AGENDA

KENT AND MEDWAY JOINT HEALTH AND WELLBEING BOARD

Thursday, 16th September, 2021, at 2.00 pm Ask for: **Ann Hunter**

Council Chamber, Sessions House, County Hall, Maidstone (Please enter the building via the entrance in the Courtyard which will bring you to reception) Telephone **03000 416287**

Membership

Mrs C Bell (Chairman), Cllr David Brake (Vice-Chairman), Dr J Allingham, Ms L Ashley, Mr P Bentley, Dr B Bowes, Ms J Brown, Sir Paul Carter, CBE, Mrs S Chandler, Cllr H Doe, Dr A Duggal, Mr M Dunkley CBE, Dr L Farach, Dr J Findlay, Mr R W Gough, P Graham, Mr P Gulvin, Cllr Mrs A Harrison, Cllr Mrs J Hollingsbee, Cllr A Jarrett, Ms R Jones, Dr N Kumta, Cllr M Potter, Mr M Riley, Mr Rivers, Mr M Scott, Mr M Scott, Ms C Selkirk, Mr R Smith, Mr J Williams and Mr W Williams

UNRESTRICTED ITEMS

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

1. Election of Chair

2. Election of Vice-Chair

3. Apologies and Substitutes

4. Declarations of Interest by Members in items on the agenda for this meeting

To receive any declarations of interest by Members in items on the agenda for the meeting

5. Minutes of the meeting held on 10 March 2021 (Pages 1 - 6)

6. COVID-19 Local Outbreak Control Plan (Pages 7 - 16)

7. Feedback from Health Inequalities Workshop on 10 June 2021 and Next Steps (Pages 17 - 24)

8. Update on the establishment of a Kent and Medway Integrated Care System - August 2021 (Pages 25 - 68)

9. The Appointment of a representative to attend meetings of the Kent and Medway Primary Care Commissioning Group (Pages 69 - 100)

10. Kent and Medway Joint Health and Wellbeing Board - Co-option of Members (Pages 101 - 102)

11. Kent and Medway Prehabilitation Programme (Pages 103 - 108)

12. Preventing Suicide in Kent and Medway: 2021-25 Strategy (Pages 109 - 212)

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)

Wednesday, 8 September 2021

Medway Council

Virtual Meeting of Kent and Medway Joint Health and Wellbeing Board

Wednesday, 10 March 2021

3.04pm to 4.00pm

Record of the meeting

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

Present:

Mrs Clair Bell, Cabinet Member for Adult Social Care and Public Health, Kent County Council (Vice-Chairman)
Councillor David Brake, Portfolio Holder for Adults' Services, Medway Council (Chairman)
Jackie Brown, Assistant Director Adults' Social Care, Medway Council
Sir Paul Carter, CBE, Kent County Council
Mrs Sue Chandler, Cabinet Member for Integrated Children's Services, Kent County Council
Councillor Howard Doe, Deputy Leader and Portfolio Holder for Housing and Community Services, Medway Council
Mr Roger Gough, Leader, Kent County Council
Penny Graham, Heathwatch Kent
Pat Gulvin, Healthwatch Medway
Councillor Angela Harrison, Cabinet Member for Health and Wellbeing, Swale Borough Council
Councillor Mrs Jenny Hollingsbee, Deputy Leader and Cabinet Member for Communities, Folkestone and Hythe District Council
Councillor Alan Jarrett, Leader, Medway Council
Councillor Martin Potter, Portfolio Holder for Education and Schools, Medway Council
Councillor John Rivers, President, Kent Association of Local Councils
Andrew Scott-Clark, Director of Public Health, Kent County Council
Dr Robert Stewart, Clinical Designer, Design and Learning Centre for Clinical and Social Innovation
Ian Sutherland, Director of People - Children and Adults Services, Medway Council
James Williams, Director of Public Health, Medway Council

Substitutes:

Dr Bob Bowes, Governing Body Member, NHS Kent and Medway CCG (Substitute for Navin Kumta)
Stephen Fenlon, Medical Director, NHS Dartford and Gravesham NHS Trust (Substitute for Louise Ashley)
Dr Amanjit Jhund, Programme Director for West Kent ICP (Substitute for Miles Scott)
Chris McKenzie, Director of Adult Social Care and Health West

Kent, Kent County Council (Substitute for Richard Smith)
Caroline Selkirk, Executive Director of Health Improvement/ Chief Operating Officer, NHS Kent and Medway CCG (Substitute for Wilf Williams)
Mark Walker, Director for Special Educational Needs, Disabled Children and Young People, Interim, Kent County Council (Substitute for Matt Dunkley, CBE)

In Attendance: Donna Carr, Senior Programme Manager, Population Health, NHS Kent and Medway CCG
Karen Cook, Policy and Relationships Adviser (Health), Kent County Council
Jade Hannah, Democratic Services Officer, Medway Council
Dr Logan Manikam, Interim Public Health Consultant, Medway Council
Jacqueline Shicluna, Lawyer (Adults), Medway Council

788 Apologies for absence

Apologies for absence were received from Dr John Allingham (Kent Local Medical Committee), Louise Ashley (Dartford, Gravesham and Swanley ICP Senior Responsible Officer (SRO) Representative), Matt Dunkley CBE (Corporate Director, Children, Young People and Education, Kent County Council), Navin Kumta (Clinical Chair, NHS Kent and Medway CCG), Rachel Jones (Executive Director of Strategy and Population Health, NHS Kent and Medway CCG), Matthew Scott (Kent Police and Crime Commissioner), Miles Scott (West Kent ICP SRO Representative), Richard Smith (Corporate Director Adult Social Care and Health, Interim, Kent County Council) and Wilf Williams (Accountable Officer, NHS Kent and Medway CCG).

789 Chairman's Announcements

The Chairman informed the Joint Board that Ian Sutherland, Medway's Director of People - Children and Adults Services would shortly be leaving Medway Council. Mr Sutherland would be retiring after 38 years in public service; he joined Medway in 2014 as Deputy Director of Children and Adults and he was appointed as Director in 2017. The Chairman expressed that Mr Sutherland had worked tirelessly to improve services in both Children and Adults and had been invaluable to the Joint Board. On behalf of the Joint Board, he thanked him for his contribution to the Joint Board and wished him a very happy retirement.

The Chairman also announced that Dr Lee-Anne Farach, Medway's current Assistant Director, Children's Services had been appointed as Medway's new Director of People and would formally be taking up her new role at the beginning of April when Mr Sutherland retired. He looked forward to welcoming Dr Farach to the Joint Board in due course.

790 Record of Meeting

The record of the meeting held on 8 December 2020 was agreed and signed by the Chairman as correct.

791 Declaration of Disclosable Pecuniary Interests and other interests

Dr Bob Bowes, Governing Body Member, NHS Kent and Medway CCG advised the Joint Board that as a GP he was a member of a Primary Care Network and had received income as a result of the vaccination programme.

792 Urgent matters by reason of special circumstances

There were none.

793 COVID-19 Local Outbreak Control Plan

Discussion:

The Director of Public Health, Medway Council introduced this report which provided an update on action undertaken to mitigate rising cases of COVID-19 across both Kent and Medway as it related to the Local Outbreak Control Plan (LOCP). It also included a summary of LOCP-related questions received from members of the public and answers provided by Public Health Officers as set out in Appendix 1 to the report.

A detailed presentation was given by the Directors of Public Health, Medway Council and Kent County Council, which provided an epidemiological assessment of COVID-19 prevalence across Kent, Medway, and comparison districts. Overall, COVID-19 rates had fallen steadily in all districts since the latest lockdown began. An update was provided on asymptomatic testing as well as testing to understand the prevalence of novel strains within the community, particularly the recent targeted surge testing conducted in the ME15 postcode area. Finally, the presentation provided an update on the vaccination programme across Kent and Medway and the Government's 'roadmap' for leaving lockdown. The Joint Board was reassured about the additional measures put in place to enable the safe return to schools.

The Joint Board was advised that the LOCP was required to be updated and resubmitted to the National Contain Team by the 31 March 2021. A cautious approach to moving forward with the 'roadmap' was being undertaken in conjunction with the local resilience forum. There would be ongoing publicity to support the community to keep themselves safe as the locality moved through the phases of the 'roadmap' whilst the vaccination programme continued to be rolled out.

With respect to communication, the importance of continuing to communicate a strong message to the public was emphasised. A long period of difficulty was nearing an end and with vigilance and hard work, restrictions would ease later in the year but now was not the time to relax.

Asked whether data was collected on hard-to-reach cohorts and how these groups were supported to receive vaccinations, the Joint Board was assured that data was collected and monitored and that rates of vaccination uptake across Kent and Medway were very good. The importance of ensuring equity of vaccine access was acknowledged to control COVID-19. The more people vaccinated, the better.

With reference to an example of how homeless individuals had been supported to receive vaccinations, it was explained that there was a multi-agency 'vaccination board' which looked at issues of equity and a public health consultant was tasked to lead on this area of work. The Communications team at the NHS Kent and Medway CCG were also working extensively in this regard.

It was recognised that more support was required to reach some individuals within priority group 6, such as unpaid carers. It was important that these individuals were registered with the appropriate organisations for them to be called forward centrally, by the system, to receive their vaccinations.

Decision:

The Kent and Medway Joint Health and Wellbeing Board:

a) noted the update report and the questions submitted by members of the public on the Local Outbreak Control Plan together with the responses provided by stakeholders from both Kent and Medway Council (Appendix 1).

b) agreed that the questions submitted by members of the public on the Local Outbreak Control Plan together with the responses set out at Appendix 1 to the report are published on each Council's website in accordance with the agreed engagement strategy.

794 Strategic Plan to Mitigate the Impacts of COVID-19 on Health Inequalities: Progress Update

Discussion:

The Joint Board considered a progress update on the Strategic Plan to mitigate the impacts of Covid-19 on health inequalities, which was introduced by the Senior Programme Manager, Population Health, NHS Kent and Medway CCG.

A project plan had been drafted, with initial work to bring together existing data and intelligence underway. Although some data was already available, it was acknowledged that the COVID-19 pandemic was not over, and more and updated data would become available in the future. The mapping of existing activity to reduce widening inequalities was also underway in order to avoid duplication and enable initiatives and resources to be aligned where appropriate.

A small interim task and finish group had been established to provide direction and oversight. This group had met to agree the approach to and scope of the work. A second meeting of the group was planned for 8 April 2021, where an initial review of existing data would be undertaken and a plan for the proposed Joint Board development session on 10 June 2021 would also be discussed. It was noted that the development session had been expanded to include members of the Integrated Care System/STP Partnership Board.

It was recognised that the COVID-19 pandemic had focused attention on the need to address health inequalities. Indeed, a view was expressed that it was critical to address widening inequalities to ensure a sustainable health system going forward. It was added that much learning could be taken from the implementation of the COVID-19 vaccination programme which arguably was one of the first, big population health management programmes which had demonstrated that a lot could be achieved in a short timescale if the system worked together.

Acknowledging the range of organisations which were involved across health, social care, public health, and those dealing with wider determinants of health, the challenge of taking this work forward as a Joint Board and as individual organisations to give this important issue traction was highlighted. It was an area that the Joint Board could advance joint working.

Decision:

The Kent and Medway Joint Health and Wellbeing Board:

a) noted the initial progress made on the development of the joint strategic plan to mitigate the impacts of COVID19 on health inequalities.

b) agreed to hold a development session in private on 10 June 2021 to be informed about the emerging impact of COVID-19, understand the wider health inequalities found in Kent and Medway and recommend the priority areas for focus.

795 Work Programme

Discussion:

The Democratic Services Officer advised the Joint Board that an agenda setting meeting had taken place on 3 February 2021. Proposed amendments to the work programme were set out in section 2 of the report and reflected in the work programme attached at Appendix 1 to the report.

Decision:

The Kent and Medway Joint Health and Wellbeing Board agreed the work programme set out at Appendix 1 to the report.

Chairman

Date:

Jade Hannah, Democratic Services Officer

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KENT AND MEDWAY
JOINT HEALTH AND WELLBEING BOARD

16 SEPTEMBER 2021

COVID-19 LOCAL OUTBREAK CONTROL PLAN

Report from: Allison Duggal, Director of Public Health for Kent County Council

James Williams, Director of Public Health for Medway Council

Author: Logan Manikam, Interim Public Health Consultant

Summary

This report provides an update on steps taken to mitigate rising cases of COVID-19 across both Kent and Medway as it relates to the Local Outbreak Management Plan (LOMP). It also includes a summary of LOMP-related questions received from members of the public and answers provided by Public Health Officers (located in Appendix 1).

1. Budget and Policy Framework

1.1. As part of the Department of Health and Social Care's COVID-19 response and recovery strategy, Upper Tier and Unitary Local Authorities in England were mandated to develop a COVID-19 Local Outbreak Management Plan (LOMP)- formerly known as the COVID-19 Local Outbreak Control Plan-to reduce the spread of the virus within the community.

1.2. On 28 February 2021, Department of Health and Social Care (DHSC) requested that the LOMP be updated to reflect the changed landscape of the pandemic and to consolidate best practice that has emerged locally in its first year through the creation of a Best Practice Document. The objectives of these updates are outlined below:

- to ensure that updated fit for purpose local outbreak management plans are in place across England;
- to identify any additional support Local Authorities may need from national or regional teams, particularly in relation to surge activity to detect new variants:
- to identify good practice at local and regional levels– most particularly in respect to Non-Pharmaceutical Interventions (NPIs) that can be used to reduce/prevent transmission of the virus and use this learning to inform regional and national policies;
- to ensure there is effective governance and clarity on roles/responsibilities at all levels of response; and

- to ensure LOMP reflect cross-cutting considerations, such as inequalities;
- to provide ongoing assurance and justification of the need for financial support from the COVID Outbreak Management Fund (COMF) and self-isolation fund.

1.2.1 On 22 February 2021, the Government announced the National Spring 2021 Roadmap out of Lockdown. This is a 4-step data-driven approach to enable the relaxation of restrictions. Before proceeding through each stage of the roadmap, the Government committed to examining the most current data and evidence to determine whether it was feasible to progress to the next phase of opening. The four tests that inform the progression through each phase are:

- Rollout of the national vaccine programme continues successfully
- Evidence showing vaccines are sufficiently effective in reducing hospitalisations and deaths in those vaccinated.
- Infection rates do not risk a surge in hospitalisations and therefore do not put unsustainable pressure on the NHS; and
- Assessments of the risks is not changed fundamentally by new Variants of Concern (VOCs).

1.2.2 On 5 July the Government published guidance that would inform its decision (Moving to Step 4 of the Roadmap) to move to Step 4 on the 19th of July 2021. This is the current stage that England is at. The move to Step 4, shifts the national emphasis on managing the risk of disease transmission, away from regulation and blanket legal restrictions, to one of targeted local action and collaborative population engagement. This Step has seen the end of all legal limits on social contact, the reopening of nightclubs, large events, and performance venues. Directors of Public Health and other public health agency do still possess powers to take action to address outbreaks. Central government has also tried to mitigate the impact of opening up society by:

- Aiming to achieve ‘herd immunity’ by increasing uptake in areas where vaccine coverage is low and providing additional booster jabs for specific groups
- Retaining proportionate test, trace, and isolate plans
- Managing risks at the UK border and supporting a global response to reduce the risk of variants emerging globally and entering the UK
- Retaining contingency measures to respond to unexpected events

1.2.3 There is now a recognition that COVID-19 is endemic. Action to respond and manage this disease will be shaped into business-as-usual planning and preparation. Local Outbreak Management Plans will be critical to this endeavour.

1.3. Central government has provided funding to facilitate the delivery of LOMP to enable local authorities and their partners to put in place local measures to prevent, identify, and contain COVID-19 outbreaks. The Kent and Medway LOMP was published online on 30 June 2020; its most recent iteration was published on the 16 April 2021. Revisions and updates to the LOMP are

currently underway and are being informed by the COVID-19 Contain Framework, recently updated on 30 July 2021. The contain framework will be subject to revision in line with organisational transformation associated with the creation of the UK Health Security Agency.

2. Background

2.1 Responding to the Rise in Cases Nationally & Locally

2.1.1. Transmission rates of COVID-19 in Kent and Medway have reduced considerably over the course of the months that followed the last convening of the Joint Health and Wellbeing Board. This reduction was attributed to the success of the vaccination programme and asymptomatic testing at scale. However, in recent weeks there has been an increase in transmission nationally and locally. This increase has been associated with the emergence of new variants of concern (VOC). These VOC can be more transmissible and, in some cases, potentially more deadly. The most recent increase in infection rates across the UK and Kent and Medway is associated with a VOC of concern first identified in India (B.1.617.2-Delta). This variant is now the dominate circulating strain in the UK. No surge testing for new variants has been required or undertaken in Medway.

2.1.2. Surge testing was recently launched in the ME14 area of Kent (Canterbury, Dartford and Sevenoaks area) in response to the initial increase of the most recent VOC (B.1.617.2-Delta) to better understand the prevalence of the novel strain within the community.

2.1.3. While there used to be a need to undertake population surge testing to identify new variants, changes to the way in which UK laboratories work, mean there is now more capacity to routinely sequence all positive samples from PCR tests submitted for analysis. It is therefore easier to identify VOC as they emerge without the need for mass population testing. More stringent restrictions have been put in place on the public to contain these novel variants and protect NHS capacity. These include; travel restrictions, quarantine, and COVID-test requirements on travellers into the country. Detailed information on new variants can be found on the website for the Centres for Disease Control and Prevention (CDC).

2.2. Updates to Local Testing and Tracing Capabilities

2.2.1. Changes to Testing and Tracing protocols in Kent and Medway have been made to meet the constant changing nature in demand seen over the last few months. The roll-out of rapid symptom free testing and local tracing partnerships managed by local authorities, have successfully built on local knowledge and infrastructure to reduce community transmission levels. Locality based door-to-door testing has also contributed to national surveillance for novel variants.

2.2.2. Since the last JHWB meeting convened, Medway Council and Kent County Council have adopted new innovative ways to offer symptom free testing to

the local community. This has meant a move away from solely using fixed permanent test sites. Testing is now more flexible and dynamic, comprising a hybrid model of outreach, home direct online testing, and community pharmacy access. These alternative, more holistic models, have enabled both authorities to better serve the needs of their communities. This has also led to greater efficiencies within the testing programme, facilitating a reduction of fixed sites from 5 in Medway and 24 in Kent to 1 and 2 respectively. Residents are able to access testing in more convenient ways, including online home test kits, workplace testing, and pharmacy collect options. Multiple pop-up sites are also available to meet local surge requirements.

2.2.3. Both programmes have been developed in partnership with the Department of Health and Social Care (DHSC) using local data on disease transmission and prevalence.

2.2.4. In partnership with NHS Test and Trace, both Kent and Medway have also launched their own Local Tracing Partnerships. These services verify the contact details of those whom national handlers are unable to trace using local data sources. These individuals are then followed by local test and trace staff to ensure they comply with necessary self-isolation or testing measures.

2.3. The Vaccine Programme

2.3.1. The management and roll-out of the vaccination programme is the responsibility of the DHSC. Both Medway and Kent County Council are working closely with stakeholders from the DHSC to support them in meeting their vaccination targets for the local area. At the time of report compilation over 47 million people in the UK had been fully vaccinated in-line with the Medicines and Healthcare Regulatory Authority Guidance. Over 1 million and 180,000 Kent and Medway residents respectively had been vaccinated. Vaccination has been undertaken within the prioritisation framework set out by the Joint Committee on Vaccination and Immunisation (JCVI):

- all residents in a care home for older adults and their carers;
- all those 80 years of age and over and frontline health and social care workers;
- all those 75 years of age and over;
- all those 70 years of age and over and clinically extremely vulnerable individuals;
- all those 65 years of age and over;
- all individuals aged 16 years to 64 years with underlying health conditions which put them at higher risk of serious disease and mortality;
- all those 60 years of age and over
- all those 55 years of age and over;
- all those 50 years of age and over;
- all those aged 18 and over*

2.3.2. Vaccines are currently delivered by two types of vaccination sites:

1. Vaccination centres – using large-scale venues such as football stadiums; accessed via a national booking service
2. Local vaccination services – made up of sites led by general practice teams collaborating via pre-established primary care networks and pharmacy teams through community pharmacies

2.3.3. From 4 August 2021, all 16- and 17-year-olds are also advised to receive their first dose of the Pfizer-BioNTech vaccine. Work is currently underway to ensure all those aged 16/17 are offered and take up vaccination, before returning to an educational setting following the summer break. Children aged 12 to 15 with specific underlying health conditions that put them at risk of severe COVID-19 are advised to receive two doses of Pfizer-BioNTech vaccination with an interval of 8 weeks between doses. All conditions are currently listed in the Green Book. Anyone who, for whatever reason, was missed in priority groups 1-9 (section 2.3.1) is also being offered the vaccine.

2.3.4. On 30 June 2021 the JCVI was asked to consider the option for a potential COVID-19 booster programme for 2021 to 2022 by reviewing the emerging evidence on the need for and timing of an additional vaccine dose. The JCVI's interim advice is that any potential COVID-19 booster programme should be offered in 2 stages from September, starting with those most at risk from serious disease. This includes care home residents, people aged over 70, frontline health and social care workers, clinically extremely vulnerable adults and those who are immunosuppressed. In stage 2, groups to be offered a booster dose include all adults aged 50 years and over, all adults aged 16 to 39 years who are in an influenza or COVID-19 at-risk group and adult household contacts of immunosuppressed individuals. This is in order to maximise individual protection and safeguard the NHS ahead of winter. All groups would also be eligible for the annual flu vaccine and are strongly advised to have the flu vaccine.

2.3.5. From 16 August 2021 as part of Step 4 of the Government's COVID-19 roadmap, individuals who are identified as a contact of a confirmed case of COVID-19 in England, will be exempt from the legal duty to self-isolate if they meet one of four exemption criteria:

- Individuals who have been vaccinated in line with an MHRA vaccine and recommended schedule at least 14 days prior to contact with a positive case
- Children and young people under the age of 18 years and 6 months
- Clinical trial participants: those who have taken part in- or are currently taking part in- an MHRA approved COVID-19 vaccine clinical trial
- Medical exemptions: those who can evidence that they cannot be vaccinated for medical reasons

2.4. **Local Outbreak Engagement Board (LOEB) Public Engagement Strategy**

2.4.1. In accordance with the recommendations made by the Joint Board at its meeting on 17 September 2020, a form for residents to engage with the Joint Board regarding the LOMP will be made available online prior to each Joint Board meeting. For this meeting, the form was hosted online on the Medway Council website between 13 August 2021 and 27 August 2021; Kent residents were signposted to the link via the Kent County Council's COVID web pages.

2.4.2. Appendix 1 to the report sets out the questions falling within the agreed criteria that emerged during this process and have been answered by stakeholders from both Kent and Medway Council. The Joint Board are invited to discuss the key themes and public concerns in the upcoming meeting.

3. Risk Management

3.1. By running stress test exercises on a variety of scenarios related to the LOMP, as outlined in Section 2.6, we aim to minimise the risks associated with similar events occurring by: (i) identifying any gaps within the LOMP; (ii) creating awareness of the communication channels that exist between the agencies; (iii) creating awareness of the roles of different agencies; (iv) clarifying the escalation triggers and process; (v) identifying areas where additional support may be required; (vi) identifying any potential challenges and their solutions; and (vii) identifying actions that need to be taken and when.

4. Financial Implications

4.1. As a result of recent changes made to the Contain Outbreak Management Fund, additional resources are now available for eligible councils who need support in enforcing Local COVID Alert Levels in their communities.

4.2. Initial funding was provided through the Test, Track & Trace Support Grant using 2020/21 Public Health allocations as a basis for distribution. Additional funding of £8 per head of population for those Local Authorities in the highest tier of national restrictions was in place up to 2 December 2020. Since then, Funding allocations to local authorities is currently being managed through a variety of mechanisms. Resources for testing are being provided on a quarterly basis, based on a business case submitted by each local authority. Resources to support the activities of the Local Outbreak Management Plan are provided through arrangements with DHSC and MHCLG.

4.3. Monitoring and oversight of expenditure is managed via the Contain Programme Regional Convenor for the South East. There is a detailed framework that sets out the key areas that can be funded; these will evolve over time and are tailored to local need.

5. Legal Implications

5.1 Kent County Council (KCC) and Medway Council, under the leadership of the Directors of Public Health, have a statutory duty to protect the population's health by responding to and managing communicable disease outbreaks which requires urgent investigation and presents a public health risk.

5.2 The legal context for the councils' response to COVID-19 sits within the following Acts:

- The Coronavirus Act 2020
- Health and Social Care Act 2012
- Public Health (Control of Disease) Act 1984

5.3 The Kent and Medway Joint Health and Wellbeing Board has been established as an advisory joint sub-committee of the Kent Health and Wellbeing Board and the Medway Health and Wellbeing Board under Section 198(c) of the Health and Social Care Act 2012 for a time limited period of four years from 1 April 2020.

5.4 The Joint Board seeks to encourage persons who arrange for the provision of any health or social care services in the area to work in an integrated manner and ensure collective leadership to improve health and well-being outcomes across both local authority areas.

5.5 The Joint Board is advisory and may make recommendations to the respective Kent and Medway Health and Wellbeing Boards.

5.6 As part of the Department of Health and Social Care's COVID-19 response and recovery strategy, Upper Tier and Unitary Local Authorities in England were mandated to develop a COVID-19 Local Outbreak Management Plan to reduce the viruses' spread.

5.7 The Health Protection (Coronavirus, Restriction) (Steps) (England) (No.364) Regulations 2021 came into force as legislation on 29 March 2021, setting out the National Spring Roadmap and giving DsPH authority to apply step-by-step restrictions, close individual premises and public outdoor places as well as restrict events with immediate effect if they conclude it is necessary and proportionate to do so without making representations to a magistrate. DsPH are required to notify the Secretary of State as soon as reasonably practicable after the direction is given and review to ensure that the basis for the direction continues to be met, at least once every 7 days.

5.8 The Government made the decision to move to Step 4 of the National Spring Roadmap on 19 July 2021, removing many of the restrictions previously in force.

1.1. The Health Protection (Coronavirus, Restrictions) (England) (No.3) Regulations 2020 which came into force on 18 July 2020 will continue to apply until the end of 27 September 2021. These regulations grant powers to local authorities to make directions which respond to a serious and imminent

threat to public health. Any direction must be necessary and proportionate in order to manage the transmission of coronavirus in the local authority's area. The regulations contain powers for local authorities to give directions which:

- restrict access to, or close, individual premises
- prohibit or restrict certain events (or types of events)
- restrict access to, or close, public outdoor places (or types of outdoor public places) following procedural requirements set out in the regulations.

The powers may be used up to the date of expiry, 27 September 2021. A local authority must review a direction it has issued under the regulations at least once every 7 days and determine whether the legal conditions stipulated in the regulations for making the direction continue to be met.

6 Recommendation

6.1 The Kent and Medway Joint Health and Wellbeing Board is asked to consider and note this update report and the questions submitted by members of the public on the LOMP together with the responses provided by stakeholders from both Kent and Medway councils (Appendix 1).

6.2 The Kent and Medway and Joint Health and Wellbeing Board is asked to agree that the questions submitted by members of the public on the LOMP Plan together with the responses set out at Appendix 1 to the report are published on each council's website in accordance with the agreed engagement strategy.

Lead Officer Contact
Dr Logan Manikam, Interim Public Health Consultant
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Appendices
None

Background papers
None

Appendix 1 – Public questions on the Local Outbreak Control Plan and Answers

PLACEHOLDER – QUESTIONS ARE CURRENTLY BEING VETTED AND ANSWERED FOR PUBLICATION ON 1ST SEPTEMBER 2021.

NONE

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KENT AND MEDWAY
JOINT HEALTH AND WELLBEING BOARD

16 SEPTEMBER 2021

Feedback from the Health Inequalities Workshop held on June 10 2021 and Next Steps

Report from: Rachel Jones, Executive Director of Strategy and Population Health, Kent and Medway CCG

Author: Karen Cook, Policy and Relationships Adviser KCC
Sharease Gibson Deputy Director Strategy and Population Health Kent and Medway Clinical Commissioning Group

Summary
This report sets out the key findings from the Health Inequalities workshop held on the 10 June 2021 and proposes the next steps in the development of a Health Inequalities Action Plan for Kent and Medway Integrated Care System for approval by the Kent and Medway Joint Health and Wellbeing Board.

1. Introduction

1.1 On 17th September 2020 the Kent and Medway Joint Health and Wellbeing Board (The Joint Board) agreed to hold a development session about the emerging impact of Covid 19 and the wider health inequalities found in Kent and Medway. The development session took place on June 10th, 2021 and included the members of The Joint Board and the members of the Integrated Care System Partnership Board, bringing together the widest leadership of the Kent and Medway Integrated Care System for the first time.

1.2 The session was used as an introduction to the issues facing Kent and Medway and looked at how other areas in the Country had responded to health inequalities through a system wide approach. It was agreed that the System would develop agreed priorities out of the learning from that day and with further analysis and consideration.

1.3 This paper sets out next steps to consider our priorities. A Kent and Medway health inequalities action plan will then be developed to reflect areas of focus agreed by the Board and the wider system.

2. Background

2.1 As was set out in the paper on 17th September 2020 Covid 19 has impacted on our citizens and our workforce in ways that are becoming clearer. Certain populations have been affected more than others, such as people from black and minority ethnic backgrounds. Other issues are also known to have a

bearing on health inequalities. These include gender and age. People with underlying health conditions, for example diabetes, asthma and cardiovascular disease are known to have experienced worse physical and emotional outcomes during the pandemic. What is clear is that the wider determinates, poverty, housing conditions, job insecurity and worklessness, have played a pivotal role in terms of increasing inequalities during the pandemic. Some people are facing job loss, debt and homelessness, whilst others are facing new or more serious mental health illness. Our workforce has been tremendous in responding to the demands of the pandemic, but has faced traumatic and challenging events, particularly our front line health and social care staff. So, whilst there have always been health inequalities in Kent and Medway, the effect of Covid-19 will be to exacerbate and increase the inequalities experienced by our population.

2.2 Covid 19 response measures have also led to some services being stepped down. We know that latent demand has developed in the population. This could lead to poorer health outcomes as a result of delayed cancer screening, loss of herd immunity and an increase in vaccine preventable diseases arising from a reduction in population coverage of routine child and adult vaccination programmes. There will likely be an effect associated with the postponement of elective care procedures, or through people not accessing routine primary care for fear of visiting their GP during the pandemic.

2.3 Health inequalities are caused by much more than an individual's actions or access to traditional health care. Green spaces; social activities; education and employment opportunities; healthy food; good housing and transport services all play a hugely important role, and all have been disrupted by the pandemic.

2.4 The Kent and Medway Joint Health and Wellbeing Board remains in the unique position of having a wide partnership membership. Its purpose includes promoting health integration and supporting partners to address health inequalities.

2.5 In light of this the Joint Board agreed to take the broadest view of its purpose and to place an unrelenting focus on health inequalities. This includes more focus on children and young people, those with a learning disability, autism or mental health problems and those environmental and lifestyle factors (the wider determinants of health- such as housing, employment and education) that have the greatest impact on health outcomes.

On 17 September 2020 the Joint Board agreed to:

i. develop a plan to publicly set out its vision, strategic aims and ambitions regarding how the partnership could work together to tackle those areas of health inequalities identified as priorities for the system.

ii. hold a development session to better understand the emerging impact of Covid-19 and the wider health inequalities found in Kent and Medway to inform the plan. This took place on June 10th 2021.

iii. the Executive Director of Strategy and Population Health for Kent and Medway CCG being the lead officer for this work on behalf of the Joint Board, informed by the Public Health Directors of both Medway and Kent.

3 Outcomes of the Workshop: Key Findings

3.1 The content of the workshop set out the current headlines about Health Inequalities in Kent and Medway. Health inequalities are caused by many factors, most of which are beyond the gift of the individual to change.
COVID has shone a light on health inequalities and made them worse, but health inequalities will not simply disappear once COVID is over. Potentially, inequality gaps will widen as we emerge from the epidemic, with disadvantaged communities having disproportionately suffered from its impact.

3.2 In summary the workshop highlighted that:

a) Living in a deprived area negatively affects your health and wellbeing:
- If you live in the most deprived ward in Kent you are likely to die before someone who lives in the least deprived. In the most extreme case, there is a 25-year age gap between the average age of death for the least deprived and most deprived in our area.
- You are more likely to go into hospital as an emergency case if you live in a poorer ward. For example, there are more emergency admissions for chronic obstructive pulmonary disease and stroke for people in more deprived areas.
- You are more likely to have more than one thing wrong with you i.e. Diabetes AND high blood pressure if you live in a more deprived area.
- As deprivation increases school examination attainment decreases. Children from poorer areas receive far lower grades than those in less deprived areas.
- If you live in a deprived area, you were more likely than those living in more affluent areas to die from Covid

b) However not all inequality is related to poverty:

- If you have a mental illness, you are more likely than the general population to have a physical illness and to die younger.
- If you grow up and have experienced more than 4 adverse childhood events- such as parental separation, any kind of mental or physical abuse or experienced mental health problems - you are more likely as an adult to go on to use drugs, become involved in violence or go to jail than a child who has had no or fewer adverse experiences.
- The increase in mortality compared to before COVID was greater in people who were from Black and Asian minority ethnic backgrounds.

- If you eat a poor diet, smoke or drink too much alcohol or take drugs you are more likely to develop a preventable illness and your long-term health and wellbeing will be severely affected.

3.3 The workshop emphasised that life chances of individuals are severely impacted by the inequalities they face in their lives. Tackling the root causes of inequality is the right thing to do for any public sector organisation involved in serving, supporting and championing their communities. However, it will also provide wider benefits not just to the individuals affected but to wider society as there is an economic burden to be borne, not only in the costs of health and social care but also in years of working life lost to ill health and disability.

3.4 It must be recognised that not all the solutions to tackling inequalities are in the hands of local public sector organisations. National approaches are also needed to deal with income and benefits, planning and infrastructure, air quality and emissions, food quality and sugar content etc. But there is no doubt that there are opportunities through the power of our wider partnership to do more together and to focus unrelentingly on the things we can change to tackle d disadvantage in our community.

3.5 Reflections from system leaders on the event

a) Leadership

- Leadership is vital, however it has to be system wide and all recognised as equal partners to ensure this works well in order to ensure the best outcomes

- We need a sustained commitment to this and we must use our span of influence

- Deciding where to put resource is key. We need to be clear and confident in what we want to achieve.

- We need to challenge ingrained adverse culture and understand the importance of place-based context and know and act on how people could be empowered.

- Involving the local community is a key part of a number of the key points we have raised today.

- Find one small thing that we can do together (with thought and based on data) and DO IT!

- Focus on staff inequalities as much as community inequalities.

b) Areas of Priority for system working

- Collectively driving cultural change and holding each other to account.

- Using and understanding our own data and developing it to give us better access across the whole system.

- Focus on mental health and multi-morbidity

- We know the interventions that work, we need to do them at scale. The selection of interventions and how they are implemented needs to be worked out within the community.

- Our leadership needs to be aligned across all levels – we need to commit to that alignment and hold each other to account.

- We need to both enable local pilots with multiple partners including voluntary sector, while building in the right enablers to scale things across the whole system – can't do one without the other.

- Get together as leaders around the shared purpose more often and trigger the conversations in our own organisations.

- We need to build health inequalities into our agenda and take a more integrated, proactive approach to our business to incorporate action to address health inequalities.

4. Next steps

a) To capitalise on the energy and motivation expressed by those senior leaders who attended the workshop.

b) To feed the outputs and views from the health inequalities workshop into the population health management (PHM) programme to develop a system wide understanding of the leadership required to make the best of this learning and development programme opportunity.

c) To support the new programme of work that launched on 22 July 2021 looking at PHM and how, as a system we understand and plan health and care services for our communities. This is a 22 week externally supported programme which works with each tier of the system to link local data, build analytical skills to find at risk cohorts and design and deliver new models of care. The aim of the programme is to accelerate changes to care delivery to achieve better outcomes and experiences for selected populations and secure the skills to spread the approach to other cohorts. Please see Appendix 1 for the structure of the PHM programme and the priority cohorts identified.

   This is a whole system programme, and the Directors of Public Health from Kent and Medway are joint chairs of the Kent and Medway Population Health and Prevention Group. The programme is being managed by the Strategy and Population Health Team in the CCG and local authority officers as well as Members are engaged in the programme.

d) It is important that the learning from this programme influences the priority setting for the Health Inequalities Action Plan and the two link together to provide a coherent strategic approach for joint planning and working going forward.

5. Recommendations

The Joint Board is asked to agree to receiving a discussion paper at the December meeting of the Joint Health and Wellbeing Board that sets out the learning from the PHM programme and the proposed priority areas for the health inequalities action plan to focus on

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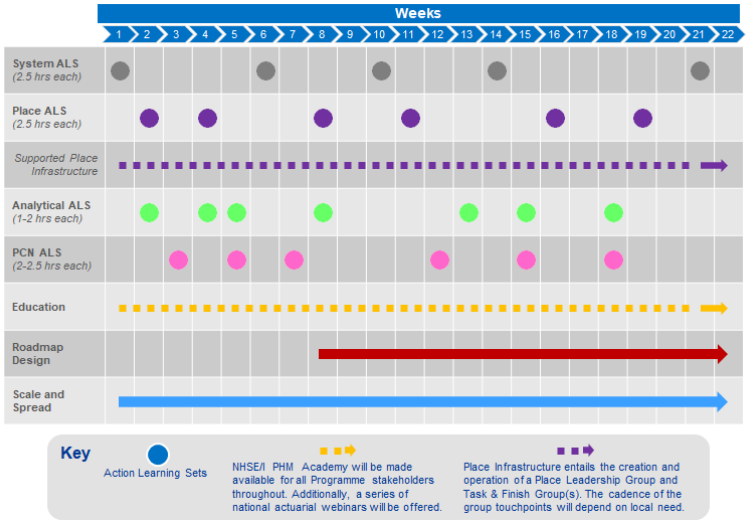
Appendices
Appendix 1 – PHM 22 week programme structure & priority cohorts

Appendix 1 – PHM 22 week programme structure & priority cohorts

Kent and Medway is participating in the Wave 3 population health management development programme run by NHS England and NHS Improvement. There are two Integrated Care Partnerships (ICPs), and five Primary Care Networks (PCNs) each with a buddy PCN participating in the progamme.

There are 4 levels of Action Learning Sets (ALS) delivered as part of the 22 week programme; System, ICP (including finance & contracting) – labeled as Place below, PCN and analytics. The cadence of each of these action learning sets is shown in the diagram below.



A PHM roadmap for Kent and Medway will be developed throughout the 22 weeks and is a key deliverable at the end of the programme. This enables systems to think about their own approach to spread the learning and build on PHM capabilities within and across partner organisations.

The programme is currently in week 7 (as at 06/09/21); ICPs and PCNs teams participating in the programme have all completed two action learning sets and have identified priority cohorts using their data and will start to focus on designing opportunities for intervention. The priority cohort for each ICP and PCN is detailed below along with the cohort size.

ICP / PCN	Cohort details	Cohort size
Medway & Swale ICP	Children between the age of 5-19 years, who have obesity with either asthma or diabetes from the 2 highest deprivation deciles	1,250
East Kent ICP	Diabetics in the chronic segment* with depression, live in highly deprived areas, and have an additional 3 or more co-morbidities	727
ABC PCN (West Kent)	Aged 10-59 years, obese with depression and live in highly deprived areas	107
Dover Town PCN (East Kent)	Aged 40-69 years, who are obese, hypertensive with depression; with mid-level complexity across all deprivation scales	131
Garden City PCN (DGS)	Aged 40-60 years, obese with anxiety and smokers across all deprivation levels	137
Medway Central PCN (Medway & Swale)	Aged 20-39 years, obese and hypertensive across all deprivation levels. Targeting those at risk of diabetes.	166
Ramsgate PCN (East Kent)	All age-groups, with diabetes and housebound; all levels of complexity and deprivation	118

*Chronic – those with at least 1 chronic condition but are not included the complex or end-of-life segments

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Transforming health and social care in Kent and Medway

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From: Wilf Williams, Senior Responsible Officer, Kent and Medway ICS

Lisa Keslake, Executive Director of System Development and Assurance, NHS Kent and Medway

To: Kent and Medway Joint Health and Well-Being Board

Subject: **Update on the establishment of a Kent and Medway Integrated Care System – August 2021**

Summary:

Major changes are taking place in the way health and care is organised in England as the emphasis of national policy continues to shift towards promoting collaboration within local health and care systems. Integrated care systems (ICSs), of which Kent and Medway is one, are being established in all areas of the country to drive change intended to lead to better, more joined-up care for patients and improvements in population health. In November 2020 NHS England published *Integrating care: Next steps to building strong and effective integrated care systems across England*. It described the core purpose of an ICS being to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

It emphasised that the next phase of ICS development should be rooted in underlying principles of subsidiarity and collaboration. It also described common features that every system is expected to have and develop, as the foundations for integrating care, with local flexibility in how best to design these to achieve consistent national standards and reduce inequalities.

This was further defined in February of this year, when the Department of Health and Social Care published its legislative proposals in the White Paper: *Integration and Innovation: working together to improve health and social care for all*. The White Paper promotes service integration with each area being led through new statutory ICS bodies, bringing together health and local government to plan and coordinate care and well-being. Subject to legislation being passed later this year – note the Bill has gone through its first and second stage reading in Parliament - the plan is to implement these proposals from April 2022, placing ICSs on a statutory footing. However, April 2022 is not end-state, but simply a major milestone in the evolution and development of collaborative partnership working.

This paper provides a summary of latest national guidance relating to ICS establishment, along with details of the evolving Kent and Medway plans and operating model. It should be noted that national guidance is being published on a weekly basis from mid-August through to mid-September so further verbal updates on any new material information will be provided at the meeting.

This paper is for INFORMATION

The National ICS Design Framework

In June 2021 NHS England (NHSE) published the much awaited design framework to guide next steps in developing ICS's in line with the White Paper. (The NHS Confederation have published a helpful summary of the whole framework - www.nhsconfed.org/publications/ics-design-framework). It should be noted that until this is taken through the Parliamentary process the move to create new statutory bodies remains a proposal. The following narrative provides the key headlines.

The ICS Design Framework sets out expectations for the next stage of system development. It sets out the core features of every ICS, while emphasising the need for local flexibility and determination. It also outlines the expectations NHSE has in terms of

- ICS roles and accountabilities
- governance and management arrangements
- financial allocations
- models for clinical and professional leadership and
- working with people and communities

Further national guidance is being published during late August / early September and should include:

- detailed governance arrangements of the new NHS Body – see below - as defined in a model constitution
- the national people (workforce) framework
- management of conflicts of interest guidance
- NHS provider governance and collaborative arrangements

Integrated care systems will include two core elements, alongside existing partnerships and statutory organisational arrangements:

- An **ICS Partnership** as the collective of all local partners including NHS organisations, local authorities and other key stakeholders.

- A statutory NHS organisation to be known as an **Integrated Care Board** (ICB) that will take on the responsibilities of Clinical Commissioning Groups, which will be dissolved on 1 April 2022, and any further responsibilities delegated by NHSE, for example the commissioning of dentistry and pharmacy services.

<u>The ICS Partnership</u>

Each ICS will have a Partnership Committee, responsible for **agreeing an integrated care strategy** for improving health and well-being across the totality of the population it serves, using the best insights from data available, built bottom-up up from local assessments of

needs and assets identified at place level, and focusing on reducing inequalities and addressing the consequences of the pandemic for communities.

The ICS Partnership will be a Joint Committee established by the relevant local authorities and the ICB, evolving from existing arrangements and with mutual agreement on its terms of reference, membership, appointment of Chair, ways of operating and administration.

The Partnership will act as a forum rather than a statutory board or committee. Its terms of reference will be determined locally and any decision making responsibilities (if any) outside of developing the integrated care strategy will be delegated by partner organisations.

