ADULT SOCIAL CARE AND PUBLIC HEALTH CABINET COMMITTEE

Wednesday, 21st January, 2026

2.00 pm

Council Chamber, Sessions House, County Hall, Maidstone

AGENDA

ADULT SOCIAL CARE AND PUBLIC HEALTH CABINET COMMITTEE

Wednesday, 21 January 2026 at 2.00 pm
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Ruth Emberley**
Telephone: **03000410690**
ruth.emberley2@kent.gov.uk

Membership (13)

Reform UK (8):	Mr A Kibble, Mr R Mayall, Mr S Dixon (Chair), Mr M Brown, Mrs B Porter, Mr T L Shonk, Mr T Mole (Vice-Chair), and Mrs S Roots
Liberal Democrat (1):	Mr C Sefton
Conservative (1):	Mr A Kennedy
Green (1):	Mr S Jeffery
Independent Group (1):	Mr O Bradshaw
	Vacancy

UNRESTRICTED ITEMS

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

1 Introduction/Webcasting Announcement

2 Apologies and Substitutes

3 Declarations of Interest by Members in items on the agenda

4 Minutes of the meeting held on 12 November 2025 (Pages 1 - 12)

5 Verbal Updates by Cabinet Member, Director of Public Health and Corporate Director

6 Draft Revenue, Capital Budget and Mid Term Financial Plan for Adult Social Care and Public Health (Pages 13 - 28)

7 Performance Dashboard (Pages 29 - 38)

8 25/00105 Suicide and Self Harm Prevention Strategy 2026 - 2030 - Key Decision (Pages 39 - 206)

9 25/00106 Kent Drug & Alcohol Services - Key Decision (Pages 207 - 224)

10 25/00107 Suicide Bereavement Service (Non Key Decision) (Pages 225 - 244)

11 25/00116 Kent Carers' Support Service Contract Award - Key Decision (Pages 245 - 266)

12 25/00117 Learning Disability/Physical Disability and Mental Health Contract Extension - Key Decision (Pages 267 - 292)

13 25/00118 Adult Social Care Provider Fee Uplifts 2026/2027 - Key Decision (Pages 293 - 310)

14 Exercise Pegasus Update (Pages 311 - 314)

15 Work Programme (Pages 315 - 318)

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)

Benjamin Watts
Deputy Chief Executive
03000 416814

Tuesday, 13 January 2026

Please note that any background documents referred to in the accompanying papers maybe inspected by arrangement with the officer responsible for preparing the relevant report.

KENT COUNTY COUNCIL

ADULT SOCIAL CARE AND PUBLIC HEALTH CABINET COMMITTEE

MINUTES of a meeting of the Adult Social Care and Public Health Cabinet Committee held at Council Chamber, Sessions House, County Hall, Maidstone on Wednesday, 12th November, 2025.

PRESENT: Mr A Kibble, Mr R Mayall, Mr S Dixon, Mrs B Porter, Mr T L Shonk, Mr T Mole, Mr R Palmer, Mrs S Roots, Mr C Sefton, Mr S Jeffery, Mr A Kennedy and Ms C Nolan

ALSO PRESENT: Miss D Morton, Mr M Mulvihill and Ms G Foster

IN ATTENDANCE: Dr Anjan Ghosh (Director of Public Health), Dr Ellen Schwartz (Deputy Director of Public Health), Sarah Hammond (Interim Corporate Director of Adult Social Care), Helen Gillivan (Interim Director of Adults and Integrated Commissioning), Victoria Tovey (Assistant Director for Integrated Commissioning), Mark Albiston (Director for Adult Social Care), Sydney Hill (Director for Adult Social Care), Sue Ashmore (Assistant Director for Prevention and Adult Social Care Connect), Helen Groombridge (Adult Social Care and Health Performance Manager), Pascale Blackburn-Clarke (Customer Experience and Relationship Manager), Sarah Challiss (Senior Commissioner), Toyin Sosanya (Pharmacy and Quality Lead), Hannah Brisley (Senior Commissioner), Nathalie Reeves (Public Health Specialist), Professor Durka Dougall (Public Health Consultant) and Ruth Emberley (Democratic Services).

UNRESTRICTED ITEMS

30. Election of Chair
(Item. 1a)

Mr Spencer Dixon was nominated by the Leader to be the Chair of the Adult Social Care and Public Health Cabinet Committee. The Committee agreed the nomination and Mr Dixon was declared as Chair of the Committee.

