed earlier in this paper, the existing ESD and community rehabilitation service providers also had to adapt a range of their pathways and service configurations to support those changes. Our community providers and partners are working hard to meet the recently published National Clinical Guidelines for Stroke (April 2023). It is clear there is variation in service delivery and funding across acute and community settings. The recent updated guidance provides benchmarking information to support systems to commission and configure services to consistently better meet patient needs. There are workforce gaps to be addressed but there is also poor-quality data linked to how current services are configured. This includes shortcomings associated with the ESD and community rehabilitation elements of the national SSNAP database.

The ISDN has established a workstream to focus on ESD and community rehabilitation services across Kent and Medway. The group is currently undertaking a gap analysis across the current service delivery in comparison to the recent guidance requirements. It is likely the improvement plan will be phased to take account of the current financial constraints in the system as well as the workforce challenges.

The network plans to present this phased improvement plan to the ICB and the Integrated Care System (ICS) partners in Q1 of 2024/25. This plan will include ensuring the ICB and ICS are aware of the full costs and resource implications associated with meeting the new guidance. There is no indication that further national funding will be provided to deliver the new guidance. As a result, the improvement plan will include a phased and prioritised approach over a number of years. This improvement approach will also make best use of opportunities associated with digital developments as well as ensuring innovative approaches to addressing workforce gaps.

Stroke Quality Improvement for Rehabilitation (SQuiRE) catalyst projects: Time to Care and vocational rehabilitation

Following successful expression of interest (EOI) applications over the past 18 months, Kent and Medway has been awarded two allocations to test change within local ESD and community rehabilitation services.

The Time to Care catalyst project aims to embed consistent data administration support and validation processes into each community stroke team. The investment will fund a data analytics and data quality improvement manager to develop a timely and accurate system-wide standardised dataset. This dataset will inform community provider processes to improve data compliance and quality (including SSNAP and national ISDN key performance indicators) and deliver efficiencies. In addition, clinicians within the community will be freed up to concentrate on care delivery.

The recruitment of the data analytics and data quality improvement manager is to commence in April. The relevant community providers are preparing this now.

The vocational rehab project sets out to deliver a timely, structured vocational rehabilitation service to stroke survivors of working age in Medway and Swale. The project is anticipated to start in March 2024 and will run for 12 months. The final report on the outcomes of the project will be completed March 2025. The project team will establish links with employers in the local area who may be able to assist with return-to-work programmes, run a six week return to work programme to improve work related skills and improve current knowledge and confidence of staff within stroke services in delivering vocational rehab.

The team has successfully recruited to occupational therapist (OT) post for commencement in April 2024.

Life After Stroke

The ISDN is working with the Stroke Association on a potential test for change project, focussed on equitable access to life after stroke support. The model of support will reach people across Kent who have had a stroke diagnosis, and provide equitable access to a stroke key worker, within the six-month follow-up post-stroke review for those affected by stroke.

All those recently affected by stroke will be proactively contacted to start a personalised support journey and will have access to 1:1 support from a stroke key worker.

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Item 10: Child and Adolescent Mental Health Services (CAMHS) Tier 4 provision

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 29 February 2024

Subject: Child and Adolescent Mental Health Services (CAMHS) Tier 4 provision

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Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by the Kent and Sussex CAMHS tier 4 Provider Collaborative and NELFT.

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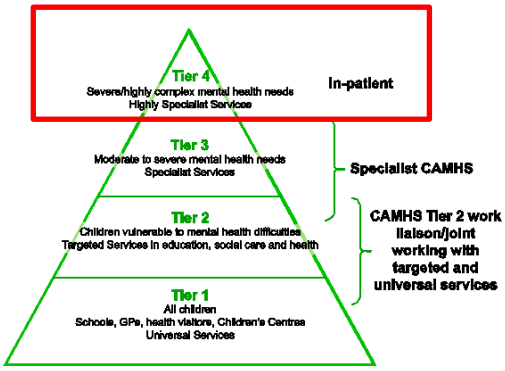
1) Introduction

a) Children and Adolescent Mental Health Service (CAMHS) *(also referred to locally as Children and Young People's Mental Health Services (CYPMHS))* is an umbrella term covering a wide range of services commissioned by the NHS and local government. The diagram to the right helps explain the four-tiered provision of the overall service.[1]



b) Tier 4 is commissioned by the Kent and Sussex Provider Collaborative, with the lead provider being Sussex Partnership NHS Foundation Trust (SPFT). They have commissioned North East London NHS Foundation Trust (NELFT) to provide the service.