Membership will include local authority and ICB representation plus representatives, yet to be agreed, from health and wellbeing boards; other statutory organisations; voluntary, community and social enterprise (VCSE) sector partners; social care providers; and organisations with a relevant wider interest such as employers, housing and education providers. The membership may change as the priorities of the Partnership evolve.

<u>The Integrated Care Board (ICB)</u>

The ICB will be a statutory NHS Body established from 1 April 2022. As a minimum, all CCG functions and duties will transfer along with all CCG assets and liabilities, including commissioning responsibilities and contracts. NHSE may also delegate functions and responsibilities currently undertaken by them. The ICB will be responsible for:

- Establishing joint working arrangements with partners that embed collaboration as the basis for delivery of joint priorities. The ICB may choose to commission jointly with local authorities across the whole system; at place where that is the relevant local authority footprint.

- Developing a plan to meet the health needs of the population within their area, having regard to the partnership's strategy and the local health and wellbeing strategy.

- Arranging for the provision of health services in line with the allocated resources across the ICS footprint through a range of collaborative leadership activities, including: putting contracts and agreements in place to secure delivery of its plan by providers; convening and supporting providers to lead major service transformation programmes; and putting in place personalised care.

- Allocating resources to deliver the plan by deciding how its national allocation will be spent across the system.

- Leading system implementation of the People Plan by aligning partners across each ICS to develop and support the 'one workforce'.

- Leading system-wide action on digital and data to drive system working and improved outcomes. This includes using joined-up data and digital capabilities

to understand local priorities, track delivery of plans, monitor and address variation and drive continuous improvement in performance and outcomes.

- Working alongside councils to invest in local community organisations and infrastructure and, through joint working between health, social care and other partners including police, education, housing, safeguarding partnerships, employment and welfare services, ensuring that the NHS plays a full part in social and economic development and environmental sustainability.

- Driving joint work on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support these wider goals of development and sustainability.

- Establishing governance arrangements to support collective accountability between partner organisations for whole-system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations, to ensure the plan is implemented effectively within a 'system financial envelope' set by NHSE.

The ICB will have a unitary board providing strategic leadership. All members of the Board will have collective and corporate accountability for delivery of the functions and duties of the ICS and the performance of the organisation. The statutory **minimum** membership of the ICB Board will be confirmed in legislation, but is expected to include:

- An independent Chair plus a minimum of two other independent non-executive directors. (These individuals will normally not hold positions or offices in other health and care organisations within the ICS footprint.)

- One member drawn from NHS trusts who provide services within the ICS area

- One member drawn from general practice from within the area

- One member drawn from the local authority or authorities, with statutory social care responsibility within the area

- Four executive directors: Chief Executive, Director of Finance, Director of Nursing and a Medical Director

Beyond these positions, the ICB may establish other specific executive or non-executive members to ensure that the Board is well governed, can meet its statutory duties and objectives, and can effectively manage conflicts of interest. Importantly, these members, along with members of the ICS Partnership and other ICS bodies or groups as outlined below, will be able to include individuals from respective partner organisations to act in both decision making and advisory capacities.

Other local partnerships/organisations

- Place-based partnerships, historically known as local '**Integrated Care Partnerships**', are collaborative arrangements between health and care partner organisations, that provide local services across a defined geography (usually between 250,000 and 750,000 people). In K&M we have four place based partnerships that have been evolving over the past couple of years. These are the engine room for local planning and delivery of services. Once fully developed, decisions will be increasingly made at place (rather than system) level to enhance integration, improve local outcomes and focus on pathways redesign so that individuals get the best care from the most appropriate local services.

- **Primary Care Networks** (PCNs) play a fundamental role in improving health outcomes and joining up services within small neighbourhoods (circa 30,000 people). Led by groups of local GP practices with community, social and voluntary care involvement, they have a close link to local communities, enabling them to identify priorities and address health inequalities. There are currently 42 PCNs covering the whole population of our 198 practices.

- '**Provider Collaborative**' describes partnerships involving two or more NHS trusts working across multiple places at an appropriate scale to realise mutual benefits and/or benefits for the wider system. It will be up to providers, working with partners, to decide on the specific model and best governance arrangements for their collaboratives. Whilst we do not currently have any formal collaboratives in place in Kent and Medway, it is expected that by the end of this financial year every acute provider and mental trust in the country will be part of at least one collaborative.

- **Individual providers** of care are of course the **foundation** of our local health and care system. They include, NHS Trusts and FTs, independent sector community and voluntary care providers, GP practices, social care providers, and other primary care services such as pharmacies, dentists and optometrists. Whilst they are key partners across the Kent and Medway system, each remains directly accountable for the services they deliver, in terms of both regulatory and contractual accountability. Their internal governance arrangements are not affected by the NHS Bill.

People and culture

From April 2022, ICSs will be expected to shape the approach to growing, developing, retaining and supporting the people employed by the ICS and its constituent organisations, ensuring the delivery of high-quality services and care for the population. The ICB will be expected to adopt a 'one workforce' approach and develop shared principles and ambitions for people and culture with local authorities, the VCSE sector and other partners.

Employment commitment

Whilst the national HR framework is awaited, NHSE has published guidance on the 'employment commitment' made by the Government in the White paper. This is intended to provide people in organisations directly affected by the proposed legislative changes with employment stability throughout the transition period while minimising uncertainty as much as reasonably possible. The employment commitment asks all organisations not to carry out significant internal organisational change or to displace people during the transition period. It also states that NHS people (below board level) affected directly by these legislative changes, will receive continuity of terms and conditions (even if not required by law) to enable all affected colleagues to be treated in a similar way despite any variation in current contractual relationships. It is designed to provide stability and remove uncertainty during transition.

Quality governance

The ICB will be required to resource quality governance arrangements appropriately, including leading system quality groups and ensuring that clinical and care professional leads have capacity to participate in quality oversight and improvement.

Operational support will be provided through NHSE regional and national teams in line with National Quality Board guidance, namely the refreshed *Shared Commitment to Quality and the Position Statement*. This sets out the core principles and consistent operational requirements for quality oversight that ICSs are expected to embed during the transition period (2021/22) and beyond.

Voluntary, community and social enterprise partners

The framework stipulates that VCSE partnership should be involved in governance structures and system workforce, population health management and service redesign work, leadership and organisational development plans. By April 2022, ICSs will be required to have developed a formal agreement for engaging and embedding the VCSE sector in system level governance and decision-making arrangements.

Clinical and professional leadership

All ICSs should develop a model of distributed clinical and care professional leadership, and a culture which actively encourages and supports such leadership to thrive. Specific models for clinical and care professional leadership will be for ICSs to determine locally, but the emphasis is on care professional from across the health and wider care sector being actively involved, rather than historic arrangements which have largely focused on clinical and medical leadership.

Working with people and communities

ICSs will need to build a range of engagement approaches into their activities at every level and to prioritise engaging with groups affected by inequalities. It is expected this will be supported by a legal duty for ICBs to make arrangements to involve patients, unpaid carers and the public in planning and commissioning arrangements.

Working with a range of partners such as Healthwatch, the VCSE sector and experts by experience, the ICB should assess and where necessary strengthen public, patients' and carers' voice at place and system levels. Arrangements in a system or place should not just provide commentary on services, but should be a source of genuine co-production and a key tool for supporting accountability and transparency of the system.

NHSE has set out seven principles for how ICSs should work with people and communities. These principles should be used as a basis for developing a system-wide strategy for engaging and involving people and their communities. As part of this the ICB will be required to work with partners to develop arrangements for:

- Ensuring the ICS partnership, and place-based partnerships have representation from local people and communities in priority setting and decision-making forums; and

- Gathering intelligence about the experience and aspirations of people who use care and support, using these insights to inform decision-making and quality governance.

Primary care in integrated care systems

The framework emphasises the role of primary care in decision-making at all levels of the ICS, including strategic decision-making forums at place and system level. In particular, ICSs should ensure primary care professionals are involved in the development of shared plans at place and system, ensuring they represent the needs of their local populations at the neighbourhood level of the ICS, including with regards to health inequalities and inequality in access to services.

ICSs and place-based partnerships should also consider the support that PCN clinical directors, as well as the wider primary care profession, may need to develop primary care and play their role in transforming community-based services.

Accountability and oversight

Building on the relationships and ways of working that have developed to date, system partners (including local government) will need to maintain a working principle of mutual accountability, where, irrespective of their formal accountability, all partners consider themselves collectively accountable to the communities they serve, and to each other for their contribution to the ICS's objectives.

Financial allocations and funding flows

NHS funding allocations will be made via the ICB for the delivery of functions across the whole system. This will include the budgets for acute, community, mental health and primary care services and the running costs of the NHS Body. It will be for the ICB to agree with partners the allocation of this funding across the system. Increasingly, funding will be expected to link to population need with allocations based on longstanding principles of supporting equal opportunity of access for equal needs and contributing to the reduction of health inequalities.

The Kent and Medway Integrated Care System Development Plan

System partners have already demonstrated their commitment to work together to improve the quality of our services, the care people receive and the experience of our combined workforce. Indeed, over the past eighteen months in particular, have evidenced both the benefits and our willingness to collaborate and integrate services more than ever before. We will do this as part of our commitment to delivering the NHS triple aim:

- better health for everyone
- better care for all
- efficient use of NHS resources

The **Kent and Medway System Development Plan** and **draft Operating Model** maps our programme of work over the next year and beyond towards achieving our ambition. The current document, which has recently been approved by the current Partnership Board and reviewed by NHSE, is attached at **Appendix A.**

It should be noted that this is a dynamic and evolving set of plans, given the considerable pace that we are having to work to, alongside delivering current operational priorities, and moreover, the fact that much of the national guidance is yet to be published: whilst it will be for systems to determine many of the local arrangements put in place, we will need to constantly revise our plans as further guidance is published.

The proposals outlined in our Operating Model are founded first and foremost on the need to tackle health inequality and improve health and well-being across the whole of our population. The Operating Model, governance framework and architecture will be developed and refined based on this core principle, ensuring the way we go about our work will be inclusive, fair, consistent, transparent and efficient.

The merger of the eight Kent and Medway CCGs in 2020 and the subsequent restructuring of the single organisation puts us in a good position in terms of ICS transition, whilst recognising that the ICS will be different from the existing CCG. The future architecture will build on existing arrangements in place across the system where they are working well and be further informed by:

- The ICB model constitution

- Local functional design work, taking place from July through to October and
- Completion of the local system governance review which is currently underway

Our plans will continue to be refined over the summer and autumn months, building on the key national guidance, including the ICS Design Framework and model ICB Constitution. This is in the context that the accountability for delivering services within available resources remains with individual partner organisations of the ICS. Thus we need to align system and place responsibilities with the continued responsibilities of those organisations.

The expectation is that during from January 2022 we will move to shadow running the new ICS framework and associated arrangements alongside the existing statutory bodies until planned go-live in April 2022.

Recommendations:

The Joint Health and Well-Being Board is asked to NOTE this update for information

Authors:

Lisa Keslake, Executive Director of System Development and Assurance, NHS Kent and Medway

Mike Gilbert, Executive Director of Corporate Affairs, NHS Kent and Medway

Appendices:

Appendix 1: Kent and Medway, Integrated Care System Development Plan, 30 June 2021

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Transforming health and social care in Kent and Medway

Kent and Medway Integrated Care System Development Plan

30 June 2021

Incorporating:

Our Draft Operating Model and Next Steps

Contents

Appendices

1. Stakeholder engagement: Key Issues relating to the establishment of an ICS
2. The K&M System and ICS Body Transition and Development Plan
3. Our draft ICS NHS Body functional model
4. ICS development excerpt from our nine system priorities - Plans on a Page
5. Additional documents and products development plan

Glossary

CCG	Clinical Commissioning Group
H&WBB	Health and Well-Being Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
KM	Kent and Medway
NHSEI	NHS England and Improvement
OD	Organisational Development
PCN	Primary Care Network
PHM	Population Health Management
QI	Quality Improvement
SOF	System Oversight Framework
SQG	System Quality Group

1 Introduction and context

Our Vision:

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

By doing this, we will:

- **Give children the best start in life** and work to make sure they are not disadvantaged by where they live or their background, and are free from fear or discrimination.
- **Help the most vulnerable and disadvantaged in society** to improve their physical and mental health; with a focus on the social determinants of health and preventing people becoming ill in the first place.
- **Help people to manage their own health and wellbeing** and be proactive partners in their care so they can live happy, independent and fulfilling lives; adding years to life and life to years.
- **Support people with multiple health conditions** to be part of a team with health and care professionals working compassionately to improve their health and wellbeing.
- **Ensure that when people need hospital services**, most are available from people's nearest hospital; whilst providing centres of excellence for specialist care where that improves quality, safety and sustainability.
- **Make Kent and Medway a great place** for our colleagues to live, work and learn.

As we progress our plans to be a thriving Integrated Care System, our vision and ambition will drive everything we do. All system partners will work together to improve the quality of our services, the care people receive and the experience of our combined workforce. We will do this as part of our commitment to delivering the triple aim:

- better health for everyone
- better care for all
- efficient use of NHS resources.

The Kent and Medway System Development Plan and Operating Model map our programme of work over the next year towards achieving this ambition. This plan is not a stand-alone document and is aligned to the following:

- K&M System Priorities
- The Kent and Medway Operating Plan
- NHS Long Term Plan (2021)
- ICS Accreditation Submission
- The Kent and Medway CCG merger application

To support our journey to becoming a thriving system, we have an agreed a set of principles which describe how we will work together including, making decisions as close to communities as possible, listening and acting on the views of our staff and developing our digital capabilities to provide one version of the truth.

Alongside existing challenges and health inequalities, we recognise the impact that the COVID-19 pandemic has had on our population and workforce. We are therefore currently focussing on priority areas that both support our individual organisations and provide system leadership in key areas where working together will get better results.

This document outlines our proposals for the development of the Kent and Medway Integrated Care System and in particular our plans relating to the ICS Operating Model and the transition to an ICSNHS Body in April 2022 (subject to parliamentary approval of the NHS Bill).

The draft proposals outlined for the ICS Operating Model are founded first and foremost on the need to tackle health inequality and improve health and well-being across the whole of our population. The Operating Model, governance framework and architecture will be developed and refined based on this core principle, ensuring the way we go about our work will be inclusive, fair, consistent, transparent and efficient.

Our plans will continue to be refined over the summer and autumn months, building on the key national guidance, including the ICS Design Framework and model NHS Body Constitution. This is in the context that the accountability for delivering services within available resources remains with individual partner organisations of the ICS. Thus we need to align system and place responsibilities with the continued responsibilities of those organisations.

The Kent and Medway context

The Kent and Medway System has much to be proud of and the vast majority of our population receives good care and treatment. There are many services that provide high quality care day after day and will continue to do so. Indeed, since the establishment of CCGs in 2013 and the sustainability and transformation partnership in 2016 the NHS and social care in Kent and Medway have had a number of successes improving local services and improving patient outcomes. Many of our providers within community, mental health and primary care services are now rated good or outstanding and we have seen sustained improvement in cancer pathways, the delivery of diagnostic and elective activity and, of course, the monumental effort of all of our staff pulling together during the COVID-19 pandemic, vaccination and recovery

programmes. This has already brought real benefits to the way we plan and deliver services at a system, place and neighbourhood level; and, we are working closer than we have ever done before.

We recognise that whilst we have many achievements to be proud of, there are fundamental challenges that we have not yet been able to fully tackle and which have impacted negatively on individual patient experience, care and well-being. Not least that we need to focus more on working together to support people so they don't get ill in the first place.

Indicators of the challenges we must address together

- Only 2% of health and social care funding is spent on public health interventions to reduce the risk of avoidable disease and disability.
- Around 1,600 early deaths each year could have been avoided with the right early help and support.
- There are stark health inequalities across Kent and Medway. This is a particular issue for people who live in deprived areas and those with severe mental illness more likely to be affected.
    - There is wide variation in life expectancy across Kent and Medway, for example life expectancy for women in Weald East ward is 35% higher than for men in Margate Central ward, a 25 year difference.
    - Emergency admissions for COPD are higher in people from the most deprived 10% of our population compared to the least deprived 10% in almost all districts.
    - Emergency admission rates for stroke and TIA are 43% higher in the most deprived 10% of the population compared to the least deprived 10%.
    - People in the most deprived 10% of the population have multiple morbidities equivalent to people 10 years older in the least deprived 10%.
- There are significant workforce issues across a range of health and care roles. Coastal areas in particular, have additional recruitment and retention challenges. Whilst workforce challenges are seen across the country, Kent and Medway is behind the national average.

To respond to these challenges, and deliver our vision, we have identified nine improvement and development priorities for 2021/22 which map directly back to our purpose and principles.

These priorities formed a key part of our ICS accreditation process in February 2021. Each of the priorities has an assigned system Senior Responsible Officer (SRO) and lead Director, working together to ensure progress, alignment and oversight.

The nine Kent and Medway system improvement and development priorities

We are committed to tackling health inequalities and improving health and well-being across the totality of our population. We will do this through:

- **Greater collaboration and integration of our partners across various levels of the system:** this will lead directly to better quality of care and better outcomes for local people. Whilst a primary design principle is one of subsidiarity and local autonomy, we also recognise that together, the system can be more than the sum of the parts and we will maximise the potential for improved health and well-being outcomes through integrated delivery.
- **Clinical and professional system leadership**: Strategic, tactical and operational initiatives should be led by clinical and professional experts from across health and care, based on shared learning and improvement founded in a desire to eliminate unwarranted variation and maximise quality, safety and patient experience.
- **A principle focus on population health** and being data and quality driven.
- **Engaging and meaningfully supporting** the wider voluntary and community sector, which plays a vital role in care delivery and is a critical link to local communities.
- **Greater meaningful involvement of local people, local government and other stakeholders** in the development and delivery of strategies and plans that improve the quality of life, reduce health inequalities and deliver the best outcomes.

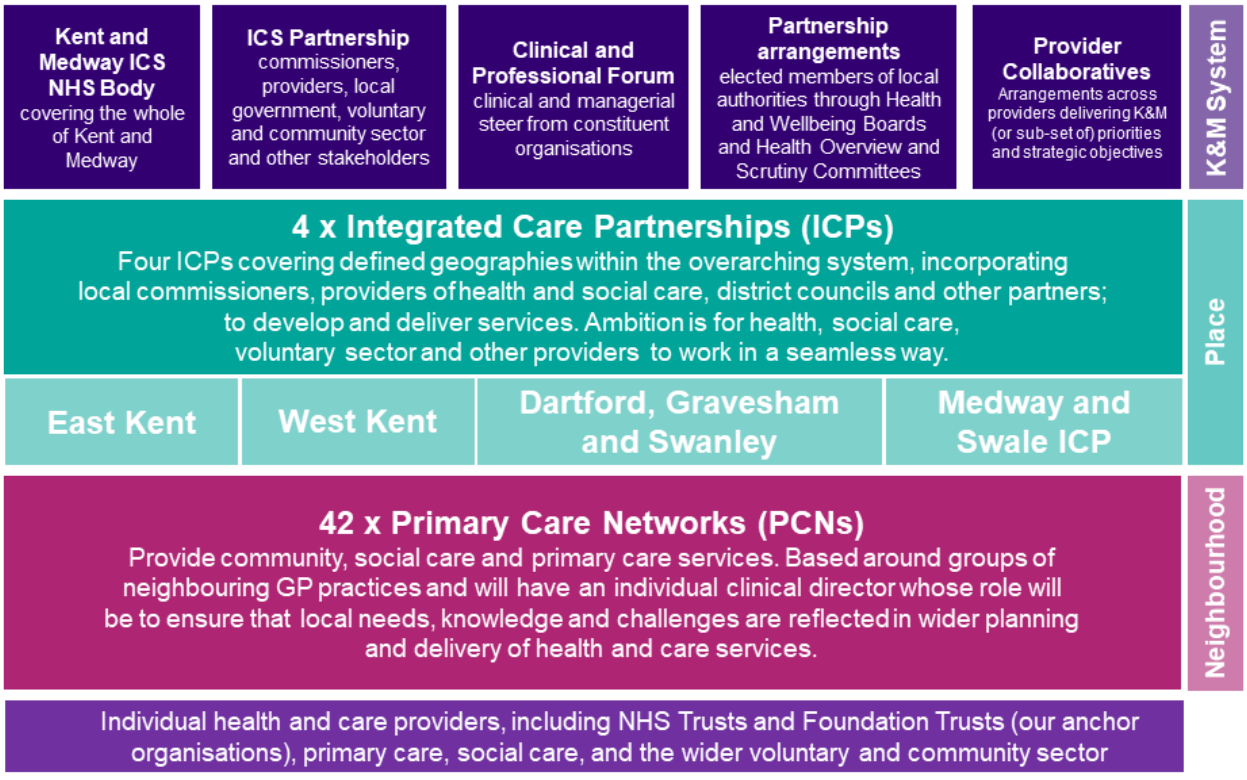
The system wide plans we are developing, as outlined in this plan and supporting documents, will secure the next stage of our transformation programme.

2 The proposed Kent and Medway system architecture

The Kent and Medway System is responsible for leading, improving and transforming population health and well-being and for delivering high quality, accessible health and care services that meet the needs of local people. As well as reducing health inequalities, improving productivity and contributing to the broader economic and social development of Kent and Medway.

The system that is expected to be formally in place from April 2022 will be made up of the two upper tier councils' Health and Wellbeing Boards, an ICS Partnership, an ICS NHS Body, our four Integrated Care Partnerships (ICPs), our 42 Primary Care Networks (PCNs), provider collaboratives (yet to be defined) and our individual NHS and independent provider organisations. Stakeholder representation across the system will come from all of our health and care organisations, upper and lower tier local government, the voluntary and community sector, health and care regulators, other public services and of course our local people.

Likely high level K&M system architecture from April 2022



The **ICS Partnership** will succeed the current ICS Partnership Board. It will have a wider remit and membership. Its primary responsibility will be to develop and oversee achievement of an integrated care strategy, alongside developing health and well-being outcomes for the whole population. It will be established jointly by our two upper tier local authorities, the ICS NHS Body, and partner organisations. It will likely operate through a Joint Committee arrangement. The ICS Partnership will include a broad range of partners from the wider care and well-being system. The relationship between the ICS Partnership and two Kent and Medway Local Authority Health and Well-being Boards (H&WBBs) will be further defined over the summer.

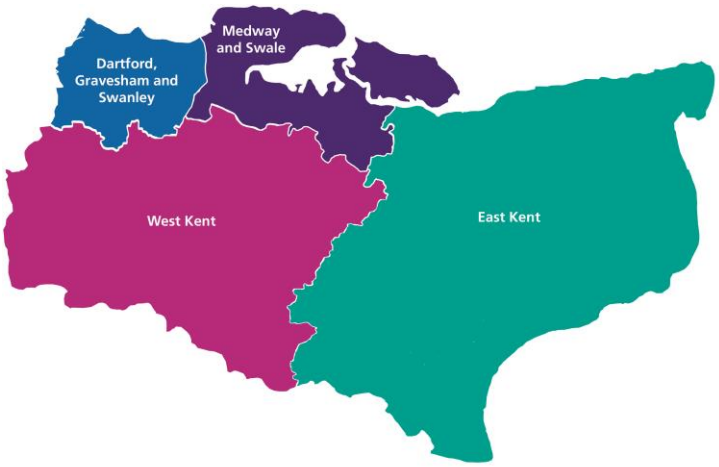
The **ICS NHS Body** is the statutory NHS organisation that will succeed Kent and Medway Clinical Commissioning Group (CCG). It will have the statutory responsibility for planning and securing services. However, it is not simply a replacement of the CCG: it will be a new organisation that brings together all health partners working alongside social care and other partners.

Subject to local agreement, we expect the current functions of KM CCG to transfer to the new body in April 2022, alongside some functions that may be delegated or assigned from NHS England. At a later date functions may then be delegated to ICPs or provider collaboratives.

A Kent and Medway **Clinical and Professional forum** or senate will be established over the course of summer 2021. It will replace the Clinical and Professional Board which was suspended at the start of the pandemic to enable clinicians to focus on the pandemic response. The forum is likely to have responsibility for overseeing clinical and professional input in the development of system strategies and outcome measures; providing objective clinical leadership and whole-system scrutiny to major strategic change and care pathway transformation; and reviewing delivery strategies, to ensure they are effectively addressing system and place based priorities.

Place-based partnerships, or **Integrated Care Partnerships** are collaborative arrangements agreed between the ICS NHS Body, Local Authorities and organisations that provide local health and care services across a defined geography.
In Kent and Medway we have four ICPs[1].

Membership varies based on the local context, but typically incorporates representation of local people, service users, social care providers and commissioners, public health, local government functions, voluntary sector, general practice (represented by the LMC and primary care networks) and providers of community, mental health and acute healthcare.



Provider Collaboratives describes partnerships involving two or more NHS trusts working across multiple places at an appropriate scale to realise mutual benefits and/or benefits for the wider system. Collaboratives are expected to contribute to the strategic planning of the system and may cover one or more place-based partnership. Our approach to provider collaboratives is in development and will be agreed and shared by the end of September 2021. This will confirm our arrangements for collaboration across acute, community and mental health providers.

[1] Dartford, Gravesham and Swanley ICP; East Kent ICP; Medway and Swale ICP; and West Kent ICP

Primary Care Networks (PCNs) play a fundamental role in improving health outcomes and joining up services. They operate at the level of local communities, enabling them to identify and address local health priorities and address health inequalities and are developing integrated multi-disciplinary teams that include staff from community services and other NHS providers, local authorities and the voluntary sector to support effective care delivery. There are currently 42 PCNs covering the whole population of our 198 practices.

Individual providers of care are of course the foundation of our local health and care system. They include, NHS Trusts and Foundation Trusts, independent sector community and voluntary care providers, GP practices, social care providers, and other primary care services such as pharmacies, dentists and optometrists. Whilst they will be key partners across various levels of the Kent and Medway system, they will each remain directly accountable for the services they deliver, in terms of both regulatory and contractual accountability.

At all levels of our system, partnership working will shape better planning and improved services for the residents of Kent and Medway.

3 Stakeholder engagement - defining the end state

Whilst recognising our considerable achievements in developing an ICS across Kent and Medway, including the merger and subsequent restructure of the CCG, there remain some outstanding important issues that need to be agreed as part of our critical path to achieving the April 2022 milestone and then moving beyond to a thriving system. This is an evolutionary journey that all of our partners are involved with and have a clear 'line of sight' on developments.

Through April and May 2021 we began an extensive engagement programme across a wide range of stakeholders to develop our design principles, the system operating model and the governance framework and architecture. Further engagement will continue throughout the summer and autumn months focusing more on the detail of key 'knotty issues'.

Appendix 1 outlines the results from the engagement discussions along with a number of proposed recommendations that have since been agreed. The following provides a headline summary and highlights the strong commitment from all partners to drive greater collaboration and integration to deliver our collective vision:

1. **A cultural shift of hearts and minds is needed**, away from traditional relationships and ways of working, to stronger partnership working and a real move towards improving population health and well-being outcomes is critical. This 'shift' in culture should not be under-estimated in terms of the organisational development required across the system.

2. **We need to up the pace on tackling health inequalities and reducing unwarranted variation in quality** as well as developing PCNs, ICPs and provider collaboratives, noting that all three of these 'layers' will determine how care and well-being services are to be effectively delivered to local people. Furthermore, system wide 'Organisational Development' is needed to support all partners with the shift of responsibilities, relationships and culture.

3. **All elements of our system should be inclusive**, with appropriate engagement with local people and our staff as well wider sector stakeholder involvement in design and decision making.

4. **ICP frameworks should be permissive** and not prescriptive with a mixed economy of approaches and pace determined locally. There needs to be broader collaboration than just health that captures the culture within the local area and addresses the need for greater partnership engagement.

5. **The four ICPs have differing approaches on future levels of ambition and future accountability**. This is understandable and will be a conscious decision of partners with no model being seen as superior over the other. Regardless of approach, there is a broadly supported view that the ambition should be for subsidiarity, local autonomy and self-management.

6. **There is a unanimous view that primary care core GMS commissioning and contracting should remain at an ICS level**, whether or not legislation allows for delegation.

7. **There is an absolute willingness from both Kent County Council (KCC) and Medway Councils to be full partners** in the ICS and at a place level.

8. **There is consensus that partnerships at system, place and neighbourhood level need to include a 'broader church' of partners** from the wider well-being and care system, potentially including welfare, housing, leisure, education; alongside population health, professional and local people representation.

9. **There is unanimous praise for the clinical and professional response to the recent pandemic** and a view that many of the achievements over the past fifteen months should be 'locked in' going forward.

10. **There is a consistent view that future strategies and outcomes need to focus more on addressing the wider determinants of well-being and good health** and less (albeit important) through a clinical lens.

11. **There is a strong consensus on the importance of effective involvement of local people** in order to influence discussion and decision making at all levels. An ICS engagement framework is being developed later this year. There was clear articulation that non-executive directors, lay and independent members and other patient and public representatives are a valuable resource that could be better utilised to champion collaborative working and break down barriers.

Recognising the evolutionary nature of the system's development, the feedback also highlighted a strong sense of needing to map out the functional design of the system to determine which functions are likely to remain at a system level and which might be assigned or delegated to a place or collaborative, from April 2022 and the future. Initial work on this is detailed in a later section and will be completed by September 2021 alongside a detailed review of the existing and future governance framework and architecture.

Further detailed actions plans relating to the specific recommendations from the engagement are now being finalised and implemented.

4 Design Principles

The ICS Partnership is where the leadership from partner organisations come together to:

- understand problems and create the solutions to address them
- set the vision and long-term objectives for the system as a whole
- develop governance and accountability arrangements which support effective delivery of strategy at system, place and neighbourhood; and
- assure and self-manage achievement of improved outcomes for the population.

On this basis, the following agreed design principles will inform the operating model, functional design and governance framework that will enable planned shadow-running of the system from January 2022 and go-live on 1 April 2022. This recognises that much of what is currently in place, particularly in relation to service improvement and delivery frameworks, will require refinement rather than starting from scratch:

1. Improving the health and well-being of local people, addressing health inequalities and reducing unwarranted variation in the most effective and efficient way will be at the heart of every decision we make: our operating model, functional design and governance framework should honour this commitment.

2. The strategy of the system and the setting of outcomes and priorities will be co- designed with care and well-being professionals and informed by the experiences of local people in concert with robust population health information.

3. The establishment of the ICS will represent a fundamental move away from historic commissioner provider relationships with a move to more integrated and collaborative working across system partners and stakeholders.

4. The system needs to be data and quality improvement driven. This will be at the heart of all strategies and priorities. We will also ensure that we better join up digital and data priorities with the clinical strategy and with initiatives in general practice and social care.

5. The principle of subsidiarity will apply to decision making with the following four tests (as included in our ICS accreditation process) applied to assist in deciding when we need to work together as a system on a particular challenge / area of opportunity:

    a. Are we likely to need a critical mass of scale or expertise beyond the place level to deliver the safe and sustainable services which achieve the best outcomes?

    b. Is this a programme or responsibility where all places or more than one place or provider, are experiencing similar challenges (potentially to different degrees) which may benefit from collective problem solving?

    c. Do we believe that working together on a particular issue will create greater power / influence / impact than working alone?

    d. Is this a problem not amenable to local solution?

6. Place and collaboratives are the engine rooms of our system – they are responsible for delivering improved outcomes and driving continuous improvement. They are founded from our individual NHS trusts and foundation trusts (our anchor organisations), primary care, social care, and the wider voluntary and community sector.

7. Neighbourhoods play the most crucial role in improving health and care outcomes within individual communities. Outcomes will only improve if the priorities for and delivery within our neighbourhoods align with our ambitions at place and system level.

8. The system is where our strategic direction of travel and our ambitions around transformation and improvement will be set. Our architecture will reflect this.

9. Trust and mutual respect are at the heart of effective system, place, collaborative and neighbourhood level working. Whilst recognising our ICPs and collaboratives are in a developmental phase, especially in 2021/22 and into 22/23 with a key focus on delivering local priorities and strengthening the relationships, they will nonetheless hold all partners to account for collective delivery of agreed priorities with formal oversight and assurance being carried out by the ICS NHS Body.

10. The ICS NHS Body will proactively support ICPs and provider collaboratives to deliver their priorities and develop their infrastructure including taking further steps to align resources and increase the amount of resource working to and with the ICPs. Existing ICP facing teams within the CCG and new ICS NHS Body will need to maintain an appropriate balance between supporting the pathway and performance improvement work on the ground while also holding other commissioning and oversight functions. This particularly applies to health improvement, quality, safety, safeguarding and finance.

11. The ICS Partnership will develop wider health and well-being strategies and outcomes. It will include a broad range of partners from the wider care and well-being system. Partnerships will need good mechanisms for ensuring strategies are developed with people and communities, drawing on best engagement practice.

12. We will not seek to pre-empt the outcome of the learning from the Wave 3 population health management (PHM) programme. However, a key working assumption is that the ICS NHS Body will develop the strategy and the key frameworks and tools for PHM.

13. Membership of, and involvement in, system and place-based fora should depend on the local context, but we expect they will typically incorporate representation of local people and service users; social care providers local and district authority commissioners; public health leaders; primary care, community, mental health and acute providers; and the voluntary and community care sector.

5 System Development Plan

Our system development plan is detailed in **Appendix 2** with core work streams identified and deliverable and milestones for each set out. The plan supports a number of our nine improvement and development priorities and spans critical areas such as population health management, development of ICPs, PCNs and collaboratives, system organisational development, digital and analytics, and confirmation of our functional models.

The System Development Plan pulls all of these programmes together under one umbrella, where they relate to system development, to enable a coordinated and consistent approach in respect of delivering agreed critical activities during the course of this year and beyond. The system priority programmes that relate to system development are:

Development Programme	System SRO / System Chair
PHM and strategic commissioning	**SRO – James Williams / Alison Duggal** (Public Health Dirs) **Chair – Joanne Palmer** (Chair MFT)
Provider collaboratives	**SRO – Paul Bentley** (CEO KCHFT) **Chair – David Highton** (Chair MTW)
Digital and analytics transformation	**SRO – Susan Acott** (CEO EKHUFT) **Chair – David Highton** (Chair MTW)
Quality and Service Improvement Strategy and Leadership	**SRO – Wilf Williams** (AO KMCCG /ICS SRO) **Chair – Navin Kumta** (Clinical Chair KMCCG)
Implementing the Integrated Care System ICP development	**SRO – Wilf Williams** (AO KMCCG /ICS SRO) **Chair – John Goulston** (Chair KM ICS / KCHFT)

We have detailed plans and headline 'plans on a page' for each of the nine system priorities, including for each of the above programmes. The relevant plans on a page are included at **Appendix 4** for information. They set out our ambition to become a thriving ICS with each plan providing:

- a high level overview of work under each theme,
- critical deliverables and
- expected outcomes to be achieved.

Each of these programmes has its own Senior Responsible Officer and Chair from across the system, as well as an Executive Lead.

6 The Draft Operating Model

6.1 The Kent and Medway ICS Governance Model

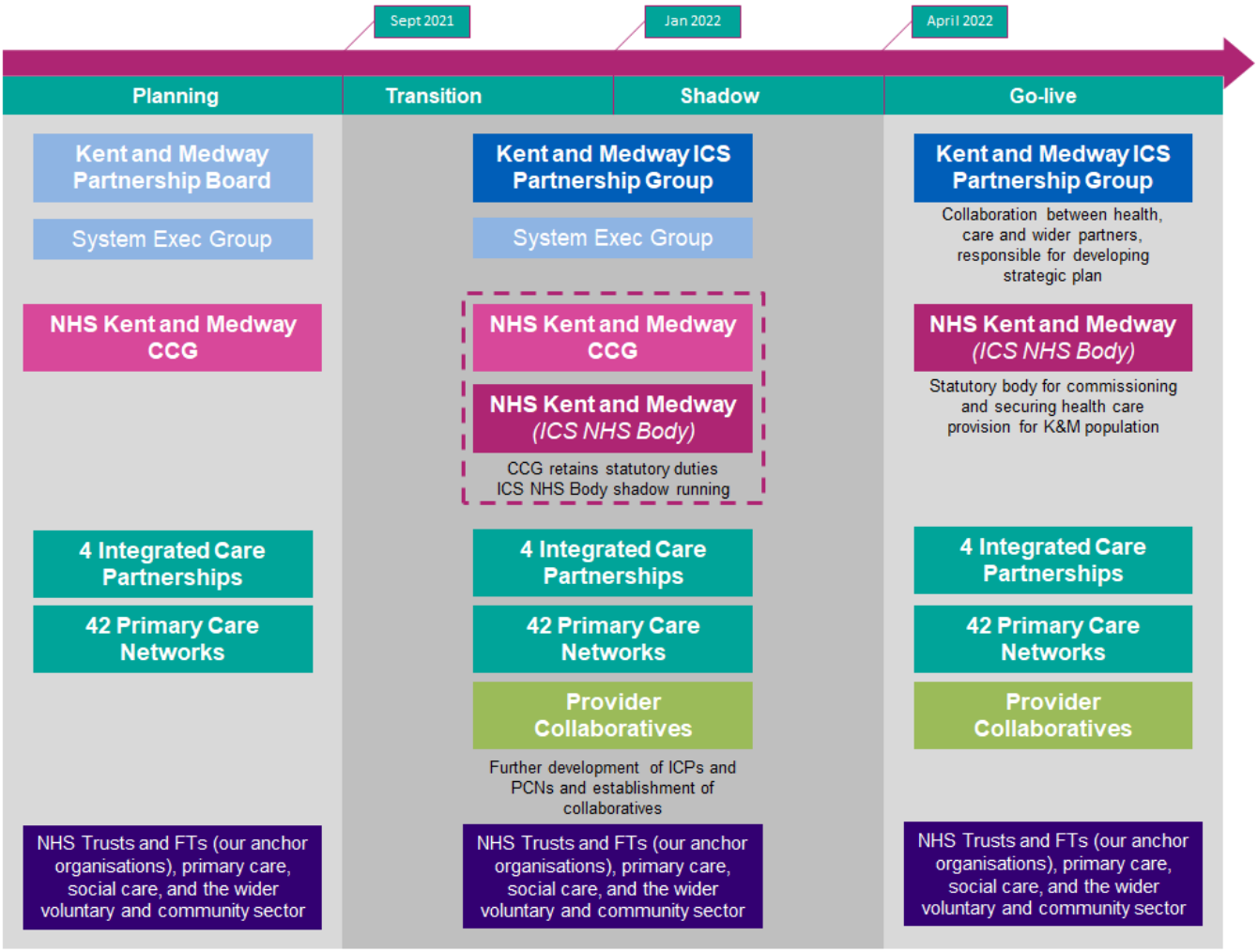
The ICS governance model is driven by the challenges we face and enables the solutions we need to succeed. The merger of the eight Kent and Medway CCGs in 2020 and the subsequent restructuring of the single organisation has been helpful for ICS transition and will support the requirement in the employment commitment for minimum restructuring. However,

the ICS is and will be different from the CCG. The future ICS governance framework and architecture will build on existing arrangements in place across the system where they are working well and be further informed by:

- National ICS Design Framework
- The ICS NHS Body Model Constitution requirements
- The KM functional model work, taking place locally from June to September
- Completion of the system governance review and redesign work currently underway

The expectation is that during Q3 and the beginning of Q4 we will move to shadow running the new ICS framework and associated arrangements.

Kent and Medway ICS - simplified transitional system governance plan



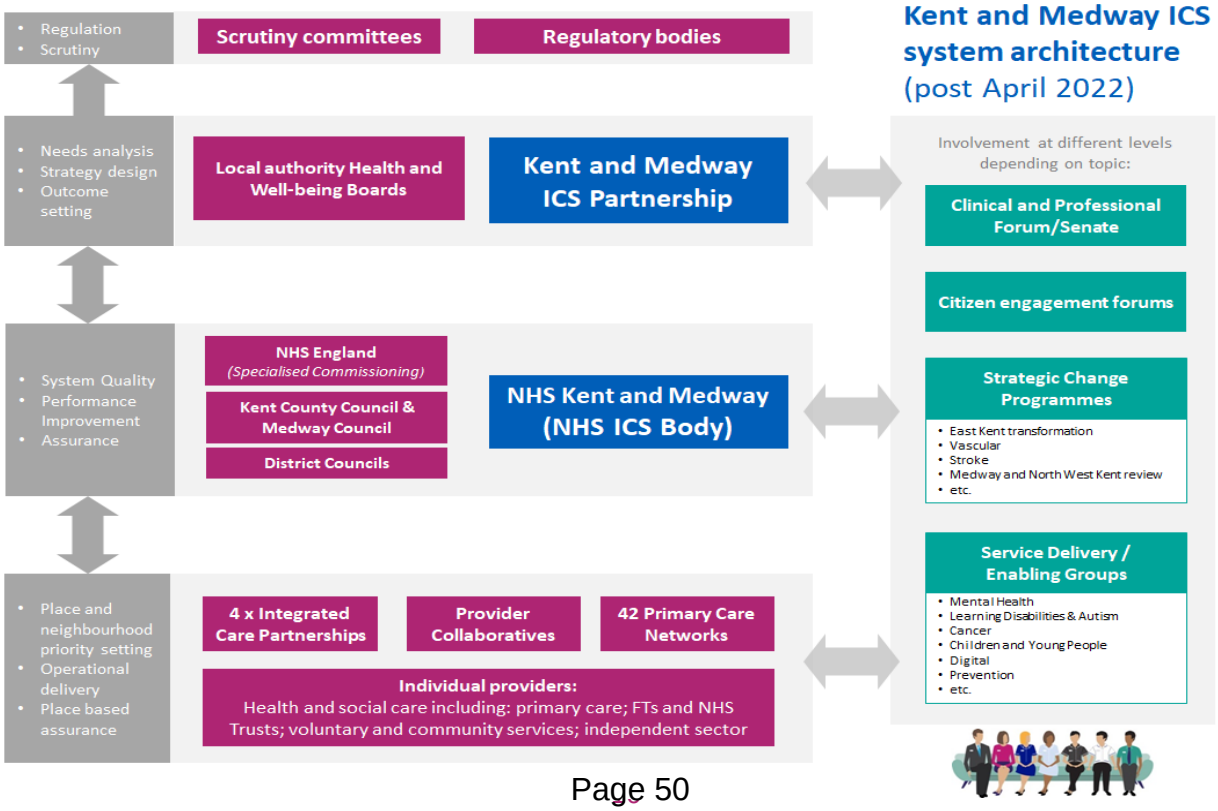
Critical path actions

The **functional model work** will determine which functions are expected to remain at a system level and which might be assigned to a place or collaborative from April 2022: recognising the evolutionary nature of ICP and provider collaborative development, it is likely that significant functions and responsibilities will remain at an ICS level in the first instance, with a longer term plan to delegate or assign responsibilities over the following 12 to 24 month period as partnerships mature. The initial functional model work is planned to be completed by the end of September 2021.

A comprehensive **review of system governance and architecture** has already commenced and a detailed timetable and programme plan for this work is being finalised. More detail on this plan is set out within **Appendix 2** - The K&M System and ICS Body Transition and Development Plan.

The review will consider the totality of the existing architecture and governance framework; refine this to meet the requirements for the new landscape; and ensure robust arrangements are in place for the smooth transition to April 2022. Again, the review will be completed by September 2021. Some elements of the architecture do not need to wait until the outcome of the review, such as the establishment of the clinical and professional forum, however, the main transition to the new ICS bodies will commence from October with full-shadow-running planned from January 2022.

The outcomes from our recent engagement exercise, alongside the design principles, will be effectively played in to the future governance framework, with a particular focus on: clear articulation of remit, roles and responsibilities; inclusive, equitable stakeholder involvement; and an architecture that is fit for purpose for the medium term and consistently defined.