RESOLVED that Mr Spencer Dixon be elected Chair of the Committee

31. Election of Vice Chair of the Committee
(Item. 2)

Mr Richard Palmer proposed that Mr Terry Mole be elected as Vice-Chair of the Adult Social Care and Public Health Cabinet Committee. This nomination was seconded by Mr Adrian Kibble. There were no further nominations.

RESOLVED that Mr Terry be elected as Vice-Chair of the Committee.

32. Apologies and Substitutes
(Item. 3)

Apologies were received from Mr Michael Brown, with Ms Sharon Roots attending as substitute.

33. Declarations of Interest by Members in items on the agenda
(Item. 4)

1. A Member declared that he had a family Member currently working for the NHS.

2. RESOLVED that there were no other Member declarations of interest for any items on the agenda.

34. Minutes of the meeting held on 10 September 2025
(Item. 5)

RESOLVED that the minutes of the Adult Social Care Cabinet Committee held on the 10 September 2025 were a correct record and a paper copy to be signed by the Chair.

35. Verbal Updates by Cabinet Member, Corporate Director and Director of Public Health
(Item. 6)

1. The Cabinet Member for Adult Social Care and Public Health, Miss Diane Morton provided an update for Committee Members. Some of the key highlights were as follows:

   a) Congratulations were extended to Mr Dixon on his new appointment as Chair of the Committee.

   b) Tribute was paid to Mr Richard Smith, KCC's previous Corporate Director of Adult Social Care, who had joined Nottingham City Council. Sincere thanks were expressed in relation to all his work and achievements. A warm welcome was extended to Sarah Hammond, the Interim Corporate Director of Adult Social Care.

   c) Miss Morton and the two Deputy Cabinet Members for Adult Social Care, Mr Mark Mulvihill and Ms Georgia Foster, had visited several organisations and services across Kent, including Spadeworks, the Blackthorn Trust and Kenwood House.

   d) Miss Morton recently attended the Registered Managers Conference, alongside a variety of committed care professionals and providers.

   e) Kent Wellbeing Award took place recently in Ashford. Miss Morton was in attendance and presented the Kent Champion Award to Justin Blackman from North Kent Mind.

   f) It was confirmed that close work had continued with partners in health and the voluntary sector, with Miss Morton recently meeting with the new Integrated Care Board Chief, Mr Doyle.

   g) The first Kent Health and Wellbeing Board had taken place which involved District Councils and system partners, the primary focus

being prevention and integration. Miss Morton confirmed that she had requested both voluntary and community sectors be represented on the board, given their vital insight and connection to residents' everyday lives.

h) The new integration brokerage service was fully in place across hospital transferer care hubs. Sincere thanks were expressed to the Interim Director of Adults and Integrated Commissioning, Helen Gillivan, and her team for their hard work in the project.

i) The Baton of Hope passed through Kent recently as part of a national tour. The event was well attended and successful.

2. Director of Public Health, Dr Anjan Ghosh provided a verbal update to the Committee. Some of the key points included the following:

a) A heavy Influenza season was coming, with high levels in children and young adults. The Emergency Department attendance for Influenza had increased. Kent was supporting the NHS and UK Health Security Agency by promoting vaccines for high-risk groups.

b) Experts had indicated that it was not a matter of 'if' but 'when' the next pandemic would occur and in recognition of this, a national exercise called Exercise Pegasus had been completed in three phases, across all 4 nations. KCC was developing a framework from Exercise Pegasus that would be flexible enough to fit into any possible future pandemic.

c) Dr Ghosh confirmed that the Council was 1 year into an initial 2 year phase of the Marmot Coastal Region works and reminded Members that the programme focused on getting people back into work and the pathways into employment, particularly among high-risk groups.

d) The East Kent Neighbourhood Health Programme was part of the Marmot region and used Marmot principles to improve the building blocks of health.

e) The pharmaceutical needs assessment was published in September. Dr Ghosh confirmed that this was a statutory requirement of the Council under the Health and Wellbeing Board. The assessment laid out the current picture of community pharmacies and highlighted where there was need.

f) The Kent Annual Conference was scheduled for the 27 November 2025 at the Detling Showground. Dr Ghosh and Mr Mulvihill would be speaking at the conference, in connection to the Batton of Hope.

