Medway Council
Serving You

Health and Adult Social Care Overview and Scrutiny Committee

19 August 2026

Addendum Report: Changes to ADHD and Autism Services in Kent and Medway

Report from: NHS Kent and Medway Integrated Care Board

Author: Teri Reynolds, Principal Democratic Services Officer

Summary

This addendum report sets out the draft minutes of the Children and Young People Overview and Scrutiny Committee on 12 August 2026 where this report was also considered.

1. Children and Young People Overview and Scrutiny Committee – 12 August 2026

1.1. The Children and Young People Overview and Scrutiny Committee (CYPO&SC) considered the report on ADHD and Autism Services in Kent and Medway at its meeting on 12 August and the draft minutes are summarising its discussion on the item are set out as follows.

1.2. The Deputy Chief Executive and Chief Strategic Commissioning Officer, along with the Clinical Lead Learning Disability and Autism from NHS Kent and Medway Integrated Care Board (ICB) introduced the report accompanied by the ICB's Chief Medical and Outcomes Officer.

1.3. The Committee was informed that the approach regarding the ADHD and Autism Right to Choose Pathways (RTC) was as a result of a combination of increased demand, growth in spend, along with a need to better manage the market of providers and quality of assessments provided by them, whilst balancing the obligations of the ICB to provide services to meet needs, as well as parents and carers right to choose providers.

1.4. A fundamental aspect to proposed intervention and how processes would be managed was based on clinical prioritisation and a categorisation framework had therefore been developed to group children, young people and adults by need to ensure that those with the most significant needs were prioritised. The categorisation framework operated on three levels of need which were classed as immediate, escalating and waiting list. This categorisation

framework was a model that was already in place and had been used by statutory providers for the past 24 months. It was being developed for RTC providers to ensure that all children, young people and adults were able to access the same model of pathway. Those on the waiting list category would be reviewed on a regular basis to ensure that changes in need were identified immediately and re categorisation made as required. Reference was also made to other intervention support tools that could be provided irrespective of assessments, such as 'This is me'.

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

1.5.1. **Waiting lists** – Questions were raised regarding the waiting lists for Medway children on statutory and right to choose pathways and how the changes would impact current wait times. Members were informed that it was difficult to clarify the exact numbers of those on the RTC pathway, but the numbers waiting for statutory providers were approximately 10,000 on Autism and 4,000 on ADHD waiting list across Kent and Medway, and of total combined approximately 4,000 related to those in Medway and Swale. There were currently approximately 40 providers in the RTC market, and the data they held was unclear due to the quality of data and multiple submission routes. Some children were on more than one waiting list and recorded separately which had resulted in children and young people on multiple waiting lists for assessments. The waiting lists for those in the non-priority category was long and it was important that those children be assessed on the basis of clinical prioritisation.

1.5.2. **Clinical quality** – Going forward, all RTC providers would be required to work in the same way as statutory providers and ensure that decisions made were based on clinical need. Clinical quality remained a concern, and consideration was being given to undertaking clinical and spot audits on all providers.

1.5.3. **'This is me' intervention** – Questions were asked about what the 'This is me' tool included and how accessible it was for parents and carers. The 'This is me tool' had been developed 24 months ago and had been trailed. The trial had identified that if a child's strengths and issues were identified prior to diagnosis, work could be undertaken to support the needs of that child whilst they were waiting for formal diagnosis and prior to presentation of trauma. A Member of the committee expressed that formal diagnosis was often a gateway to accessing support, with many Medway parents and carers highlighting that support prior to diagnosis was limited, and any services signposted to were often based in Kent. It was vital that diagnosis should not be the point at which support and access to services was provided. There were serious concerns as to the impact this decision could have, which may not be realised until much later and may result in increased detrimental impact to mental health and wellbeing of children, young people and adults in the future.

1.5.4. **Equality Impact Assessment (EIA)** – In response to whether an EIA was completed it was confirmed this was actioned and looked at the demographics of all children and adults across the system and impact

would continue to be monitored as the plan to categorise through all-age arrangements was progressed.

1.5.5. **Looked after children (LAC)** – In response to a question on why LAC were not included category one and who was responsible for making decisions on categorisations, the Committee was informed that all categorisations were clinically led and the categorisation for LAC was based on the fact that that cohort of children would likely already be receipt of support services. Looked after status would and should not necessarily determine an immediate need categorisation as this was based on clinical need for assessment. Equally if a LAC had the relevant clinical need they should be prioritised.

1.5.6. **Impact on children and in particular girls** – A Member expressed a view that the approach [EW1] did not align with the ICB's draft commissioning intentions and aspirations for all age model as delays, resulting in some children not being progressed through the pathway until at least April 2027, could result in a significant impact to children and young people's wellbeing. Particular reference was made to females, and that it often took longer to diagnose girls. It was asked what assurance could be given that Medway children and young people would not be adversely impacted by the decisions made. The Committee was informed that the all age proposals were devised to enable more clinicians to be able to deal with both children and adults and that this would ensure more all-round support and resilience in the system. Members were reminded that the commissioning intentions were draft, were being consulted on and Members were encouraged to provide feedback to help shape the final intentions. In relation to the diagnosis of females, it was explained that the national framework of diagnosis model that was being utilised across the country was historical and designed for white young boys and therefore females were often not identified as early on as they otherwise would be. However, it was confirmed that ever effort was being made to identify and prioritise need early, regardless of gender

1.5.7. **Lack of data** – Members asked about why there was a lack of data and that it was difficult to determine the scale of the issues as a result of the lack of Medway specific data contained in the report. A member stated that it was unclear how long Medway children and young people would have to remain on the waiting list for assessment. It was further commented by members of the committee that the prioritisation model could have been better co-produced as the partnership meetings which took place in the production of the priority banding had heavily represented by Kent colleagues and there may be a need and opportunity for review.

1.5.8. A Member asked the ICB to share additional data as it was gathered to assist with effective scrutiny going forward. The Committee was informed that it was difficult to make a commitment to share all the data as some of the providers operating in Kent and Medway would have contracts with other ICBs that were not governed by Kent and Medway ICB, officers however agreed to share description of data points being collected as they were developed.

1.6. The Committee agreed to:

a) Note the report.
b) Request that the Integrated Care Board share description of data points being collected as they were developed.

Lead officer contact

Teri Reynolds, Principal Democratic Services Officer
Teri.reynolds@medway.gov.uk (01634) 332104

Appendices

None

Background papers

None