In parallel, a **review of ICP governance frameworks** will also be completed, to ensure similar arrangements are in place and, where appropriate, consistently applied. Notwithstanding the governance review to be completed, the diagram above shows a potential high level governance framework that could be adopted based on refining the current operating model.

There is an absolute willingness from both Kent County Council (KCC) and Medway Council to be full partners in the ICS both at system and place level. In addition there is a willingness of our district councils to be integral to the work on the wider determinants of health. As previously noted, discussion with both local authorities are already underway to consider any new joint commissioning/partnership arrangements and confirm future H&WBB and Partnership Group relationships, which will then be played in to the governance design work.

Current working assumptions and principles

As we complete the next stages of ICS transition, the following working assumptions and principles apply:

- **Accountability and oversight:** The system oversight approach for Kent and Medway in 2021/22 is aligned with the proposed NHSEI System Oversight Framework (SOF) published in March 2021 and consists of four distinct strands:

  (i) oversight through the ICS governance structure – mainly focused on delivery of the system's nine improvement and delivery priorities
  (ii) oversight through the CCG governance structure – noting the statutory role of the Finance & Performance Committee, the Quality, Safety and Safeguarding Committee, and the Primary Care Commissioning Committee
  (iii) oversight at ICP level – focused on oversight of delivery of local ICP priorities and discussion of wider challenges/risks to the place
  (iv) oversight at provider level – noting that in 21/22 the primary accountability relationship remains between NHSEI and providers.

  Individual providers will have contractual accountability to the ICS NHS Body. NHS Trusts and FTs will be accountable for the discharge of their statutory duties to NHSEI with and through the ICS NHS Body. The ICS NHS Body will be accountable to NHSEI and NHSEI will be accountable to the Department for Health and Social Care (DHSC).

  NHSEI continue to lead on the intensive support process and accompanying oversight process for challenged providers but with the joint chairing of meetings. In addition, NHSEI and the ICS/CCG continue to jointly oversee the Recovery Support Programme approach in East Kent and Medway and Swale. NHSEI have already delegated responsibility for the Surveillance Quality Group (SQG) to the ICS/CCG meaning the ICS/CCG holds providers to account for the quality of their services unless there is an issue requiring escalation, whereby NHSEI are in the lead role.

- **Quality governance:** We are building on existing quality governance principles and mechanisms for delivery and will resource quality governance arrangements appropriately; including ensuring that clinical and care professional leads and staff have capacity to participate in quality oversight and improvement. In Kent and Medway the quality governance framework is being developed with Chief Nurses, Medical Directors and other clinical and professional colleagues and tested with the chairs of Quality Committees in individual providers over the next twelve weeks. Responsibility for the Quality Surveillance Group will be handed over from NHSEI to the CCG, with its first meeting taking place in July - membership going forward will include representation from all main healthcare providers. Other parts of the governance framework will likely include the requisite statutory groups for example system safeguarding; ICP quality forums and Quality Committees of Kent and Medway NHS providers; the Local Medical System Group; and potentially a quality and performance improvement committee. The key will be not to duplicate quality assurance by being clear on the purpose, scope and outputs of each assurance group.

- **Financial allocations:** The ICS NHS Body will agree how the allocation it receives will be distributed to perform its functions, in line with locally determined health and care priorities. Funding will flow from the ICS NHS Body to providers through contracts it holds with them for services and outcomes. Within Kent and Medway we will need to develop an agreed framework, building on the work of the existing System Finance Group, for collectively managing and distributing resources so they can be used to address the greatest need and tackle inequalities in line with the NHS system and health and care partnership plans. NHS trusts and foundation trusts remain accountable to the efficient and effective use of resources within the context of the need to meet overall system control totals for capital and revenue.

- **Services currently commissioned by NHS England:** Legislation will enable the direct commissioning functions of NHSEI to be jointly commissioned, delegated or transferred to ICS NHS bodies or NHS providers at an appropriate time. It is the intention of NHSEI to enable ICS NHS bodies to take on responsibility as soon as they are ready to do so after the enactment of legislation. Kent and Medway will need to consider in discussion with NHSEI both the opportunities and risks that this poses before taking on any additional responsibilities.
- **People function:** The ICS NHS Body will have a specific responsibility for leading system implementation of the NHS People Plan, by aligning partners across the system to develop and support the ‘one workforce’ approach as set out in national guidance. As part of this there will need to be clear arrangements in place between the work of the ICS Body, all NHS trusts and other employers of our workforce. In Kent and Medway there are a number of workforce challenges that we believe greater integrated working as a system will help us to tackle. We already have a People Board and have developed local plans setting out how we will deliver the ambition of having more people, working differently, in a compassionate and inclusive culture. Over the next few months these will

be aligned with the ICS Partnerships' plan and then refreshed annually taking into account national priorities.

- **Digital and analytics function:** a comprehensive review of data and analytics systems, capabilities and operating models across the ICS has recently been completed, with recommendations and next steps, which have now been signed off by the ICS Executive Group. This work will focus on developing a core resource across Kent and Medway to take forward the future strategic and operational priorities relating to both the analytical and digital functions. The Kent and Medway Digital Board will take ownership of the analytics strategy, reporting in to the NHS ICS Body. It will also ensure digital data and technology allows information to flow throughout the system; facilitating collaboration and enhancing population health focussed decision making. As an ICS we will build on innovation and underpin integration to:

    - Ensure adherence by partners to standard and processes to allow interoperability.
    - Cultivate a cross cutting system intelligence function.
    - Agree a plan for embedded Population Health Management capabilities.
    - Refresh the digital and data governance, to ensure better join up with the clinical strategy, and with initiatives in general practice and social care.
    - Implement clinically led programmes that support clinical transformation.
    - Invest in training and upskilling workforce.

- **Population Health Management:** Our work to develop PHM is progressing well, with involvement in wave three of the NHSEI development programme starting in July. We will build capacity and capability by working across all tiers of the system to transform service delivery around key population groups:

    - Supporting and sustaining changes to integrated care delivery - through PCNs, community, acute and mental health providers, public health and social care teams; to achieve demonstrably better outcomes and experience for selected population cohorts and support knowledge transfer to spread the approach to other cohorts.

    - Advancing the system's infrastructure and building sustainable capability across all tiers of the system which supports a focus on proactive population health management and tackling unwarranted risk and variation.

- **Other assumptions:**

    - At system and place we will need to continually demonstrate effective clinical, professional and public involvement in decision making within organisations and partnerships. Work is underway to develop our models of clinical and public engagement with plans to be agreed by September 2021 and implemented for April 2022.

- National guidance is awaited on the relationship between the ICS NHS Body and ICPs and provider collaboratives, including leadership roles and responsibilities. However, based on published guidance, it is anticipated that this may include provision for joint committees and/or committees of the ICS NHS Body where appropriate. Subject to guidance we will be developing an ICP framework that applies consistent core requirements across each of the four ICPs whilst enabling local flexibility where this is more beneficial. Notwithstanding any delegation or assignment of functions or responsibilities to ICPs or provider collaboratives, it is expected that the ICS NHS Body will remain accountable.
  As such, the governance and leadership arrangements will be designed to support effective delivery of these functions and responsibilities with clear arrangements in place for assurance.

6.2 The ICS Partnership

6.2.1 Responsibilities of the ICS Partnership

It is clear in the White Paper and NHSEI design framework that the ICS Partnership will have wider responsibilities than our current ICS Partnership Board. Similar to existing arrangements the new ICS Partnership will operate as a forum that brings partners together from across system, but membership will need to be wider to take account of the new mandated responsibilities:

- Agreement and oversight of delivery of an integrated care strategy for improving health and wellbeing across Kent and Medway, built bottom-up from local assessments of need and assets identified at place level, with a specific focus on reducing inequalities and addressing the consequences and lessons from the recent pandemic.

- Aligning partner ambitions through convening and involving all stakeholders across health, social care and more widely across sectors in developing strategy and action to improve health and wellbeing and wider socio-economic conditions for our population.

6.2.2 Partnership principles

Our ICS Partnership will play a key role in nurturing the culture and behaviours of a system that works together to improve health and care for local citizens. In line with current national thinking, the ICS Partnership will give due consideration to the ten key partnership principles:

- Come together under a distributed leadership model and commit to working together equally.

- Use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate.

- Operate a collective model of accountability, where NHS and local government partners hold each other mutually accountable for their respective contributions to shared objectives.

- Agree arrangements for transparency and local accountability, including for example meeting in public with minutes and papers available online.
- Focus on improving outcomes for people, including improved health and wellbeing and reduced health inequalities.
- Champion co-production and inclusiveness throughout the ICS.
- Support the triple aim, the legal duty on statutory bodies to collaborate and the principle of subsidiarity (that decision-making should happen at the most local level that is appropriate).
- Ensure place-based partnership arrangements are respected and supported, and have appropriate resource, capacity and autonomy to address community priorities, in line with the principle of subsidiarity.
- Draw on the experience and expertise of professional, clinical, political and community leaders.
- Create a learning system, sharing improvements across the ICS geography and with other parts of the country, crossing organisational and professional boundaries.

Importantly, the ICS Partnership will need to champion local engagement, inclusion, transparency and tackling inequalities in ways which deliver our collective ambition.

6.2.3 Accountability and leadership

As a mutual forum that brings partners together, the ICS Partnership will be formally accountable to member organisations, with decision making authority limited to that delegated to each member by their respective organisation.

The ICS Partnership will be established by Kent County Council, Medway Council and the ICS NHS Body, along with partner organisations. It will evolve from existing arrangements and with mutual agreement on its terms of reference and ways of operating and administration. Based on recently published guidance, this may be a Joint Committee of the three statutory bodies. A formal decision will be confirmed by September 2021.

Discussion with both councils are continuing during the summer in terms of the relationship between the ICS Partnership and the two existing Health and Well-being Boards, recognising the commitment between all partners for closer collaboration and integration where this benefits local people. This will also be dependent on further national guidance.

Early discussions have commenced about appointment of an ICS Partnership Chair. The local authorities and NHS partners will work together to select a Partnership Chair and define their role, term of office and accountabilities. To provide greater scope for democratic representation, the ICS Partnership Chair may not be the Chair of the ICS NHS Body.

In line with wider national expectation, membership of the Kent and Medway ICS Partnership is expected to include local government, healthcare organisations, voluntary, community and social enterprise sector partners; social care providers and organisations with a relevant wider interest, for example housing, education and leisure. For clarity, this has yet to be agreed by partners, as we are awaiting further national guidance. However, there is a commitment to ensure the ICS Partnership is fully inclusive. In addition, as a key forum for setting strategy and outcomes, the ICS Partnership will be transparent with formal sessions held in public.

Given the size and complexity of Kent and Medway, it is likely that the ICS Partnership will have a large membership. Our governance review over the summer and autumn will confirm how this can be most effectively established, possibly through the use of sub-groups and/or other networks, to ensure effective discussion and decision making within the remit of the ICS Partnership.

6.3 The ICS NHS Body

6.3.1 Responsibilities of the ICS NHS Body

The design of the ICS NHS Body functional model is being based on the key duties, functions and responsibilities as outlined by national guidance.

The board of the ICS NHS Body will be responsible for ensuring that the organisation meets its statutory duties, which will include supporting achievement of the triple aim, improving quality of services, reducing inequalities, ensuring public involvement, obtaining clinical and public health advice in strategic change and pathway developments, and promoting innovation and research. More specifically, responsibilities will include:

- Developing a plan to meet the health needs of the population within their area, having regard to the ICS Partnership's strategy.
- Allocating resources to deliver the plan across the system.
- Establishing joint working arrangements with partners that embed collaboration as the basis for delivery of joint priorities within the plan.
- Establishing governance arrangements to support collective accountability between partner organisations for whole-system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations, to ensure the plan is implemented effectively within a system financial envelope set by NHS England and NHS Improvement.
- Arranging for the provision of health services in line with the allocated resources across the ICS through a range of activities including:
    - Putting contracts and agreements in place to secure delivery of its plan by providers.
    - Convening and supporting providers (working both at scale and at place) to lead major service transformation programmes to achieve agreed outcomes.
    - Working with local authority and VCSE partners to put in place personalised care for people.

- Leading system implementation of the People Plan by aligning partners across the ICS to develop and support a 'one workforce' approach, including through closer collaboration across the health and care sector, and with local government, the voluntary and community sector and volunteers.
- Leading system-wide action on data and digital: The ICS NHS Body will work with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services and ultimately transform care to put people at the centre of their care.
- Using joined-up data and digital capabilities to understand local priorities, track delivery of plans, monitor and address variation and drive continuous improvement in performance and outcomes.
- Working alongside councils to invest in local community organisations and infrastructure and, through joint working between health, social care and other partners ensuring that the NHS plays a full part in social and economic development and environmental sustainability.
- Driving joint work on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support wider goals of development and sustainability.
- Planning for, responding to and leading recovery from incidents (EPRR), to ensure NHS and partner organisations are joined up at times of greatest need, including taking on incident coordination responsibilities as delegated by NHS England and NHS Improvement.
- Functions NHS England and NHS Improvement will be delegating and transferring including commissioning of primary care services and appropriate specialised services.

Relevant statutory duties of CCGs regarding safeguarding, children in care and special educational needs and disabilities (SEND) will transfer to the ICS NHS Body. In addition, it is expected that all current, still relevant, CCG functions and duties, assets and liabilities will transfer to the ICS NHS Body.

Additionally, through the work we have done locally on system development, we have identified the following important features of how the ICS NHS Body will exercise the above responsibilities and add value (as detailed in our ICS accreditation submission):

- Defining population health priorities and outcomes for Kent and Medway and tackling health inequalities, starting with analysed data to develop an understanding of population needs, setting a strategy focused on those outcomes, working at a system level but recognising a need for tailoring at place level.
- Ensuring involvement with local people to set the priorities for outcomes planning.
- Ensuring strong clinical and professional leadership working with our staff and local people to improve services and outcome and reduce inequalities and unwarranted variations in quality.
- Management of finances within a collective control total and oversight of spend to ensure alignment to priorities (via Kent and Medway Finance Group).

- Working with NHSEI specialised commissioning teams to manage operating model and assurance framework for populations accessing services from outside of Kent and Medway.
- Facilitating and leading on the development of a system approach to Quality Improvement.

In advance of further system discussions during the summer and autumn, a draft ICS Body directorate functional model has been developed with an approach of mapping functions against the purposes of an ICS, to begin to further outline the ICS NHS Body's form. This is detailed at **Appendix 3**.

6.3.2 Leadership and accountability

Formal accountability will be to NHS England for the delivery of the organisation's duties and functions as set out in its Constitution, Standing Orders, Scheme of Delegation and other primary policies. Locally the ICS Partnership will hold the ICS Body and the ICPs, provider collaboratives and individual health and care providers to account for the delivery of the system's integrated care strategy.

Based on national guidance, it is likely that the Board of the Kent and Medway ICS NHS Body will be made up as a minimum of the following roles:

- Independent Chair
- Two Independent Non-Executive Directors
- Four members drawn from local partners:
  - one member, ideally at CEO level, drawn from NHS trusts who provide services within the ICS's area;
  - one member drawn from GP providers from within the area of the ICS NHS Body;
  - (two members) one drawn from each of KCC and Medway Council. This could be the CEO, Director of Social Services or the Director of Public Health
- A Chief Executive Officer
- A Chief Finance Officer
- A Medical Director
- A Chief Nurse

The final number of roles on the Board will be agreed with ICS partners during the summer.

The appointment of the Chair and Chief Executive Officer will be subject to national guidance. It is expected that both of these roles will be appointed to by October 2021. Other executive and director leadership roles will be appointed based on national ICS guidance, stipulations in the model Constitution and national and local HR frameworks.

Following ICS accreditation we have been developing a set of structured options for the new role of Medical Director within the ICS Body with a defined set of directorate responsibilities.

Stakeholders are currently being engaged on the appraisal of the options, with a view to advertising this role in the autumn as part of the leadership appointment process.

Outside of the committee structures, the day to day operational model and directorate working of the NHS Body will be for the Chief Executive to determine in consultation with members of the Board and wider partners.

The merger of the previous CCGs and subsequent restructuring during 2020, which recognised the direction of travel towards a single system with four ICPs, puts Kent and Medway in a stronger position than many other areas. Therefore, notwithstanding the discussions that need to take place over the summer regarding functional model in readiness for April 2022, current planning assumptions are that any need for significant reorganisation within the NHS ICS Body at this time will be minimal.

6.3.3 Committees and decision making

Membership of decision making and advisory groups within the NHS ICS Body and across the wider system, will depend on the local context and requirements. Where appropriate they will incorporate representation of clinical and professional leaders, local people and service users; and provider representation from across health, social care and the voluntary and community care sectors.

In particular, it is expected that legislation will allow ICS NHS bodies flexibility in how they establish committees and in particular, that we are likely to be able to appoint individuals who are not ICS Body Board members or staff of the organisation to be members of a committee. This would enable, for example, other clinical and professional leaders, ICP and collaborative directors, and local non-executive directors to become members of the ICP Body committees. We are proactively looking at these opportunities to ensure appropriate partnership involvement whilst maintaining effective and efficient governance.

The ICS NHS Body will maintain a ‘functions and decision making map’ articulating where accountability and decision making sits/flows, including any new commissioning functions delegated or transferred by NHS England. This may be required to form part of the organisation’s Constitution which will be formally approved by NHSEI.

Alongside the statutory committees of the Board (Audit and Remuneration committees):

- other decision making committees with responsibility for quality, performance and financial assurance will be established.
- advisory committees regarding the discharge of certain statutory duties, such as local people involvement are likely to be established.
- other system forums that provide direct influence in decision making, such as the clinical and professional forum, the People Board and system service improvement and delivery groups, will also link in to the ICS Body and Partnership governance structure.

- dependent upon the legislation and local discussions, ICPs may become committees of the ICS NHS Body with decision making responsibilities delegated through the scheme of delegation (see below).
- joint committees may also be established where joint decision making is required, for example with NHS England for other delegated services such as pharmacy and dentistry.

The governance review to be completed by the end of September will confirm these proposals.

As previously noted, the outcomes from the recent engagement exercise, alongside the design principles, will be actively played in to the future governance framework and committee structure, with a particular focus on clear articulation of remit, roles and responsibilities; interdependencies; and importantly inclusive, equitable stakeholder involvement.

6.3.4 Relationship between ICS Body and ICPs

Following confirmation in the ICS design framework, the ICS NHS Body will agree with local partners the membership and form of governance that ICPs adopt, building on existing local configurations and arrangements. The NHS ICS Body will remain accountable for NHS resources deployed at place-level and governance and leadership arrangements will need to support safe and effective delivery of the Body's functions and responsibilities. The possible governance arrangements an ICS Body could establish for ICPs include:

- Consultative forum, *informing* decisions by the ICS NHS Body.
- A committee of the ICS NHS Body, with delegated authority.
- Joint committee of the ICS NHS Body and one or more statutory provider(s), where the relevant statutory bodies delegate decision making to the joint committee.
- Individual directors of the ICS NHS Body having delegated authority (the director could be a joint appointment with delegated authority from respective bodies).
- Lead provider arrangements.

As we work through the functional design and governance architecture during the summer, system leaders will consider how best to approach and adopt these arrangements, whilst maintaining the principle of subsidiarity and local autonomy.

7 The transition from CCG to ICS NHS Body

This section principally relates to the technical and administrative close down of the current CCG and transfer of responsibilities to the NHS ICS Body. Elements of this will be undertaken in partnership with stakeholders outside of the CCG, for example development of the constitution, functional architecture and governance framework; whilst other elements relate to critical internal operational and corporate deliverables, such as the transfer of staff and close down of financial ledgers.

The merger of the eight Kent and Medway CCGs in 2020 and subsequent restructuring has established a structure that includes system and place facing functions and directorates with system development responsibilities beyond core CCG statutory responsibilities. This minimal need to restructure and recent experience of closing down CCGs and transitioning staff to a new organisation puts us in a strong position for managing the transition. Key areas have been outlined and learning established from the merger, which will support the safe and successful transfer.

A significant amount of 'transactional' planning and implementation is underway to deliver a safe transition. This includes:

- Development of the ICS NHS Body Constitution, Standing Orders, Standing Financial Instructions, Schemes of Delegation, and primary corporate policies.
- Appointment to Board and leadership roles and review and alignment of directorate responsibilities.
- Establishment of the ICS NHS Body governance framework, including the Board, committees, sub-committees and associated arrangements.
- Transfer of all assets and liabilities including: all information, IT, HR, contracts, estate, litigations, etc.
- Establishment of all corporate governance arrangements, including for example indemnity, legal and constitutional, regulatory assurance, audit and risk and compliance obligations.
- TUPE transfer of staff and associated HR arrangements including HMRC and pension transfers.
- NHS Digital transfers, including transfer of arrangements for CCG and GP practice information
- Financial close down of CCG ledgers and re-opening of new accounts, including potential significant work with SBS, suppliers and contracts.
- Marketing, communications and engagement transfer, including website and intranet arrangements, signage, branding, etc.

We will manage this in the same way as our successful merger of the eight CCGs in April 2020. A working group has already been established with senior managers and subject matter experts from across all CCG directorates and a line-by-line implementation plan has been developed. The plan will continue to develop as more national guidance confirms requirements.

A detailed plan for each transition workstream will manage and track requirements to enable a safe transfer of people and services. The main work streams for the technical transition are:

Transition Theme (underpinned by detailed project plan)		Lead Executive Director
Governance and decision making changes and transition		Mike Gilbert, Corporate Affairs
ICS leadership, people processes and OD		Becca Bradd, People and OD
Functional model for the ICS body	Changes to commissioning	Wilf Williams, Accountable Officer
	Changes to analytics operating model	Morfydd Williams, Digital
	Creation of Medical Directorate	Wilf Williams/ Becca Brad
Digital and data transfer / transition		Morfydd Williams, Digital
Procurement and contracting		Ivor Duffy, Finance
Finance		Ivor Duffy, Finance
Oversight/assurance – set up		Lisa Keslake, System Development and Assurance
Engaging with staff and stakeholders on the transition		Becca Bradd / Tom Stevenson, People, OD / Communications

Notwithstanding the need to confirm system functional responsibilities by the end of September, our planning assumption for April 2022 is for minimal reorganisation/restructuring. Within this we will make sure the model we put in place is dynamic and able to respond to the developmental approach being taken by ICPs and provider collaboratives; which may at some point in the future result in greater formal delegation of responsibilities and ICS NHS Body resources (including staffing).

Having merged eight CCGs in April 2020 and undertaken a major restructure we are not envisaging any major structural changes within the transition period. We are working through the recently published guidelines on the 'employment commitment' for appropriate staff. We will be joining the South East HR partnership group to work with other organisations to affect the change to an ICS structure. We continue to work in partnership with our staff side colleagues and our HR Directors are due to meet again in early July.

8 Communications and Engagement

The Kent and Medway system has an established network across its NHS communications and engagement teams which has been strengthened by close joint working through the pandemic. We will use this network, together with a wider network covering all Local Resilience Forum partners, to make sure ICS transition communications and engagement activities reach all audiences.

A dedicated ICS transition bulletin is being established to share key progress and gather feedback from stakeholders through the next stages of transition. Our objectives for communications and engagement on the transition were agreed by the CCG Governing Body in May 2021:

1. Deliver timely and effective communications on the transition of K&M CCG to a new ICS NHS Body to all audiences.

2. Develop, agree and implement a patient and public engagement framework for the Integrated Care System that incorporates principles of co-design and co-production, community development and on-going dialogue with patients and the public.

3. Develop, agree and implement the approach to shared responsibility across ICS partners for resourcing communications and engagement requirement at all ICS levels.

4. Develop, agree and implement an overarching communications and engagement strategy for the ICS, focussed on supporting delivery of the nine ICS priorities.

5. Ensure smooth transition of statutory duties to engage and consult from the CCG to the new ICS NHS Body with no interruption to live engagement projects.

6. Establish communications and engagement tools and channels for new ICS NHS Body and ICS Partnership.

A list of core deliverables, timelines and measures of success has been developed. A further detailed action plan is being developed in July.

Internal Communications on CCG to ICS Body Transition

We have good internal communications and engagement channels in the CCG and through the communications teams of all ICS partners. Specifically for CCG colleagues facing the transition to a new organisation we will continue our:

- Monthly executive led webinars (regularly attended by 300 people)
- A leadership forum of 70+ service and team leaders with regular meetings and online discussion channel; with key messages shared for cascade across all teams
- Weekly news bulletin and fortnightly Accountable Officer blog
- Staff networks and a newly established People Partnership Board
- A staff portal (intranet)
- Executive video updates

9 Risks and the risk management approach

Risks directly relating to the CCG transition to the ICS NHS Body are managed through the CCG risk management framework, risk registers and board assurance process. Wider risks relating to ICS development and transition are managed through respective programme SROs and their teams up to the current System Executive Group.

A draft assurance framework for the transitional work is currently being developed and will be presented to the executive group in July and Partnership Board in early August. Alongside this, work is about to commence with an external partner to develop a long term system risk management and Partnership assurance framework. This is not a simple transfer of organisational risks and assurance challenges, but will require a shift in culture in terms of agreeing those material issues that will impact on system and place based priorities, and agreement of where risk 'sits' and who 'owns' this. This type of system-wide risk management and assurance framework has not yet been developed across any of the south east ICS': once developed, we expect to share the outcome with partnering systems.

With regard to transition and preparations for April 2022, the following headline risks and mitigations have been identified *(risk scores are impact if risk materialises x likelihood)*:

1. **Delays in approval of the Parliamentary Bill** and/or national guidance particularly relating to ICS Constitution, HR Framework and wider ICS mandated guidance leading to insufficient time to agree and implement final governance models and architecture.

   Amber / 12 *(4 x 3)* Current structures and programme arrangements are such that local decisions and implementation should not be adversely affected, unless material changes or a lack of fundamental guidance is extremely delayed

2. A **lack of clarity in national guidance** could impact on local partners reaching agreement on key governance and constitutional matters, leading to material delays in ICS implementation and/or a lack of clarity/consensus that will materially impact on future relationship and delivery arrangements

   Amber / 12 *(4 x 3)* Whilst there will inevitably be local discussions and some 'negotiation' on roles, responsibilities and associated governance arrangements, there is a growing level of maturity and partnership working in the system, that should highlight any key differences/issues and effectively work through these. The risk becomes greater if national guidance is delayed.

3. Key **leadership appointments to the ICS NHS Body are delayed** leading to growing unrest amongst existing system leaders and an inability to make important decisions on future working arrangements.

   Red / 16 *(4 x 4)* National guidance on the HR framework and appointment to the key leadership roles, such as ICS NHS Body Chair and CEO, are awaited. Whilst local discussion on potential mitigating actions is taking place and we are involved in the national engagement, the likelihood of this risk materialising is dependent on the national timetable and process.

4. There is a risk that **critical operational and tactical priorities** across the system – including a third wave of the pandemic and extended vaccination programme - will take priority and impact on the capacity of system leaders to effectively engage in the development of the ICS across all layers (system, place, collaborative, neighbourhood), leading to a lack of consensus and/or clarity on authority, remit and governance. This includes clinical and professional and wider system leadership capacity.

   Red / 15 *(5 x 3)* Staff recuperation remains an issue, with all organisations focusing on balancing operational delivery with staff recovery. Effective arrangements are in place to manage this risk within each organisation. However it remains an issue that needs close attention. Organisational development plans for system, ICPs and PCNs are in place and will be enhanced over the summer months. Targeted development and discussion on 'knotty issues' will be prioritised as these materialise.

5. There is concern about the **timing, scale and available resourcing** of those functions likely to be delegated to systems by NHSEI, leading to systems being delegated responsibilities with sufficient time, capability or resource to effectively manage these, resulting in an inability to effectively manage new services.

   Amber / 12 *(4 x 3)* Close discussions with regional NHS England colleagues will continue over the summer months to understand the timing and phasing of any delegation. Learning the lessons from GMS contract delegation, effective resourcing of these functions, particularly the availability of experienced subject matter experts is the primary risk, alongside management capacity and capability to manage issues and challenges as they are subsequently identified.

6. **Loss of key staff and clinical membership** during transition, leading to organisational instability, deterioration of assurance and a loss of corporate memory, resulting in the ICS NHS Body not being able to meet its statutory duties and corporate responsibilities.

   Amber / 12 *(4 x 3)* CCG transition programme in place with lead executives and functional leads; CCG and system development programme defined and played in to forward planners; People and OD plan and staff engagement plans developed; regular staff briefings; Regional approach on critical staff messaging and national workforce guarantee. Functional design (ICS/ICP/collaborative) yet to be completed – this will give staff further assurances once complete alongside senior leadership appointments. Continuous programme of staff involvement, engagement and communication, including GP membership; Pace of development programme for ICS, ICPs and PCNs to be increased; programming and completion of functional design during the summer.

7. There is a risk that the system partners do not engage in meaningful discussions about **forming and developing effective and innovative provider collaboratives**. This will impact on the governance development for the ICS as well as hindering the ability of the system to deliver parts of the operational strategy.

   Red / 16 *(4 x 4)* A National work stream focussing on provider collaboratives has been created and the CCG and its partners will receive guidance and direction from this.

10 Conclusion and next steps

The Kent and Medway system is progressing well in developing the new model of Integrated Care Systems. We are building on the excellent partnership working across the NHS and with wider health and care partners which has been so critical in responding to the pandemic.

As a sustainability and transformation partnership we made good progress with service transformations to improve health and healthcare for local people. As an ICS we are now taking this to the next level and as our shared vision states: **we will work together to make health and wellbeing better than any partner can do alone.**

Following the recent publication of the ICS Design Framework, local design and governance decisions will now be made to continue developing the system operating model. We are continuing our extensive engagement exercise with all ICS partners over the summer to ensure that we co-design a governance and operating model that supports all partners to work together to tackle our shared challenges and deliver on our agreed priorities.

At the end of September 2021, we expect to have completed the Kent and Medway governance review and have our approach to system architecture and governance signed off by the current ICS Executive Group and ICS Partnership Board.

As noted in earlier sections, critical programmes of work taking place in coming months include:

- Reconfirming the level of ambition at system, place and collaborative level and completion of the first phase of the **functional design** work in order to inform April 2022 architecture – to be completed by 30 September 2021.
- Comprehensive **review of the system governance framework** to be timetabled by the end of June and completed by 30 September 2021. This will include discussions with Kent County Council and Medway Councils on future working relationship and potential areas for greater joint working.
- Develop our HR framework and transition plan detailing a step by step approach to transition affected staff to the ICS NHS Body. This will also detail our plans for recruitment to the ICS NHS Body Chair, Chief Executive and other Executive Board roles. First draft by end July 2021.
- Re-establish a **Clinical and Professional Forum** with a clear articulation of remit, authority and the clinical and professional governance framework that will sit around it at place and service delivery level, by 30 August 2021.
- Establish a **patient and public engagement framework** by December 2021.
- Further development and prioritisation of the **Organisational Development programme** for all layers of the system from June 2021.

We will regularly review our transition and development plans to ensure key milestones are being met and decisions are made at the identified decision points.

Further detail on our progress so far and next steps for ICS transition in Kent and Medway are set out in the supporting documents:

- **Appendix 1 - Stakeholder engagement initial discussions**
  Summary of key issues relating to the establishment of an ICS gathered through extensive engagement with ICS partners through April and May 2021.

- **Appendix 2 - The K&M System and ICS Body Transition and Development Plan**
  High level overview of the transition work programme. Highlights key milestones for delivery and decision points between June 2021 and the end of March 2022. Detailed plans for each of the programme areas are available on request.

- **Appendix 3 - Our draft ICS NHS Body functional model**
  Initial views on functions that will be the responsibility of the ICS NHS Body, subject to any future decisions on delegation to ICPs or provider collaboratives.

- **Appendix 4 - ICS development excerpt from our nine system priorities**
  Plans on a Page covering the four system priorities that directly link to our ICS transition programme.

- **Appendix 5 - Additional documents and products development plan**
  Details of the Kent and Medway ICS key documents and products list that will be developed as part of our transition journey.

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From: Clair Bell, Cabinet Member for Adult Social Care and Public Health

To: Kent and Medway Joint Health and Wellbeing Board – 16 September 2021

Subject: The appointment of a representative to attend meetings of the Kent and Medway Primary Care Commissioning Group

Classification: **Unrestricted**

Past Pathway of report: None

Future Pathway of report: None

Electoral Division: All

Summary: This report asks the Joint Board to note the agreement of the Medway Health Wellbeing Board and the Kent Health and Wellbeing Board following a request from the Kent and Medway Clinical Commissioning Group (CCG) that a representative of the KAMJHWB attend meetings of the Kent and Medway Primary Care Commissioning Group (PCCG)

Recommendation
The Kent and Medway Joint Health and Wellbeing Board is asked to note the decisions of the Medway Health and Wellbeing Board and the Kent Health and Wellbeing Board:

1) that a member of the Kent and Medway Joint Health and Wellbeing Board be nominated to attend meetings of the Kent and Medway Primary Care Commissioning Group's Primary Care Commissioning Committee (PCCC) in accordance with paragraph 4 of the terms of reference of the PCCC;

2) that James Williams, Director of Public Health at Medway attends the PCCC's meetings as the representative of the KAMJHWB; and

3) that this appointment is reviewed in 12 months' time in line with the development of the Integrated Care Systems boards.

1. Introduction

1.1 A request has been received from the Kent and Medway Clinical Commissioning Group (CCG) asking that a representative of the Kent and Medway Joint Health and Wellbeing Board (KAMJHWB) be nominated to attend meetings of the Kent and Medway Primary Care Commissioning Committee (PCCC), in accordance with the PCCC's terms of reference (attached at appendix 1 to this report). Paragraph 4.1 of the terms of reference requires the PCCC to invite a representative of the health and wellbeing board to attend its meetings. Paragraph 4.5.5 indicates that the representative of the health and

wellbeing board can comment but not vote on matters considered at meetings of the PCCC.

1.2 The CCG is seeking one representative from the KAMJHWB to attend meetings in a non-voting capacity. They are particularly keen for the representative to be involved in discussions relating to strategy and population health.

1.3 It has been suggested that having one representative would enable engagement without creating a greater burden by asking a representative from each local authority to attend monthly three-hour meetings of the PCCC.

1.4 James Williams, Director of Public Health at Medway has indicated his willingness to attend these meetings subject to the agreement of Kent County Council.

1.5 The KAMJHWB has no delegated authority to make this appointment. The Medway Health and Wellbeing Board considered this matter at its meeting on 2 September and agreed

1) that a member of the Kent and Medway Joint Health and Wellbeing Board be nominated to attend meetings of the Kent and Medway Primary Care Commissioning Group's Primary Care Commissioning Committee (PCCC) in accordance with paragraph 4 of the terms of reference of the PCCC;

2) that James Williams, Director of Public Health at Medway attends the PCCC's meetings as the representative of the KAMJHWB; and

3) that this appointment is reviewed in 12 months' time in line with the development of the Integrated Care Systems boards.

1.6 A report recommending a similar agreement will be considered by the Kent Health and Wellbeing Board at its meeting on 16 September 2021 and its decision will be reported verbally at the meeting of the Kent and Medway Joint Health and Wellbeing Board.

2. Financial Implications

2.1 There are no financial implications arising from the implementation of the recommendation.

3. Legal implications

3.1 The legal and constitutional implications are set out in the paragraphs above.

4. Equalities implications

4.1 There are no equalities implications arising from this report.

5. Recommendations

5.1 The Kent and Medway Joint Health and Wellbeing Board is asked to note the decisions of the Medway Health and Wellbeing Board and the Kent Health and Wellbeing Board:

1) that a member of the Kent and Medway Joint Health and Wellbeing Board be nominated to attend meetings of the Kent and Medway Primary Care Commissioning Group's Primary Care Commissioning Committee) in accordance with paragraph 4 of the terms of reference of the PCCC;

2) that James Williams, Director of Public Health at Medway attends the PCCC's meetings as the representative of the KAMJHWB and

3) that this appointment is reviewed in 12 months' time in line with the development of the Integrated Care Systems boards

6. Background Documents

None.

7. Contact details

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Kent and Medway Clinical Commissioning Group
Primary Care Commissioning Committee
Terms of Reference

1. Introduction

1.1 In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended) (the NHS Act), NHS England delegated the exercise of the functions specified in Clause 3 to NHS Kent and Medway Clinical Commissioning Group (CCG).

1.2 The CCG has established the Primary Care Commissioning Committee (the Committee). The Committee is established as a Committee of the Governing Body in accordance with Schedule 1A of the NHS Act. The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.

1.3 The Committee will consider local commissioning needs within its decision making. This will ensure that Integrated Care Partnerships (ICPs) and Primary Care Networks are able to co-ordinate through general practices, community services and hospitals to meet the needs of local people requiring care.

1.4 These terms of reference set out the membership, the remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the Constitution.

2. Statutory Framework

2.1 NHS England has delegated to the CCG the authority to exercise the primary care commissioning functions set out in Annex A in accordance with section 13Z of the National Health Service (NHS) Act. (for information, Annex B provides the definition and interpretation of terms in the Delegation Agreement between the CCG and NHS England)

2.2 Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the CCG.

2.3 Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it) it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

2.3.1 Management of conflicts of interest (section 14O)

2.3.2 Duty to promote the NHS Constitution (section 14P)

2.3.3 Duty to exercise its functions effectively, efficiently and economically (section 14Q)

2.3.4 Duty as to improvement in quality of services (section 14R)

2.3.5 Duty in relation to quality of primary medical services (section 14S)

2.3.6 Duties as to reducing inequalities (section 14T)

2.3.7 Duty to promote the involvement of each patient (section 14U)

2.3.8 Duty as to patient choice (section 14V)

2.3.9 Duty as to promoting integration (section 14Z1)

2.3.10 Public involvement and consultation (section 14Z2)

2.4 In respect of the delegated functions from NHS England the CCG will need to specifically exercise those functions set out below in accordance with the relevant provisions of section 13 of the NHS Act:

2.4.1 Duty to have regard to impact on services in certain areas (section 13O)

2.4.2 Duty as respects variation in provision of health services (section 13P)

2.5 Members of the Committee acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.

3. Role of the Committee

3.1 The Committee has been established in accordance with the above statutory provisions to enable the members to make collective decisions on the review, planning and procurement of primary care medical services in the CCG, under delegated authority from NHS England.

3.2 In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and the CCG, which will sit alongside the delegation and terms of reference.

3.3 The functions of the Committee are undertaken in the context of a desire to improve the sustainability of primary care and promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

3.4 The Committee will have due regard to any relevant quality and safety issues which may arise as agreed by Committee members.

3.5 The role of the Committee shall be to carry out the functions relating to the commissioning

of primary medical services under section 83 of the NHS Act. This includes the following:

3.5.1 GMS, PMS and APMS contracts (including procurement of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract)

3.5.2 Decisions in relation to Enhanced Services

3.5.3 Decisions in relation to Local Incentive Schemes

3.5.4 Decisions in relation to the establishment of new GP practices (including branch surgeries) and closure of GP practices

3.5.5 Decisions about 'discretionary' payments

3.5.6 Decisions about commissioning urgent care (including home visits as required) for out of area registered patients

3.5.7 The approval of practice mergers

3.5.8 Planning primary medical care services in the area, including carrying out needs assessments

3.5.9 Undertaking reviews of primary medical care services in the area

3.5.10 Decisions in relation to the management of poorly performing GP practices and including, without limitation, decisions and liaison with the Care Quality Commission (CQC) where the CQC has reported non-compliance with standards. For clarity, this excludes any decisions in relation to the performers list

3.5.11 Management of delegated funds in the area

3.5.12 Premises costs directions functions

3.5.13 Oversee the implementation of the Kent and Medway primary care strategy as it relates to the remit of the Committee

3.5.14 Coordinating a common approach to the commissioning of primary care services with other commissioners in the area where appropriate

3.5.15 Such other ancillary activities that are necessary in order to exercise the Delegated Functions

3.6 The Committee will also carry out the following activities:

3.6.1 Plan, including needs assessment, primary medical care services in the CCG's geographical area

3.6.2 Undertake reviews of primary medical care services in the CCG's geographical area

3.6.3 Co-ordinate a common approach to the commissioning of primary care services generally

3.6.4 Approve the policies and operating procedures that the Primary Care Operational Groups will adhere to when considering routine business items, for example requests for a boundary change to a GP practice; and

3.6.5 Manage the budget for commissioning of primary medical care services in the CCG's geographical area.

4. Membership

4.1 This Committee is constituted with a lay and executive majority, and includes a requirement to invite a Health and Well-Being Board and Healthwatch representative to attend (as per paragraph 97 onwards of the Managing Conflict of Interest: Revised Statutory Guidance for CCGs 2017).

4.2 The voting membership of the Committee is as follows:

4.2.1 Independent Lay Member for Primary Care

4.2.2 Lay Member for Patient and Public Engagement

4.2.3 The Accountable Officer or their nominated deputy

4.2.4 The Executive Director for Health Improvement or their nominated deputy

4.2.5 The Chief Finance Officer or their nominated deputy

4.2.6 The Chief Nurse or their nominated deputy

4.2.7 The Governing Body independent secondary care specialist

4.2.8 The Governing Body independent registered nurse

4.3 The Chair of the Committee shall be the Governing Body Lay Member for Primary Care

4.4 The Vice-Chair of the Committee shall be the Governing Body Lay Member for Patient and Public Engagement.

4.5 The Committee shall have the following standing attendees who may be invited to comment but shall not vote:

4.5.1 One GP member from each of the Primary Care Co-Commissioning Operational Groups

4.5.2 The Chairs of Primary Care Commissioning Operational Groups (PCOGs)

4.5.3 An NHS England Primary Care representative

4.5.4 A Local Medical Committee Representative

4.5.5 A Kent and Medway Joint Health and Wellbeing Board representative

4.5.6 A Representative on behalf of Kent Healthwatch and a representative on behalf of Medway Healthwatch

4.5.7 Head of Primary Care commissioning (one per each PCOG)

4.6 Officers of the CCG may nominate deputies to represent them in their absence and make decisions on their behalf. Non-voting members may nominate deputies to attend in their absence.

4.7 As Chair of the Audit Committee, the Independent Lay Member for Governance shall receive all papers for the Primary Care Commissioning Committee meetings and shall have the right to attend any meeting of the Committee, but shall not be a voting member.

4.8 Whilst not part of the quorum, Committee members should have access to appropriate clinical and operational expertise in order to inform their deliberations, subject to the CCG's policies on business standards and conflicts of interest requirements.

4.9 GP members shall not vote on any matter considered by the Committee. However, GP members shall participate in Committee discussions, subject to the CCG's policies on business standards and conflicts of interest requirements.

4.10 The Committee may call additional individuals to attend meetings on a case by case basis to inform discussion. The Committee may also invite or allow additional individuals to attend meetings on a regular basis. Attendees and additional members may present at Committee meetings and contribute to discussions, but are not allowed to participate in any vote.

4.11 The Committee may invite or allow people to attend meetings as observers. Observers may not present or contribute to any Committee discussion unless invited by the Chair of the Committee, and may not vote.

5. Meetings and Voting

5.1 Meetings of the Committee will be open to the public unless the Chair resolves that the public be excluded from the meeting, whether for the whole or part of the proceedings on the grounds that publicity would be prejudicial to the public interest or the interests of the CCG by reason of the confidential nature of the business to be transacted or for other

special reasons stated in the resolution and arising from the nature of the business to be transacted or the proceedings.

5.2 Meetings held in public will be referred to as Part 1 meetings. Meetings or parts of meetings held in private will be referred to as Part 2 meetings.