g) Progress had been made in relation to the improvement of pathways for opiate and crack substance misuse. Work had been carried out in association with prisons and Probation Services to secure additional funding for the medication Buvidal, for the treatment of addiction. Pathways for treating people with Ketamine addiction were also being reviewed and work has been carried out with Health Care

Professionals (HCPs) to create better care for hospital to community pathway.

h) A new health needs assessment had been completed for young peoples' drug and alcohol needs.

i) An annual conference on trauma informed care and healing centred care was scheduled for the 14 November 2025.

j) A post incident guide had been developed with Adult Social Care and a healing centred practitioner toolkit had been created for trauma informed care networks.

k) A Mental Health Needs assessment had just been published which underpinned the work the directorate carried out.

l) Dartford was due to start becoming a Health Alliance; it was confirmed that 11 out of the 12 District Boroughs were a Health Alliance and each had a £30,000 innovation fund administered through social enterprise.

m) A new smoking cessation pilot was being carried out in hospital A&E settings, with a view to expanding this to other health and Wellbeing Services operating from A & E departments.

3. The interim Director of Adult Social Care, Sarah Hammond, provided the following update for Members:

a) Ms Hammond had agreed to offer her leadership to the directorate during the process of recruitment of a new Director of Adult Social Services.

b) Ms Hammond confirmed that she had been involved in several extended senior leadership meetings across the county and met with key partners such as the Chair of the Adult Safeguarding Board and colleagues from the Mental Health Trust and Integrated Care Board. In addition, Ms Hammond had also met with improvement partners who were charged by the Local Government Authority and the Department of Health to assist Kent with its improvement journey within Adult Social Care

c) In the coming weeks, Ms Hammond planned to go on several site visits to meet front line staff.

d) Work into understanding the finances of Adult Social Care was being conducted to understand the reasons for the increase in cost and some understanding into the cost drivers had been established.

4) In answer to Member comments and questions, the following was said:

a) Dr Ghosh confirmed that KCC were promoting Influenza vaccinations amongst eligible staff, particularly within Adult Social Care and Health.

Issues around mass vaccination were national decision and therefore made by Central Government before they could be executed by Local Government.

b) The Deputy Director of Public Health, Dr Ellen Schwartz explained that the most recent strain of virus had undergone various changes that resulted in making it more easily transmittable. The vaccine was modelled on the previous one, which meant efficacy was good in children and young people and moderately good in adults.

c) Dr Schwartz confirmed that NHS colleagues monitored the uptake of Influenza vaccines and COVID boosters, however the directorate worked closely with them and provided support by targeting and raising awareness of Kent residents. Low levels of COVID activity were confirmed, meaning there was no current need for additional awareness of the vaccination. The date collated by the NHS was shared with the directorate which enabled them to provide support around the vaccine uptake.

d) Dr Ghosh confirmed there was a lot of misinformation in social media around vaccinations and there had been a backlash from the pandemic and COVID vaccination. However, there was no hard evidence to show that wariness of vaccines had impacted the overall uptake.

e) It was confirmed that Adult Social Care staff working in care homes were eligible for the Flu vaccine.

5. RESOLVED Members noted the verbal updates delivered by the Cabinet Member for Adult Social Care, the Director of Public Health and the Interim Director of Adult Social Care.

36. Adult Social Care and Health Complaints Report 2024/2025
(Item. 7)

1. The report was presented by the Customer Experience and Relationship Manager, Pascale Blackburn-Clarke.

2. Ms Blackburn-Clarke highlighted the key points of the Adults Social Care and Health Complaints report 2024/2025 to Members.

3. In answer to Member comments and questions, the following was said:

a) Of the 380 complaints about 'Quality of Care' included in the total, assurance was given that all complaints which came to the directorate were reviewed and lessons were learnt.

b) Officers worked closely with care providers and provider markets to ensure a drive in quality. It was explained to Members that whilst this information was not included in the report, officers were provided with a breakdown of the specifics.

4) RESOLVED that Members CONSIDERED and COMMENTED on the content of the report.

37. Annual Report on Quality in Public Health (including Annual Complaints)
(Item. 8)

1. The report was presented by the Deputy Director of Public Health, Dr Ellen Schwartz. The key points were highlighted to Members as follows:

   a) The paper provided an overview of the quality assurance and governance processes currently in place for Public Health and those which were under development to ensure high quality Public Health services were provided.

   b) In going forward, commissioned services will be reviewed, as well as advisory services and a more comprehensive approach would be examined.

   c) A review was undertaken in 2023 of the existing quality assurance processes focusing on commissioned services, which resulted in a list of recommendations. Some of these recommendations had been enacted, for instance the recruitment of a dedicated officer for quality and the development of a Public Health quality assurance framework.

   d) The patient safety incident policy would be reviewed, as well as other elements of safety and quality.