2) Monitoring by HOSC

a) HOSC has scrutinised tier 4 children's mental health services for a number of years. A particular area of focus has been the provision of in-patient beds.

b) The last update to HOSC was in March 2023. The Committee discussed the development of a Psychiatric Intensive Care Unit (PICU) in Kent and Sussex which had not progressed due to a lack of capital funding. The Chair requested that the guests provide an update once the funding had been resolved. He understood that NHS England had funded the revenue but the Kent & Medway and Sussex Integrated Care System's had yet to approve the capital. He offered the Committee's help in managing that situation, if required.

c) The Committee were also interested in the recruitment of a family ambassador role to support families/carers along with peer support workers.

[1] Parliament (2014) CAMHS as a whole system https://publications.parliament.uk/pa/cm201415/cmselect/cmhealth/342/34206.htm#note29

d) The Committee resolved to note the report and asked that SPFT provide a further update once capital funding for the proposed Psychiatric Intensive Care Unit (PICU) in Kent and Sussex had been resolved; and the posts of family ambassador and trust liaison nurse had been recruited to.

e) The Committee have requested the Provider Collaborative and NELFT attend today's meeting to provide these updates.

3) Recommendation

a) RECOMMENDED that the Committee consider and note the update.

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

Kent County Council (2023) *'Health Overview and Scrutiny Committee (31/01/23)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=9051&Ver=4

Kent County Council (2023) *'Health Overview and Scrutiny Committee (28/03/23)'*, https://democracy.kent.gov.uk/ieListDocuments.aspx?CId=112&MId=9052&Ver=4

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Health Overview and Scrutiny Committee Report

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) went live on October 1st 2021.

2 Background

The principle behind Provider Collaboratives is to enhance collaboration between NHS trusts and independent and voluntary sector providers to deliver more efficient and sustainable services, work in partnership with people with lived experience to improve the quality of care provided - in the least restrictive environment - and tackle health inequalities for their local population.

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. A key objective of the Kent & Sussex CAMHS Tier 4 Provider Collaborative is to identify and invest in alternatives to hospital admission, so that young people can be supported, where possible and if applicable, at home or in the community.

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 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.

The Kent & Sussex CAMHS Provider Collaborative has mobilised a range of services including alternatives to admission and improvements to high dependency care areas in addition to quality improvements within existing services. Additional services include:

- 3 GAU/ED beds at Kent and Medway Adolescent Hospital and 3 short stay beds. The Eating Disorder beds are overseen by the All Age Eating Disorder service which allows a young person to remain with their community consultant and team members whilst accessing inpatient care.
- The short stay beds will allow for a seamless pathway from crisis to inpatient and discharge back to the home/community setting.
- The PC with the ICB commission the CrEST pathway (Crisis enhanced support team). This team has allowed young people to access intensive home treatment at home as an alternative to inpatient care.
- An eating disorder day service based in Sussex

Due to interventions in the community there were 15 less admission in 2022/2023 than the previous year and a further 59 referrals were offered alternatives to admission.

It should be noted that harm is most likely when the child or young person does not have a ‘safe base’ (i.e. home with attuned carers). There is ample evidence that if this ‘safe base’ is not present that the young person will not be able to access therapy and will continue, and likely escalate, their use of risk behaviours to communicate their distress, leading to greater, and longer-term harm if they were to be admitted. Research evidence on this by Sherbersky, H., Vetere, A. & Smithson, J. (2023) ‘Treating this place like home’: An exploration of the notions of home within an adolescent inpatient unit with subsequent implications for staff training. Journal of Family Therapy, 45, 392–413.)] indicates that CAMHS inpatient units, when inappropriately used, can be considered by young people as ‘home’ and lead to significant and long-term harm. The routes to harm are described well in other data and include: dislocation, institutionalisation and loss of identity.

Update on Psychiatric Intensive Care Unit (PICU) -

Since the last HOSC which the Provider Collaborative there have been updates to the Provider Collaborative footprint. There has been an opportunity to establish one CAMHS T4 PC for Kent, Sussex, Hampshire and the Isle of Wight. This allows for a wider scope of pathways of beds as Hampshire has a low secure unit. We are working with partners in Hampshire to develop a PICU in Southampton which will serve the new Provider Collaborative which includes Kent and Medway. Our current PC footprint only requires 2 to 3 PICU beds at any one time with a focus on stepping young

people down to the least restrictive environment as soon as possible. The anticipated opening date is April 2024.