5.3 Non-voting members, observers and the public may be excluded from all or part of a meeting at the Chair's absolute discretion whenever the business to be considered would be prejudicial to the public interest by reason of:

5.3.1 The confidential nature of the business to be transacted

5.3.2 The matter being commercially sensitive or confidential

5.3.3 The matter being discussed is part of an on-going investigation

5.3.4 The matter to be discussed contains information about individual patients or other individuals which includes sensitive personal data

5.3.5 Information in respect of which a claim to legal professional privilege could be maintained in legal proceedings is to be discussed

5.3.6 Other special reasons stated in the resolution and arising from the nature of that business or of the proceedings

5.3.7 Any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time

5.3.8 To allow the meeting to proceed without interruption, disruption and/or general disturbance

5.4 The Committee will operate in accordance with the CCG's Standing Orders. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as they shall specify.

5.5 The aim of the Committee will be to achieve consensus decision-making wherever possible with the show of hands. Each member of the Committee shall have one vote. The Committee shall reach decisions by a majority of members' present, subject always to the meeting being quorate. The Chair shall have a second and deciding vote, where the vote is tied.

5.6 If an urgent decision is needed prior to the next scheduled meeting and or it is not considered possible to call a full meeting, the Committee Chair may decide to convene a virtual meeting. The arrangements for such meeting will be determined by the Chair in discussion with the Executive Director of Corporate Affairs, but will normally include the invitation of all voting and non-voting members. Where possible the details of the meeting will be publicised in advance of the meeting unless the meeting is confidential or of such an urgent nature that it would not reasonably be possible to do so. In all other

respects the meeting will be managed in accordance with these Terms of Reference, as if it were a planned meeting of the Committee, including the minute taking and decision making. Any decision made virtually will be noted at the next available and appropriate meeting of the Committee.

5.7 All members (voting and non-voting) and any other participant in the discussions are required to declare any interest relating to any matter to be considered at each meeting, in accordance with the CCG's Constitution and the CCG's policies on business standards and managing conflicts of interest. At the sole discretion of the Chair, individuals who have declared an interest may be allowed to participate in the discussion but will not participate in any vote and may be requested to leave the meeting for any or all of the items in question.

6. Quorum

6.1 A quorum shall be four voting members, two of whom shall be independent or lay members, one shall be a CCG officer and one shall be a clinician. The clinician members of the committee are the Independent Nurse member of Governing Body, the Independent Secondary Care Doctor member of Governing Body and the Chief Nurse. For the avoidance of doubt, any other voting member of the committee who may also be clinically qualified, will not count as a clinician for the purposes of this committee or its quorum. Deputies are invited to attend in the place of the regular members as required.

6.2 Deputies approved by the Chair count toward quorum requirements

6.3 Whilst not part of the quorum, the Committee shall endeavour to always have a GP representative or a representative from the LMC in attendance, unless conflicts of interest precludes this.

6.4 At the discretion of the Chair, members who are not physically present at a Committee meeting but are present through tele-conference or other acceptable media, shall be deemed to be present and count towards the quorum as appropriate. In this, the Chair will consider an appropriate balance between demands on committee members (for instance during any period of major incident management) and the sizeable geography of the CCG, whilst ensuring ease of access to the meetings proceedings for members of the press and public.

6.5 If any representative is conflicted on a particular item of business they will not count towards the quorum for that item of business. If this renders a meeting or part of a meeting non quorate, a non-conflicted person may be temporarily appointed or co-opted to satisfy the quorum requirements, subject to the agreement of the Chair.

6.6 If a group of members are temporarily excluded due to a conflict of interest, and this results in a failure to meet the requirements of paragraph 6.1, with the agreement of the chair the requirement for that category of member to be present may be relaxed.

6.7 Members of the Committee have a collective responsibility for the operation of the

Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

7. Frequency and Notice of Meetings

7.1 The Committee shall meet monthly unless circumstances necessitate the need to meet more frequently as agreed by the Committee. Meeting venues will where possible rotate across Kent and Medway in accordance with the local agenda items.

7.2 Notice of any Committee meeting must indicate:

7.2.1 Its proposed date and time, which must be at least seven (7) days after the date of the notice, except where a meeting to discuss an urgent issue is required (in which case as much notice as reasonably practicable in the circumstances should be given)

7.2.2 Where it is to take place

7.2.3 An agenda of the items to be discussed at the meeting and any supporting papers

7.2.4 If it is anticipated that members of the Committee participating in the meeting will not be in the same place, how it is proposed that they should communicate with each other during the meeting

7.3 Notice of a Committee meeting must be given to each member of the Committee in writing.

7.4 Failure to effectively serve notice on all members of the Committee does not affect the validity of the meeting, or of any business conducted at it.

7.5 Where Committee meetings are to be held in public the date, times and location of the meetings will be published in advance on the CCG's website.

Where appropriate meetings held in public will be divided into two sessions:

7.6.1 Part 1a – first session to discuss Kent and Medway system agenda items

7.6.2 Part 1b – second session with a local focus on specific geographical area

7.6.3 The Chair will ensure that critical items of business from any part of the county are not delayed should the item apply to an area that is not the specific local focus for any given meeting.

8. Secretary

8.1 The Executive Director of Corporate Affairs or their nominated representative shall be the Secretary to the Committee and will ensure the provision of administrative support and advice. The duties of the Secretary include but are not limited to:

8.1.1 agreement of the agenda with the chair of the Committee and attendees together with the collation of connected papers;

8.1.2 taking the minutes and keeping a record of matters arising and issues to be carried forward.

9. Agendas and Circulation of Papers

9.1 Before each Committee meeting an agenda and papers will be sent to every Committee member and where appropriate published on the CCG website no less than five (5) Business Days in advance of the meeting.

9.2 If a Committee member wishes to include an item on the agenda they must notify the Chair via the Committee's Secretary no later than ten (10) Business Days prior to the meeting. In exceptional circumstances for urgent items this will be reduced to five (5) Business Days prior to the meeting. The decision as to whether to include the agenda item is at the absolute discretion of the Chair.

10. Minutes and Reporting

10.1 Minutes of the Committee shall be prepared by the Committee's Secretariat and submitted for agreement at the following Committee meeting.

10.2 A copy of the minutes and or a summary of Committee meetings will be presented the CCG Governing Body as appropriate. The approved minutes will also be made available to NHS England on request.

11. Conflicts of Interest

11.1 Conflicts of Interest shall be dealt with in accordance with the CCG policy on business standards and managing conflicts of interest.

11.2 The Committee shall have a Register of Business Interests that will be presented as a standing item on the Committee's agenda.

11.3 In accordance with 5.3, at the absolute discretion of the Chair, non-voting members may be excluded from all or any part of a meeting where the business to be considered would be prejudicial to the public interest. This includes issues of confidentiality and commercial sensitivity that may require GP members to be excluded as a result of any potential or actual conflict of interest.

12. Confidentiality

12.1 Members of the Committee shall respect the confidentiality requirements set out in the CCG's Standing Orders, relevant corporate policies and these Terms of Reference unless separate confidentiality requirements are set out for the Committee in which event these shall be observed.

12.2 Committee meetings may in whole or in part be held in private. Any papers relating to these agenda items will be excluded from the public domain. For any meeting or any part of a meeting held in private all attendees must treat the contents of the meeting, any discussion and decisions, and any relevant papers as confidential.

12.3 Decisions of the Committee will be published by the Committee except where matters under consideration or when decisions have been made in private and so excluded from the public domain in accordance with Clause 5 above.

13. Conduct of the Committee

13.1 The Committee shall undertake a self-assessment of its effectiveness on at least an annual basis. This may be facilitated by independent advisors if the Committee considers this appropriate or necessary.

13.2 Members of the Committee should aim to attend all scheduled meetings, but must attend at least 75% of scheduled meetings in any financial year.

13.3 Having due regard to clause 14.1, the Chair will reserve the right to refer a matter to the Governing Body should an item or issue arise where it is judged that the view of the Governing Body would secure essential good corporate governance and decision making.

13.4 Committee members, members and/or invited observers must maintain the highest standards of personal conduct and in this regard must comply with:

13.1.1 The laws of England and Wales

13.1.2 The spirit and requirements of the NHS Constitution

13.1.3 The Nolan Principles

13.1.4 The standards of behaviour set out in the CCG's Constitution and supporting documents and policies, as they would be reasonably expected to know

13.1.5 Any additional regulations or codes of practice relevant to the Committee

14. Sub-Committees

14.1 The Committee may not delegate to a Committee or Sub-committee any functions or

statutory responsibilities delegated to it by NHS England. The Committee may, however, appoint Sub-committees and/or working groups to advise and assist it in carrying out its functions.

14.2 The Committee may appoint tasks to such Sub-committees, working groups or individual members as it shall see fit, provided that any such appointment is consistent with NHS England regulations and the CCG's Constitution and associated documents and policies, including but not limited to Standing Orders, the Overarching Scheme of Reservation and Delegation and the Scheme of Delegated Financial Limits. Any such appointment shall be appropriately recorded by the Committee.

14.3 One or more Primary Care Operational Groups (PCOGs) may be established as a Sub-Committee of the Committee. The PCOG(s) will:

14.4.1 Provide a strategic forum to develop commissioning plans and commissioning opportunities for the development and delivery of high quality local primary care services

14.4.2 Oversee and co-ordinate the operational delegated arrangements, supporting the delivery of the delegated responsibilities relating to the commissioning of primary care medical services under section 83 of the NHS Act, and

14.4.3 Assure the day to day business associated with the commissioning and contracting of primary care medical services in line with delegated arrangements, and delivery of the delegated functions in line with the statutory framework.

14.4 Separate terms of reference will be compiled to cover the scope of the PCOG(s) and will be approved by the PCCC.

14.5 Officers of the Primary Care Commissioning Committee, who have the appropriate level of delegated authority, may be able to approve PCOG recommendations outside of the Committee meeting so long as they comply at the time with any requirements of the Committee and any relevant operational policies in place. These decisions will subsequently be acknowledged at the next available Committee meeting.

15. Review of Terms of Reference

15.1 The terms of reference of the Committee will be approved by Governing Body and shall be reviewed by the Governing Body at least annually.

Approved: August 2020

Version Control:

Version No	Amendment	Amendment Owner	Date of Amendment
1.0	Original Draft	Company Secretary	Dec 2019
1.01	Final Draft – Post GP Members and NHSE	Company Secretary	Feb 20
2.0	Approved Governing Body		02 April 2020
2.1	Content updated; 6.0, 7.6 Approved by Governing Body on 30 April 2020	Company Secretary	30 April 2020
2.3	Change in director titles	Exec Director of Corporate Affairs	August 2020

Annex A to Appendix 8 to
NHS Kent and Medway Clinical Commissioning Group Constitution

Delegated Functions

The following narrative forms Schedule 2 to the Delegation Agreement between NHS England and the Kent and Medway Clinical Commissioning Group pertaining to the delegation of primary care medical services to the CCG.

"Schedule 2

Delegated Functions

Part 1: Delegated Functions: Specific Obligations

1. Introduction

1.1. This Part 1 of Schedule 2 *(Delegated Functions)* sets out further provision regarding the carrying out of each of the Delegated Functions.

2. Primary Medical Services Contract Management

2.1. The CCG must:

2.1.1. manage the Primary Medical Services Contracts on behalf of NHS England and perform all of NHS England's obligations under each of the Primary Medical Services Contracts in accordance with the terms of the Primary Medical Services Contracts as if it were named in the contract in place of NHS England;

2.1.2. actively manage the performance of the counter-party to the Primary Medical Services Contracts in order to secure the needs of people who use the services, improve the quality of services and improve efficiency in the provision of the services including by taking timely action to enforce contractual breaches and serve notice;

2.1.3. ensure that it obtains value for money under the Primary Medical Services Contracts on behalf of NHS England and avoids making any double payments under any Primary Medical Services Contracts;

2.1.4. comply with all current and future relevant national Guidance regarding PMS reviews and the management of practices receiving Minimum Practice Income Guarantee (MPIG) (including without limitation the *Framework for Personal Medical Services (PMS) Contracts Review* guidance published by NHS England in September 2014 (http://www.england.nhs.uk/wp-content/uploads/2014/09/pms- review-guidance-sept14.pdf));

2.1.5. notify NHS England immediately (or in any event within two (2) Operational Days) of any breach by the CCG of its obligations to perform any of NHS England's obligations under the Primary Medical Services Contracts;

2.1.6. keep a record of all of the Primary Medical Services Contracts that the CCG manages on behalf of NHS England setting out the following details in relation to each Primary Medical Services Contract:

2.1.6.1. name of counter-party;

2.1.6.2. location of provision of services; and

2.1.6.3. amounts payable under the contract (if a contract sum is payable) or amount payable in respect of each patient (if there is no contract sum).

2.2. For the avoidance of doubt, all Primary Medical Services Contracts will be in the name of NHS England.

2.3. The CCG must comply with any Guidance in relation to the issuing and signing of Primary Medical Services Contracts in the name of NHS England.

2.4. Without prejudice to clause 13 *(Financial Provisions and Liability)* or paragraph 2.1 above, the CCG must actively manage each of the relevant Primary Medical Services Contracts including by:

2.4.1. managing the relevant Primary Medical Services Contract, including in respect of quality standards, incentives and the QOF, observance of service specifications, and monitoring of activity and finance;

2.4.2. assessing quality and outcomes (including clinical effectiveness, patient experience and patient safety);

2.4.3. managing variations to the relevant Primary Medical Services Contract or services in accordance with national policy, service user needs and clinical developments;

2.4.4. agreeing information and reporting requirements and managing information breaches (which will include use of the HSCIC IG Toolkit SIRI system);

2.4.5. agreeing local prices, managing agreements or proposals for local variations and local modifications;

2.4.6. conducting review meetings and undertaking contract management including the issuing of contract queries and agreeing any remedial action plan or related contract management processes; and

2.4.7. complying with and implementing any relevant Guidance issued from time to time.

Enhanced Services

2.5. The CCG must manage the design and commissioning of Enhanced Services,

including re-commissioning these services annually where appropriate.

2.6. The CCG must ensure that it complies with any Guidance in relation to the design and commissioning of Enhanced Services.

2.7. When commissioning newly designed Enhanced Services, the CCG must:

2.7.1. consider the needs of the local population in the Area;
2.7.2. support Data Controllers in providing 'fair processing' information as required by the DPA;
2.7.3. develop the necessary specifications and templates for the Enhanced Services, as required to meet the needs of the local population in the Area;
2.7.4. when developing the necessary specifications and templates for the Enhanced Services, ensure that value for money will be obtained;
2.7.5. consult with Local Medical Committees, each relevant Health and Wellbeing Board and other stakeholders in accordance with the duty of public involvement and consultation under section 14Z2 of the NHS Act;
2.7.6. obtain the appropriate read codes, to be maintained by the HSCIC;
2.7.7. liaise with system providers and representative bodies to ensure that the system in relation to the Enhanced Services will be functional and secure; and
2.7.8. support GPs in entering into data processing agreements with data processors in the terms required by the DPA.

Design of Local Incentive Schemes

2.8. The CCG may design and offer Local Incentive Schemes for GP practices, sensitive to the needs of their particular communities, in addition to or as an alternative to the national framework (including as an alternative to QOF or directed Enhanced Services), provided that such schemes are voluntary and the CCG continues to offer the national schemes.

2.9. There is no formal approvals process that the CCG must follow to develop a Local Incentive Scheme, although any proposed new Local Incentive Scheme:

2.9.1. is subject to consultation with the Local Medical Committee;
2.9.2. must be able to demonstrate improved outcomes, reduced inequalities and value for money; and
2.9.3. must reflect the changes agreed as part of the national PMS reviews.

2.10. The ongoing assurance of any new Local Incentive Schemes will form part of the CCG's assurance process under the CCG Assurance Framework.

2.11. Any new Local Incentive Scheme must be implemented without prejudice to the right of GP practices operating under a GMS Contract to obtain their entitlements which are negotiated and set nationally.

2.12. NHS England will continue to set national standing rules, to be reviewed

annually, and the CCG must comply with these rules which shall for the purposes of this Agreement be Guidance.

Making Decisions on Discretionary Payments

2.13. The CCG must manage and make decisions in relation to the discretionary payments to be made to GP practices in a consistent, open and transparent way.

2.14. The CCG must exercise its discretion to determine the level of payment to GP practices of discretionary payments, in accordance with the Statement of Financial Entitlements Directions.

Making Decisions about Commissioning Urgent Care for Out of Area Registered Patients

2.15. The CCG must manage the design and commissioning of urgent care services (including home visits as required) for its patients registered out of area (including re-commissioning these services annually where appropriate).

2.16. The CCG must ensure that it complies with any Guidance in relation to the design and commissioning of these services.

3. Planning the Provider Landscape

3.1. The CCG must plan the primary medical services provider landscape in the Area, including considering and taking decisions in relation to:

3.1.1. establishing new GP practices in the Area;
3.1.2. managing GP practices providing inadequate standards of patient care;
3.1.3. the procurement of new Primary Medical Services Contracts (in accordance with any procurement protocol issued by NHS England from time to time);
3.1.4. closure of practices and branch surgeries;
3.1.5. dispersing the lists of GP practices;
3.1.6. agreeing variations to the boundaries of GP practices; and
3.1.7. coordinating and carrying out the process of list cleansing in relation to GP practices, according to any policy or Guidance issued by NHS England from time to time.

3.2. In relation to any new Primary Medical Services Contract to be entered into, the CCG must, without prejudice to any obligation in Schedule 2, Part 2, paragraph 3 *(Procurement and New Contracts)* and Schedule 2, Part 1, paragraph 2.3:

3.2.1. consider and use the form of Primary Medical Services Contract that will ensure compliance with NHS England's obligations under Law including the Public Contracts Regulations 2015/102 and the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013/500 taking into account the persons to whom such Primary Medical Services Contracts may be awarded;

3.2.2. provide to NHS England confirmation as required from time to time that it has considered and complied with its obligations under this Agreement and the Law; and

3.2.3. for the avoidance of doubt, Schedule 5 *(Financial Provisions and Decision Making Limits)* deals with the sign off requirements for Primary Medical Services Contracts.

4. Approving GP Practice Mergers and Closures

4.1. The CCG is responsible for approving GP practice mergers and GP practice closures in the Area.

4.2. The CCG must undertake all necessary consultation when taking any decision in relation to GP practice mergers or GP practice closures in the Area, including those set out under section 14Z2 of the NHS Act (duty for public involvement and consultation). The consultation undertaken must be appropriate and proportionate in the circumstances and should include consulting with the Local Medical Committee.

4.3. Prior to making any decision in accordance with this paragraph 4 *(Approving GP Practice Mergers and Closures)*, the CCG must be able to clearly demonstrate the grounds for such a decision and must have fully considered any impact on the GP practice's registered population and that of surrounding practices. The CCG must be able to clearly demonstrate that it has considered other options and has entered into dialogue with the GP contractor as to how any closure or merger will be managed.

4.4. In making any decisions pursuant to paragraph 4 *(Approving GP Practice Mergers and Closures)*, the CCG shall also take account of its obligations as set out in Schedule 2, part 2, paragraph 3 *(Procurement and New Contracts)*, where applicable.

5. Information Sharing with NHS England in relation to the Delegated Functions

5.1. This paragraph 5 *(Information Sharing with NHS England)* is without prejudice to clause 9.4 or any other provision in this Agreement. The CCG must provide NHS England with:

5.1.1. such information relating to individual GP practices in the Area as NHS England may reasonably request, to ensure that NHS England is able to continue to gather national data regarding the performances of GP practices;

5.1.2. such data/data sets as required by NHS England to ensure population of the primary medical services dashboard;

5.1.3. any other data/data sets as required by NHS England; and

5.1.4. the CCG shall procure that providers accurately record and report information so as to allow NHS England and other agencies to discharge their functions.

5.2. The CCG must use the NHS England approved primary medical services dashboard, as updated from time to time, for the collection and dissemination of information relating to GP practices.

5.3. The CCG must (where appropriate) use the NHS England approved GP exception reporting service (as notified to the CCGs by NHS England from time to time).

5.4. The CCG must provide any other information, and in any such form, as NHS England considers necessary and relevant.

5.5. NHS England reserves the right to set national standing rules (which may be considered Guidance for the purpose of this Agreement), as needed, to be reviewed annually. NHS England will work with CCGs to agree rules for, without limitation, areas such as the collection of data for national data sets and IT intra-operability. Such national standing rules set from time to time shall be deemed to be part of this Agreement.

6. Making Decisions in relation to Management of Poorly Performing GP Practices

6.1. The CCG must make decisions in relation to the management of poorly performing GP practices and including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list).

6.2. In accordance with paragraph 6.1 above, the CCG must:

6.2.1. ensure regular and effective collaboration with the CQC to ensure that information on general practice is shared and discussed in an appropriate and timely manner;
6.2.2. ensure that any risks identified are managed and escalated where necessary;
6.2.3. respond to CQC assessments of GP practices where improvement is required;
6.2.4. where a GP practice is placed into special measures, lead a quality summit to ensure the development and monitoring of an appropriate improvement plan (including a communications plan and actions to manage primary care resilience in the locality); and
6.2.5. take appropriate contractual action in response to CQC findings.

7. Premises Costs Directions Functions

7.1. The CCG must comply with the Premises Costs Directions and will be responsible for making decisions in relation to the Premises Costs Directions Functions.

7.2. In particular, but without limiting the generality of paragraph 7.1, the CCG shall make decisions concerning:

7.2.1. applications for new payments under the Premises Costs Directions (whether such payments are to be made by way of grants or in respect of recurring premises costs); and

7.2.2. revisions to existing payments being made under the Premises Costs Directions.

7.3. The CCG must comply with any decision-making limits set out in Schedule 5 *(Financial Provisions and Decision Making Limits)* when taking decisions in relation to the Premises Costs Directions Functions.

7.4. The CCG will comply with any guidance issued by the Secretary of State or NHS England in relation to the Premises Costs Directions, including the Principles of Best Practice, and any other Guidance in relation to the Premises Costs Directions.

7.5. The CCG must work cooperatively with other CCGs to manage premises and strategic estates planning.

7.6. The CCG must liaise where appropriate with NHS Property Services Limited and Community Health Partnerships Limited in relation to the Premises Costs Directions Functions.

Part 2 – Delegated Functions: General Obligations

1. Introduction

1.1. This Part 2 of Schedule 2 *(Delegated Functions)* sets out general provisions regarding the carrying out of the Delegated Functions.

2. Planning and reviews

2.1. The CCG is responsible for planning the commissioning of primary medical services.

2.2. The role of the CCG includes:

2.2.1. carrying out primary medical health needs assessments (to be developed by the CCG) to help determine the needs of the local population in the Area;

2.2.2. recommending and implementing changes to meet any unmet primary medical services needs; and

2.2.3. undertaking regular reviews of the primary medical health needs of the local population in the Area.

3. Procurement and New Contracts

3.1. The CCG will make procurement decisions relevant to the exercise of the Delegated Functions and in accordance with the detailed arrangements regarding procurement set out in the procurement protocol issued and updated by NHS

England from time to time.

3.2. In discharging its responsibilities set out in clause 6 *(Performance of the Delegated Functions)* of this Agreement and paragraph 1 of this Schedule 2 *(Delegated Functions)*, the CCG must comply at all times with Law including its obligations set out in the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013/500 and any other relevant statutory provisions. The CCG must have regard to any relevant guidance, particularly Monitor's guidance *Substantive guidance on the Procurement, Patient Choice and Competition Regulations*

(https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/283505/SubstantiveGuidanceDec2013_0.pdf).

3.3. Where the CCG wishes to develop and offer a locally designed contract, it must ensure that it has consulted with its Local Medical Committee in relation to the proposal and that it can demonstrate that the scheme will:

3.3.1. improve outcomes;
3.3.2. reduce inequalities; and
3.3.3. provide value for money.

4. Integrated working

4.1. The CCG must take an integrated approach to working and co-ordinating with stakeholders including NHS England, Local Professional Networks, local authorities, Healthwatch, acute and community providers, the Local Medical Committee, Public Health England and other stakeholders.

4.2. The CCG must work with NHS England and other CCGs to co-ordinate a common approach to the commissioning of primary medical services generally.

4.3. The CCG and NHS England will work together to coordinate the exercise of their respective performance management functions.

5. Resourcing

5.1. NHS England may, at its discretion provide support or staff to the CCG. NHS England may, when exercising such discretion, take into account, any relevant factors (including without limitation the size of the CCG, the number of Primary Medical Services Contracts held and the need for the Local NHS England Team to continue to deliver the Reserved Functions)."

NHS Kent and Medway Clinical Commissioning Group Constitution

Definitions and Interpretation

The following narrative forms Schedule 1 to the Delegation Agreement between NHS England and the Kent and Medway Clinical Commissioning Group pertaining to the delegation of primary care medical services to the CCG. This provides the definitions used in Schedule 2 to the Delegation Agreement.

"Schedule 1

Definitions and Interpretation

In this Agreement, the following words and phrases will bear the following meanings:

Agreement	means this agreement between NHS England and the CCG comprising the Particulars, the Terms and Conditions and the Schedules;
Agreement Representatives	means the CCG Representative and the NHS England Representative as set out in the Particulars;
APMS Contract	means an agreement made in accordance with section 92 of the NHS Act;
Assigned Staff	means those NHS England staff as agreed between NHS England and the CCG from time to time;
Caldicott Principles	means the patient confidentiality principles set out in the report of the Caldicott Committee (December 1997 as amended by the 2013 Report, The Information Governance Review – "*To Share or Not to Share?"*) and now included in the NHS Confidentiality Code of Practice, as may be amended from time to time;
Capital	shall have the meaning set out in the Capital Investment Guidance or such other replacement Guidance as issued by NHS England from time to time;
Capital Expenditure Functions	means those functions of NHS England in relation to the use and expenditure of Capital funds (but excluding the Premises Costs Directions Functions);

Capital Investment Guidance	means any Guidance issued by NHS England from time to time in relation to the development, assurance and approvals process for proposals in relation to: - the expenditure of Capital, or investment in property, infrastructure or information and technology; or - the revenue consequences for commissioners or third parties making such investment;
CCG Assurance Framework	means the assurance framework that applies to CCGs pursuant to the NHS Act;
Claims	means, for or in relation to the Primary Medical Services Contracts (a) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal or any governmental, regulatory or similar body, or any department, board or agency or (b) any dispute with, or any investigation, inquiry or enforcement proceedings by, any governmental, regulatory or similar body or agency;
Claim Losses	means all Losses arising in relation to any Claim;
Complaints Regulations	means the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009/309;
Contractual Notice	means a contractual notice issued by NHS England to the CCG or all CCGs (as the case may be) from time to time and relating to the manner in which the Delegated Functions should be exercised by the CCG, in accordance with clause 24.3;
CQC	means the Care Quality Commission;
Data Controller	shall have the same meaning as set out in the GDPR;
Data Processor	shall have the same meaning as set out in the GDPR;
Data Subject	shall have the same meaning as set out in the GDPR;
Delegated Functions	means the functions delegated by NHS England to the CCG under the Delegation and as set out in detail in this Agreement;
Delegated Funds	shall have the meaning in clause 13.1;

Enhanced Services	means the nationally defined enhanced services, as set out in the Primary Medical Services (Directed Enhanced Services) Directions 2014 or as amended from time to time, and any other enhanced services schemes locally developed by the CCG in the exercise of its Delegated Functions (and excluding, for the avoidance of doubt, any enhanced services arranged or provided pursuant to the Section 7A Functions);
Escalation Rights	means the escalation rights as defined in clause 16 *(Escalation Rights)*;
Financial Year	shall bear the same meaning as in section 275 of the NHS Act;
GDPR	means the General Data Protection Regulation
GMS Contract	means a general medical services contract made under section 84(1) of the NHS Act;
Good Practice	means using standards, practices, methods and procedures conforming to the law, reflecting up-to-date published evidence and exercising that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced commissioner;
Guidance	means any protocol, policy, guidance or manual (issued by NHS England whether under this Agreement or otherwise) and/or any policy or guidance relating to the exercise of the Delegated Functions issued by NHS England from time to time, in accordance with clause 24.4;
HSCA	means the Health and Social Care Act 2012;
HSCIC	means the Health and Social Care Information Centre;
Information Law	the GDPR, the Data Protection Act 2018, regulations and guidance made under section 13S and section 251 of the NHS Act; guidance made or given under sections 263 and 265 of the HSCA; the Freedom of Information Act 2000; the common law duty of confidentiality; the Human Rights Act 1998 and all other applicable laws and regulations relating to processing of Personal Data and privacy;

Law	means any applicable law, statute, bye-law, regulation, direction, order, regulatory policy, guidance or code, rule of court or directives or requirements of any regulatory body, delegated or subordinate legislation or notice of any regulatory body (including, for the avoidance of doubt, the Premises Costs Directions, the Statement of Financial Entitlements Directions and the Primary Medical Services (Directed Enhanced Services) Directions 2014 as amended from time to time);
Local Incentive Schemes	means an incentive scheme developed by the CCG in the exercise of its Delegated Functions including (without limitation) as an alternative to QOF;
Local Terms	means the terms set out in Schedule 7 *(Local Terms)*;
Losses	means all damages, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services) proceedings, demands and charges;
National Variation	an addition, deletion or amendment to the provisions of this Agreement mandated by NHS England (whether in respect of the CCG or all or some of other Clinical Commissioning Groups) including any addition, deletion or amendment to reflect changes to the Delegation, changes in Law, changes in policy and notified to the CCG in accordance with clause 22 *(Variations)*;
National Variation Proposal	a written proposal for a National Variation, which complies with the requirements of clause 22.7;
Need to Know	has the meaning set out in paragraph 6.2 of Schedule 4 *(Further Information Sharing Provisions)*;
NHS Act	means the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 or other legislation from time to time);
NHS England	means the National Health Service Commissioning Board established by section 1H of the NHS Act, also known as NHS England;
Non-Personal Data	means data which is not Personal Data;
Operational Days	a day other than a Saturday, Sunday or bank holiday in England;
Particulars	means the Particulars of this Agreement as set out in clause 1 *(Particulars)*;

Party/Parties	means a party or both parties to this Agreement;
Personal Data	shall have the same meaning as set out in the General Data Protection Regulation and shall include references to Special Category Personal Data where appropriate;
Personal Data Agreement	means the agreement governing Information Law issues completed further to Schedule 4 *(Further Information Sharing Provisions)*;
Personnel	means the Parties' employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of either Party (whether or not the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors' and their sub-contractors' personnel;
PMS Contract	means an arrangement or contract for the provision of primary medical services made under section 83(2) of the NHS Act (including any arrangements which are made in reliance on a combination of that section and other powers to arrange for primary medical services);
Premises Agreements	means tenancies, leases and other arrangements in relation to the occupation of land for the delivery of services under the Primary Medical Services Contracts;
Premises Costs Directions	means the National Health Service (General Medical Services Premises Costs) Directions 2013, as amended;
Premises Costs Directions Functions	means NHS England's functions in relation to the Premises Costs Directions;
Primary Medical Care Infrastructure Guidance	means any Guidance issued by NHS England from time to time in relation to the procurement, development and management of primary medical care infrastructure and which may include principles of best practice;

Primary Medical Services Contracts	means: - PMS Contracts; - GMS Contracts; and - APMS Contracts, in each case as amended or replaced from time to time and including all ancillary or related agreements directly relating to the subject matter of such agreements, contracts or arrangements but excluding any Premises Agreements;
Prime Minister's Challenge Fund	means the Prime Minister's challenge fund announced in October 2013 to help improve access to general practice and stimulate innovative ways of providing primary care services;
Principles of Best Practice	means the Guidance in relation to property and investment which is to be published either before or after the date of this Agreement;
QOF	means the quality and outcomes framework;
Relevant Information	means the Personal Data and Non-Personal Data processed under the Delegation and this Agreement, and includes, where appropriate, "confidential patient information" (as defined under section 251 of the NHS Act), and "patient confidential information" as defined in the 2013 Report, The Information Governance Review – "To Share or Not to Share?");
Reserved Functions	means the functions relating to the commissioning of primary medical services which are reserved to NHS England (and are therefore not delegated to the CCG under the Delegation) and as set out in detail in clause 8.2 and Schedule 3 *(Reserved Functions)* of this Agreement;
Secretary of State	means the Secretary of State for Health from time to time;
Section 7A Functions	means those functions of NHS England exercised pursuant to section 7A of the NHS Act relating to primary medical services;
Section 7A Funds	shall have the meaning in clause 13.18.1;
Special Category Personal Data	shall have the same meaning as in GDPR;

Specified Purpose	means the purpose for which the Relevant Information is shared and processed, being to facilitate the exercise of the CCG's Delegated Functions and NHS England's Reserved Functions as specified in paragraph 2.1 of Schedule 4 *(Further Information Sharing Provisions)* to this Agreement;
Statement of Financial Entitlements Directions	means the General Medical Services Statement of Financial Entitlements Directions 2013, as amended or updated from time to time;
Statutory Guidance	means any applicable health and social care guidance, guidelines, direction or determination, framework, standard or requirement to which the CCG and/or NHS England have a duty to have regard, to the extent that the same are published and publicly available or the existence or contents of them have been notified to the CCG by NHS England from time to time;
Survival Clauses	means clauses 10 *(Information Sharing and Information Governance),* 13 *(Financial Provisions and Liability),* 14 *(Claims and Litigation)* 17 *(Termination),* 18 *(Staffing),* 19 *(Disputes)* and 20 *(Freedom of Information)*, together with such other provisions as are required to interpret these clauses (including the Schedules to this Agreement); and
Transfer Regulations	means the Transfer of Undertakings (Protection of Employment) Regulations 2006, as amended."

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From: Clair Bell, Cabinet Member for Adult Social Care and Public Health

To: Kent and Medway Joint Health and Wellbeing Board – 16 September 2021

Subject: **Kent and Medway Joint Health and Wellbeing Board – Co-option of Members**

Classification: **Unrestricted**

Past Pathway of report: None

Future Pathway of report: None

Electoral Division: All

Summary: This report asks the Joint Board to consider re-appointing Dr Bob Bowes as a non-voting member for a further year to July 2022.

Recommendation(s):

The Joint Board is asked to consider and agree the re-appointment of Dr Bob Bowes as a non-voting member for a further year to July 2022.

1. Introduction

1.1 The Kent and Medway Joint Health and Wellbeing Board was established as a joint advisory committee of the health and wellbeing boards of Kent County Council and Medway Council under Section 198(c) of the Health and Social Care Act 2012 for a time limited period of two years commencing on 1 April 2018. On 18 February and 26 February 2020, the Health and Wellbeing Boards of Medway Council and Kent County Council respectively agreed to the continuation of the Joint Board together with the terms of reference and procedure rules set out in Appendix 1 of this report**.**

1.2 Paragraph 5(e) of the terms of reference of the Joint Board provide that it may appoint other persons to be non-voting members as it considers appropriate. In addition, paragraph 5(f) of the terms of reference provides that with the agreement of the Joint Board, voting or non-voting members from the new structures that are emerging in Health may also be included.

1.3 In accordance with this provision the Joint Board at its meeting on 28 July 2020 agreed that Dr Bowes be appointed in a non-voting capacity for a year to July 2021 to support to the clinical chair of the Kent and Medway CCG and in recognition of the work he had done on system transformation and with the Joint Board. (minute number 133 refers) This followed an earlier decision of the Joint Board on 14 December 2018 to appoint Dr Bowes as a voting member of

the Joint Board in his capacity as Chairman of the Strategic Commissioner Steering Group. (minute number 645 refers)

1.4 This report asks the Joint Board to consider re-appointing Dr Bob Bowes as a non-voting member of the Board for a further year to July 2022.

2. Financial Implications

2.1 There are no financial implications arising from the implementation of the recommendation.

3. Legal implications

3.1 The legal and constitutional implications are set out in the paragraphs above.

4. Equalities implications

4.1 There are no equalities implications arising from this report.

5. Recommendation(s):

5.1 The Kent and Medway Joint Health and Wellbeing Board is asked to consider and agree the re-appointment of Dr Bob Bowes as a non-voting member of the board for a further year to July 2022.

6. Background Documents

6.1 Minutes of the meeting of the Kent and Medway Joint Health and Wellbeing Board held on 14 December 2018 and 28 July 2020.

6.2 Minutes of the Medway Health and Wellbeing Board meeting on 18 February 2020 and minutes of the Kent Health and Wellbeing Board meeting on 26 February 2020.

7. Contact details

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Medway Council
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KENT AND MEDWAY JOINT HEALTH AND WELLBEING BOARD

THURSDAY 16 SEPTEMBER 2021

KENT AND MEDWAY PREHABILITATION PROGRAMME

Report from: Dr Tarannum Rampal, Clinical Lead, Kent and Medway Prehab

Author: Scott Elliott, Head of Health and Wellbeing, Medway Council

Summary

The following paper details the progress to date of the innovative Kent and Medway Prehabilitation service that is available for residents with a new cancer diagnosis. The service supports individuals improve their health and wellbeing in advance of starting their cancer treatment, which results in positive short and long term outcomes for the patient and savings to the system.

The board are asked to formally endorse the Kent and Medway Prehabilitation Service.

1. Budget and Policy Framework

1.1 The prehabilitation programme supports the Kent and Medway Joint Health and Wellbeing Strategy priority of "*quality of life for people with long term conditions is enhanced and they have access to good quality care and support".*

1.2 The programme also supports the Kent and Medway Sustainability and Transformation Partnership priorities of "*investing in population health, ensuring prevention is part of every single health and care pathway"* and "*taking positive action on underlying issues, such as smoking, obesity and alcohol consumption, reducing deaths and disability caused by cardiovascular disease, stroke, diabetes, respiratory disease and some cancers such as lung and colon".*

2. Background

2.1 The focus on early cancer diagnosis, increasing prevalence and genetic profiling provides a greater focus for prehabilitation in cancer care. Prehabilitation closely aligns with many elements of the NHS England Long-

Term Plan (LTP) including personalised care, screening and early diagnosis, tackling health inequalities and maximising value.

2.2 Prehab interventions which empower patients to take control of their care are very much aligned with the personalised care agenda. Kent and Medway Prehab team have adopted the national priorities for increased service delivery in the community, upstream prevention of avoidable illness and its exacerbations (e.g. alcohol reduction, reducing obesity and smoking cessation) and better support for patients, carers and volunteers to enhance 'supported self-management' particularly of long-term health conditions. With over 70% of patients affected by cancer having other long term health conditions (LTC) prehab encourages service users to adopt longer term healthy lifestyle behaviours which can impact on long term health.

2.3 The need for prehabilitation, as part of the rehabilitation pathway, starts at the point of diagnosis (and in some cases before a confirmed diagnosis) helping patients prepare for treatment and discharge home. It can help patients get well and stay well and addresses the practical problems caused by the disease and treatment, helping patients become as independent as possible and minimising the impact on carers and support services.

2.4 Prehabilitation interventions, used with population health data can help to tackle health inequalities by offering targeted support for patients' physical and mental health needs. Prehab adds value through reducing short-term harm and resource as well as potentially improving long term behaviour and health. This maps onto the Getting it Right First Time (GIRFT) initiative across surgery and perioperative care.

2.5 Smoking, alcohol consumption, and obesity increase the risk of the development of cancer and other long-term conditions and are closely related to the social determinants of health which in turn are in part geographically determined. Kent and Medway have wards with some of the highest levels of smoking and obesity across the South East. Barriers to high quality, personalised care for socioeconomically deprived people include poorer conversations with health and care professionals, less involvement in decisions about care and treatment and less support after treatment from community and social providers. The Prehab team can further embed personalised care at the point of diagnosis, enhance engagement through the cancer pathway as well as links to community support post treatment.

2.6 If prehabilitation was a desirable step in patients' cancer journey prior to the Covid-19 pandemic, it is indispensable in the post pandemic world. Crucial to understanding why prehabilitation may be valuable during the recovery from a pandemic is to recognise that the strategies that help slow the spread of disease and perhaps reduce its overall incidence—such as social distancing and sheltering in place—could have the unintentional effect of decreasing physical activity and contributing to cardiopulmonary deconditioning. The emotional turmoil from social isolation and delays in treatment have negative consequences far beyond the immediate period. In particular, the elderly, who are most vulnerable to pulmonary complications from coronavirus, may show a decrease in their baseline cardiac and pulmonary fitness that could increase morbidity and mortality.

3. History of Kent and Medway Prehabilitation service

3.1 Following a successful pilot period within Medway Foundation Trust, the Kent and Medway Prehabilitation service moved to a community based service in January 2020 hosted and delivered by the Medway Public Health team, in collaboration with Phase B C.I.C. This community based service was funded by Kent and Medway Cancer Alliance for an initial two year period, which ends on 31st December 2021. The service is far exceeding its annual target of supporting 100 pre cancer treatment patients.

3.2 The service is provided by a highly experienced and knowledgeable team. The team have established and experienced service personnel with a track record of delivering high quality, award winning services. The service has been cited in a number of publications. The team has also established a trusted relationship with secondary and primary care colleagues throughout Kent and Medway. In addition, the service has an active patient participation steering committee, ensuring that the service continues to be influenced by the views and experience of patients.

3.3 The multi-disciplinary team is clinically lead and due to social distancing has been delivered virtually, with a restoration of face to face services likely to resume at some stage in 2021, with the service maintaining a strong virtual support offer as it is well received by patients. Newly diagnosed cancer clients who are referred by a range of clinicians and self-referrals are supported and supervised to become fitter, physically and emotionally in the weeks before their treatment, also receiving nutritional, emotional and other healthy lifestyle specialist advice. This significantly improves treatment outcomes for patients, and leads to reductions in hospital length of stay, excess bed days and emergency re-admissions. Crucially, the programme seeks to embed positive lifestyle changes, meaning that the benefits to patients' health and wellbeing are seen beyond the period of cancer treatment in terms of techniques for a healthier lifestyle.

3.4 Key Benefits of Prehabilitation

- Prehabilitation supports people awaiting cancer treatment to prepare for treatment.
- It promotes healthy behaviours, prescribes and supervises exercise, nutrition and psychological interventions based on a person's needs, to help them find their best way through.
- It has a strong evidence base in its effectiveness and helps to tackle health inequalities. Cancer Prehabilitation is aligned with the personalized care agenda in the NHS Long Term Plan and NICE guidance https://www.bmj.com/content/bmj/369/bmj.m1386.full.pdf
- A Danish study has shown a £430 per patient saving on a prehabilitation integrated programme compared to the standard care programme with the reductions showing in length of stay, postoperative Primary Care and Emergency contacts (Faithfull S, Turner L, Poole K, et al. (2019).
- Prehab offers opportunities to reduce patient length of stay, reduce complications, manage risk factors such as anaemia and malnutrition, and allow more aggressive surgical interventions thereby reducing need to return to surgery.
- Prehabilitation encourages service users to adopt longer term healthy lifestyle behaviours, helping to address the population health problems of obesity,

physical inactivity and smoking, which are the largest preventable causes of cancer. The adoption of lifestyle modification by the services' users offers the benefit of secondary prevention of cancer. (The service has an acceptance and adherence rate of 84%).

- The service also supports mental wellbeing often providing the only regular social contact for patients, particularly during the pandemic restrictions. In July 2020 Public Health England estimated that having a BMI of 35 to 40 could increase a person's chances of dying from covid-19 by 40%, while a BMI greater than 40 could increase the risk by 90%.

3.5 Kent and Medway Prehabilitation has delivered on its feasibility and adoption targets and responded to the challenge of restricted face to face delivery of interventions by becoming one of the first services globally to transit seamlessly to a digital platform. Innovative as always, the service now offers a complete Prehab to Rehab package for patients tailored to their baseline capacity and tumour group.

4. Service delivery and outcomes

4.1 Eligible patients were referred from multiple centres to the regional prehabilitation unit providing home-based "virtual" prehabilitation. Enrolled patients performed prehabilitation prior to commencing cancer treatment. The home-based programme consisted of 1) training exercises, 2) nutritional advice, 3) medical-optimising measures (including referrals to stop smoking and alcohol reduction services) and 4) counselling. The primary outcome was to investigate the feasibility and acceptance of the programme.