2. In answer to a Member's question, Dr Schwartz explained that the data for the report had been taken from the Adult Social Care and Public Health overarching collection of complaints, compliments and comments and therefore the specific details relating to the sewage outage were not readily available. Dr Schwartz confirmed a response could be provided after the meeting, once the information had been identified.

3. RESOLVED that the Committee NOTED and COMMENTED on the content of the report.

38. Adult Social Care Performance Dashboard Quarter 2 2025/2026
(Item. 9)

1. The report was introduced by the Adult Social Care and Health Performance Manager, Helen Groombridge, who highlighted the key points for Members as follows:

   a) The report provided an overview of Adult Social Care activity and performance for Quarter 2, being a period of between July and September 2025.

   b) Of the 7 Key Performance Indicators (KIPs):

i) 4 were RAG rated green (having met or exceeded target)
ii) 3 were RAG rated amber (having not met target but were within the floor target or upper threshold)

c) Of the amber rag rated KPIs, one had improved by a 2% increase of the Care Needs Assessments completed within 28 days.

d) Increased activity had occurred with the amount of Occupational Therapy Assessments completed, as well as the number of residents who received the enablement service, Kent Enablement at Home.

e) The number of people requiring short term residential nursing beds had decreased. The number of people who required a first or annual review of their care and support plan continued to decrease.

f) The highest number of Care Needs Assessment first reviews were completed in July and ongoing reviews had been completed for the prior 14 months.

g) Contact for the Adult Social Care Connect Service, incoming safeguarding concerns and referrals for carers had all increased, whilst the Incoming Care Needs assessment and Deprivation of Liberty Safeguard application had decreased.

h) Once the National Adult Social Care Returns had been published, the team would add in benchmarking information for 2024 and 2025 to show how trends and demands equated to the national position.

2. In answer to Member comments and questions, the following was said:

a) Director for Adult Social Care Mark Albiston explained that various factors impacted the increase of the cost of care, such as the increase in people requiring care and provider failure which resulting in recommissioning. It was highlighted to Members that two provider failures resulted in a cost of £1.5 million. In addition, the pressures of supporting hospital discharge in the NHS were a significant factor

b) Annual provider fee uplifts meant that an increase in cost was anticipated. The 18 to 25 Transition Service had moved back into Adult Social Care and factored into the increase of people who required support.

c) Quarter 1 showed an increase in short term pathways (residents discharged from hospital who required short term placement) and this increase was in both volume and average cost.

3. RESOLVED the Committee NOTED the performance of the Adult Social Care Services in Quarter 2 2025/2026

39. Adult Social Care Operational Pressures Escalation Plan 2025/2026
(Item. 10)

1. The report was presented by the Deputy Cabinet Member for Adult Social Care and Public Health, Mr Mark Mulvill. Mr Mulvihill highlighted the following points to Members of the Committee:

   a) The plan had been developed in collaboration with NHS and Community Partners to ensure that KCC could effectively manage times of heightened pressure across Health and Social Care Services.

   b) In additional, the plan set out a clear structured framework to help provide a swift and proportional response to demand. It clarified and provided governance arrangements and operational triggers that enabled local managers and system leaders to make coordinated decision when pressures mounted.

   c) The strengthened framework enabled protection to the most vulnerable residents by anticipating pressures through early coordination of date monitoring, risk assessment, streamlining communication between services, the deployment of staff and flexible resourcing.

   d) In order to prevent hospital admissions and support timely discharge, the Escalated Pressures Plan provided methods to strengthen links with the NHS, District Councils and voluntary sectors.

   e) Embedded learning from previous winters, rather than focusing on crisis response, was a key element to ensure workforce and partner agencies were able to plan, maintain resilience and uphold quality of care.