Family Ambassador Programme

Family Ambassadors are non-clinical professionals with lived experience of CAMHS services, who can work with parents/carers and the clinical teams to help families to navigate the inpatient journey. Family Ambassadors provide emotional and practical support to parents/carers and families of young people who are admitted to Tier 4 inpatient CAMHS units.

Parents/Carers have a unique perspective on the care needs of their child. Family Ambassadors aim to ensure that parent/carers voices are heard and that they feel empowered to become an equal partner in their child's care.

The Family Ambassador programme is a pilot project, with the first local Family Ambassadors joining the South-East team in June 2023. The second wave of local Family Ambassadors were recruited in September 2023 and are currently in post part-time (approx. 2 days per week) at the following Tier 4 units; Bere Clinic, Brighton and Hove Clinic, Pebble Lodge, Austen House Leigh House and Kent and Medway Adolescent. Due to a resignation, there is currently no local Family Ambassador assigned to Chalkhill, however, this post will be recruited for as soon as possible.

Ongoing data is being recorded by the Regional Family Ambassador, a summary of findings is below (data period Sept - Dec 2023):

- **137** families have actively been supported
- **767** individual contacts have been made
- **Types of support being offered:** Information Sharing (37%), General Support (26%), Emotional Support (14%), Support Around Communication With Unit (8%), Contact/Leave (6%), Concerns re Care (3%), Other (6%)

Feedback to date:

Please see below some of the positive feedback on the Family Ambassador role that has been received from parents/carers to date:

The NDTi (National Development Team for Inclusion) are completing Phase 2 of a National Evaluation of the Family Ambassador programme (field work and interviews currently being undertaken in South-East region). The report was completed in Dec 2023 and results are due to be published asap.

Trust Liaison Nurses

As part of successful winter pressures monies bids in 2022/2023 the PC were able to secure funds to pay for acute hospital liaison nurses across Kent and Medway. These posts have been well received by acute an provide support for CYP who have mental health difficulties across the wards. They will see CYP who require a Tier 4 placement but this is not an accepting criterion. All posts were recruited to at that time.

The ICB has utilised non-recurrent NHSE paediatric mental health champions funding to help enhance the delivery of the paediatric mental health nursing role so that it can extend beyond the current Monday -Friday 0900-1700 service.

Item 11: Work Programme 2024

By: Kay Goldsmith, Scrutiny Research Officer

To: Health Overview and Scrutiny Committee, 29 February 2024

Subject: Work Programme 2024

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 work programme.

Background Documents

None

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Work Programme - Health Overview and Scrutiny Committee

1. Items scheduled for upcoming meetings

23 April 2024		
Item	**Item background**	**Substantial Variation?**
MTW Clinical Strategy – general update	To receive an update on the progress of the Trust's clinical strategy.	-
MTW Mortuary Services	To receive a progress update on the implementation of the 16 recommendations from the Phase 1 mortuary inquiry report.	-
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.	-

17 June 2024		
Item	**Item background**	**Substantial Variation?**
South East Coast Ambulance Service - update	To receive an update on performance.	-
Sustainability and the green agenda	To receive information about what the NHS is doing locally to reach net zero.	-
Winter rehabilitation and reablement pilot in east Kent	To receive the outcome of the pilot run between November 2023 – April 2024.	-

2. Items yet to be scheduled

Item	Item Background	Substantial Variation?
ICB Digital Transformation Strategy	Members have asked to view the Strategy once available.	-
Maidstone and Tunbridge Wells NHS Trust – outcome of review into serious incident	The Committee would like to understand what lessons have been learnt following the review into a child death at Tunbridge Wells Hospital.	-
Ophthalmology Services (Dartford, Gravesham, Swanley)	To receive updates about the long term provision of the service.	No
Orthotic Services and Neurological Rehabilitation	To receive information on the provision of these services in Kent for adolescents. (This was a member request).	-
Podiatry Services	To receive an update on the service following its relocation.	No
Transforming mental health and dementia services in Kent and Medway	To receive information about the various workstreams under this strategy.	TBC
Edenbridge Memorial Health Centre	The committee has requested an update once the centre has been open for one year.	No
Mental Health Transformation - Places of Safety	The committee has requested an update once the unit has been operational for a meaningful period of time.	-

3. Items that have been declared a substantial variation of service and are under consideration by a joint committee

No proposals are currently under scrutiny by the Kent and Medway Joint HOSC.