4.2 Within the first year of the community based service 300 patients were referred or self referred. Of those patients that were referred, 84% patients agreed to partake. The most common reasons for non-participation included self-perceived lack of benefit, cancer treatment beginning within weeks and did not want to enrol unless it was face-to-face. The mean age was 67 years old (60-73). The mean duration of the programme was 4 weeks (3-9). Paretian classification of health change found 38% of the patients "improved" their health status after prehabilitation ($p=0.092$). Patients significantly improved self-perceived health ($p=0.001$), and fatigue ($p=0.000$).

4.3 Client feedback on the programme has been extremely positive, in terms of the difference that having access to the programme has made to those that have used it. A clear theme of the many positive testimonials received is that clients are treated as individuals, and their needs fully reflected in how the programme works for them individually. Experience and feedback from those that have used the service is also an integral part of developing the programme, and the provider has established a dedicated patient steering committee, which ensures that the programme remains responsive to patient feedback.

4.4 One testimony includes this comment from a lady who accessed the service in 2020 "*My GP asked if I would like to be referred to prehabilitation as I cried down the telephone at him. He explained a little, I said yes. It was the best thing I could have done. I have met a wonderful team of people who have my best interests at heart. It is regular ie. Every week. Same person, Roberto, caring, thoughtful and funny. I have seen student physios, been given*

exercises, diet plans. I also talk with a counsellor, Lyndsey a lovely lady. I feel listened to, cared about and comforted. Excellent service."

5. Future service plans

5.1 The Kent and Medway Cancer Alliance have formally committed to funding a one year extension to the Kent and Medway Prehabilitation Programme. The total funding will be £315k which will enable a further 400 patients to be treated through the programme. The extension will commence on 1 January 2022 and will end on 31 December 2022. For the duration of this extension, the service will transfer to be exclusively delivered by Phase B C.I.C, with Medway Council Public Health team providing support with local delivery in Medway and any transition assistance needed by the lead provider.

5.2 On 5 August 2021, Kent and Medway CCG Clinical Cabinet discussed the prehabilitation service and formally endorsed it. The CCG will continue to discuss longer term funding options to ensure this important and innovative front line service is present for Kent and Medway residents beyond 2022.

6. Risk management

Risk	Description	Action to avoid or mitigate risk	Risk rating
Long term sustainable funding for the service	The Cancer Alliance has committed to funding a scaled up service in 2022, however long term and sustainable funding needs to be secured from the NHS system locally	Approval of a long term funding from Kent and Medway CCG/ Integrated Care System	D2

7. Financial implications

6.1 There are no immediate financial implications resulting from this report. T

8. Legal implications

7.1 There are no legal implications arising from this report.

8. Recommendations

8.1 The Health and Wellbeing Board are asked to endorse and support the Kent and Medway Prehabilitation Service

Lead officer contact

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Appendices

- www.gov.scot/news/investment-for-cancer-services/ - Prehab part of Covid 19 Cancer services Recovery Plan
- https://gov.wales/rehabilitation-framework-continuity-and-recovery-2020-2021-appendix-2-html- Prehabilitation for cancer patient part of the plans
- NIHR recognises the need - https://www.nihr.ac.uk/funding/20142-prehabilitation-living-with-and-beyond-cancer/26350
- www.cancerresearchuk.org/sites/default/files/local-cancer-stats/faversham_and_mid_kent_20200210.pdf
- www.macmillan.org.uk/assets/forgotten-c-impact-of-covid-19-on-cancer-care.pdf
- www.bmj.com/content/bmj/369/bmj.m1386.full.pdf
- www.bmj.com/content/371/bmj.m4130
- https://journals.sagepub.com/doi/abs/10.1177/0310057X20947731
- The feasibility of prehabilitation as part of the breast cancer treatment pathway. Original research, F.Wu, M.El Gammal, and T. Rampal, , 2020. PM&R, 25 Dec 2020, https://doi.org/10.1002/pmrj.12543
- Getting fit for Surgery: A protocol for implementing a breast Prehabilitation service in a district hospital. Fiona Wu, Tara Rampal et al.,2020. European Journal of Surgical Oncology, 2020.03.099. P060 (Abstract only)
- Effects and feasibility of a prehabilitation programme incorporating a low-carbohydrate, high-fat dietary approach in patients with type 2 diabetes: A retrospective study. Laza-Cagigas, R., Chan, S., Sumner, D., & Rampal, T. (2020). Diabetes & Metabolic Syndrome: Clinical Research & Reviews, 14(3), 257–263

From: Clair Bell, Cabinet Member for Adult Social Care and Public Health, Kent County Council

Allison Duggal, Interim Director of Public Health, Kent County Council

To: Kent and Medway Joint Health and Wellbeing Board

Date: 16th September 2021

Subject: Preventing Suicide in Kent and Medway: 2021-25 Strategy

Classification: Unrestricted

Past Pathway: KCC Health Reform and Public Health Committee, Medway Council Overview and Scrutiny Committees

Future Pathway: N/A

Introduction:

This paper provides an update on the suicide prevention programme and includes information on;

- The impact of Covid-19 on suicide rates and the Suicide Prevention Programme
- The Preventing Suicide in Kent and Medway: 2021-25 Strategy (amended following recent public consultation)
- Kent and Medway Better Mental Health Pledge / Prevention Concordat for Better Mental Health
- New Support Service for People Bereaved by Suicide

Recommendation(s):
The Joint Health and Wellbeing Board is asked to;

1) Consider and endorse the Preventing Suicide in Kent and Medway: 2021-25 Strategy
2) Comment on the suicide prevention programme

1. Introduction and context

1.1 The Kent and Medway Suicide Prevention Programme is hosted by Kent County Council's (KCC's) Public Health department and sits within the Public Mental Health portfolio. The majority of the funding for the programme (approx. £480k annually) comes from the Kent and Medway CCG, while KCC PH contribute the costs relating to hosting the programme and the Programme Manager.

1.2 Effective suicide prevention relies on a multi-agency approach and partnerships. Therefore, KCC PH co-ordinates the Kent and Medway Suicide Prevention Network of over 150 organisations, agencies, charities and individuals living with experience of suicidal thoughts, self-harm or bereavement by suicide.

1.3 Suicide rates in Kent and Medway have fallen slightly over recent years, at a time when the national average has stayed virtually unchanged (Table 1).

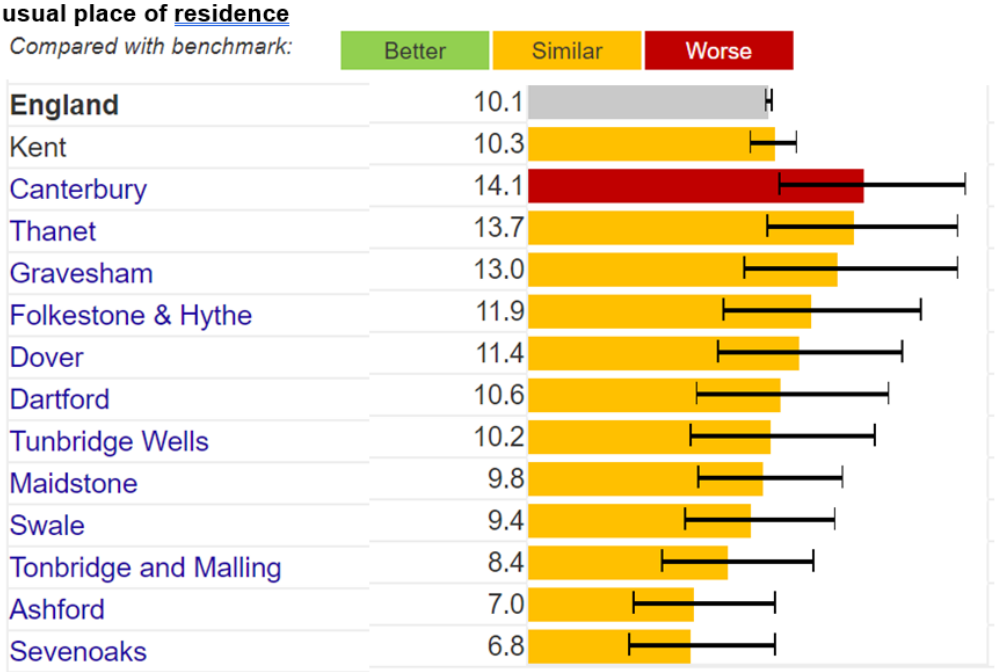
Table 1 Age-standardised suicide rates (per 100,000) rolling three year aggregates, deaths registered 2011 to 2019. (By area of residency, 10+, male and female)

	2013-15	2014-16	2015-17	2016-18	2017-19
England	10.1	9.9	9.6	9.6	10.1
Kent	12.0	11.6	10.5	10.0	10.3
Medway	11.7	11.2	9.7	9.4	8.3

Source:
www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/suicidesbylocalauthority

1.4 There is however, wide variation across Kent as seen in Figure 1 below. Canterbury and Thanet have the highest suicide rates in the county although once confidence intervals are applied, only Canterbury has a statistically worse suicide rate than the national average.

Figure 1: 2017-19 3 year rolling suicide rates by District per 100,000, male & female, 10+, usual place of residence



Source: https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide

2. The impact of Covid-19 on suicide rates and the Suicide Prevention Programme

2.1 It is too early to speculate about the long-term impact of covid-19 on suicide rates. While there is currently no evidence[1] of an increase in overall suicide numbers, we will continue to remain vigilant particularly as the financial protections (eg furlough, mortgage repayment pauses, eviction bans etc) are removed. However national research has indicated that there has been considerable impact of COVID19 on the nation's mental wellbeing and resilience which is why mental wellbeing and listening to people's experience's remains a priority for the suicide prevention strategy and public mental health in general.

2.2 We will also continue to monitor groups in society who may have been at increased risk because of Covid-19. This could include people impacted by domestic abuse or substance misuse or who are part of particular ethnic minority communities.

2.3 The Suicide Prevention Programme responded to Covid-19 in a number of ways, some of which are outlined below;

- We developed Real Time Surveillance System with Kent Police which now provides weekly intelligence on suspected suicides
- We launched a new 24-hour mental health support service via text (which has held an estimated 25,000 text conversations already)
- We increased funding for the 24-hour helpline at the heart of the Release the Pressure campaign (over 20,000 calls last year).
- We secured additional funding for Citizens Advice to support MH initiatives reflecting concerns over the financial impact of Covid-19
- We moved all suicide prevention training (delivered by Mind) onto Zoom (nearly 1000 people completed the workshops last year)

2.4 For a more detailed view of the Suicide Prevention Programme in 2020/21 please see the infographic in Appendix A

3. The 2021-25 Suicide Prevention Strategy

3.1 Throughout 2020, the Suicide Prevention team worked with members of the Suicide Prevention Network to develop a draft 2021-25 Strategy (which covers both Kent and Medway).

3.2 Following early discussions with Network members, it was clear that the majority of stakeholders felt that the previous 2015-2020 Strategy was effective and therefore evolution was needed rather than revolution.

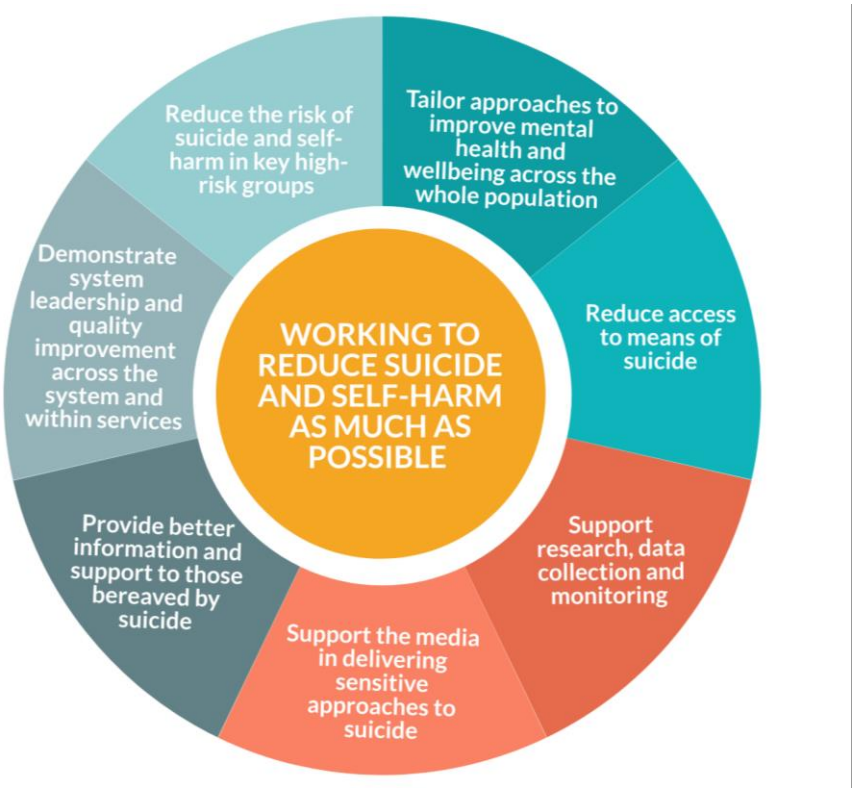
3.3 Therefore the same six Strategic Priorities were rolled forward from the 2015-2020 Strategy into the 2021-25 Strategy. A seventh priority was added around System Leadership. (Please see Figure 1 below).

[1] **Suicide in England in the Covid-19 Pandemic – University of Manchester**

3.4 There were some changes to the high-risk groups identified in the updated strategy. Middle-aged men continue to be the demographic group which sees the highest numbers of suicides, but our Real Time Suicide Surveillance has also highlighted other high-risk groups such as people who misuse substances or who have problematic debt.

3.5 We have also completed nationally unique research highlighting the links between domestic abuse and suicide (of both victims and perpetrators). Therefore people impacted by domestic abuse will also be considered a high risk group going forward.

Figure 1 The seven strategic priorities of the 2021-25 Suicide Prevention Strategy



3.5 The 2021-25 Strategy also features supporting positive mental wellbeing more prominently (as opposed to just responding to people in crisis) when compared to the previous strategy. A Kent and Medway Better Mental Health Pledge is in development (see Section 4 below).

3.6 The final major difference from the 2015 approach is the fact that we have also produced a separate (but aligned) 2021-25 Children and Young People's Suicide Prevention Strategy.

<u>Analysis from the public consultation</u>

3.7 The draft strategy went out to public consultation between early Feb and late March 2021. A full analysis of the responses is included in the Appendix, but a summary is included below.

3.8 *How many people responded to the consultation?*

- 95 responses received through the online form
- 2 additional responses received by email

3.9 *Who responded to the consultation?*

- Most responses were from individual residents of Kent and Medway
- A small number of schools, colleges, parish councils and voluntary sector organisations also responded.

3.10 *What was the consensus view?*

- The vast majority of responses (92%) supported the Strategic Priorities that are set out in the draft strategy
- There was also strong support for the identified high-risk groups within the strategy

3.11 *Did anyone disagree with the contents of the strategy?*

- While there was broad support for the strategy, some people felt that other groups of individuals should be considered high risk, while other people commented that identifying any particular groups was inappropriate and everyone should be treated as an individual
- A lot of responses highlighted that the full impact of COVID-19 on the population's mental health isn't known yet, and the full economic fall out is still to be felt, so additional monitoring and flexibility in the response may be needed
- Some people felt that increased level of priority should be given within the strategy to people who self-harm and who have made a suicide attempt

3.12 *How will the final strategy reflect the comments received by the consultation?*

- Greater emphasis will be given to monitoring the long-term impact of COVID-19 on the mental wellbeing of the population
- The draft strategy and associated action plan have been amended to take account of the feedback received.
- Comments will shape the way specific elements of the action plan are delivered, including the 2021 Innovation Fund and the 2021 research programme.

3.13 The updated Preventing Suicide in Kent and Medway; 2021-25 Strategy

Preventing suicide in Kent and Medway: 2021-2025 Strategy

Updated strategy following public consultation (with updates in red)

1. Reducing the risk in high priority groups

- We will continue to promote the Release the Pressure social marketing campaign, including the 24 hour helpline and the new text support service.
- Where funding allows, we will support innovative approaches to reduce suicide and self-harm amongst high-risk groups.
- We will ensure more integrated and effective support for individuals with both mental health and substance misuse conditions.
- We will offer more effective and sustained support for individuals who self-harm.
- We will continue to offer a range of free to access suicide prevention or mental health training.

We will also work with all relevant partners on specific projects to reduce the risk of suicide and self harm in high risk groups including:

- Middle aged men.
- People with previous suicide attempts / self harm.
- People known to secondary mental health services.
- People who misuse drugs and alcohol.
- People who are impacted by domestic abuse.
- New high risk groups as identified by real time suicide surveillance.

2. Tailor approaches to improve mental health and wellbeing across the whole population

- We will continue to monitor the impact of Covid-19 on the mental health and wellbeing of the population.
- We will develop and implement a Kent and Medway Mental Health Prevention Concordat for Better Mental Health.
- We will continue our integrated and multi-level approach to reducing suicides within the higher and further education communities in Kent and Medway.
- We will develop increased support for individuals with problematic debt.

We will also work with all relevant partners to improve the mental health and wellbeing in high risk groups including:

- LGBTQI+.
- Military and veterans.
- People with learning disabilities.
- Ethnic and religious minorities.
- Individuals impacted by family breakdown.
- Prisoners and other people in contact with CJS.
- Families of people who self-harm.
- Health care staff (who have worked through the pandemic)
- Young women (particularly pre- and post-natal)
- Children and adults with neuro-development disorders.

3. Reduce access to the means of suicide

- We will strengthen our Real Time Surveillance System, ensuring we can work with partners, such as Kent Police, Network Rail, KCC and Medway Council Highways,. Highways England and others to identify, intervene and respond to high risk locations or other means.

4. Support research, data collection and monitoring

- We will review the latest available statistics and evidence about suicide and self-harm.
- We will conduct regular analysis of our Real Time Suicide Surveillance, which will give us the ability to design targeted and evidence based interventions.
- We will conduct or commission bespoke research into emerging or high risk topics.

5. Support the media in delivering sensitive approaches to suicide

- We will work with local, national and social media outlets to promote positive stories about mental health and help-seeking behaviours.
- We will monitor media coverage of incidents and remind journalists of the Samaritans' guidelines for reporting on suicide.
- We will ask editors and reporters to amend inappropriate reporting.

6. Provide better information and support for those bereaved by suicide

- We will commission a new Support Service for People Bereaved by Suicide.
- We will also continue to work closely with the charity Survivors of Bereavement by Suicide with the objective of increasing the number of groups there are available in Kent and Medway.

7. Demonstrate system leadership and quality improvement across the system and within services

- We will continue to develop and strengthen the multi-agency suicide prevention networks.
- We will continue to adopt a whole systems approach to suicide prevention.
- We will work with commissioners and service providers to improve access to high quality service (for examples, through the Community Mental Health Transformation Programme).
- We will design and implement a '*Learning from Suicide*' system and structure.
- We will encourage all partners to play their part in suicide prevention.

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3.14 The updated Preventing Suicide in Children and Young People in Kent and Medway: 2021-25 Strategy on a page

Preventing Suicide in Children and Young People in Kent and Medway: 2021-2025 Strategy

Updated strategy following public consultation (with updates in red)

Actions in **purple** will be funded or led by the Suicide Prevention Team

Actions in **blue** will be funded or led by other partners within the system

1. Reduce the risk of suicide and self-harm in key high-risk groups of children and young people

- We will promote the recommendations made by the 2020 Thematic Analysis into children and young people suicides undertaken by the University of Kent.
- We will continue to provide suicide prevention training for people working with children and young people to increase the probability that high risk individuals will be identified and supported.
- Where funding allows, we will support innovative approaches to reduce suicide and self-harm amongst high risk groups.

We will also work with relevant partners to reduce the risk of suicide and self harm in high risk groups including:

- Children and young people known to mental health services (including the 18-25 transition to adult MH services).
- Children and young people in care and care leavers.
- Children and young people in custodial settings.
- Children and young people with neuro disabilities.
- Children and young people who identify as LGBTQ+.
- CYP who self-harm or engage in other risky behaviour.
- Unaccompanied Asylum-Seeking children and young people.
- Children and young people impacted by Adverse Childhood Experiences (ACES).

2. Tailor approaches to improve mental health and wellbeing of all children and young people in Kent and Medway

- We will continue to monitor the impact of Covid-19 on the mental health and wellbeing of the population.
- We will work with partners to support implementation of the Kent and the Medway Children and Young People Mental Health Local Transformation Plans. We will also support the implementation of the Medway Self-Harm action plan, and the KCC adolescent strategy.
- We will work with partners to ensure that all children and young people have access to a range of easily accessible and evidence-based support services.
- We will support the HeadStart programme to increase resilience amongst children and young people in Kent.
- We will encourage services and education settings to adopt a trauma informed care approach.

3. Reduce access to the means of suicide

- We will further strengthen the Real Time Surveillance System, ensuring we can work with partners, such as Kent Police, Network Rail, KCC and Medway Highways, Highways England and others to identify, intervene and respond to high risk locations or other means.

4. Provide better information and support to those children and young people bereaved by suicide

- We will commission a new all-age Support Service for People Bereaved by Suicide.
- We will work with partners to commission a specialist bereavement support service for children and young people.

5. Support the media in delivering sensitive approaches to suicide

- We will work with local media outlets to place positive stories about how children and young people can improve their wellbeing.
- We will monitor media coverage of incidents and remind journalists of the Samaritans' guidelines for reporting on suicide.
- We will ask editors and reporters to amend inappropriate reporting.

6. Support research, data collection and monitoring

- We will work with all partners (including the Child Death Overview Panel, Kent Police, NELFT and social care teams) to monitor local data relating to suicide and self-harm. This includes establishing a new real time suicide surveillance system and undertaking Positive Practice Audits where appropriate.
- We will review national research, and undertake our own detailed research projects into relevant topics (including, online harms, the impact of domestic abuse and suicide risk amongst young trans people).

7. Demonstrate system leadership and quality improvement in relation to children and young people suicide and self-harm prevention

- We will facilitate the Children and Young People Suicide and Self-Harm Prevention Network ensuring system wide engagement and learning.
- We will invoke the Suicide Prevention Multiple Incident Response Protocol when appropriate to co-ordinate a system wide response.

4. Kent and Medway Better Mental Health Pledge / Prevention Concordat

4.1 The second priority within the new strategy is a commitment to improve the wellbeing of the whole population. One related action is to ensure Kent and Medway sign up to the national Prevention Concordat for Better Mental Health. The aim of which is to galvanise, structure and raise the profile of the work currently underway to improve the mental wellbeing of the population.

4.2 This includes our planning for World Mental Health Day (10th October 2021) where we aim to publicly launch a new Kent and Medway Better Mental Health Pledge and announce a wide number of signatories (eg local authorities, charities, agencies and businesses). Each signatory will be required to develop their own mini action plan which could include initiatives to the support the wellbeing of their own staff as well as the people they work on behalf of (customers, residents, patients etc).

4.3 The wording of the Pledge is as follows;
"We pledge to take action to improve the mental health of our individuals and communities in Kent. We are proud to work with others across Kent and Medway to do the same. To ensure we get it right, we know that we must listen to our local population and to take the time to understand what impacts on their wellbeing."

4.4 In addition we will also be shortly launching the "*Kent and Medway Listens*" project. This will involve working with four community organisations across Kent to have conversations with individuals across the county, particularly those communities which are seldom heard, about their wellbeing after 18 months of living with COVID-19. We want to know what, and how, people are feeling, and what needs to be done (at individual, community or system level) to improve wellbeing.

5. New support service for people bereaved by suicide

5.1 Three years' worth of external funding has been secured to provide a new support service for people bereaved by suicide. This service provides emotional and practical support to individuals and families in the days, weeks and months after the death of a loved one in suspected suicide. They can also provide support to people who have been bereaved by suicide in previous years. The new service (provided by an independent charity Listening Ear) started operating in July 21 and anyone can make referrals by visiting www.amparo.org.uk/refer/

6. Recommendation(s):
The Joint Health and Wellbeing Board is asked to;

1) Consider and endorse the Preventing Suicide in Kent and Medway: 2021-25 Strategy
2) Comment on the suicide prevention programme

7. Appendix

Appendix A 2020/21 Suicide Prevention Programme

Appendix 1 Supporting context and detail for KM Suicide and self-harm prevention strategies 2021-25

Appendix 2 The detailed report analysing the responses to the public consultation to the Kent and Medway Suicide Prevention Strategy

Appendix 3 The detailed report analysing the responses to the public consultation to the Kent and Medway Children and Young People Suicide Prevention Strategy

8. Paper prepared by

Jessica.Mookherjee@kent.gov.uk KCC Public Health Consultant
tim.woodhouse@kent.gov.uk KCC Suicide Prevention Programme Manager

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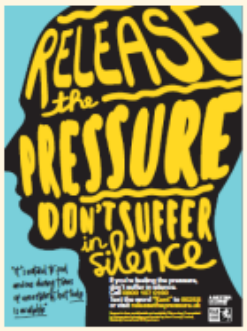
Appendix A 2020/21 Suicide Prevention Programme

Kent & Medway Suicide and Self-Harm Prevention Programme

Annual Report 2020/21

Reducing the risk in high priority groups



20,000 people helped by calling our 24/7 helpline

"You guys are amazing, you have saved my life"

27,000 visitors to www.releasethepressure.uk

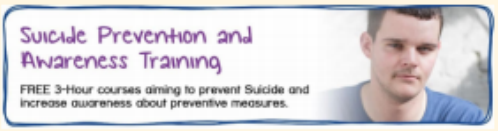
768 people completed our adult suicide prevention training

1,339 people completed our suicide prevention e-learning modules

218 people completed our children and young people suicide prevention training

"I'm really grateful that I had someone to turn to in times of need"

19,000 people found support through our new 24/7 text message support service



Tailored approaches to improve mental health and wellbeing across the whole population

Funded 11 community level projects via the Saving Lives Innovation Fund

Supported delivery of over 800,000 "How are you feeling?" booklets to every household in Kent & Medway

www.kentandmedwayccg.nhs.uk/mental-wellbeing-information-hub

Reduced access to the means of suicide

Kent Police

Developed a new Real Time Surveillance System in partnership with Kent Police, which provides regular insights into the latest incidents.

Supported research, data collection and monitoring

Completed nationally unique research into the relationship between domestic abuse and suicide which is already shaping national and local policy

"We don't know a lot - but we know enough to know that we should be concerned."

Worked with Canterbury Christ Church University on a piece of research 'Factors Deterring and Promoting the Decision to Attempt Suicide at CostalL Locations: A Multi-Methodological Analysis'

Supported the media in delivering sensitive approaches to suicide

Placed a number of positive stories on mental health in local media and corrected insensitive reporting

Provide better information and support for those bereaved by suicide

AMPARO support following suicide

Secured three year funding for a new support service for people bereaved by suicide - https://amparo.org.uk/refer

Distributed over 200 copies of Help is at Hand to funeral directors across Kent & Medway

Secured an additional £450k funding for other suicide prevention projects

BeYou PROJECT

citizens advice

we are withyou

NHS Kent and Medway NHS and Social Care Partnership Trust

Transforming health and social care in Kent and Medway

Supporting context and detail for;

Preventing Suicide in Kent and Medway: Strategy 2021-25, and the Preventing Suicide in Children and Young People in Kent and Medway: Strategy 2021-25

This strategy has been updated following consultation feedback. It is due to go for approval this Autumn, after which the final version will be uploaded to the consultation webpage.

If you have any comments or questions about this document please email suicideprevention@kent.gov.uk

Philosophy:
The ultimate aspiration and motivation is to have zero suicides within our community

Our objective:

To reduce suicide and self-harm as much as possible in Kent and Medway

Contents

Introduction

It is important to understand how this strategy is set out in order to proceed with the consultation process

Overview

Every suicide is a tragic event which has a devastating impact on the friends and family of the victim, and can be felt across the whole community.

This document provides the context and detail for:

The Kent and Medway Suicide and Self-harm Prevention Strategy 2021-25 &

The Children and Young People Suicide and Self-harm Prevention Strategy 2021-25

The economic cost of every suicide in England is estimated at…

£1.7 mil

.. but that pales into insignificance when you consider the pain and grief experienced by families and friends.

"Now that they are gone, I know I will never be truly happy again."

Research has found that up to

135

people are affected to some degree, by every person lost to suicide.

These strategies are the continuation of work undertaken as a result of the **2015-2020 Kent and Medway Suicide Prevention Strategy.**

While local suicide rates have gone **down slightly** in recent years, even one death is one too many so there is still much to be done.

Kent and Medway currently has a **similar rate of suicide** compared to the national average.

These strategy combine evidence from suicide patterns in Kent & Medway with national research and policy direction.

It is clear from both local and national experience that it is not possible for one agency working alone to prevent suicides; most progress can be made when the public sector, charities and companies **work together to deliver a range of measures.**

These strategies have been developed by the Kent and Medway Suicide and Self-harm Prevention Network, which consists of over 130 partners working together to reduce the number of suicides.

A **consultation** (featuring discussions with existing partnerships and an online survey) was undertaken to ensure that the widest number of individuals and organisations had their chance to input into the strategies. Further details can be found on the next slides.

To ensure that these strategies do not discriminate unfairly against any particular group within Kent and Medway, an **equality impact assessment** (EqIA) has also been undertaken, which is available on request.

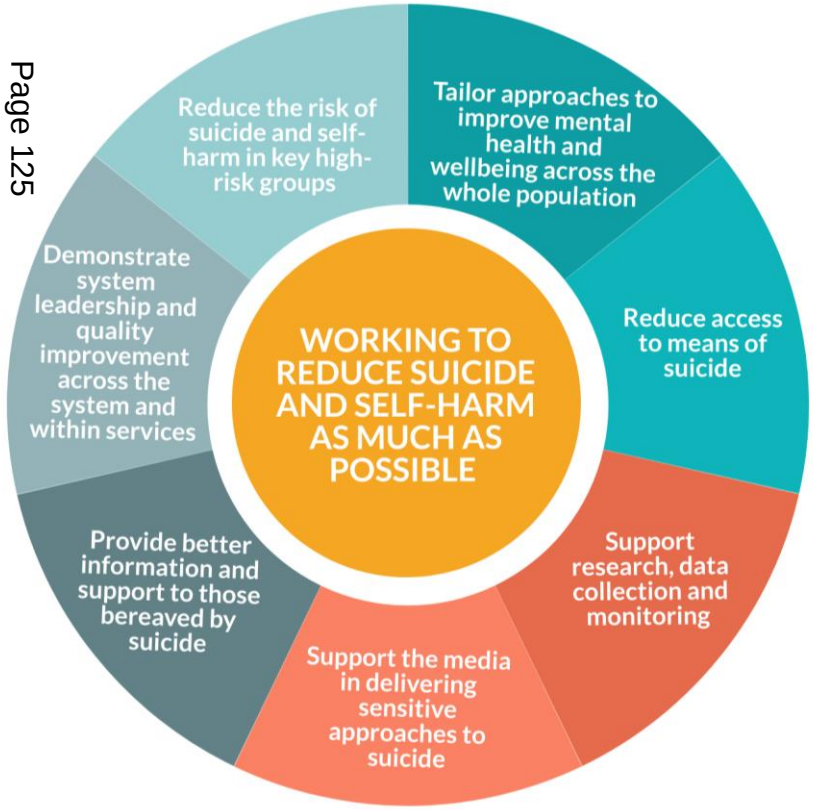
The Suicide Prevention Network will co-ordinate the Strategies' action plan and monitor progress against the strategic priorities at regular meetings.

Consultation process

Consultation process timeline

As part of the consultation process, we invited responses from as many **organisations, agencies and individuals with lived experience** as possible.

During the consultation process we took people's views on our seven strategic priorities;



The public consultation opened on 3rd February 2021 and ran until 18th March 2021.

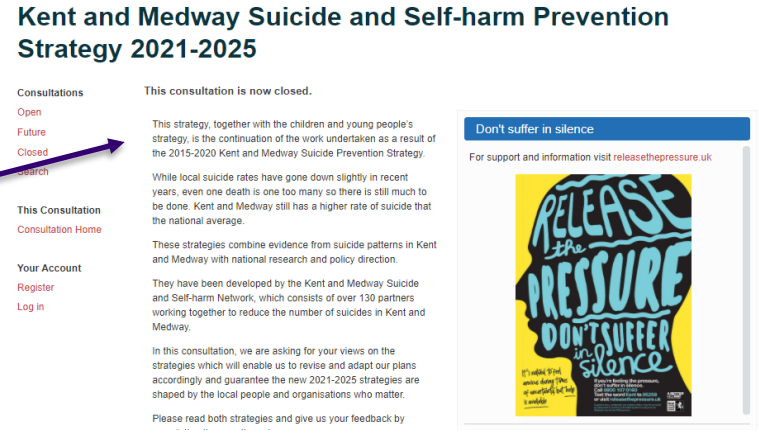
Ensuring we had responses from a range of individuals has allowed us to revise and adapt our plans accordingly and guarantee the **new 2021-2025 strategies are shaped by the local people and organisations who matter.**

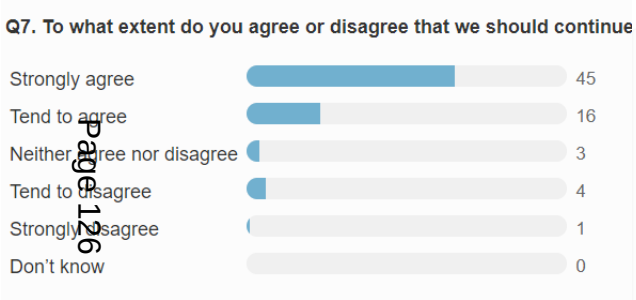
The following documents were available as part of the consultation
The Kent and Medway Suicide Prevention Strategy
The Children and Young People Suicide and Self-harm Prevention Strategy
Supporting context and detail for the Strategies (this document)
Data and evidence updates for both the all-age Strategy and the CYP Strategy
An Equality Impact Assessment

Taking this strategy out to consultation ensures peoples views and experiences are heard; this allows us to further inform our strategy and make amendments where appropriate

Methodology

- 95 responses were received using our online consultation webpage. An additional 2 responses were received by email.





- Quantitative responses were generated through our consultation page.

- Qualitative (free text) responses were analysed using a thematic analysis/coding (involving a lot of reading and re-reading!)

	A	B	C	D	E	F	G	H	I	J
	Insert questions in columns A & B, Row 2 Add a new worksheet for each question	Add codes / theme / category to row 2 - one per column - starting on column C (add more columns as required)								
	Q9. Please let us have any suggestions for specific actions that could be taken to reduce the suicide risk in any of the priority groups.	**Code / Theme 1**	**Code / Theme 2**	**Code 3**	**Code 4**	**Code 5**	**Code 6**	**Code 7**	**Code 8**	**Code 9**
		0	0	0	0	0	0	0	0	0

Demographics

Who responded to the consultation?

71 residents of K&M

1 representative of a local community group

2 On behalf of a council (in an official capacity)

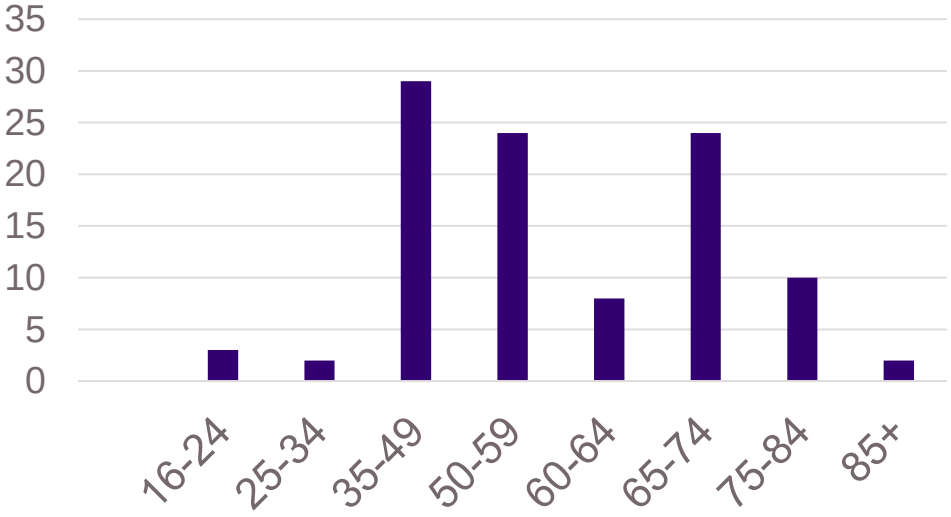
3 Parish/town/ borough/ district/county councillor

4 On behalf of an educational establishment

6 On behalf of a charity or VCS organisation

8 *'other'*

Respondents age range



45% male **53% female**

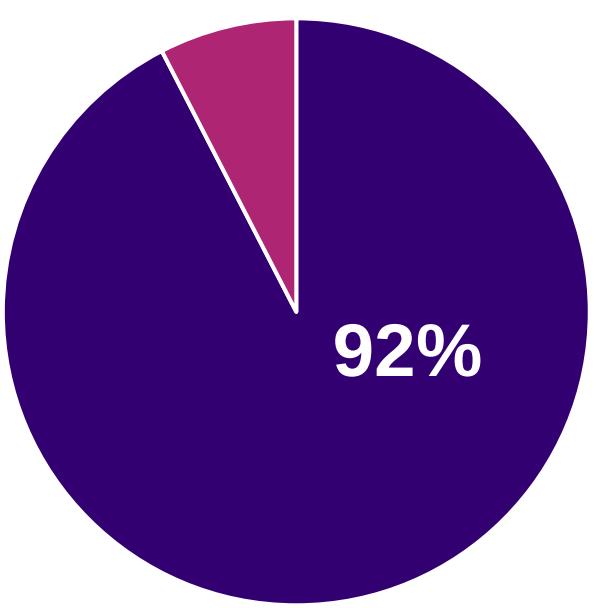
2% preferred not to disclose gender

- **30%** considered themselves to have a disability
- **87%** identified as heterosexual, **8%** identified as bisexual, a gay man or a gay women.
- **84%** were White English, **15%** included individuals who were White Irish, White Other, White Asian, Mixed Other, Asian or Asian British: Pakistani.

Feedback from consultation

The responses were a mix of quantitative and qualitative feedback. We saw **overwhelming support** for our **strategic priorities** and key areas of focus.

Q6 To what extent do you agree or disagree that we should continue to follow national priorities?



Free text responses were analysed and put into key themes. Some examples of recurring themes are as follows (and on the next slides)*

The impact of Covid-19

"The potential risks that Covid-19 has caused, e.g. isolation intensifying / job loss / relationship breakdowns, all will have negative affects and people will need more support ."

How the final Strategy will address these points:

- We will strengthen our actions in monitoring the impact of Covid-19 on the mental health of the population.
- We will conduct an engagement/listening event as part of signing up to the Mental Health Concordat and will ensure the impact of Covid-19 is explored.

*please note these are only some examples of responses.

Feedback from consultation

Engaging and listening to local needs

"There needs to be involvement with the members of the public, as they are the ones who know their areas and communities best."

How the final Strategy will address these points:

- We will continue to follow national strategic priorities, but will make sure that our action plan is adapted to meet the needs of our local population.
- We will conduct an engagement event with seldom heard communities to ensure better understanding of our local public needs.

Training and education

"Better training is needed, especially those who are front line. Everyone should know practical steps and where to signpost"

How the final Strategy will address these points:

- We will continue to invest in suicide prevention training.
- We will continue to promote our Release the Pressure campaign to raise awareness of our two 24-hour support services.
- Promotion of ACE aware training

Feedback from consultation

Specific key groups that need more focus

"Health staff that have worked during the Covid pandemic."

"Help for the individual's family."

"Autistic adults."

How the final Strategy will address these points:

- Our Innovation Fund (of at least £250k) will be launched in 2020/21 to support community level projects to reduce suicide and self-harm in any of the high-risk groups identified.
- This feedback will also inform our programme of bespoke research into emerging or high-risk topics.

Improved support (access and availability)

"There needs to be a simple and clear message so Kent residents know exactly where to find support should they need it."

How the final Strategy will address these points:

- ..continue to promote our Release the Pressure campaign to raise awareness of our two 24 hour support services
- ..continue to invest in suicide prevention training
- ..continue promotion of Help is at Hand resources

National context

Taking a national policy context first, identifies the prevalence of suicides in England, before taking a local and more specific focus

Context

10%

Target to reduce suicide rates across the country by March 2021

The NHS Long-term Plan reaffirms the Government's commitment to making suicide prevention a priority over the next decade.

Page 33

The Long Term Plan commits over

£20.5bil

into the NHS over the next five years…

...including

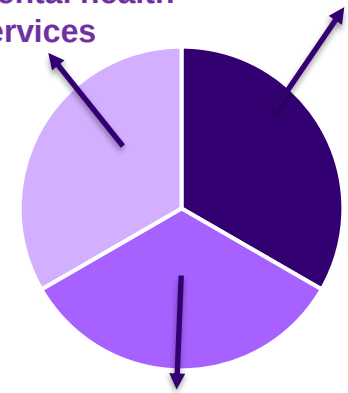
£2.5bil

for mental health

In the year before a death by suicide and in relation to **contact with the NHS**:

Around **1/3** have contact **with secondary mental health services**

Around **1/3** have contact **with primary care only**



Around **1/3** have **no contact with the NHS**

Prevalence

14

people take their own life everyday in England

5,316

registered suicides in 2019 in England

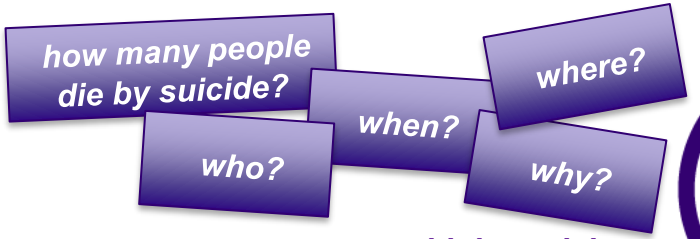
In 2018 the standard of proof used by coroners to determine whether a death was caused by suicide was changed. It is likely that lowering the standard of proof may result in an increased number of suicides.

3/4 of suicide deaths in 2019 were male

males aged **45-49 years** had the highest age-specific suicide rate

rates among the **under 25s** have increased, particularly **10-24 year old** females

To **try and prevent suicides** we need to know…



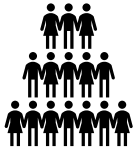
…so we can **target groups at highest risk**.

Kent policy context

It is crucial to understand the Kent policy context, structures and priorities in order to understand where focus and activity is already happening or needed

Context

Kent County Council's Public Health team co-ordinates and leads the Kent and Medway Suicide and Self-harm Prevention Network, which includes a collection of over..



140

individuals representing a variety of agencies, charities and organisations.

We are led by data and evidence, however we are not afraid to try new innovative ideas.

We also lead the Children and Young People Suicide and Self-harm Prevention Network

Monthly update calls and highlight reports ensure our delivery stays on track

The Network developed and owns our 2015-2020 multi-agency suicide prevention strategy and action plan, which follows the national six priorities to reduce suicides:

Kent & Medway priorities
1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health and wellbeing in Kent and Medway
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved by suicide
5. Support the media in delivering sensitive approaches to suicide
6. Support research, data collection and monitoring

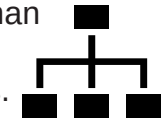
The Strategy is overseen by **KCC, Medway Council** and the **H&WB Board**

Because Kent and Medway suicide rates were higher than the national average, we were selected to be amongst **8 STP areas** to receive additional suicide prevention funding in 2018/19 for three years from **NHS England…**

Kent and Medway CCG have agreed to continue to fund the Suicide Prevention Programme when national funding stops

The 2021-2025 strategy aims to continue, refine and build upon the successful elements of the 2015/20 programme, but also to become more influential in wider parts of the system.

By shaping pathways and changing practice, the long-term impacts of the programme are going to be much more than the sum of the funded elements.