2. In answer to Member questions and comments, the following was said:

   a) Miss Morton confirmed that Kent County Council had a statutory responsibility to provide a Care and Support Plan if one was required.

   b) The Assistant Director Prevention and Adult Social Care Connect, Sue Ashmore confirmed that the Single Health Resilience Early Warning Database (SHREWD) was used by Kent County Council's health colleagues, however Ms Ashmore confirmed that it was also used for staffing and care enablement and was updated regularly.

   c) Staffing levels were categorised as green, despite having a 30% reduction, as staff were utilised from across the system. Work was carried out with partners in health to consider duality of roles and how to collaborate more closely.

d) Ordinary Residence was a reoccurring issue; work was being conducted exponentially to ensure packages of support were identified for people in their residential area, as well as conducting work with families to ensure any restricted moves or care packages required for a timely hospital discharge were sourced on a locality basis. The Medway Hospital system was supported by Social Work Practitioners from Kent County Council who worked directly with Kent residents, as well as Medway Council and the Community Health Providers, to ensure the correct social care input for the Kent Residents discharged form Medway Hospital.

e) An Integrated Brokerage Team hosted within Kent County Council ensured that work was conducted across the system, to enable the right support to be provided and at the right price for individuals being discharged from hospital.

f) It was confirmed that, other than the staffing pressures already discussed, nothing further of significance has been escalated.

3. RESOLVED the Committee NOTED the content of the report and the Adult Social Care and Health Operational Pressures Escalation Plan 2025/2026.

40. Accommodation Market Position Statement
(Item. 11)

1. The item was introduced by the Cabinet Member for Adult Social Care and Public Health, Miss Diane Morton. Miss Morton explained that the Position Statement was part of the directorate's 10-year vision on supporting adults who draw on social care and young people transitioning into adulthood, helping them to live independently, safely and with choice.

2. Senior Commissioner, Sarah Challiss presented a PowerPoint presentation to Members of the Committee.

3. A Member commented that, whilst the direction of the Position Statement was strongly supported, it was felt that the approach was too optimistic, given the current state of finances for Adult Social Care and Public Health. Concern was raised in connection with property developers and how they could be engaged in the extra care housing model.

4. In answer to a Member's question, it was explained that the growing demographic of older people within Kent was acknowledged, as well as the consequential growing need for residential care, however it was clarified that the overall aim was to reduce the over-reliance on residential care. In relation to nursing, the specific client group who required support included residents with Dementia and bariatric needs of people with significant complex support needs. It was confirmed that the next steps involved working through District profiles to establish what was required on each part of the market, to ensure sustainability to meet care need.

5. Ms Hammond explained that empty beds arise from either high expense or the provider being unable to meet the need of the individual who requires placement, or the bed was not in the correct place. Part of the Accommodation strategy was ensuring the right provision was in the right place.

6. It was confirmed that when the Position Statement was published, the evidence base document would be available so Members could see the data and figures used. Work was currently underway with the analytics teams and therefore timescales for implementation would be provided in due course.

7. RESOLVED the Committee NOTED the contents of the Accommodation Markert Position Statement.

41. 25/00094 Long Acting Reversable Contraception - Key Decision
(Item. 12)

1. The item was introduced by the Cabinet Member for Adult Social Care and Public Health, Miss Diane Morton.

2. Public Health Consultant, Professor Durka Dougall, highlighted key points to Members. These included:

   a) This was a proposed 6 year commissioning strategy, Kent County Council had statutory duty to provide comprehensive sexual health care.

   b) Long Acting Reversable Contraception (LARC) was an effective, evidence based contraceptive method, with services funded entirely through the Public Health Grant.

   c) LARC is currently delivered through more than 100 GP practices across Kent and through the Council's Integrated Sexual Health Service.

   d) The current contract was due to conclude in December 2026; based on the findings of the Sexual Health Needs Assessment, analysis of different commissioning practices and options and the wish to align primary care contracts from 2026, the proposal was to recommission the LARC services in primary care for a period of 6 years 4 months for a value of £13 million, commencing on 1 December 2026.

3. In answer to Member comments and questions, the following was said:

   a) It was acknowledged that existing provider GP practices were under pressure and therefore the aim was to recommission in a streamlined way across several public health services. It was confirmed that this was part of suite of initiatives; the aim was to work with local GP Practices to build relationships and understand what some of the blockers and obstacles were.

b) It was confirmed that previously a year-by-year contract extension model was being used however taking a 6-year 4-month approach prevented the need for annual re-bidding.

4. RESOLVED the Committee CONSIDERED and ENDORSED the Cabinet Member for Adult Social Care and Public Health in relation to the proposed Key Decision, as detailed in the Proposed Record of Decision document for 25/00094.

42. Work Programme
(Item. 13)

RESOLVED Members noted the Work Programme.

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From:	Linden Kemkaran, Leader of the Council Brian Collins, Deputy Leader of the Council Diane Morton, Cabinet Member for Adult Social Care and Public Health
To:	Adult Social Care and Public Health Cabinet Committee – 21 January 2026
Subject:	**Draft Capital Programme 2026-2036, Revenue Budget 2026-2027 and Medium Term Financial Plan (MTFP) 2026-2029**
Classification:	Unrestricted
Electoral Divisions:	All

Summary: This report outlines the key policy considerations within the draft capital and revenue budget proposals for the Cabinet portfolios and council departments relevant to this committee. This is a tailored report for each committee and should be considered within the context of the overall whole council budget proposals published separately to support the budget scrutiny process.

Recommendations: The Adult Social Care and Public Health Cabinet Committee is asked to:
a) **NOTE** the draft capital and revenue budget proposals
b) **SUGGEST** any alternatives which should be considered related to the Cabinet Committee's portfolio, before the final draft budget is considered by Cabinet on 29 January 2026 and presented to Full County Council on 12 February 2026

1. Background and Context

1.1 The setting of the budget is a decision reserved for Full Council. The Council's Budget and Policy Framework requires a draft budget is issued for consultation with the Cabinet and Scrutiny Committees to allow for their comments to be considered before the final budget proposals are made to Full Council.

1.2 The Council is under a legal duty to set a balanced and sustainable budget for the forthcoming year (2026-2027) within the resources available from local taxation and central government grants, and to maintain adequate reserves. This duty applies to the final draft budget presented for Full Council approval at the annual budget meeting and does not necessarily apply the preceding drafts or plans for subsequent years. The overall strategy for the budget is to ensure that the Council continues to plan for revenue and capital budgets which are affordable, reflect the Council's strategic priorities, allow the Council to fulfil its statutory responsibilities and continue to maintain and improve the Council's financial resilience within the overall resource constraints.

1.3 A medium term financial strategy covering the entirety of the resources available to the Council is the best way for resource prioritisation and allocation decisions to be considered and agreed in a way which provides a stable and considered approach to service delivery and takes into account relevant risks and uncertainty.

A report on the purpose of medium term financial planning was presented to the Policy and Resources Cabinet Committee on 8 July 2025 P&R MTFP Update. This report identified that the strategy should pull together in one place all known factors affecting the financial standing and sustainability of the Council over the medium term. The draft budget publication sets out all this necessary information for the scrutiny process. The final draft will include all the necessary information for the approval process. These are not necessarily the same and the final draft will include supporting strategies e.g. treasury management strategy, necessary for final budget approval.

1.4 The primary focus within the capital programme must be to ensure the Council has sufficient capacity to meet legal and regulatory requirements where there is risk of death or serious harm to residents and service users. This means first call on capital is to address “safety vital” works. The secondary focus is to reduce the impact on the revenue budget. This can be achieved through using the flexibility to use capital receipts to fund permitted revenue costs and reducing borrowing requirements. The capital programme will still include individual project schemes and rolling programmes funded from external sources.

1.5 The primary focus of the revenue budget must be to strike an appropriate balance between fulfilling the Council’s statutory obligations on service provision and the administration’s strategic priorities. However, these aims are not always compatible and involve difficult decisions about service levels and provision both for the forthcoming year and over the medium term. In reaching this balance the budget has to include provision for forecast spending growth (base budget changes to reflect full year impact of current variances, contractual price uplifts, staff pay awards, other cost drivers such as market availability, demand increases and service improvements). The revenue budget must also include planned efficiency, policy and transformation savings and plans to generate additional income necessary to balance any differences between spending growth and the available resources from central government and local taxation.

1.6 As part of budget scrutiny process it is worth clarifying that savings relate to reducing current recurring spend whereas bearing down on future growth is cost avoidance. Both amount to the same end outcome of reducing planned spending in the forthcoming year from what would otherwise have been needed without action and intervention. Both savings and cost avoidance are essential to ensure the statutory requirement for a balanced budget is met.