Kent and Medway suicide prevention structures

Kent and Medway Suicide Prevention Strategic Oversight Board

- Consists of Public Health, KMPT and CCG
- Meets monthly
- Responsible for setting strategic direction and taking financial decisions
- Prepares formal reports into KCC, Medway Council and CCG structures

Kent and Medway Suicide Prevention Network

- Consists of over 140 charities, agencies, individuals, academics etc
- Meets quarterly
- Responsible for drafting the 5 year strategy, best practice sharing, facilitating lived experience input, discussing issues and opportunities

Kent and Medway Children and Young People Suicide and Self-Harm Prevention Network

- Consists of charities, statutory agencies, individuals, etc
- Meets quarterly
- Responsible for drafting CYP Chapter for 5 year strategy, best practice sharing, discussing issues

Covid 19 Suicide Prevention Surveillance Group

- Consists of over PH, CCG, KMPT, Live Well, Healthwatch Kent
- Meets fortnightly
- Currently time limited to during coronavirus period

The impact of Covid-19

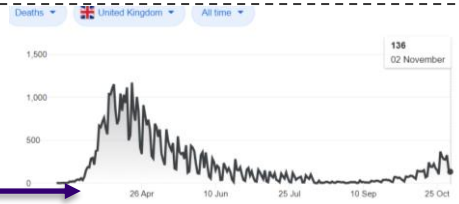
As a result of the current Covid-19 pandemic, the world has changed, therefore, it is important to set this context and look at how we have responded and reacted to the needs of our local population

National impact

The 2020 **Covid-19 global pandemic** has changed everything; how we live, work and socialise.

The various **lockdowns in 2020** resulted in school and work closures, as well as a societal change and strict restrictions and measures never seen before.

As of June 2021, there have been approx. **4.52 million confirmed** cases of the virus, of which has sadly resulted in at least **128K deaths.**



Unfortunately, many people's jobs were been placed on furlough, children remained home, and stressors and insecurity have never been so prevalent.

Lives have been lost as a result of the virus, causing bereavement, anxiety, and uncertainty for the future.

Nationally, in England, modelling predicts that up to **10 million people** (almost 20% of the population) will need **either new or additional mental health support** as a direct consequence of the crisis.

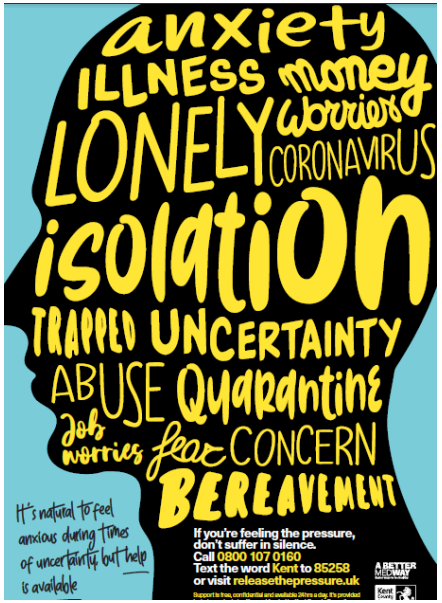
2020 will be remembered as the year the world changed; but so much is still unknown..

- *The mental health implications?*
- *The impact on suicide / self-harm rates?*
- *The impact on other risk factors (i.e. domestic abuse / job loss) that may subsequently impact mental health / suicidality amongst the population.*

Local response

Kent County Council and Medway Council have responded to the Covid-19 pandemic by changing the way some services are delivered and enhancing others.

In response to the mental health impact, **the Release the Pressure campaign was modified** to reflect the coronavirus circumstances. A new 24hr **text support service** was also introduced.



Suicide prevention training continued to be provided by MIND, this is now being presented via zoom. The take up rate of training remained strong during lockdown and there has been positive feedback.

We will continue to monitor the COVID impact and remain flexible to react according to the needs of the population and high risk groups.

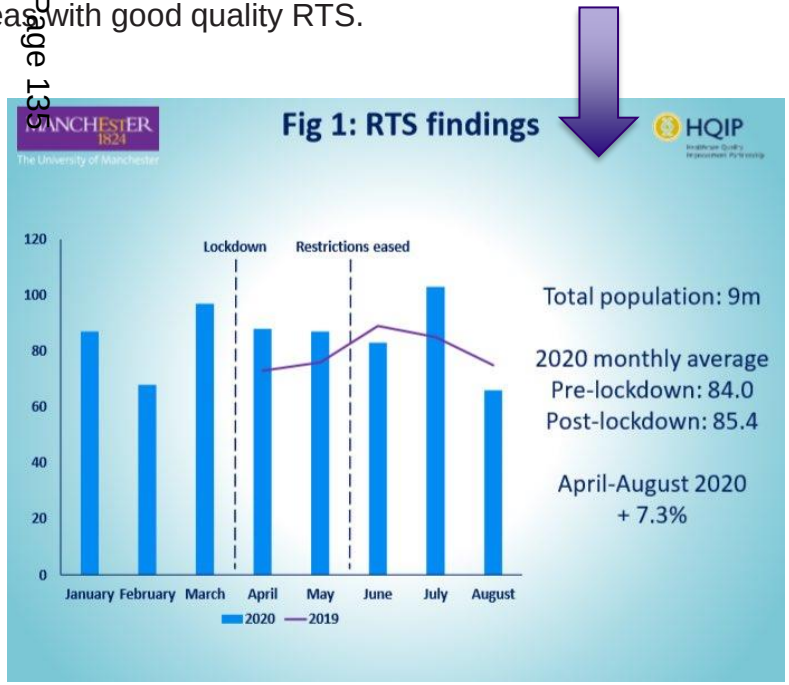
The impact of Covid-19

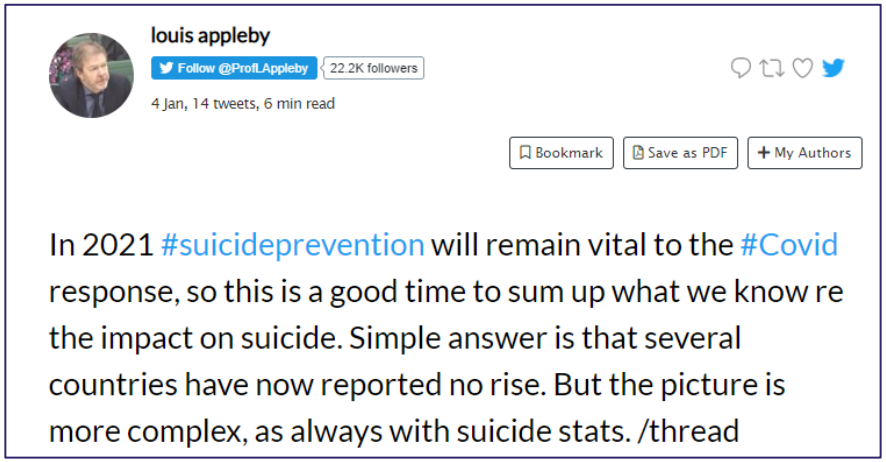
Research findings from NCISH

From the **start of the pandemic**, there was a concern that **suicide rates would rise.**

A number of countries have published national or state-level suicide data. **Most have found no effect.**

NCISH set up a new data collection ***real time surveillance (RTS) -*** as inquests can take months. The table below shows **no change pre – to post lockdow**n, at least in those areas with good quality RTS.





NCISH explained that their **conclusions were cautious.** These are very early figures and may change.

Within the overall finding, there could be different effects between populations sub-groups or geographical areas – after all, **the impact of COVID-19 itself has not been uniform across communities.**

What does this mean for Kent and Medway?

- We have established a new Real Time Suicide Surveillance system with Kent Police and will use it to monitor deaths and the factors influencing the individuals who die. We will respond to any trends and high risk groups we identify.

Suicide rates since 2011

Latest 3-year rolling average age-standardised suicide rates

	2011-13	2012-14	2013-15	2014-16	2015-17	2016-18	2017-19
England	9.8	10.0	10.1	9.9	9.6	9.6	10.1
Kent	10.3	11.4	12.0	11.6	10.5	10.0	10.3
Medway	9.3	11.4	11.7	11.2	9.7	9.4	8.3

Age-standardised suicide rates (per 100,000) for local authorities, rolling three year aggregates, deaths registered 2011 to 2019. (By area of residency, 10+, male and female)

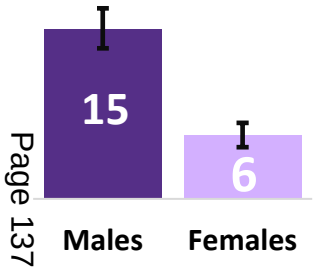
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/suicidesbylocalauthority

Suicide statistics

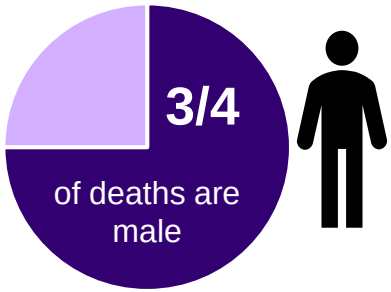
Kent and Medway suicide data

479

deaths from suicide across Kent & Medway in 2017-2019.



Rates per 100,000 population by gender in 2016-2018



Suicide rates in **Canterbury and Thanet** are the highest in Kent.

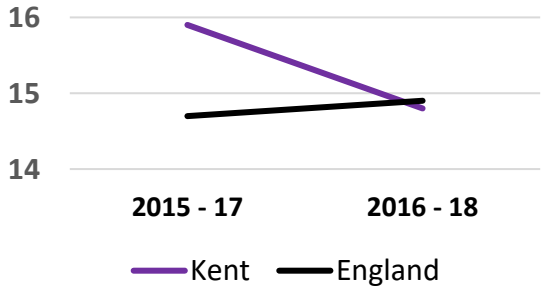
	2015-17	2016-18	2017-19
England	9.6	9.6	10.1
Kent	10.5	10.0	10.3
Medway	9.7	9.4	8.3

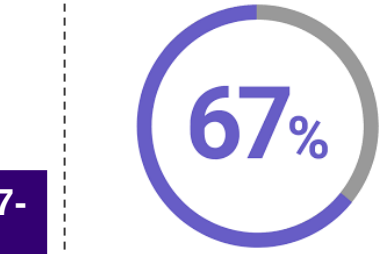
10.3 suicide deaths per **100,000 Kent** population in **2017-2019.**

8.3 suicide deaths per **100,000 Medway** population in **2017-2019.**

Kent and Medway have statistically similar 3-year rolling suicide rates when compared to the national average.

The male suicide rate in Kent has fallen in recent years



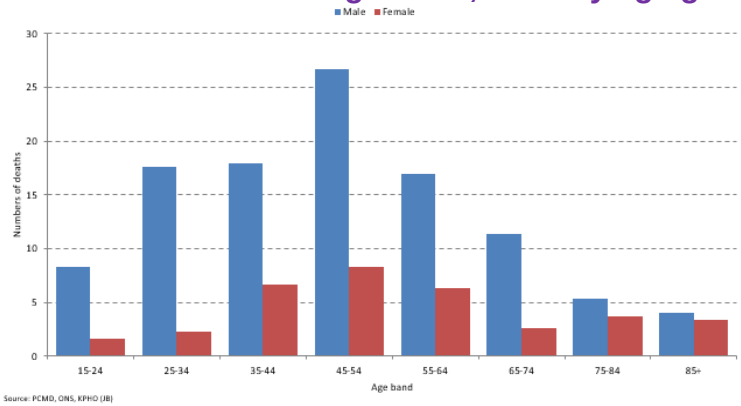


of people who died by suicide in Kent & Medway were…

…**NOT** known to secondary mental health services..

…but many of these people were in contact with primary care.

Middle aged men are at most risk, but deaths by **suicide occur in both genders, in every age group.**



Some **occupational groups** are at a particularly high suicide risk. Kent specific research found an increased suicide-risk for individuals who work in the..

- ❑ manual industry
- ❑ agriculture
- ❑ are unemployed

Debt, domestic abuse and **substance misuse** were additional risk factors relating to suicide attempts.

Self-harm statistics

Kent and Medway self-harm data

50%

of people who die by suicide have a history of self-harm

Self-harm is a marker of mental distress and the single biggest risk factor for suicide

…but not everyone who dies by suicide will have a **history of self-harm…**

…and not everyone who self-harms will go on to **attempt suicide.**

Between 2011/12 and 2015/16 more **young women aged 10-19** were **seen at A&E and admitted into hospital** than young men.

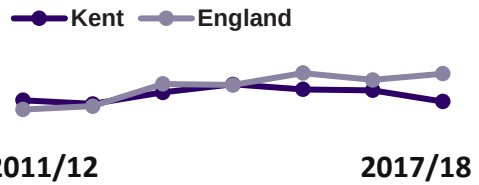
	males	females
A&E	1,060	2,160
hospital admission	620	2,480

1,165

hospital admissions as a result of self-harm per 100,000 Kent and Medway population aged **10-24 years** in 2017/18.

16,733

hospital stays for self harm, per 100,000 in Kent and Medway.



the Kent crude rate of hospital admissions as a result of self-harm in 15 to 19-year old was higher than England in 2011/12, but is now lower than England in 2017/18.

It is estimated that

1in12

young people will self-harm at some point, and it can happen at any age.

It should be noted that **self-harm is a major risk** factor with **older adults** and **national research** is focusing on this age group and the extent of the problem of self harm.

Types of self-harm

There are many different ways people can intentionally self-harm:

- ❑ cutting or burning skin
- ❑ punching or hitting themselves
- ❑ poisoning themselves with tablets or liquid

There are also less risky "replacement" habits which can be encouraged

Research probably **under-estimates** how common self-harm is.

Data is usually based on surveys of people who go to hospital or their GP, but we know a lot of people **do not seek help after self-harming.**

Children and Young People

Kent and Medway Children and Young People

Although deaths by suicide at any age are tragic, deaths amongst children and young people are particularly painful.

Lives ended before they really begin are extremely upsetting for friends, parents, siblings and the whole community.

We have produced a separate **CYP 2021-2025 Suicide and Self-Harm Prevention Strategy.** This is available on request.

The Child Death Overview Panel investigates each individual death of children and young people in Kent.

Any lessons that can be learnt are shared with relevant partners.

The University of Kent have completed a thematic analysis of recent suicides amongst children and young people, to identify trends and opportunities to do things differently. To read the document in full, see link https://tinyurl.com/y2wt3bo3

It is estimated that in Kent and Medway..

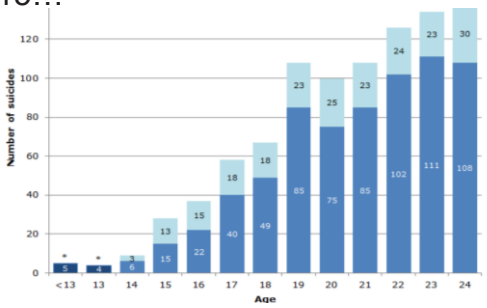
35,856

children and young people have a mental health condition.

Suicides by women under 25 have increased over recent years nationally. These deaths accounted for **10%** of all female suicides in the UK, a similar proportion compared to young men.

National research into children and young people suicides has found:

Of **922 suicides** by people aged **under 25** in England and Wales during 2014-2015…



The number of suicides at each age rose steadily in the late teens and early 20s.

The research also identified several themes:

25% of **under 20s** and **28%** of **20-24 year olds** had experienced **bereavement.**

21% of **under 20s** and **14%** of **20-24 year olds** were **university** or **college students.**

9% of **under 20s** who died had been **'looked after children'.**

6% of **under 20s** and **3%** of **20-24 year olds** were reported to be in the **LGBTQ+ community.**

Self-harm was reported in **52% of under 20s** and **41% of 20-24 year olds** who died.

60% in **both age groups** were **known to secondary mental health services**. Around **40%** had been in **recent contact**.

Review of 2015-2020 strategy

Reviewing the 2015-2020 strategy allows us to look back on what activity has and has not worked well, and what focus is needed for the future strategy.

The 2010-15 Kent and Medway Suicide Prevention Strategy focused on six priority areas. This table captures the headline activity over the last 5 years. (The limited space available means it is far from a complete record but we go into more details on some projects in the next few slides)

1. To reduce the risk of suicide in key high-risk groups we…

- Launched the Release the Pressure social marketing campaign to increase the chances of people seeking help
- Worked with KMPT, primary care and other health partners to increase safety and quality within services
- Funded 50 community level projects through the Saving Lives Innovation Fund
- Added a specific Children and Young People's Action Plan in 2018

2. To tailor approaches to improve mental health & wellbeing in Kent we…

- Funded over 5,000 places over Mental Health First Aid and Suicide Prevention Training
- Supported national campaigns such as Time to Change and Every Mind Matters
- Delivered specific campaigns and programmes with other high risk groups, areas or businesses

3. To reduce access to the means of suicide we…

- Adopted the Kent and Medway Suicide Cluster Protocol in 2016
- Developed an informal surveillance network which regularly identifies unusual patterns or areas of concern
- Funded a major replacement programme of Samaritan's bridge signage in 2018/19
- Worked closely with Network Rail, Highways England and major landowners regarding sites of concern

4. To support research, data collection and monitoring we…

- Conducted an annual analysis of suicide data
- Hosted a Darzi Fellowship to explore help-seeking behaviour amongst men
- Conducted bespoke research into the links between domestic abuse and suicide, as well as the impact of debt
- We commissioned a thematic analysis of suicides amongst children and young people

5. To support the media in delivering sensitive approaches to suicide we…

- Worked with local media outlets to promote positive stories about mental health and help-seeking behaviour
- Contacted editors and reporters when inappropriate reporting is identified
- Promoted the Samaritans Media Guidelines

6. To provide better information and support to those bereaved by suicide we…

- Gave support to local Survivors of Bereavement by Suicide groups (including a new group in Canterbury)
- Funded research into the needs of bereaved families as part of 2019 Innovation Fund
- Promoted Help is at Hand support toolkit to bereaved families

Release the Pressure

Kent and Medway Social Marketing Campaign

The social marketing campaign is designed to..

- Increase awareness of a **24/7 support line**
- Increase **men's willingness** to call the helpline

Since 2015, the 24hr support line at the heart of the campaign has responded to

104,245

calls from people in distress

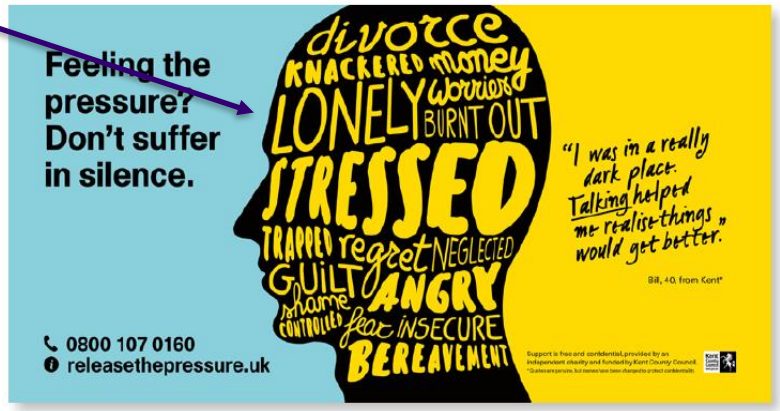
"I hope you realise you have saved my life"

"This service helped keep me alive and got me the help I needed"

"You have all saved my life several times and I thank you from the bottom of my heart"

The campaign highlights **real life events**, rather than mental illness as the potential trigger

24/7 text service available by texting the word **Kent or Medway to 85258**



The campaign is promoted with advertising in **service stations, pubs, on radio, TV and online**

Adverts are used to ensure that when people search for ***'how to kill myself'*** or similar terms, Release the Pressure is the first link they see.

Financial year	Calls handled
2015/16	14,322
2016/17	19,724
2017/18	20,445
2018/19	23,765
2019/20	25,979

113,911

visits to the Release the Pressure webpage from 2016

Other highlights from 2015-2020

Highlighting the impact of recent activity

Suicide Prevention & Awareness Training

mind for better mental health | Maidstone and Mid-Kent

mind for better mental health | West Kent

Supporting adults			Supporting young people		
2,828 people trained			**1,256** people trained		
	Before	**After**		**Before**	**After**
Knowledge	**6/10**	**9/10**	**Knowledge**	**3/10**	**8/10**
Confidence	**5/10**	**8/10**	**Confidence**	**3/10**	**8/10**

"This assisted me when I was talking to someone who was suicidal and I helped prevent them from completing their plan"

"The training you provided came in useful on Friday evening when I spent an hour persuading a young man not to {end his own life}"

1250
people have taken the Suicide Prevention & Awareness e-learning module

Innovation Fund

49
projects funded via year 1 & 2 and legacy fund

The Saving Lives Innovation Fund was **launched in 2018**

The aim is to fund new projects with innovative ideas designed to **prevent suicide, save lives and reduce self-harm**

Over 2000
people were reached through innovation fund projects

1000
of those were not already known to the organisation

"And I believe deep in my heart it {the project} will save lives. In fact, it already has"

"I have learnt to let my emotions out in a better and safer way"

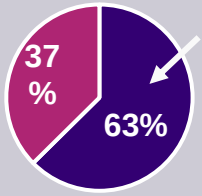
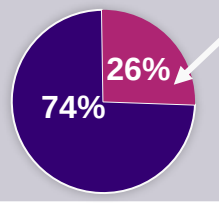
"To hear I'm not alone in how I felt is a comfort. This has been an amazing experience"

Kent and Medway recognised as best practice

- ❑ Invited to join NSPA Steering Group
- ❑ Many requests to speak at national events
- ❑ Release the Pressure and Innovation Fund replicated across the country
- ❑ Two national awards
- ❑ But we are not complacent – there is lots more to be done

Research Impact

We have conducted several pieces of our own research between 2015 & 2020

	Domestic Abuse	Debt	Coroners	Prisons
What we found	Providers were asked to provide data regarding DA and suicidality.  answered **YES** to ***'are you feeling depressed or having suicidal thoughts?'*** National Domestic Homicide Reviews were examined.  **93** DHRs 26% were **completed suicides**; either the victim or perpetrator	Nationally… **1 in 8** people in problem debt (13%) have thought about suicide and **3%** have attempted suicide. **Kent specific research** Of **119** coroner cases **6** specifically noted debt as a specific trigger.	Deep dive study into **119 inquest verdicts.** The most common characteristics were the following: • **Male** –from **50 – 59 years**. • Recent **family breakdown/bereavement** • **Unemployed** • They were **not known to secondary mental health** services • Had a **prior history of mental health issues** • History of **alcohol/drug use**.	Nationally… **1,830** deaths in prison custody from **2008 to 2016** **Kent specific research** • Particular groups of prisoners are at high risk of suicide (**on remand; history of MH, 'lifers**') • Prisons with higher proportion of the 'most vulnerable' prisoners face particular challenges.
How we used the research to shape priorities	• DA providers and staff be trained in suicide prevention training. • Mental health providers and staff to be trained in DA training. • We have funded Oasis Domestic Abuse provider to pilot an '*understanding trauma'* project.	• Funded 2 innovation projects exploring debt. • Borough level workshop to develop a local suicide prevention and self-harm reduction plan • A Money and Mental Heath project with Citizens Advice	• How best to work with the coroners office in the future • Focus on high-risk suicide triggers • Supporting families and friends bereaved by suicide • Consider a real time surveillance to provide impactful bereavement support	• Identify and respond to suicide clusters and contagion • Suicide Prevention training for Kent prison staff • Promotion of Release the Pressure in Prisons

Draft strategic priorities for 2021-2025

Proposing the new draft 2021-2025 strategic priorities ensures that comments and amendments can be made before finalising this strategy

This table sets out the strategic priorities which gained overwhelming support during our public consultation. Our annual workplan produced every year will respond in more detail into each of the below areas.

1. Reduce the risk of suicide in key high-risk groups

- Middle aged men
- People with a previous suicide attempt
- People with a history of self harm
- People known to secondary mental health services
- People who misuse drugs and alcohol
- People who are impacted by domestic abuse
- People with problematic debt
- Children and young people

2. Tailor approaches to improve mental health & wellbeing across the whole population and within the following priority groups

- LGBTQI+
- Military & veterans
- Students
- People with learning disabilities
- Ethnic and religious minorities
- Individuals impacted by family breakdown or separation
- Prisoners and other people in contact with the criminal justice system

3. Reduce access to the means of suicide and self-harm

- Continue informal surveillance network regularly identifies unusual patterns or areas of concern
- Further develop the new Real Time Suicide Surveillance system with Kent Police
- Continue to work closely with Network Rail, Highways England and major landowners regarding sites of concern
- Work closely with Port of London Authority, HM Coastguard, RNLI and other partners with an interest in water safety

4. Support research, data collection and monitoring

- Annual analysis of suicide data
- Bespoke research into new and emerging issues and trends

5. Support the media in delivering sensitive approaches to suicide

- Working with local media outlets to promote positive stories about mental health and help-seeking behaviour
- Contact with editors and reporters when inappropriate reporting is identified
- The promotion of the Samaritans Media Guidelines

6. Provide better information and support to those bereaved by suicide

- Commission a new Support Service for People Bereaved by Suicide
- Continue to support local Survivors of Bereavement by Suicide groups (including encouraging new groups across the county)
- Continued promotion of Help is at Hand

7. Demonstrate system leadership and quality improvement across the system and within services

- Work with commissioners and providers to improve safety and quality.

References

1. https://www.suicideinfo.ca/how-many-people-are-affected-by-one-suicide/
2. https://hgs.uhb.nhs.uk/wp-content/uploads/Suicide-and-Suicide-Prevention_SandB_Handout.pdf
3. https://www.samaritans.org/about-samaritans/research-policy/suicide-facts-and-figures/
4. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2019registrations
5. https://sites.manchester.ac.uk/ncish/

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Preventing Suicide in Kent and Medway: 2021 – 2025 Strategy

Consultation Report

Please note, this strategy has been updated following consultation feedback. It is due to go for approval this Autumn, after which the final version will be uploaded to the consultation webpage.

1. Executive summary

How was the draft Strategy developed?

- It was developed by the Kent and Medway Suicide Prevention Network. A partnership of over 150 organisations and individuals living with experience of suicidal thoughts, self-harm or bereavement by suicide.

How many people responded to the consultation?

- 95 responses received through the online form
- 2 additional responses received by email

Who responded to the consultation?

- Most responses were from individual residents of Kent and Medway
- A small number of schools, colleges, parish councils and voluntary sector organisations also responded.

What was the consensus view?

- The vast majority of responses supported the Strategic Priorities that are set out in the draft Strategy
- There was also strong support for the identified high-risk groups within the Strategy

Did anyone disagree with the contents of the strategy?

- While there was broad support for the Strategy, some people felt that other groups of individuals should be considered high risk, while other people commented that identifying any particular groups was inappropriate and everyone should be treated as an individual
- A lot of responses highlighted that the full impact of COVID-19 on the population's mental health isn't known yet, and the full economic fall out is still to be felt, so additional monitoring and flexibility in the response may be needed
- Some people felt that increased level of priority should be given within the Strategy to people who self-harm and who have made a suicide attempt

What will change as a result of the Consultation?

- The draft Strategy and associated Action Plan will be amended to take account of the feedback received.
- Comments will shape the way specific elements of the Action Plan are delivered, including the 2021 Innovation Fund and the 2021 research programme.

Preventing Suicide in Kent and Medway: 2021 – 2025 Strategy

Consultation Report

Table of Contents

Preventing Suicide in Kent and Medway: 2021 – 2025 Strategy

Consultation Report

1. Introduction:

This document provides a summary of the comments received through the public consultation on the draft Kent and Medway Suicide and Self-Harm Prevention Strategy 2021-2025 and provides recommendations on how these comments should be addressed in the final strategy.

The public consultation also asked for feedback on the draft Children and Young People's (CYP) Suicide Prevention Strategy 2021-2025. A detailed report of the responses received regarding the CYP Strategy can be found in a separate document. (Please email suicideprevention@kent.gov.uk for a copy).

The draft Suicide Prevention Strategy 2021-25 was developed by the Kent and Medway Suicide Prevention Network which is a well-established partnership made up of over 150 agencies, voluntary and community sector organisations and individuals living with experience of suicidal thoughts, self harm or being bereaved by suicide.

The aim of the draft Suicide Prevention Strategy is to reduce suicide and self-harm as much as possible, and the programme will work towards the ultimate philosophy and aspiration of zero suicides within our county.

It should be acknowledged that the Strategy was drafted, and the Public Consultation was held, during the global Covid-19 pandemic. The final impact of the pandemic on the mental health and well-being on the population will not be known for many months if not years, however the Suicide Prevention Programme will ensure the Strategy remains flexible enough to respond appropriately.

2. Consultation process:

In order to develop the Draft Strategy which was the subject of the Public Consultation, the Kent and Medway Suicide and Self-Harm Prevention Network discussed priorities and options during meetings in February and September 2020.

In addition, Medway Council and the Local Government Association ran a Strategy Development workshop in October 2020. This 3-hour workshop focused on reviewing the previous five year strategy and discussing around future strategic priorities. Break out rooms further enabled discussions and helped to shape the content of the draft strategy.

The input of the Kent and Medway Suicide Prevention Network during its regular meetings and through the Medway / LGA workshop was crucial in the development of the draft Strategy.

The slide below illustrates the range of organisations and individuals involved in developing the draft Strategy.

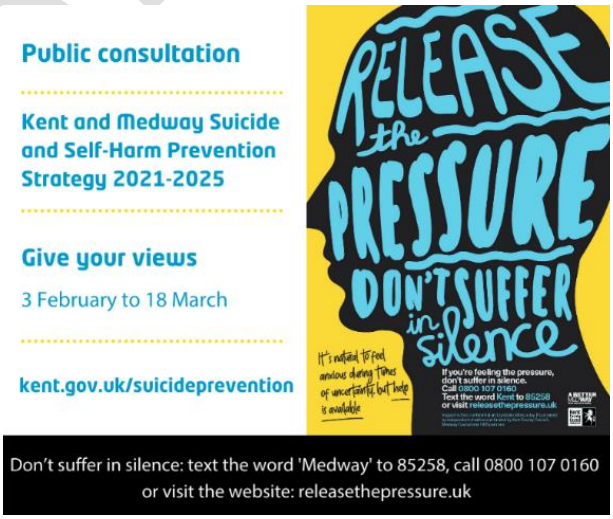
The public consultation period ran from 3rd February - 18th March 2021

The draft strategy, equality impact assessment, consultation questionnaire and other supporting documents were available online at www.kent.gov.uk/suicideprevention

2.1 Consultation and communication methods

Consultation and communication timeline:

Social media imagery example:
Alongside the promotion of the strategy, we promoted the Release the Pressure campaign, to ensure that those engaging with the consultation could seek help and support should they need it.



Equality and accessibility considerations:
KCC undertook the following steps to ensure the consultation was accessible to all:

- All consultation documents and the questionnaire were available to view and respond to online.
- Alternative formats were available on request and all promotional materials included details on how these could be requested. Microsoft Word versions of the strategy, EQIA and other supporting documents were available. There were no requests for alternative formats.

3. Respondents

3.1 Who responded?

The public consultation received 95 responses via the KCC consultation webpage. An additional 2 responses via free text (sent through to the suicideprevention@kent.gov.uk email address). From the 95 responses on the KCC consultation webpage, analysis shows in what capacity individuals were completing the questionnaire:

Table 1: Are you responding on behalf of…?

	Number
A resident of Kent or Medway	71
A representative of a local community group or residents' association	1
On behalf of a Parish / Town / Borough / District Council in an official capacity	2
A Parish / Town / Borough / District / County Councillor	3
On behalf of an educational establishment, such as a school or college	4
On behalf of a local business	0
On behalf of a charity, voluntary or community sector organisation (VCS)	6
Other	8
TOTAL	**95**

3.2 Demographics of respondents

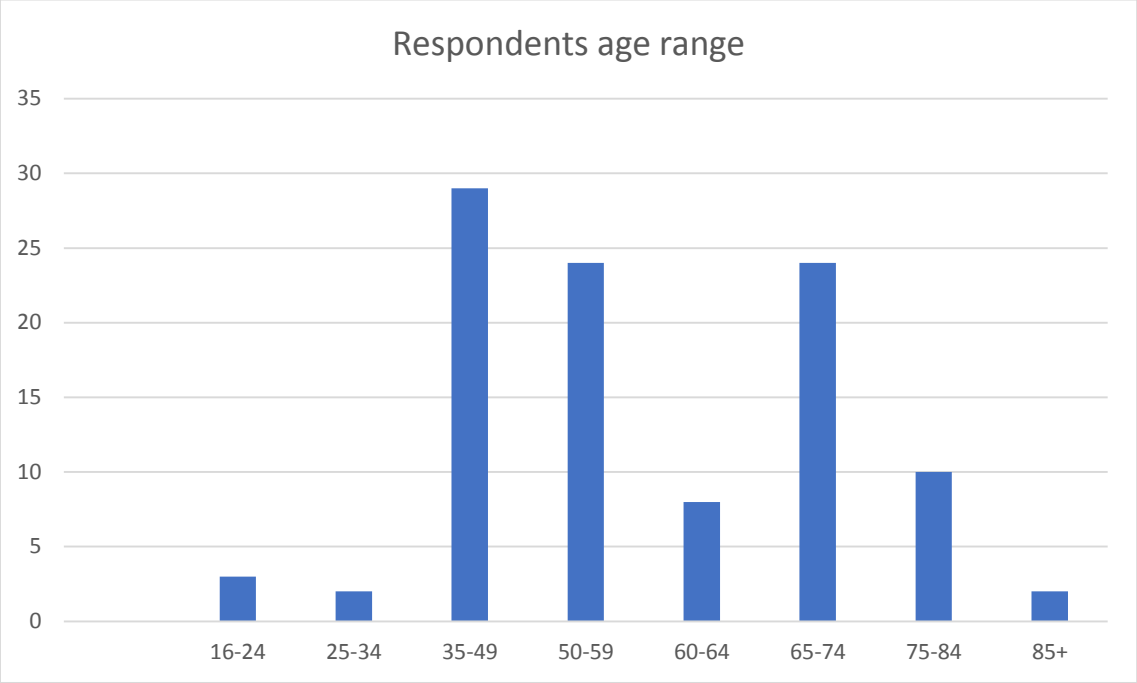
The consultation questionnaire included a series of optional '**about you'** questions, designed to capture anonymous information about the respondents' protected characteristics, such as gender, age, religion and disability. The information is used to check whether there are any differences in the views of different groups and to ensure that our strategic decisions are being made fairly.

The following analysis is based on those individuals that provided information (note that this section was optional, and some individuals preferred not to provide such information and individuals did not have to answer every question). A full profile of the respondents can be found in Appendix 1.

Of the individual respondents who provided information, the gender split was not substantial (45% of respondents were male and 53% were female and 2% preferred not to disclose their gender).

A higher proportion of people aged 35-49 responded to the consultation than any other age group (accounting for 29% of the respondents). This was closely followed by the 50-59 and 65-74 age range (both accounting for 24% of the respondents). The 16-34 age group made up only 5% of respondents. There were no respondents aged under 16, and only 1 respondent aged over 84.

Figure 1: Age of consultation respondents



Analysis of the results indicated that there is no significant variation in opinions or views between age groups, with all age groups showing similar levels of agreement to the questions.

Of those who provided information, 53% regarded themselves as belonging to a religion or belief, slightly lower than the overall population of Kent and Medway (65.5%).

Of the 95 respondents who provided information, 30% considered themselves to be disabled under the Equality Act 2010, this is significantly higher than the overall population of Kent and Medway (16.8%). Further analysis shows that 9 individuals had a mental health condition, 9 individuals had a longstanding illness or health condition, 6

had a physical impairment, 4 had sensory impairment and 1 individual had learning difficulties.

Of the those who provided information, 87% identified as heterosexual/straight. 8% identified as either bisexual, a gay man, or a gay woman/lesbian. 3 individuals 'preferred not to say'.

The final 'about you' section asked respondents about their ethnicity. 84% of respondents that answered, were White English, the remaining 15% included individuals who were White Irish, White Other, White and Asian, Mixed Other, Asian or Asian British: Pakistani and 1% preferred not to say.

4. Consultation responses:

This section will report the responses received for each question in turn. At the end of each Section of the Questionnaire, a highlighted box will outline how we will amend the Strategy as a result of the responses to the questions in that section.

(Please got to **Appendix 2** to see the full questionnaires used in the consultation).

4.1 Section 1 of the Questionnaire

Main Strategy - The review of the 2015-2020 strategy (contained within the supporting context and detail document for the draft 2021-2025 Strategy) highlighted a number of positive developments over the last five years.

Q1 Are you aware of other developments (not highlighted in the review of the 2015-2020 strategy) which should be recognized here?

Response	Number
Yes	11
No	69
Don't Know	14
TOTAL	**94**

Respondents who answered 'Yes' were asked to explain their answers. After conducting an analysis of these responses, four main themes emerged, these included:

- **The impact of Covid-19 –** responses outlined the potential change Covid-19 brings, potential unknowns around impact on mental health and suicides increasing, as well as isolation intensifying or worsening due to lockdowns.

- **The 'user voice'** – individuals noted positive progress enabling people to be honest and share their experiences.
- **Drug use** – discussion included the increase in young people taking legal and illegal drugs as well as the relationship between prescribed drugs and suicide (drugs used for hypertension, acne, depression)
- **Specific groups that need more focus** – these groups included: Supporting autistic adults; Support for those with adverse experiences by those with 'complex emotional difficulties'; Individuals impacted by family breakdown; with focus on middle aged men, relationship breakdown, family separation, victims of domestic abuse isolation, unemployment and debt.

National recommendations and discussions amongst the Kent and Medway Suicide and Self-harm Prevention Network have highlighted the following areas for increased support over the next five years:

- Strengthening support for individuals who self-harm.
- Strengthening support for individuals who have made a suicide attempt.
- Support individuals and families who have been bereaved by suicide.
- Supporting individuals impacted by domestic abuse.

Q2 To what extent do you agree or disagree that improvements can be made in these areas?

Response	Number
Strongly agree / tend to agree	88
Strongly disagree / tend to disagree	1
Neither agree nor disagree	4
Don't Know	1
TOTAL	**95**

Most comments supported the four identified areas above and there were several comments specifically encouraging additional support for individuals who self-harm. Respondents who disagreed were asked to explain their answer. After conducting an analysis of these responses, the following themes emerged:

- **Access to services** - responses outlined the issue of waiting until people reach a threshold to receive help as well as discussing access to CAMHS services needs to improve significantly.

- **Specific groups** – individuals noted several other groups they would like to see increase support, including: Females aged 15-24 years old; Exploring the social effects of the pandemic on young people.

Q3 What specific actions can be taken in relation to any of the above areas?

Responses were free text and hence a lot of qualitative feedback was provided. Respondents were asked to highlight which recommendation they were addressing, and these are detailed below. There are also other free text responses that don't necessarily fit into the four recommendations however, these have also been included to ensure we inform our strategy as closely to the views of the respondents.

Strengthening support for individuals who self-harm (8 responses)

Many responses included the need for mental health services to improve, noting that access is key. On the other hand, individuals also noted how charities and services see self-harm as too risky and therefore reject referrals, more training is needed around this issue. Specific mention of Children and Young People was also highlighted, with the need of schools to offer more support for the individual but also the families. Public awareness was also highlighted, with attitudes towards self-harm being described as more important than resources (ie not "blaming" people who self-harm).

Strengthening support for individuals who have made a suicide attempt (5 responses)

Responses all pointed towards strengthening support for individuals who have made a suicide attempt; individuals discussed the need for better support in the community, regular check-ins, interventions, and immediate support after being hospitalized. Also highlighted was the need for stronger partnerships between Community Mental Health Teams (CMHT) and third sector. Overall, individuals agreed that there is not enough capacity to support individual who need and want help, and a more understanding and responsive environment for individuals who attempt suicide is needed.

Support individuals and families who have been bereaved by suicide (5 responses)

The most common response was ensuring there is a specialized service and/or 1:1 support for individuals who have been bereaved by suicide. Practical advice such as understanding the inquest process/ coroner needs to improve, as well as training/education for front line workers, specifically individuals highlighting social workers and GPs.

Supporting individuals impacted by domestic abuse (6 responses)

Individuals discussed the need for support or funding for Refuges, and ensuring that families know where to turn to for help, including practical steps regarding awareness training for social workers so they appropriately support victims/abusers seeking information. More family support with specialist services is needed, and early intervention must be provided to reduce the long-term effects on family members. The final point made by the respondents, was more recognition needed for male victims of domestic abuse, and having a multi-agency approach to challenging how we currently support these men.

Not specific to the four highlighted recommendations but still noteworthy responses are listed below:

Reaching specific groups

- Accessibility, inclusivity and equality for Deaf and Deaf-Blind people
- Acknowledgement of hormonal/menopausal issues as a trigger of mental health
- A special effort is needed to publicize / reach out to minorities/ethnic groups
- Increased focus for Children and Young People

Support services and increases awareness of what support is available (12 responses)

Respondents discussed the importance of improving access to support and noted that secondary mental health services need to be improved. Individuals also discussed how talking therapies need to be more readily available and waiting times need to improve significantly. Another re-occurring point was ensuing that increased awareness of free resources needs to be made a priority so residents of Kent know exactly what help and support is available to them, when and if they should need it.

Q4 Are there any other areas where you believe improvements can be made?

Response	Number
Yes	59
No	12
Don't Know	22

If respondents answered 'yes' they were asked to provide further detail. Responses were very varied and focused on several areas, these are listed below:

- **Access to services** (2 responses) – Children and Adolescent Mental Health Services (CAMHS) access needs to improve, and delivery of all services needs to improve, especially regarding assessments and waiting lists.
- **Dedicated helpline** (2 responses) – Responses mentioned having a 24 hour mental health crisis service, in order to take pressure off the 999 service.

- **Focus on schools** (7 responses) – Focus was around engaging with young people at secondary school, enabling earlier identification of potential concerns and ensuring swifter support as well as more joined up thinking between schools and all agencies CYP may come into contact with.
- **Public engagement** (4 responses) – Responses discussed how there must be involvement with members of the public who know their areas and communities, as well as having a greater understanding and public awareness about mental health issues.
- **Training** (6 responses) – Individuals explained that better training is needed, especially for professionals who are front line. The breadth of training should also be widened, ensuring that individuals can offer the individual in need of support coping strategies so that they can cope short term, whilst waiting for professional help.
- **Research** (2 responses) – Responses discussed the need for research to be conducted around reducing access and means of suicide in coastal locations, and also opportunities of support groups for specific high-risk groups, with emphasis placed on experiential learning for men.
- **GPs and A&E staff** (4 responses) – Individuals noted the need for these staff groups to be trained and to have empathetic responses when dealing with individuals in need. Furthermore, responses also showed that there was concern for these staff groups too, and more support if needed for them, especially after the impact of the pandemic.

Responses to questions in Section 1 of the Consultation Questionnaire will influence our Strategy and associated Action Plan in the following ways:

We will strengthen our actions in monitoring the impact of Covid-19 on the mental wellbeing of the population.

We will conduct an engagement/listening event as part of signing up to the Mental Health Concordat and will ensure the impact of Covid-19 is explored

An Innovation Fund (of at least £250k) will be launched in 2021/22 to support community level projects to reduce suicide and self-harm in any of the high-risk groups identified.

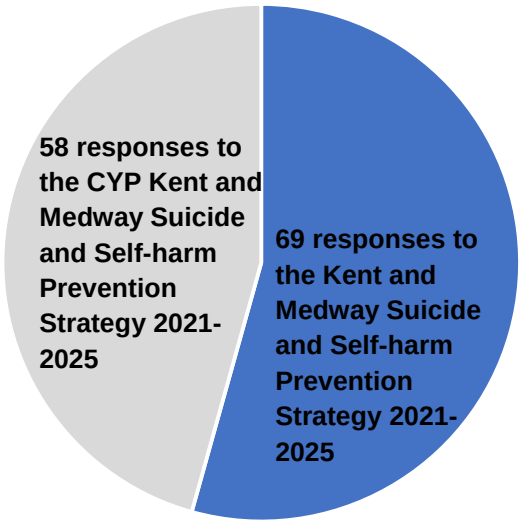
The Suicide Prevention Programme will work with the wider system to ensure improved support for people who self-harm or attempt to take their own life. Including working closely with the Community Mental Health Transformation Programme and the Crisis Care Transformation Programme

This feedback will inform our programme of bespoke research into emerging or high-risk topics.

4.2 Section 2

Q5 You can provide feedback on both the strategies or just one if you prefer, before moving on to Section 5

Figure 2: Response split to main strategy and CYP strategy



Please note than individuals could response to either strategy or both, hence why we have more than 95 responses noted above.

4.3 Section 3

Priorities for the new Strategy

The Suicide Prevention Steering Group believes that it is appropriate to adopt the national priorities below as the priorities for the Kent and Medway Suicide and Self-harm Prevention Strategy.

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring
7. Demonstrate system leadership and quality improvement in relation to children and young people suicide and self-harm prevention

Q6 To what extent do you agree or disagree that we should continue to follow the national priorities as stated above?

Response	Number
Strongly agree / tend to agree	61
Strongly disagree / tend to disagree	5
Neither agree nor disagree	3
Don't Know	1
TOTAL	**69**

If respondents answered 'tend to disagree' or 'strongly disagree' we asked them to explain their reasoning in more detail. After conducting an analysis, responses were separated into five main themes.

Covid-19 – individuals discussed the need to view everyone as 'high risk' post pandemic, specifically with concern around unemployment and impact once furlough schemes end.

Available information – 3 responses noted the importance of having simple and clear messaging, so Kent residents know where to find support should they need it. Practical steps and signposting were also highlighted.

Improvements needed locally – 6 individuals discussed the importance of local intervention and locally-focused actions specific to the local Kent population.

Reducing means of suicide – 3 individuals noted how reducing the access to means of suicide isn't as meaningful or possible to mitigate given that it is impossible to control all aspects of an individuals life; hence, more focus should be given to other areas.

Greater understanding of local public needs – an interesting point that emerged from the responses was ensuring KCC is listening to the needs of the people within our local demographic and understanding high risk groups within our population (i.e debt, housing issues, substance misuse).

Responses to Question 6 will influence our Strategy & Action Plan in the following ways:

We will continue to follow the national strategic priorities, but will make sure that our associated action plan is adapted to meet the needs of our local populations.

We will continue to promote our Release the Pressure campaign to raise awareness of our two 24 hour support options.

We will conduct an engagement event with seldom heard communities to ensure we better understand our local public needs.

Reduce the risk of suicide in key high-risk groups

The National Strategy has identified the high-risk groups, shown below, as priorities for suicide prevention interventions.

Q7 Are these the appropriate high-risk groups you would like to prioritise in the Kent and Medway Suicide and Self-harm Prevention Strategy?

The table shows whether respondents agree or disagree with the high-risk groups.

	Yes	No	Don't know
Young and middle-aged men	60	3	4
People with a previous suicide attempt	60	3	4
People with a history of self-harm	59	2	4
People known to secondary mental health services	57	3	5
People who misuse drugs and alcohol	47	9	7
People in contact with the criminal justice system	48	9	8
Specific occupational groups such as doctors, nurses, veterinary workers, farmers and agricultural workers	46	6	12
People with problematic debt	48	7	11
People who are impacted by domestic abuse	57	3	7
Children and young people	57	3	8

If respondents had answered 'no' to any of the suggested priority groups, they were asked what changed they would like to see made/what groups should be focused on. The responses are below:

- Everyone should be viewed as equal risk (3 responses)
- Health staff that have worked during the Covid pandemic (2 responses)
- LGBTQ+
- Other contributing factors; relationship and family breakdown, eating disorders.

Q7a Please let us have any suggestions for specific actions that could be taken to reduce the suicide risk in any of the priority groups.

People impacted by domestic abuse - Responses included making it easier for victims to find safe accommodation and the means to support themselves. Individuals also

discussed using schools as a safe place to request mental health support.

People with problematic debt Responses discussed linking up with banks or building societies to flag those in high levels of debt and to offer them support.

Children and young people – individuals discussed the need for targeted work with children, ensuring that they say what would help them. Other responses included creating youth and community groups to strengthen young people's self-esteem and increase their resilience. Discussion also focused on the wrap around approach needed from schools and parents, ensuring that CYP are supported, especially those with family issues which could be contributing factors to poor mental health.

Responses to Question 7 and 7a will influence our Strategy & Action Plan in the following ways:

An Innovation Fund (of at least £250k) will be launched in 2021/22 to support community level projects to reduce suicide and self-harm in any of the high-risk groups identified

This feedback will inform our programme of bespoke research into emerging or high-risk topics.

Tailor approaches to improve mental health in specific groups

The previous strategy identified the groups, shown below, as those most in need of measures to improve their mental health.

Q8. Are these the groups that you would like to see identified in the new strategy?

	Yes	No	Don't know
LGBTQ+	43	10	11
Military and veterans	54	4	8
Students	52	10	5
People with learning disabilities	46	6	11
Ethnic and religious minorities	38	13	12
Individuals impacted by family breakdown or separation	57	5	5
Prisoners and other people in contact with the	43	11	11

criminal justice system

Q8a. If you have answered 'no' to any of the suggested groups, what changes would you like to see made?

Responses were split into two main themes here; individuals wanting *other specific groups* and other individuals believing there should *not be specific groups.* More detailed analysis of responses, can be seen below:

Against having specific groups – 6 responses discussed that we need to 'break up the categories' as being part of a specific group should not see individuals get better support or determine what help they receive. Individuals discussed that everyone has issues or challenges within their lives, and not just those with protected characteristics.

Other specific groups need focus -

- Diagnosis of personality disorder
- Individuals with neurodiversity
- Asylum seekers
- Help for the individual's family seeking support, so they can best support them.

Responses to Question 8 and 8a will influence our Strategy & Action Plan in the following ways:

While we understand that every individual has a suicide risk, there is evidence to suggest that certain groups are at higher risk and by targeting campaigns, interventions and research we hope to be able to reduce the risk.

An Innovation Fund (of at least £250k) will be launched in 2021/22 to support community level projects to reduce suicide and self-harm in any of the high-risk groups identified

This feedback will inform our programme of bespoke research into emerging or high-risk topics.

Reduce access to the means of suicide

Reducing a suicidal person's access to lethal means is an important part of a comprehensive approach to suicide prevention.

Q9. How can we reduce suicides in Kent and Medway by controlling access to the means of suicide?

An analysis was conducted on the responses, which saw five key themes emerge, these included:

Unable to control access to the means of suicide – 8 responses said that you simply cannot look over someone's shoulder at all times and therefore, it is very difficult to control / achieve. Individuals noted that more focus needs to be on other preventions rather than this recommendation.

Surveillance – 4 individuals discussed the need for actively monitored CCTV, especially in known places. Responses explained that also closing specific places (coastal car parks/shopping car parks) or adding cameras to flag vulnerable individuals could be useful in reducing the access to the means of suicide.

Practical changes – 10 responses looked at changes that could happen within our local area, with 6 of these individuals specifically noting the importance of increasing the size of bridges and anti-climb proof, and therefore, making it harder for an individual to access. Other responses explained that there needs to be an increased awareness and intervention skills within the community so that those first on the scene are better equipped to deal with the situation (specifically, staff working in high-risk locations).

Research is needed – 4 individuals highlighted the need for research, so we have the intelligence that gives insight into how means of suicide are accessed. Suggestions also included looking at Serious Incident Records as well as contacting fire brigades and coast guards as these are often looked over individuals who may provide useful information and insight to this area. Also discussed were geographically profiling locations which are used more than once for either an attempted or completed suicide, enabling us to remove access if appropriate.

Social media – 5 individuals discussed the importance social media plays in reducing access to the means of suicide, as social media can play a role in promoting certain methods of suicide or self-harm and individuals can access potentially dangerous information and damaging messaging. All responses wanted to see tighter restrictions on social media, removing posts or sites that are damaging and enforce the inclusion of links to support organisations to encourage those who are suicidal to seek help.

Responses to Question 9 will influence our Strategy & Action Plan in the following ways:

We will continue regular analysis of Real Time Suicide Surveillance which will give us the ability to design targeted and evidence-based interventions.

We will conduct or commission bespoke research into emerging or high-risk topics, accounting for the responses given above.

We will consider piloting new technology to reduce the risk relating to high risk locations

We will continue to work closely with Kent Police, Highways England, the Port of London Authority and other land owners

Provide better information and support to those bereaved or affected by suicide

Q10. What is the best way of providing information and support to those bereaved or affected by suicide?

An analysis was conducted on the responses, which saw 5 key themes emerge, these included:

One to one support – 5 individuals explained that the support needed for those bereaved or affected by suicide needs to be one to one support (either face to face or over the phone) as this is thought to offer the most suitable and effective support.

Other forms of support – 10 responses discussed a varied range of support, these included, online support groups (via Facebook), creating a support network of those who have been bereaved by suicide and are willing to talk about their own experiences and coping strategies they have shared and developed, continued promotion of charities such as Survivors of Bereaved by Suicide (SOBS) and GP surgeries being trained in bereavement counselling.

An additional 3 responses noted the need for support within the community (examples that were given included; faith communities, sports clubs, schools, community organisations).

Timely support – 5 individuals discussed the importance of offering support to the families as soon as possible (preferably from the Police), this should be offered as early after the event as possible. Responses also highlighted that a follow-up support service needs to happen, as individuals may not initially accept the offer of support/ bereaved individuals needs support available whenever they need, rather than a set period of time.

An additional 3 responses highlighted the importance of the support being offer for as long as required and to avoid putting a time limit on how long support can be accessed for.

Information and education – 12 individuals highlighted the need for more information resources, specially noting that leaflets should be available (either issued by the Police or from Doctor surgeries). Bereaved individuals need basic information offering support but also practical advice. Responses discussed that written information is useful as it can be used as a tool to build conversations whilst also giving the bereaved person choice when to read the information in their own time. 4 individuals specifically highlighted the need for promotion of support through social media, ensuring individuals know where to go for support and who to contact for advice.

Research into the topic – 5 responses discussed that work needs to be done with individuals bereaved by suicide, to understand what helped or did not help when they were impacted. Individuals suggested both quantitative and qualitative research, as well

as looking at timescales regarding when the support is most needed, as immediate needs are very different to 12+ months later. The responses suggested co-production working with charities and organisations who support those affected by suicide, in order for best practice to be taken forward into Kent and Medway.

Responses to Question 10 will influence our Strategy & Action Plan in the following ways:

These responses will be shared with the provider of our new Support Service of People Bereaved by Suicide (to launch in the summer of 2021) and they will inform and shape the mobilisation and delivery of the new service.

Continued promotion of Help is at Hand resources.

Demonstrate system leadership and quality improvement across the system and within services

Q11. How can we demonstrate system leadership and quality improvement across the system and within services?

An analysis was conducted on the responses, with many varied opinions on how we can demonstrate system leadership and quality improvement across the system and within the service. 3 key themes emerged, which includes:

Promoting awareness and training – 8 individuals discussed the importance of investing in front line, well trained staff, as well as promoting awareness and training to staff and management. Responses focused on education and ensuring information is available and accessible for all.

Accountability and transparency – 7 responses focused on how there needs to be more transparency around lessons learnt from previous cases, ensuring everyone can learn from mistake, as well as having accountability within the services. Individuals highlighted that government needs to give timely direction to councils and engage with senior leadership to develop a common audit tool or framework that can be utilised across a range of settings.

Demonstrate positive practice and what's worked well – 7 individuals believed in sharing worked examples, without divulging any personal information, as an excellent way of showing that the system is working and making a difference. Discussion was around demonstrating success of projects and sharing good practice and what is currently working well.

Responses to Question 11 will influence our Strategy & Action Plan in the following ways:

We will continue to invest in suicide prevention training, including the promotion of ACE aware training.

We will continue to highlight and share best practice as well as learning from serious incidents to reduce future risk

Question 12: Please tell us if you have any other comments about the draft Kent and Medway Suicide and Self-harm Prevention Strategy.

Overall agreement and positive feedback – 6 responses highlighted that the strategy was focusing on the correct areas. Other feedback noted that the strategy was easy to read and very well written. The consultation had also inspired a particular Parish Council to publicise the Release the Pressure campaign around their village.

Highlighting specific groups – 8 responses wanted a final chance to highlight specific groups they were concerned about, these included:

- The large numbers of people who have lost their jobs/livelihoods due to the pandemic.
- The isolated/lonely
- Offering support to families that need help budgeting.
- Broadening the scope to include coastguards, ferry service, fisherman
- Exploring the intersections of groups; focusing on family separation, relationship breakdown, parental conflict, unemployment and debt, isolation and loneliness from a diverse range of ages, socio-economic backgrounds and minority backgrounds
- The Deaf Community and ensuring final and approved strategy and other resources are available in BSL.
- Ensuring support for anyone bereaved by suicide, specifically from the wider network of family and friends as they can be deeply affected.

Responses to Question 12 will influence our Strategy & Action Plan in the following ways:

We will continue to monitor the impact of COVID-19 and in particular the economic impact which has yet to be fully felt.

We will continue to monitor the Real Time Suicide Surveillance for trends and emerging high risk factors.

An Innovation Fund (of at least £250k) will be launched in 2021/22 to support community level projects to reduce suicide and self-harm in any of the high-risk groups identified

5. Equality Analysis

The Equality Impact Assessment (EQIA) for the draft version of the Kent and Medway Suicide Prevention and Self-harm Strategy 2021-25 was overall rated as **low**. After conducting analysis of the consultation responses there is still no evidence to suggest that the 2021-2025 Kent and Medway Suicide Prevention and Self-harm Strategy will have an adverse or negative impact on any protected groups. Therefore the recommended EQIA rating remains as **low.**

6. Next Steps

As a result of the Public Consultation, the draft 2021-25 Kent and Medway Suicide Prevention Strategy and associated Action Plan will be amended in the ways outlined in this report. The amended version of the Strategy will then be taken the following groups for final sign off.

- Kent County Council Health Reform and Public Health Cabinet Committee
- Medway Council: Leaders Meeting, CYP OSC, HASC OSC, Medway Health and Wellbeing Board, Cabinet Committee.
- Kent and Medway Health and Wellbeing Board
- STP MHLDA Board (SBAR report required)
- CCG Clinical Board
- KCC Corporate Management Team

Appendix 1: Respondents 'About You'

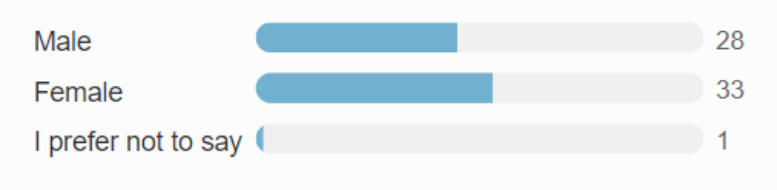
Section 6 – More about you

We want to make sure that everyone is treated fairly and equally, and that no one gets left out. That's why we are asking you these questions. We won't share the information you give us with anyone else. We'll use it only to help us make decisions and improve our services.

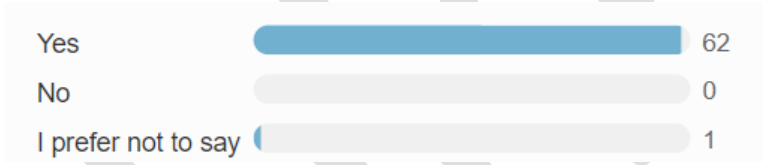
If you would rather not answer any of these questions, you don't have to.

It is not necessary to answer these questions if you are responding on behalf of an organisation.

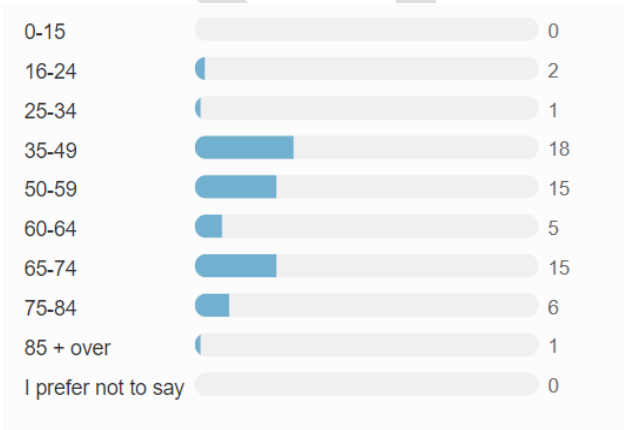
Q27. Are you….? *Please select **one** option.*



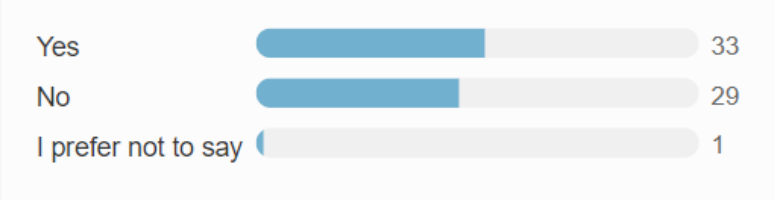
Q28. Is your gender the same as your birth? *Please select **one** option.*



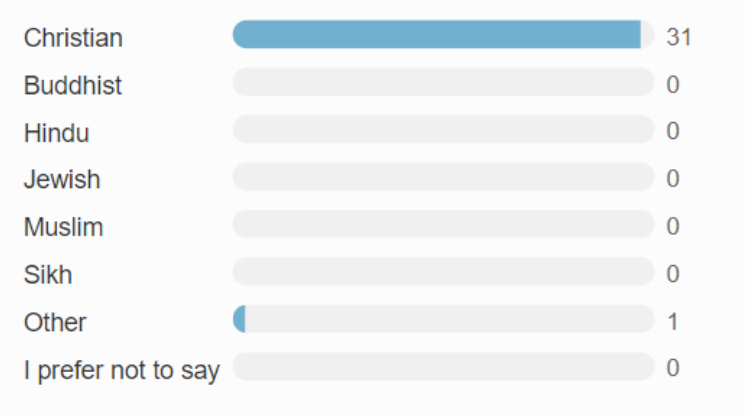
Q29. Which of these age groups applies to you? *Please select **one** option.*



Q30. Do you regard yourself as belonging to a particular religion or holding a belief? *Please select **one** option.*



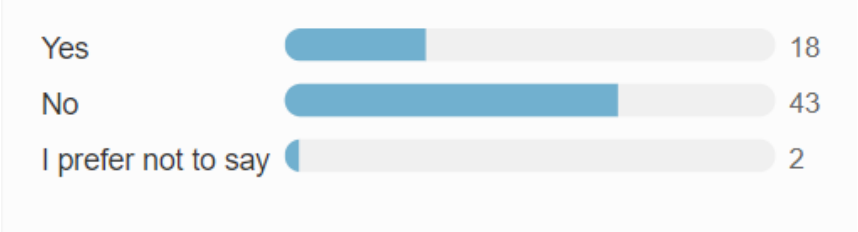
Q30a. If you answered 'Yes' to Q30, which of the following applies to you? *Please select **one** option.*



If you selected Other, please specify:

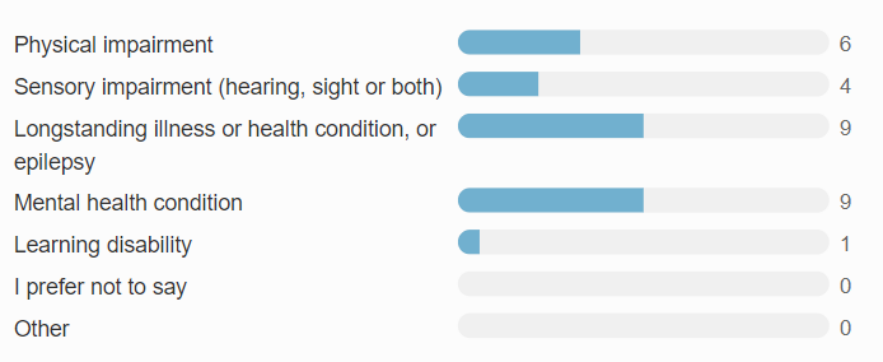
The Equality Act 2010 describes a person as disabled if they have a long standing physical or mental condition that has lasted, or is likely to last, at least 12 months; and this condition has a substantial adverse effect on their ability to carry out normal day-to-day activities. People with some conditions (cancer, multiple sclerosis and HIV/AIDS, for example) are considered to be disabled from the point that they are diagnosed.

Q31. Do you consider yourself to be disabled as set out in the Equality Act 2010? *Please select **one** option.*



Q31a. If you answered 'Yes' to Q31, please tell us the type of impairment that applies to you.

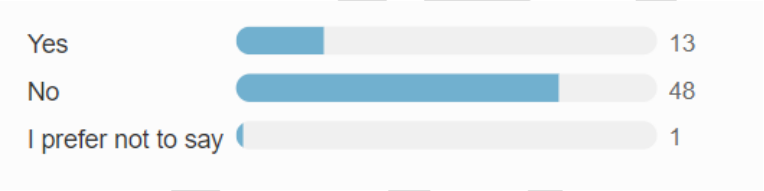
You may have more than one type of impairment, so please select all that apply. If none of these applies to you, please select 'Other' and give brief details of the impairment you have.



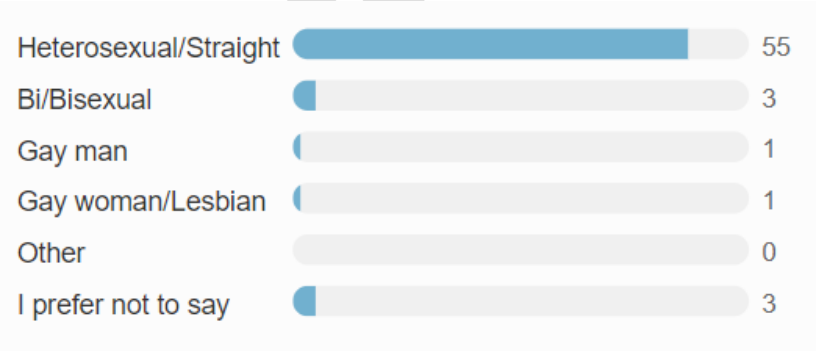
Other, please specify:

A Carer is anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support. Both children and adults can be carers.

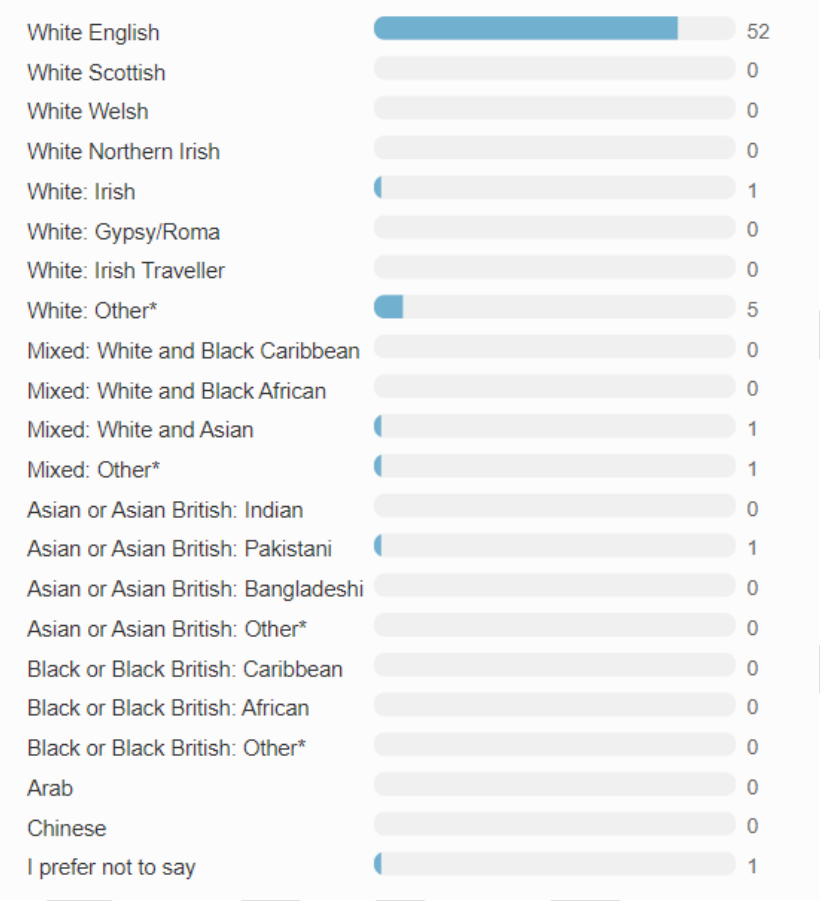
Q32. Are you a Carer? *Please select **one** option.*



Q33. Are you …? *Please select **one** option.*



Q34. **To which of these ethnic groups do you feel you belong?** *Please select **one** option.* (Source 2011 Census)



*****Other - If your ethnic group is not specified on the list, please describe it here:

Appendix 2: Strategy questionnaire (adults)

2021-2025 Kent and Medway Suicide and Self-harm Prevention Strategy Development

Consultation Questionnaire

We are keen to hear your thoughts as we further develop this draft strategy during formal consultation. We have provided this feedback questionnaire for you to give your comments.

What information do you need before completing this questionnaire?

We recommend that you view the consultation material online at kent.gov.uk/suicideprevention before responding to this questionnaire.

If you have any questions regarding these proposals, please email suicideprevention@kent.gov.uk

This questionnaire can be completed online at kent.gov.uk/suicideprevention

Alternatively, fill in this paper form and return to: suicideprevention@kent.gov.uk

Please ensure your response reaches us by midnight on 18 March 2021.

Privacy: Kent County Council (KCC) collects and processes personal information in order to provide a range of public services. KCC respects the privacy of individuals and endeavours to ensure personal information is collected fairly, lawfully, and in compliance with the General Data Protection Regulation and Data Protection Act 2018. Read the full Privacy Notice at the end of this document.

This consultation document should be read in conjunction with the 2021-2025 Kent and Medway Suicide and Self-harm Prevention Draft Strategy, and the associated Equality Impact Assessment. *If you need more space to respond, please continue on a separate piece of paper and return with your responses.*

1) Review of the 2015-2020 strategy

The review of the 2015-2020 strategy (contained within the draft 2021-2025 Strategy) highlighted a number of positive developments over the last five years.

Q1a) Are you aware of other developments (not highlighted in the review of the 2015-2020 strategy) which should be recognised here?

- ☐ Yes
- ☐ No
- ☐ Don't Know

If 'yes', what are they?

National recommendations and discussions amongst the Kent and Medway Suicide and Self-harm Prevention Network have highlighted the following areas for increased support over the next five years:

Strengthening support for individuals who self-harm.
Strengthening support for individuals who have made a suicide attempt.
Support individuals and families who have been bereaved by suicide.
Supporting individuals impacted by domestic abuse.

Q1b) Do you agree that improvements can be made in these areas?

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree nor disagree
- ☐ Disagree
- ☐ Strongly disagree
- ☐ Don't Know

If you selected 'disagree' or 'strongly disagree' please tell us why.

Q1c) What specific actions can be taken in relation to any of the above areas? (*To help us with analysing these results, please make it clear which area you are responding to*)

- ☐ Yes
- ☐ No
- ☐ Don't Know

If 'yes', please give details below

2) Priorities for the new strategy

The Suicide Prevention Steering Group believes that it is appropriate to adopt the national priorities below as the priorities for the Kent and Medway Suicide Prevention Strategy.

i. Reduce the risk of suicide in key high-risk groups
ii. Tailor approaches to improve mental health in specific groups

iii. Reduce access to the means of suicide
iv. Provide better information and support to those bereaved or affected by suicide
v. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
vi. Support research, data collection and monitoring

Q2a) Do you agree that we should continue to follow the national priorities as stated above?

- ☐ Strongly agree
- ☐ Agree
- ☐ Neither agree nor disagree
- ☐ Disagree
- ☐ Strongly disagree
- ☐ Don't Know

If you selected 'disagree' or 'strongly disagree' please tell us why.

3) Reduce the risk of suicide in key high-risk groups

The National Strategy has identified the high-risk groups, shown below, as priorities for suicide prevention interventions

Q3a) Are these the appropriate high-risk groups you would like to prioritise in the Kent and Medway Suicide Prevention Strategy?

	Yes	No	Don't Know
Young and middle-aged men			
People in with a previous suicide attempt			
People with a history of self-harm			
People known to secondary mental health services			
People who misuse drugs and alcohol			
People in contact with the criminal justice system			
Specific occupational groups such as doctors, nurses, veterinary workers, farmers and agricultural workers			
People with problematic debt			
People who are impacted by domestic abuse			
Children and young people			

Q3b) If you have answered 'no' to any of the suggested priority groups, what changes would you like to see made?

.

Q3c) Please let us have any suggestions for specific actions that could be taken to reduce the suicide risk in any of these particular groups? *(To help us with analysing*

these results, please make it clear which priority group(s) you are referring to in your response).

4) Tailor approaches to improve mental health in specific groups

The previous strategy identified the groups, shown below, as those most in need of measures to improve their mental health:

Q4a) Are these the groups that you would like to see identified in the new strategy?

	Yes	No	Don't Know
LGBTQ+			
Military and veterans			
Students			
People with learning disabilities			
Ethnic and religious minorities			
Individuals impacted by family breakdown or separation			
Prisoners and other people in contact with the criminal justice system			

If you have answered 'no' to any of the suggested groups, what changes would you like to see made?

5) Reduce access to the means of suicide
(reducing a suicidal person's access to lethal means) is an important part of a comprehensive approach to suicide prevention.

Q5a) How can we reduce suicides in Kent and Medway by controlling access to the means of suicide?

6) Provide better information and support to those bereaved or affected by suicide

Q6a) What is the best way of providing information and support to those bereaved or affected by suicide?

7) Demonstrate system leadership and quality improvement across the system and within services.

We will use this Strategy to raise the importance of suicide and self-harm prevention with partners and encourage every organisation, community and individual to play their part.

Q7) How can we demonstrate system leadership and quality improvement across the system and within services?

8) Please tell us if you have any other comments about the draft Kent and Medway Self-harm and Suicide Prevention Strategy.

Appendix 3: Strategy questionnaire (CYP)

Consultation Questionnaire

We are keen to hear your thoughts as we further develop this draft strategy during formal consultation. We have provided this feedback questionnaire for you to give your comments.

What information do you need before completing this questionnaire?

We recommend that you view the consultation material online at kent.gov.uk/suicideprevention before responding to this questionnaire.

If you have any questions regarding these proposals, please email suicideprevention@kent.gov.uk

This questionnaire can be completed online at kent.gov.uk/suicideprevention

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Alternative formats: If you require any of the consultation material in an alternative format or language, please email: alternativeformats@kent.gov.uk or call: 03000 42 15 53 (text relay service number: 18001 03000 42 15 53). This number goes to an answering machine, which is monitored during office hours.

1) Priorities for the new strategy.

The Suicide Prevention Steering Group believes that it is appropriate to adopt the national priorities below as the priorities for the Kent and Medway Children and Young People Suicide and Self-harm Prevention Strategy.

vii. Reduce the risk of suicide and self harm in key high-risk groups of children and young people (CYP)
viii. Tailor approaches to improve mental health and wellbeing of all CYP in Kent and Medway
ix. Reduce access to the means of suicide
x. Provide better information and support to those CYP bereaved by suicide
xi. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
xii. Support research, data collection and monitoring
xiii. Demonstrate system leadership and quality improvement in relation to CYP suicide and self-harm prevention

Q1a) Do you agree or disagree that we should continue to follow the national priorities as stated above?

- ☐ Strongly agree
- ☐ Tend to agree
- ☐ Neither agree nor disagree
- ☐ Tend to disagree
- ☐ Strongly disagree
- ☐ Don't Know

If you selected 'tend to disagree' or 'strongly disagree' please tell us why below.

2) Reduce the risk of suicide and self-harm in key high-risk groups of children and young people (CYP).

The National Strategy has identified the high-risk groups of CYP, shown below, as priorities for suicide and self-harm prevention interventions.

Q2a) Are these the appropriate high-risk groups of CYP you think should be prioritised in the Kent and Medway Children and Young People Suicide and Self-harm Prevention Strategy?

	Yes		No	Don't Know
Children and young people known to mental health services – including the 18-25 transition to adult mental health services.				
Children in care and care leavers				
Children in custodial settings				
Children and young people with neuro disabilities				
Children and young people who identify as LGBTQ+				
Children and young people who self harm or engage in other risky behaviour				
Unaccompanied Asylum-Seeking children and young people				
Children and young people impacted by Adverse Childhood Experiences (ACES)				

Q2b) If you have answered 'no' to any of the suggested priority groups, what changes would you like to see made?

.

Q2c) Please let us have any suggestions for specific actions that could be taken to reduce the suicide risk in any of these particular groups? (To help us with analysing

these results, please make it clear which priority group(s) you are referring to in your response).

3) Tailor approaches to improve mental health and wellbeing of all children and young people in Kent and Medway

As a reminder, the actions in the Strategy are:

- We will work with partners to support implementation of the Kent and the Medway CYP Mental Health Local Transformation Plans.
- We will support the implementation of the Medway Self-Harm action plan and the KCC adolescent strategy.
- We will work with partners to ensure that all CYP have access to a range of easily accessible and evidence-based emotional wellbeing support services.
- We will support the HeadStart programme to increase resilience amongst CYP in Kent.
- We will encourage services to adopt a trauma informed care approach.
- We will pilot innovative new ideas to improve wellbeing and reduce self-harm amongst CYP.

Q3a) Do you agree or disagree with the actions above to improve the mental health and wellbeing of all children and young people in Kent and Medway?

- ☐ Strongly agree
- ☐ Tend to agree
- ☐ Neither agree nor disagree
- ☐ Tend to disagree
- ☐ Strongly disagree
- ☐ Don't Know

Q3b) Are there any other actions you would suggest to improve the mental health and wellbeing of children and young people in Kent and Medway?

4) Reduce access to the means of suicide in children and young people.
(Reducing a suicidal person's access to lethal means) is an important part of a comprehensive approach to suicide prevention.

Q4a) How can we reduce suicides in children and young people in Kent and Medway by controlling access to the means of suicide?

5) Provide better information and support to those children and young people bereaved or affected by suicide.

Q5a) What is the best way of providing information and support to those children and young people bereaved or affected by suicide?

6) Support the media in delivering sensitive approaches to suicide.

Q6a) What is the best way of supporting the media in delivering sensitive approaches to suicide?

7) Support research, data collection and monitoring.

Q7a) Are there additional pieces of research that you believe we should be doing regarding suicide and self-harm prevention amongst children and young people?

8) Demonstrate system leadership and quality improvement in relation to children and young people suicide and self-harm prevention.

We will use this Strategy to raise the importance of suicide and self-harm prevention with partners and encourage every organisation, community and individual to play their part.

Q8a) What is the best way to demonstrate system leadership and quality improvement in relation to children and young people suicide and self-harm prevention?

Q9) Please tell us if you have any other comments about the draft Kent and Medway Children and Young People Suicide and Self-harm Prevention Strategy.

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Preventing Suicide amongst Children and Young People in Kent and Medway: 2021 – 2025 Strategy

Consultation Report

Please note, this strategy has been updated following consultation feedback. It is due to go for approval this Autumn, after which the final version will be uploaded to the consultation webpage.

1. Executive summary

How was the draft Strategy developed?

- It was developed by the Kent and Medway Children and Young People (CYP) Suicide Prevention Network. A partnership of nearly 100 organisations and individuals with experience in reducing self-harm and suicide risk amongst CYP.

A public consultation was held regarding both the CYP Suicide Prevention Strategy and the Adult Suicide Prevention Strategy. How many people responded to the consultation?

- In total 95 responses were received through the online consultation portal (2 additional responses received by email)
- Of these, 58 responses were specifically commenting on the CYP Strategy
- However, many of the remaining responses also made points referring to CYP therefore this report includes analysis on all the responses

Who responded to the consultation?

- Most responses were from individual residents of Kent and Medway
- A small number of schools, colleges, parish councils and voluntary sector organisations also responded.

What was the consensus view?

- The vast majority of responses supported the Strategic Priorities and approach that was set out in the draft Strategy.
- There was also strong support for the identified high-risk groups within the Strategy.

Did anyone disagree with the contents of the strategy?

- While there was broad support for the Strategy, some people felt that other groups of individuals should be considered high risk, while others commented that identifying any particular groups was inappropriate and everyone should be treated as an individual
- A lot of responses highlighted that the full impact of COVID-19 on the population's mental health isn't known yet, so additional monitoring is needed
- Some people felt that the importance of schools and education settings should be highlighted and that more support should be given to families of CYP who self-harm

What will change as a result of the Consultation?

- The draft Strategy and associated Action Plan will be amended to take account of the feedback received.

- Comments will shape the way specific elements of the Action Plan are delivered, including the 2021 Innovation Fund and the 2021 research programme.

Table of Contents

Preventing Suicide amongst Children and Young People in Kent and Medway: 2021 – 2025 Strategy

Consultation Report

1. Introduction:

This document provides a summary of the comments received through the public consultation on the draft Preventing Suicide amongst Children and Young People (CYP) in Kent and Medway: 2021-2025 Strategy, and provides recommendations on how these comments should be addressed in the final strategy.

The draft Strategy was developed by the Kent and Medway Children and Young People Suicide Prevention Network partnership (established in 2020) and made up of nearly 100 organisations and individuals with an interest and experience in reducing self-harm and suicide amongst CYP.

The aim of the draft Suicide Prevention Strategy is to reduce suicide and self-harm in CYP as much as possible, and the programme will work towards the ultimate philosophy and aspiration of zero suicides within our county.

It should be acknowledged that the Strategy was drafted, and the Public Consultation was held, during the global Covid-19 pandemic. The final impact of the pandemic on the mental health and well-being of children and young people will not be known for many months if not years, however the Suicide Prevention Programme will ensure the Strategy remains flexible enough to respond appropriately.

2. Consultation process:

Early engagement about the Strategy took place with stakeholders at the Kent and Medway CYP Suicide and Self-Harm Prevention Network meeting in August 2020.

This was then followed up with a half-day workshop specifically to develop the draft Strategy in November 2020. The conference included table workshops with key stakeholders identifying priorities for CYP in the new strategy.

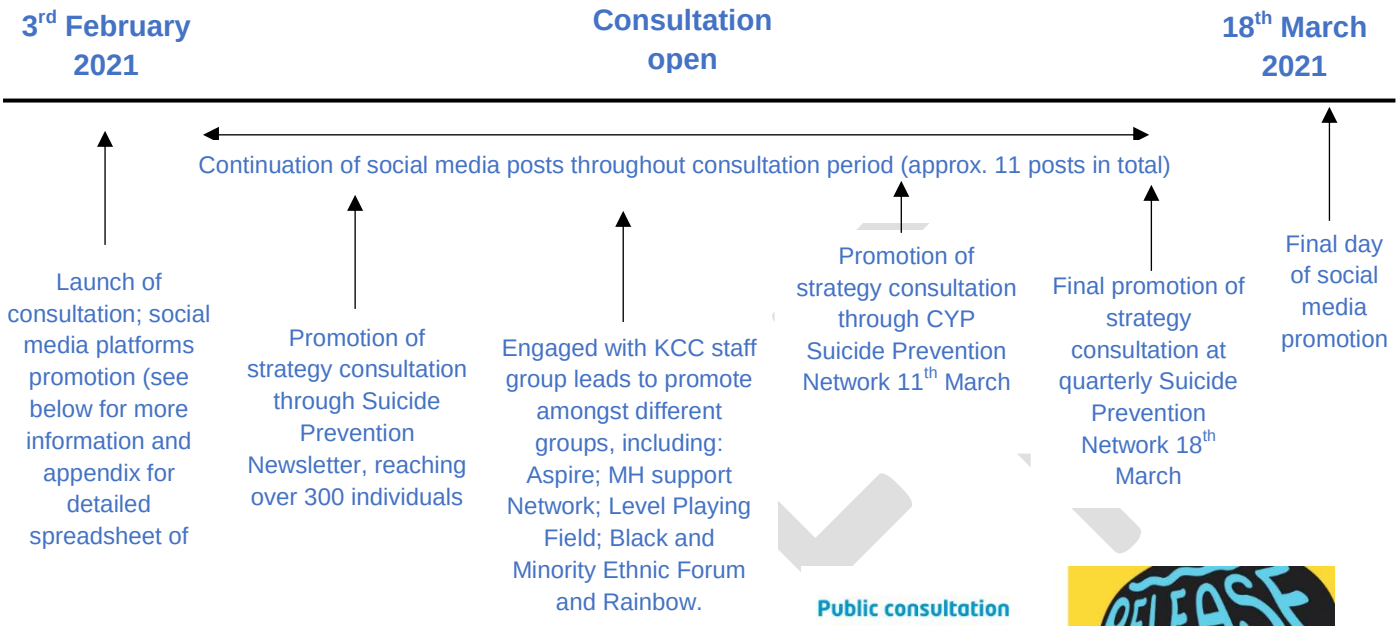
The slide below illustrates the range of organisations and individuals involved in developing the draft strategy.

The March meeting of the CYP Suicide Prevention Network also discussed the Strategy and the public consultation period ran from 3rd February - 18th March 2021.

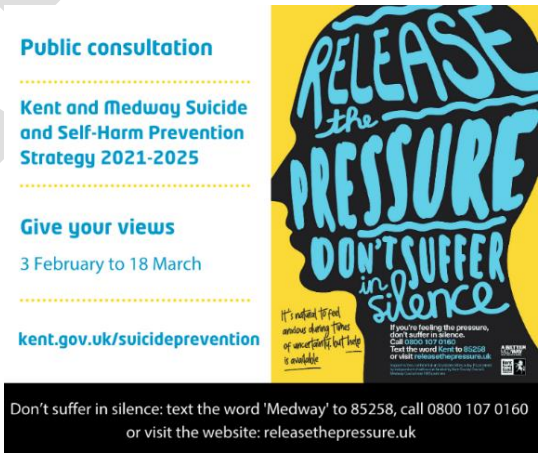
The draft strategy, equality impact assessment, consultation questionnaire and other supporting documents were available online at https://kccconsultations.inconsult.uk/suicideprevention/consultationHome

2.1 Consultation and communication methods

Consultation and communication timeline:



Social media imagery example:
Alongside the promotion of the strategy, we promoted the Release the Pressure campaign, to ensure that those engaging with the consultation could seek help and support should they need it.



Equality and accessibility considerations:
KCC undertook the following steps to ensure the consultation was accessible to all:

- All consultation documents and the questionnaire were available to view and response to online.

- All necessary alternative formats were available during the consultation period and alternative formats were available on request and all promotional materials included details on how these could be requested. Microsoft Word versions of the strategy, EQIA and other supporting documents were available. There were no requests for alternative formats.

3. Respondents

3.1 Who responded?

The public consultation received 95 responses via the KCC consultation webpage. An additional 2 responses via free text (sent through to the suicideprevention@kent.gov.uk email address).

58 responses were specifically commenting only the CYP Suicide Prevention Strategy, however, many of the remaining responses also made points referring to CYP, therefore this report includes analysis of all the responses.

From the 95 responses on the KCC consultation webpage, analysis shows in what capacity individuals were completing the questionnaire:

Table 1: Are you responding on behalf of…?

	Number
A resident of Kent	71
A representative of a local community group or residents' association	1
On behalf of a Parish / Town / Borough / District Council in an official capacity	2
A Parish / Town / Borough / District / County Councillor	3
On behalf of an educational establishment, such as a school or college	4
On behalf of a local business	0
On behalf of a charity, voluntary or community sector organisation (VCS)	6
Other	8
TOTAL	**95**

3.2 Demographics of respondents

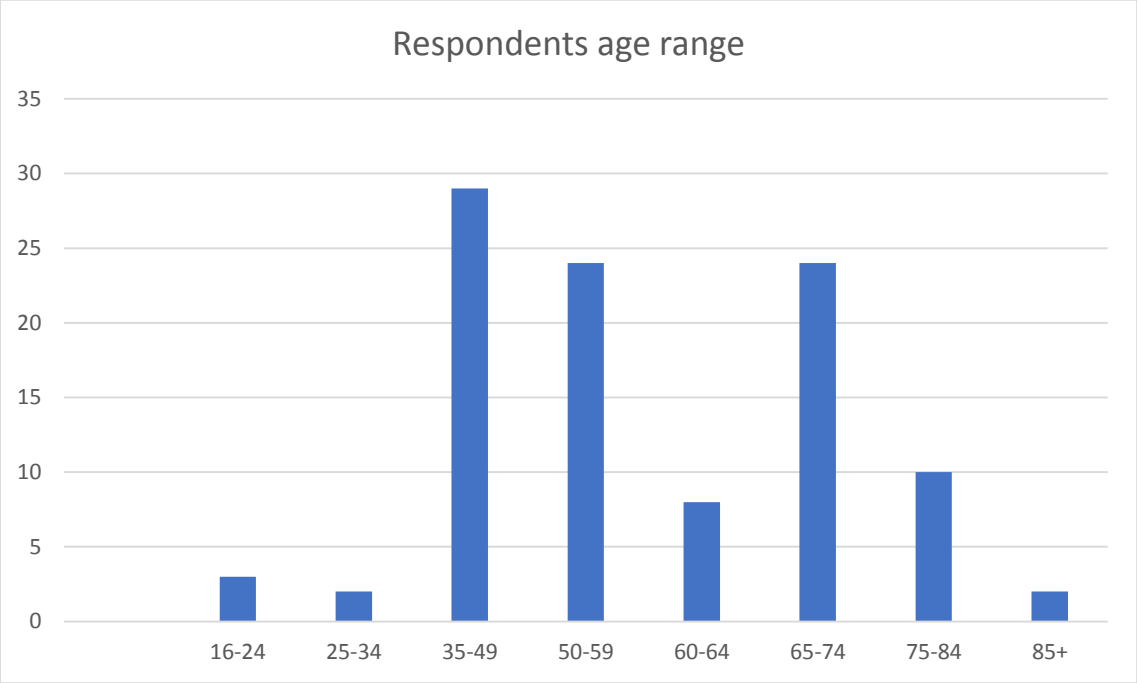
The consultation questionnaire included a series of optional '**about you'** questions, designed to capture anonymous information about the respondents' protected characteristics, such as gender, age, religion and disability. The information is used to check whether there are any differences in the views of different groups and to ensure that our strategic decisions are being made fairly.

The following analysis is based on those individuals that provided information (note that this section was optional, and some individuals preferred not to provide such information and individuals did not have to answer every question). A full profile of the respondents can be found in Appendix 1.

Of the individual respondents who provided information, the gender was split was not substantial (45% of respondents were male and 53% were female and 2% preferred not to disclose their gender).

A higher proportion of people aged 35-49 responded to the consultation (accounting for 29% of the respondents). This was closely followed by the 50-59 and 65-74 age range (both accounting for 24% of the respondents). The 16-34 age group seems under-represented, making up only 5% of respondents. There were no respondents aged under 16, and only 1 respondent aged over 84.

Figure 1: Age of consultation respondents compared to population of Kent and Medway.



Analysis of the results indicated that there is no significant variation in opinions or views between age groups, with all age groups showing similar levels of agreement to the questions.

Of those who provided information, 53% regarded themselves as belonging to a religion or belief, slightly lower than the overall population of Kent and Medway (65.5%).

Of the 95 respondents who provided information, 30% considered themselves to be disabled under the Equality Act 2010, this is significantly higher than the overall population of Kent and Medway (16.8%). Further analysis shows that 9 individuals had a mental health condition, 9

individuals had a longstanding illness or health condition, 6 had a physical impairment, 4 had sensory impairment and 1 individual had learning difficulties.

Of the those who provided information, 87% identified as heterosexual/straight. 8% identified as either bisexual, a gay man, or a gay woman/lesbian. 3 individuals 'preferred not to say'.

The final 'about you' section asked respondents about their ethnicity. 84% of respondents that answered, were White English, the remaining 15% included individuals who were White Irish, White Other, White and Asian, Mixed Other, Asian or Asian British: Pakistani and 1% 'preferred not to say'.

4. Consultation responses:

This section will report the responses received for each question in turn. At the end of each Section of the Questionnaire, a highlighted box will outline how we will amend the Strategy as a result of the responses to the questions in that section.

(Please got to **Appendix 2** to see the full questionnaires used in the consultation).

4.1 Section 1

CYP Strategy - Priorities for the new Children and Young People strategy

The Kent and Medway Children and Young People Suicide Prevention Network believes that it is appropriate to adopt the national priorities below as the priorities for the Kent and Medway Children and Young People Suicide and Self-harm Prevention Strategy.

1. Reduce the risk of suicide and self-harm in key high-risk groups of children and young people
2. Tailor approaches to improve mental health and wellbeing of all children and young people in Kent and Medway
3. Reduce access to the means of suicide
4. Provide better information and support to those children and young people bereaved by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring
7. Demonstrate system leadership and quality improvement in relation to children and young people suicide and self-harm prevention

Q1 To what extent do you agree or disagree that we should continue to follow the national priorities as stated above?

Response	Number
Strongly agree / tend to agree	53
Strongly disagree / tend to disagree	3
Neither agree nor disagree	0

Don't Know	0
TOTAL	**56**

Respondents who answered 'disagree or strongly disagree' were asked to explain their answered. After conducting an analysis of these responses, three main themes emerged, these included:

- **Innovative ideas needed –** responses here focused around the idea of innovative projects, for example, paid gym memberships, swimming passes, or personal training in small groups offer for those struggling. Another individual discussed the importance of making them feel cared about and that they have options for education and training, as well as free to access community resources.

- **Parents and family are key**– four responses looked at the critical role families play, noting that parents should have access to key information, ensuring they can help support their child if needed. Another response looked at facilitating early support for parents noting and/or notifying potentially suicidal behaviour. Lastly, another individual discussed the importance that parents should be able to disclose any fears and dilemmas that they may experience as parents; subsequently, offering a system for them to speak in confidence to someone about their concerns about their child, enabling them to better support their child and also themselves.

- **Education** –A couple of responses acknowledged the need for education about mental health, mental wellbeing and how to look after it, and this notion needs to happen earlier on and should be discussed in schools as physical health is.

The final Strategy will take these responses into account in the following ways:

We will continue to follow the national strategic priorities, but will make sure that our associated action plan is adapted to meet the needs of our local populations.

When funds allow, we will administer an Innovation Fund to support community level projects to reduce suicide and self-harm

We will strengthen the focus on supporting friends and family of children and young people at risk of suicide and self-harm within the strategy

Reduce the risk of suicide and self-harm in key high-risk groups of children and young people

The National Strategy has identified the high-risk groups of children and young people, shown below, as priorities for suicide and self-harm prevention interventions.

Q2 Are these the appropriate high-risk groups of children and young people you think should be prioritised in the Kent and Medway Children and Young People Suicide and Self-harm Prevention Strategy?

	Yes	No	Don't know
Children and young people known to mental health services – including the 18-25 transition to adult mental health services	53	2	1
Children in care and care leavers	53	2	0
Children in custodial settings	48	3	1
Children and young people with neuro disabilities	42	3	7
Children and young people who identify as LGBTQ+	44	3	5
Unaccompanied Asylum-Seeking children and young people	45	4	3
Children and young people impacted by Adverse Childhood Experiences (ACES)	50	2	2

Individuals that answered 'no' to the suggested priority groups, were asked what changes they would like to see made. The responses were as follows:

- The Covid pandemic means a total review is needed
- School children particularly around examination age groups should be included.
- Regarding young asylum-seekers, not sure whether this category needs to be separated out, given that they will already be covered by other categories.
- The above categories fail to take into account the significant increase in suicide among females 15-24 (increasing since 2012 to its highest ever in 2019). Only a few of those will have come to the attention of the MH services.
- There should also be inclusion for anyone with a SEN plan. Those would usually be covered by the above groups but there will be people missed if it were not broadened out.

The final Strategy will take these responses into account in the following ways:

We will continue to follow the nationally identified high risk groups, and will also include young women, anyone with a SEN plan and school children at exam time as groups to be considered.

We will strengthen our actions in monitoring the impact of Covid-19 on the mental wellbeing of children and young people.

Q3 Please let us have any suggestions for specific actions that could be taken to reduce the suicide risk in any of the priority groups.

An analysis was conducted on the responses, with many varied opinions on suggestions for specific actions that could be taken to reduce the suicide risk in any of the above priority groups. Five key themes emerged, which included:

Focus on education and the educational system – Eight responses discussed the importance of education regarding educating individuals around CYP and self-harm and suicide. Examples included the need for teachers to be educated around this, so they are able to look out for potential suicidal behaviours amongst their students, and also exploring the option of having greater publicity within the education system, having classes within the curriculum of secondary school students to focus on their mental health.

Another aspect of these responses discussed the need a mental health professional working in or alongside schools, and also schools and educational settings highlighting the different options of support and services available to CYP to ensure they are aware of the support to them.

Improved access to support – three individuals highlighted the need for access into CAMHS to improve, specifically discussing the need to reduce waiting times for those accessing help. Another individual noted that CYP need to be shared with other services, for example crisis teams can liaise with CYP so they have locally support, also highlighting that the support should extend to families, friends and carers inclusive.

Self-harm – two individuals highlighted that more needs to be understood around the patterns and prevalence of self-harm by CYP, and whilst many often think of self-harming as cutting, other behaviours such as eating disorders need to be taken seriously also. Responses here, highlighted the need for staff to have the knowledge and skills to intervene and offer counselling or mental health support for children, specifically those experiencing life changing situations, eg. Parents divorcing, a bereavement within the family etc.

Improved support structures – several responses discussed the importance of accessible support in many different forms, these included:

- Offering CYP support groups / workshops / youth clubs (including access to wellbeing activities that promote self-confidence, building friendship, support networks and resilience).
- Ready to access phone and text support.
- More school staff and trained workers need to be available and trained to listen and support CYP.
- Parents need to be supported, ensuring they are able to support their child.
- Using documents within this strategy to make resources to help schools teach about self-harm and suicide.

- Better careers guidance is needed as being unsure which direction you are heading in life, or not having a clear plan for their future can lead CYP to feel stressed and hopeless.

The final Strategy will take these responses into account in the following ways:

We will continue to work with partners across the system, including schools, colleges and mental health providers to ensure young people in need of mental health support are identified early and given access to high quality support

4.2 Section 2

Tailor approaches to improve mental health and wellbeing of all children and young people in Kent and Medway

The actions stated in the Strategy are:

- We will work with partners to support implementation of the Kent and the Medway Children and Young People Mental Health Local Transformation Plans.
- We will support the implementation of the Medway Self-Harm action plan and the KCC adolescent strategy.
- We will work with partners to ensure that all children and young people have access to a range of easily accessible and evidence-based emotional wellbeing support services.
- We will support the HeadStart programme to increase resilience amongst children and young people in Kent.
- We will encourage services to adopt a trauma informed care approach.
- We will pilot innovative new ideas to improve wellbeing and reduce self-harm amongst children and young people.

Q4 To what extent do you agree or disagree with the actions above to improve the mental health and wellbeing of all children and young people in Kent and Medway?

Response	Number
Strongly agree / tend to agree	56
Strongly disagree / tend to disagree	0
Neither agree nor disagree	1
Don't Know	0
TOTAL	**57**

Q4a Are there any other actions you would suggest to improve the mental health and wellbeing of children and young people in Kent and Medway?

An analysis was conducted on the responses, with many varied opinions and suggestions to improve the mental health and wellbeing of CYP in Kent and Medway. Six key themes emerged, which included:

Improving access to services and support – six responses discussed the need for services to be made more accessible and for waiting lists to be urgently reduced. Specifically, CAMHS was highlighted, with the focus of providing more help and support for CYP with quicker response times. 4 individuals acknowledged the need for better provision of services and funding for mental health services, with the ultimate aim to fund more health professionals and reduce the waiting times to zero.

Another individual offered the suggestion that whilst the CYP waits for support or access to services, perhaps an intermediate solution could be a centralized information hub, to enable those at risk, as well as the parents/carer to understand all the factors, support services and educational information to bridge the gap, before professional support can be offer, rather that CYP and families feeling left to their own devices.

A further five responses highlighted the need for support to be available and made well-known within communities. Responses discussed the need for a point of call access 24/7 phone or text service, and for that service to be common knowledge in Kent. In addition, other responses discussed that they have found resources difficult to access and this can limit support; therefore, available support needs to be promoted, also acknowledged was the need for this to be viewed as a 'whole family approach' as children do not exist in a vacuum.

Education and training – 11 responses discussed the need for education around the subject of self-harm and suicide to improve, as well as training those around CYP, to ensure they are aware of how best to support the individual. Five individuals specifically acknowledged the role schools play, and that teachers must be more informed of signs that children may need help and importantly, know how to support the CYP. In addition, suggestions also highlighted the need for educational systems to have a program of talks in schools on emotional wellbeing and/or integration of such talks as part of the K&M schools PSHE curriculum in a more meaningful way than is currently (if at all) happening. It was widely believed that greater publicity was needed within the educational system.

Regarding training, several responses acknowledged that more training is required for those who work with CYP in everyday settings, as they are the individuals who know the CYP best and can look out for 'signs' and offer support.

Support for specific groups – several groups were highlighted as needing more focus, including:

- Support for those released from custodial settings or leaving a period of probation.
- University students need much more focus and support
- More support for transition for children in care, care leavers.
- Neurodevelopmental issues need to be focused on

- The impact of Covid-19 and this last year will be huge on CYP anxiety, whether that be going back to school, socializing or living through a global pandemic; they will need to be supported.

Engaging with CYP – 5 responses noted that to understand what CYP need, we must work with them and offer a collaborative way of working. Individuals discussed reaching out to CYP to gather their opinions and how they would like to feel supported in difficult times. A couple of responses also acknowledged working with existing groups and communities where possible, for example, involving youth workers as they are working with CYP daily and can offer a different perspective of what may work to help support CYP.

The final Strategy will take these responses into account in the following ways:

We will continue to work with partners across the system, including schools, colleges and mental health providers to ensure young people in need of mental health support are identified early and given access to high quality support

Reduce access to the means of suicide in children and young people

Q5 How can we reduce suicides in children and young people in Kent and Medway by controlling access to the means of suicide?

An analysis was conducted on the responses, with several suggestions around how we can reduce suicide in CYP in K&M by controlling access to the means of suicide. Seven key themes emerged, which included:

Challenging / opposed to having this as a priority – Eleven responses shared similar views that attempting to control the access to the means of suicide is very difficult as it is impossible to remove all means. However, a few responses did touch on the suggestion of education around this and ensuring open conversations are happening, especially at schools to enable appropriate support, in turn hoping to reduce access to means.

Focusing on illegal substances – Five individuals discussed the importance of focusing on illegal substances and preventing CYP engaging in illegal substances and drug supplies. Responses also highlighted the need for amenities on weapons, encouraging confidential reporting of parties selling / making illegal substances or devices. Tougher sentences to those supplying drugs that may be used to overdose is also essential.

Social media – Seven responses acknowledged that social media needs to be improved as damaging behaviour is too easy to access via social media sites. Individuals discussed how social media is a prevalent factor in many CYP lives and therefore, some activities to help neutralize the more destructive and malevolent influences could be useful. In addition, the idea of targeting resources online or on social media was discussed, with the potential of using easy to access links to support via social media.

Education – Nine individuals highlighted again the need for education around this subject. Responses included more education and factual conversations around the topic of suicide, and education around what CYP can access and use by way of a suicide attempt needs to be understood by parents, teachers and other professionals working with CYP.

Other actions – Five other responses offered a variety of ways to reduce the access to the means of suicide, these included:

- Security at railways, bridges, high structures
- Talk to police, fire bridges, A&E workers, child death panels, coroners, CHYPS, KMPT and review the risk in levels 4 ad 5 attempts
- Anyone in charge of a child or in charge of a place where a child might gain access has a legal duty to protect that child from danger and hazards
- Work with the individual for some intense therapy to help reduce their thoughts to suicide. Working with the family too, supporting them and their ability to prevent suicide and help at home will also help.
- More support with transition for children in care, care leavers and children in custodial settings

Responses to this question will influence our Strategy & Action Plan in the following ways:

We will continue regular analysis of Real Time Suicide Surveillance which will give us the ability to design targeted and evidence-based interventions.

We will conduct or commission bespoke research into emerging or high-risk topics, for instance the impact of social media on children and young people

We will consider piloting new technology to reduce the risk relating to high risk locations

We will continue to work closely with Kent Police, Highways England, the Port of London Authority and other land owners

Q6 What is the best way of providing information and support to those children and young people bereaved or affected by suicide?

An analysis was conducted on the responses, with many varied suggestions around providing information and support to those children and young people bereaved or affected by suicide. Two key themes emerged, which included:

More education needed around this subject – five individuals highlighted the role schools and the education system plays. Responses focused on ensuring schools had the appropriate information to offer support to CYP bereaved by suicide. In addition, responses also highlighted that conversations need to be taken into the school curriculum around CYP being bereaved, and it was noted that life skills such as these stay with you and support needs to be available.

Varied forms of support – Sixteen responses discussed the need for CYP to be supported through a variety of ways when bereaved by suicide. Several individuals highlighted the need for peer support groups, so CYP can feel supported by other CYP who have experienced the same.

Other responses focused on a varied support structure, from timely face to face support given immediately after the event, to online chat forums or a text message service. Support could also be offered in the form of TV adverts or via social media as it was highlighted in the responses, this is probably the best way to reach CYP.

One individual acknowledged that schools must be trained up in how to support a CYP bereaved by suicide and/or have a designated lead who can ensure meaningful conversations are taking place and that CYP has someone they trust to speak with.

Another common response was talking to those CYP who have been bereaved and understanding what support they received or what support they feel would have benefitted them during that time. Also working with CYP to understand the best ways to provide such information so it reaches them and they engage with the support.

In addition, another individual discussed that this needs to be addressed in varied way, as this is not the sole responsibility of one person or department, therefore, all individuals involved with the bereaved CYP, family, friends, schools, social workers, doctors etc need to understand how they can support and are aware of what is available.

Responses to this question will influence our Strategy & Action Plan in the following ways:

These responses will be shared with the providers of our two new bereavement support services as they will inform and shape the mobilisation and delivery of the new service.

1) *Specialist Bereavement Support for under 25s*

2) *Support for People Bereaved by Suicide (both to launch in the summer of 2021)*

Continued promotion of Help is at Hand resources.

Support the media in delivering sensitive approaches to suicide

Q7. What is the best way of supporting the media in delivering sensitive approaches to suicide?

An analysis was conducted on the responses, with many varied suggestions supporting the media in delivering sensitive approached to suicide. Four key themes emerged, which included:

Education and guidance is essential – Fourteen individuals discussed the importance of the media having guidance on sharing appropriate information and ensuring they are educated on specific elements around best reporting of suicides. Several responses highlighted the need for information to be factual as often the media can put an incorrect 'spin' on stories as well as educating the media on the correct language to use when reporting on suicides. A common theme that emerged was stopping the sensational reporting that the media often do when writing an article on a suicide.

In addition, responses also acknowledged the need for the media to also provide a pathway to support whenever stories are published to ensure individuals who are affected by the story can seek support.

Practical changes that were discussed focused on having age restrictions on such stories and also having a member of KCC comms team to develop an ongoing relationship to censor such stories is it is required, as well holding closed seminar discussions with our local media to discuss the impact these stories can have.

Training – similar to the education responses above, 7 responses discussed the importance of specific training for those working within the local media. Individuals focused on free to access training, whether that be mental health first aid or suicide prevention training. A couple of individuals highlighted that this needs to be done through the employer, or whilst trainee journalists are still at university (suicide awareness needs to be compulsory in their training / work), so it is embedded within their learning; the responses also suggested that during the training, video testimonials from people who have been hurt or negatively influenced by insensitive reporting should be shown.

Promote positive stories – A few of the responses discussed the need for positive mental wellbeing stories, engaging in different initiatives such as the 'ask twice'; ensuring that the media are promoting good mental health. In addition another response suggested having regular discussions around mental health / suicide to break the stigma and taboo that still exists within society, and having survivors share their story; these stories don't have to be purely only 'big hitters' but also lower level real life scenarios that are commonly encountered by many, but will ensure that individuals know they are not facing anything alone, and they can see first hand that others have got through the situation.

Social media – a couple of individuals highlighted that social media platforms needs focus, regarding the content available but also how it can be used to promote good mental health stories and support should CYP need it.

Responses to this question will influence our Strategy & Action Plan in the following ways:

Where possible we will continue to work with media companies and individual journalists to educate them about existing guidelines and to ask them to change or remove insensitive coverage.

We will continue to share and promote positive stories.

We will consider research into the impact (positive and negative of social media and apps)

Support research, data collection and monitoring

Q8. Are there additional pieces of research that you believe we should be doing regarding suicide and self-harm prevention amongst children and young people?

An analysis was conducted on the responses, with different subject areas and suggestions for specific research pieces regarding suicide and self-harm. Four key themes emerged, which included:

Social media – three responses suggested research focusing on social media and how CYP are using it; specific questions that were suggested include:

- *What % of social media posts which encourage and demonstrate self harm and suicide are removed and are users banned from posting such things?*
- *Are bullies getting their social media access removed?*

Engaging with CYP – seven individuals wanted research to focus more on CYP opinions and ensuring we are asking them the right questions to support them. These responses focused on conducting surveys online speaking to CYP or conducting qualitative work with affected CYP to understand their firsthand experience and attitudes towards self-harm and suicide. More engagement work is needed to ensure we understand how CYP feel, what has led them to feeling a certain way, and how they were supported / how best they feel they could be supported in the future.

Focusing on specific groups – several individuals suggested that more research needs to be conducted into specific groups, these included:

- The impact of Covid needs to be explored, specifically regarding the mental health of anxiety and isolation the last year has had on CYP
- Trauma and brain patterns – *is there particular areas of the brain that suggests suicide is becoming an intrusive though or fluctuations in brain activity*?
- CYP from broken homes are ay risk; this needs to be further explored.
- The impact of drugs (including alcohol) on CYP mental health
- Any analysis looking at causes and/or responses to attempts to help, could be valuable in determining what did not go well in helping the CYP
- Research needs to be conducted into coroner reports as well as the family background to understand the full story of CYP who take their own life.
- Research focusing on leaving home / the transition to university
- Speaking to those who have attempted suicide and now in a mentally stable place, also speaking to families who have been bereaved by suicide or schools who have lost students; they may be able to explain the cycle and turn of events where interventions could have supported the CYP.

Schools and education – nine individuals highlighted the need for research into education and the school system. Responses focused on more research is needed to understand the stress that exams, curriculum pressure puts on CYP and how schools need to support CYP better through these stressful events. A handful on individuals also discussed that we need to understand exactly what schools are doing, regarding talking about mental health and improving mental wellbeing; CYP are at school more than anywhere else, therefore more resources are needed within the school setting to ensure they are supported or know where to turn to should they need help.
Some specific research questions that emerged were:

- *How can parents and teachers better understand and identify the signs that a young person is on the pathway to suicide or self-harm?*
- *How do schools support their CYP?*

Responses to this question will influence our Strategy & Action Plan in the following ways:

We will conduct or commission bespoke research into emerging or high-risk topics, accounting for the responses given above.

Q9. What is the best way to demonstrate system leadership and quality improvement in relation to the prevention work on suicide and self-harm in children and young people?

An analysis was conducted on the responses, discussing how best to demonstrate system leadership and quality improvement in relation to the prevention work on suicide and self-harm in CYP. Four key themes emerged, which included:

Funding – Four individuals highlighted that more money needs to be spend on mental health as a whole. The responses discussed that more money needs to be allocated to mental health services and suicide prevention.

Demonstrating success – Six responses focused on that success or 'what is working well' needs to be shared. Individuals discussed that successful cases or results with positive follow-ups and outcomes need to be published, possibly on the KCC website or through schools and colleges, so individuals, including CYP know that good work is being done and Kent residents are aware of the work that is happening and making a difference.

Engaging with CYP – Seven individuals acknowledged the need for working with CYP, ensuring they are involved form the start and they have a say in the support offered. In addition, suggestions included engaging with CYP in schools or drop in centers, or engaging with those directly affected and target those CYP who are vulnerable. A couple of responses were focused on ensuring that CYP know that their mental health and wellbeing is being taken very seriously, and that all agencies play a central part in prevention work; everyone can make a difference.

Joint up approach – Six responses highlighted the need for joint up working between providers and for messages to be consistent. Some specific examples given here, were focused on media attention to cover positive stories of work that is happening around the county, school visits and conversations happening around mental wellbeing, having prominent councilors on board and being publicly involved in events and newscasts as well as having a team of well trained individuals, who can communicate with CYP generally, not just those who are high risk and directly affected. In addition, responses discussed the importance of making it clear for CYP who or where they go to for support.

Responses to this question will influence our Strategy & Action Plan in the following ways:

We will continue to advocate for as much funding as possible to be put towards the mental health and wellbeing of CYP, and to provide leadership (such as best practice examples, and facilitating partnership working) to ensure maximum impact of the available resource

We will ensure that the voices of young people are heard as much as possible in developing programmes and initiatives. Either directly or through providers and professionals working with CYP

Q10. Please tell us if you have any other comments about the draft Kent and Medway Children and Young People Suicide and Self-harm Prevention Strategy

There were a variety of responses, summarizing their final views and opinions for the draft CYP strategy. These included:

Positive feedback – several responses highlighted the good work already being done and wanted to provide positive feedback regarding the strategy and felt on the whole their views fit with those outlines in the CYP strategy document.

A change of focus – several responses discussed specific changes they would like to see included in the strategy, these included:

- The pandemic means a total re-boot is needed
- A greater focus on support with transition for children in care, care leavers and children in custodial settings
- Cultural changes need to shift to ensuring everyone feels safe and support to talk about their mental health
- Opposing specific at risk groups and believes that the scope needs to be widened so the aim is for everyone to feel supported and earlier intervention can be given.

Education – a continued recurring theme has been a focus on education and school settings. A few final responses again highlighted that greater publicity is needed within the education system, whether this is a focused curriculum topic around mental health and wellbeing or support/resources being ready to access for CYP. Ensuring CYP learn about mental health and wellbeing from an early age is setting them up for understanding how to deal with it in later life.

Responses to this question will influence our Strategy & Action Plan in the following ways:

There was an overwhelmingly positive view of the draft strategy and the priorities contained within it however there were a number of points that will be taken note of in the final strategy and related action plan. These include ensuring a continued focus on the long-term impact of Covid-19 on the mental wellbeing of CYP, the importance of schools and education settings and supporting friends and family of CYP who self-harm.

5. Equality Analysis

The Equality Impact Assessment for the Children and Young Peoples Kent and Medway Suicide Prevention and Self-harm Strategy 2021-25 was overall rated as **low**. After conducting analysis of the consultation responses, there is still no evidence to suggest that updating the CYP Suicide Prevention and Self-harm Strategy will have an adverse or negative impact on any protected groups. Therefore the recommended EQIA rating remains as **low.**

6. Next Steps

As a result of the Public Consultation, the draft 2021-25 Kent and Medway Suicide Prevention Strategy and associated Action Plan will be amended in the ways outlined in this report. The amended version of the Strategy will then be taken the following groups for final sign off.

- Kent County Council Health Reform and Public Health Cabinet Committee
- Medway Council: Leaders Meeting, CYP OSC, HASC OSC, Medway Health and Wellbeing Board, Cabinet Committee.
- Kent and Medway Health and Wellbeing Board
- STP MHLDA Board (SBAR report required)
- CCG Clinical Board
- KCC Corporate Management Team

Appendix 1: Respondents 'About You'

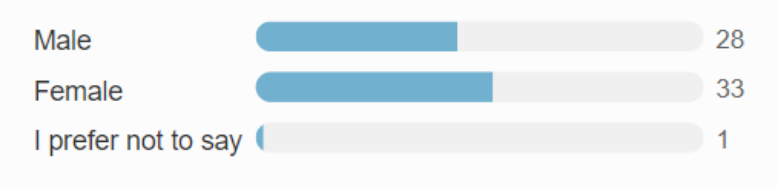
Section 6 – More about you

We want to make sure that everyone is treated fairly and equally, and that no one gets left out. That's why we are asking you these questions. We won't share the information you give us with anyone else. We'll use it only to help us make decisions and improve our services.

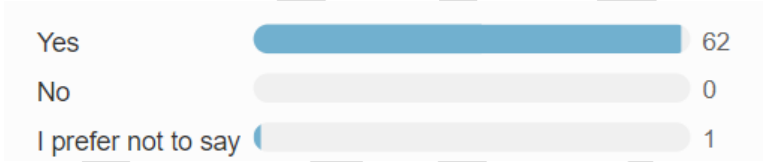
If you would rather not answer any of these questions, you don't have to.

It is not necessary to answer these questions if you are responding on behalf of an organisation.

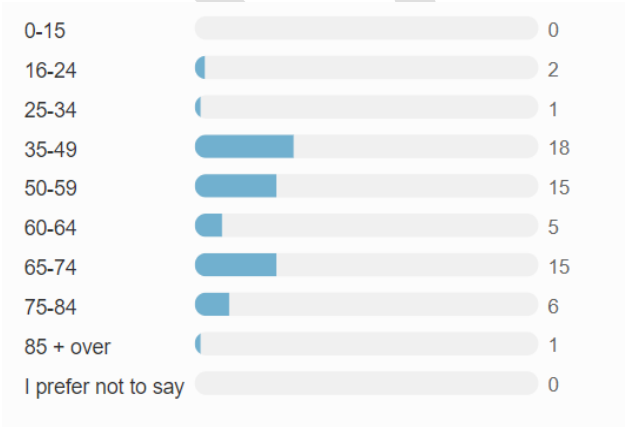
Q27. Are you….? *Please select **one** option.*



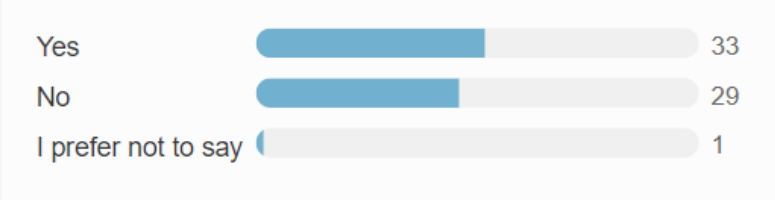
Q28. Is your gender the same as your birth? *Please select **one** option.*



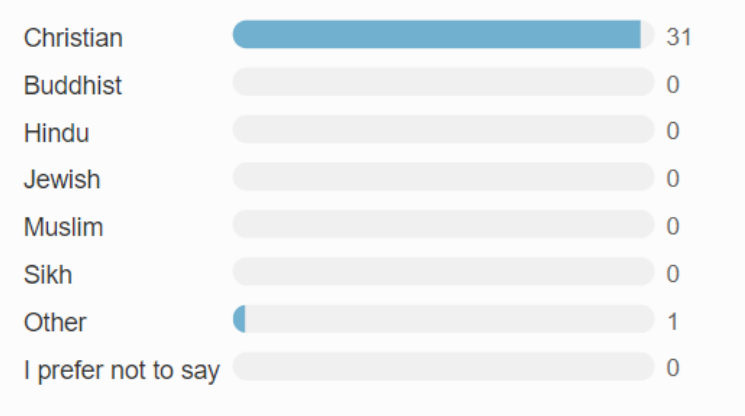
Q29. Which of these age groups applies to you? *Please select **one** option.*



Q30. Do you regard yourself as belonging to a particular religion or holding a belief? *Please select **one** option.*



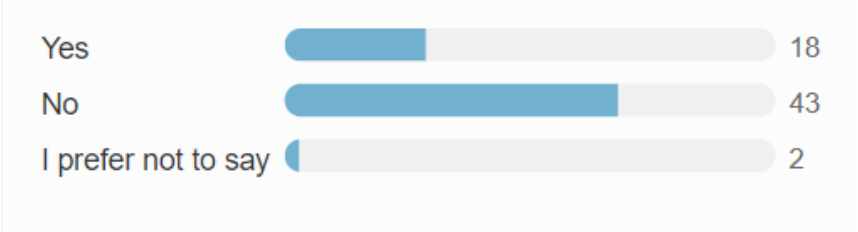
Q30a. If you answered 'Yes' to Q30, which of the following applies to you? *Please select **one** option.*



If you selected Other, please specify:

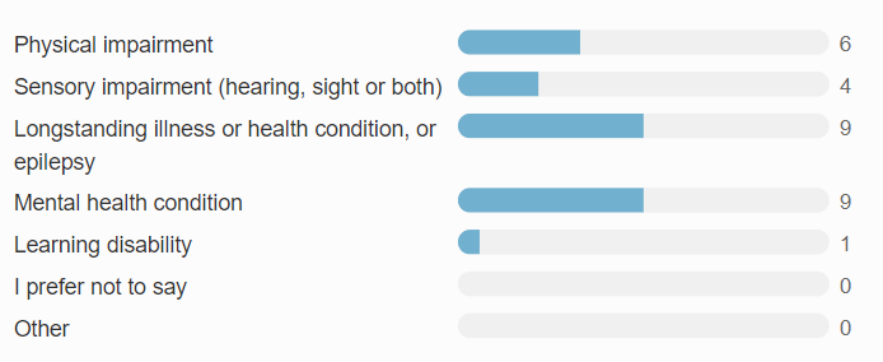
The Equality Act 2010 describes a person as disabled if they have a long standing physical or mental condition that has lasted, or is likely to last, at least 12 months; and this condition has a substantial adverse effect on their ability to carry out normal day-to-day activities. People with some conditions (cancer, multiple sclerosis and HIV/AIDS, for example) are considered to be disabled from the point that they are diagnosed.

Q31. Do you consider yourself to be disabled as set out in the Equality Act 2010? *Please select **one** option.*



Q31a. If you answered 'Yes' to Q31, please tell us the type of impairment that applies to you.

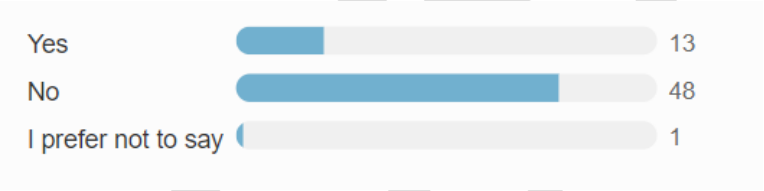
You may have more than one type of impairment, so please select all that apply. If none of these applies to you, please select 'Other' and give brief details of the impairment you have.



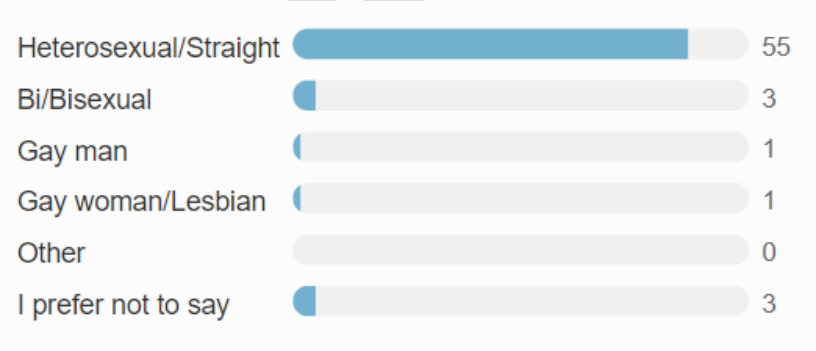
Other, please specify:

A Carer is anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support. Both children and adults can be carers.

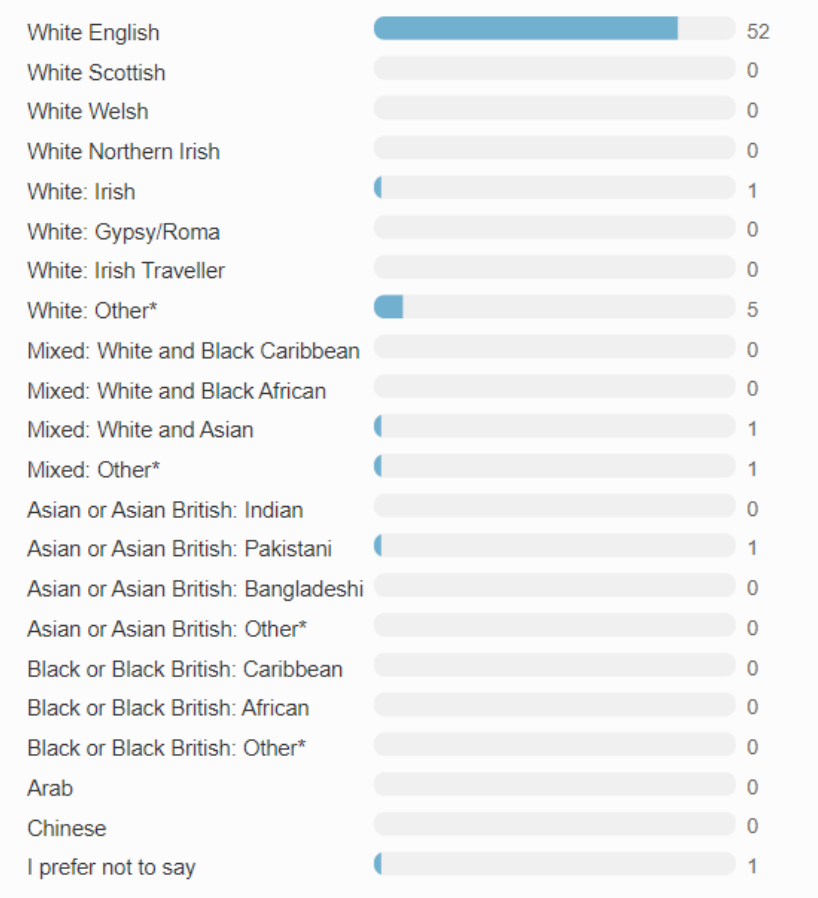
Q32. Are you a Carer? *Please select **one** option.*



Q33. Are you …? *Please select **one** option.*



Q34. **To which of these ethnic groups do you feel you belong?** *Please select **one** option.* (Source 2011 Census)



*****Other - If your ethnic group is not specified on the list, please describe it here:

Appendix 2: Strategy questionnaire (CYP)

Consultation Questionnaire

We are keen to hear your thoughts as we further develop this draft strategy during formal consultation. We have provided this feedback questionnaire for you to give your comments.

What information do you need before completing this questionnaire?

We recommend that you view the consultation material online at kent.gov.uk/suicideprevention before responding to this questionnaire.

If you have any questions regarding these proposals, please email suicideprevention@kent.gov.uk

This questionnaire can be completed online at kent.gov.uk/suicideprevention

Alternatively, fill in this paper form and return to: suicideprevention@kent.gov.uk

Please ensure your response reaches us by midnight on 18 March 2021.

Privacy: Kent County Council (KCC) collects and processes personal information in order to provide a range of public services. KCC respects the privacy of individuals and endeavours to ensure personal information is collected fairly, lawfully, and in compliance with the General Data Protection Regulation and Data Protection Act 2018. Read the full Privacy Notice at the end of this document.

Alternative formats: If you require any of the consultation material in an alternative format or language, please email: alternativeformats@kent.gov.uk or call: 03000 42 15 53 (text relay service number: 18001 03000 42 15 53). This number goes to an answering machine, which is monitored during office hours.

1) Priorities for the new strategy.

The Suicide Prevention Steering Group believes that it is appropriate to adopt the national priorities below as the priorities for the Kent and Medway Children and Young People Suicide and Self-harm Prevention Strategy.

i. Reduce the risk of suicide and self harm in key high-risk groups of children and young people (CYP)
ii. Tailor approaches to improve mental health and wellbeing of all CYP in Kent and Medway
iii. Reduce access to the means of suicide
iv. Provide better information and support to those CYP bereaved by suicide
v. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
vi. Support research, data collection and monitoring
vii. Demonstrate system leadership and quality improvement in relation to CYP suicide and self-harm prevention

Q1a) Do you agree or disagree that we should continue to follow the national priorities as stated above?

- ☐ Strongly agree
- ☐ Tend to agree
- ☐ Neither agree nor disagree
- ☐ Tend to disagree
- ☐ Strongly disagree
- ☐ Don't Know

If you selected 'tend to disagree' or 'strongly disagree' please tell us why below.

2) Reduce the risk of suicide and self-harm in key high-risk groups of children and young people (CYP).

The National Strategy has identified the high-risk groups of CYP, shown below, as priorities for suicide and self-harm prevention interventions.

Q2a) Are these the appropriate high-risk groups of CYP you think should be prioritised in the Kent and Medway Children and Young People Suicide and Self-harm Prevention Strategy?

	Yes		No	Don't Know
Children and young people known to mental health services – including the 18-25 transition to adult mental health services.				
Children in care and care leavers				
Children in custodial settings				
Children and young people with neuro disabilities				
Children and young people who identify as LGBTQ+				
Children and young people who self harm or engage in other risky behaviour				
Unaccompanied Asylum-Seeking children and young people				
Children and young people impacted by Adverse Childhood Experiences (ACES)				

Q2b) If you have answered 'no' to any of the suggested priority groups, what changes would you like to see made?

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Q2c) Please let us have any suggestions for specific actions that could be taken to reduce the suicide risk in any of these particular groups? (To help us with analysing

these results, please make it clear which priority group(s) you are referring to in your response).

3) Tailor approaches to improve mental health and wellbeing of all children and young people in Kent and Medway

As a reminder, the actions in the Strategy are:

- We will work with partners to support implementation of the Kent and the Medway CYP Mental Health Local Transformation Plans.
- We will support the implementation of the Medway Self-Harm action plan and the KCC adolescent strategy.
- We will work with partners to ensure that all CYP have access to a range of easily accessible and evidence-based emotional wellbeing support services.
- We will support the HeadStart programme to increase resilience amongst CYP in Kent.
- We will encourage services to adopt a trauma informed care approach.
- We will pilot innovative new ideas to improve wellbeing and reduce self-harm amongst CYP.

Q3a) Do you agree or disagree with the actions above to improve the mental health and wellbeing of all children and young people in Kent and Medway?

- ☐ Strongly agree
- ☐ Tend to agree
- ☐ Neither agree nor disagree
- ☐ Tend to disagree
- ☐ Strongly disagree
- ☐ Don't Know

Q3b) Are there any other actions you would suggest to improve the mental health and wellbeing of children and young people in Kent and Medway?

4) Reduce access to the means of suicide in children and young people.
(Reducing a suicidal person's access to lethal means) is an important part of a comprehensive approach to suicide prevention.

Q4a) How can we reduce suicides in children and young people in Kent and Medway by controlling access to the means of suicide?

5) Provide better information and support to those children and young people bereaved or affected by suicide.

Q5a) What is the best way of providing information and support to those children and young people bereaved or affected by suicide?

6) Support the media in delivering sensitive approaches to suicide.

Q6a) What is the best way of supporting the media in delivering sensitive approaches to suicide?

7) Support research, data collection and monitoring.

Q7a) Are there additional pieces of research that you believe we should be doing regarding suicide and self-harm prevention amongst children and young people?

8) Demonstrate system leadership and quality improvement in relation to children and young people suicide and self-harm prevention.

We will use this Strategy to raise the importance of suicide and self-harm prevention with partners and encourage every organisation, community and individual to play their part.

Q8a) What is the best way to demonstrate system leadership and quality improvement in relation to children and young people suicide and self-harm prevention?

Q9) Please tell us if you have any other comments about the draft Kent and Medway Children and Young People Suicide and Self-harm Prevention Strategy.

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