1.7 Fuller details of the budget plans are set out in the draft budget report published on 5 January 2026 to support the scrutiny process. This report is available here A separate report on responses from the public consultation on the budget strategy has also been published and is available at: KCC Draft Budget Consultation

1.8 The report to this Cabinet Committee focuses on the key policy considerations within the draft budget proposals for the directorate/Cabinet portfolio(s) relevant to each committee. To assist this, a summary of the 2026/2027 proposals for the relevant directorate/Cabinet portfolio is included as an appendix (Appendix 1) to this report. An interactive dashboard is also provided to Members, enabling the details of all proposals to be examined and scrutinised in depth.

1.9 Following the scrutiny process, a revised draft of the final budget proposals will be published in January for Cabinet consideration and approval at County Council in February 2026.

2. Key Policy Considerations – Adult Social Care

2.1 *Revenue Spending Growth*

2.1.1 The following table shows the proposed spending growth for Adult Social Care, and the more significant areas are explained below:

SPENDING	**£000**
Base Budget Changes	37,666.6
Reduction in Grant Income	756.1
Pay	15.6
Prices	9,917.3
Demand & Cost Drivers - Cost	15,778.7
Demand & Cost Drivers - Demand	25,285.2
Service Strategies & Improvement	385.0
TOTAL SPENDING	**89,804.5**

2.2 Base Budget Changes - £37,666.6k – relates to the forecast pressure in Adult Social Care as at quarter 2 of 2025/2026, including the full year effect of those people receiving services at that point in time. This does not include the impact of any savings not being delivered as these are shown as savings realignment within net savings.

2.3 Reduction in Grant Income - £756.1k – relates to the 'rolling' of some specific grants into the Revenue Support Grant, meaning the income relating to these activities will not be reflected directly in the Adult Social Care budget with spending on these activities now included within the net budget. The grants impacted are Deprivation of Liberty Safeguarding, Social Care in Prisons and War Pensions Disregard.

2.4 Prices - £9,917.3k – The Council continues to face significant and sustained financial pressure, driven by increasing demand for adult social care and rising complexity of need. Within this context, the Council has identified £9.917.3k as the provisional maximum affordable provision for adult social care fee uplifts and direct payment increases for 2026/2027. This amount reflects difficult but necessary prioritisation decisions to ensure that the Council can continue to meet its statutory duties while maintaining overall financial sustainability.

2.4.1 These proposals allow for differentiated uplifts across the main areas of adult social care provision, ascertained in accordance with the Council's Care Act Duties.

2.4.2 The proposed uplifts across the main social care contract areas are as follows:

- Care and Support in the Home Service–Consumer Price Index (CPI) as of December 2025 in conjunction with the Council's Care Act duties. (framework providers only)
- Supported Living Services– 2% and additional element to fund the increase in National Living Wage (NLW) for sleep-night provision (framework providers only)
- Residential Care (Learning Disability, Physical Disability and Mental Health) –2% (framework providers only)
- Older Person's Residential and Nursing Care– 0%
- Everyday Life Activities – 0%

2.4.3 The Council recognises the significant cost pressures facing adult social care providers and has had due regard to its duties under Section 5 of the Care Act 2014 to promote a sustainable care and support market and ensure continuity of care. However, it is not affordable to apply a full CPI uplift in excess of any uplift determined in accordance with the Council's Care Act duties universally across all services without materially impacting the Council's ability to meet its statutory duties, manage demand, and maintain financial sustainability across the wider system.

2.4.4 The proposed approach therefore represents a balanced and evidence-based exercise of commissioning judgement, targeting limited resources where they deliver the greatest strategic benefit, while retaining targeted and proportionate mitigation to manage risks to sustainability and continuity of care.

2.5 Demand and Cost Drivers - Cost - £15,778.7k – this is an estimate for increased costs for new client placements over and above the annual price uplift applied for existing clients at the start of the year (see prices section). This does assume that the increases will be lower than have been seen in the last year due to changed business processes in arranging support including the review of previous "self-funding" costs, and also because of the new contract for Older Person Residential and Nursing proposed to be in place during the summer of 2026, which it is anticipated will heavily influence our ability to manage the cost of new placements

2.6 Demand and Cost Drivers – Demand - £25,285.2k – this is an estimate for increased costs due to increased numbers of people requiring support and those with increased complexity. This does assume that the unprecedented increases in demand and costs over the last year will not continue at the same rate in the future years and new client demand will be managed within this lower provision. This will require an ongoing focus on assessment of eligible need meeting statutory local authority duties only.

2.7 Revenue Savings and Income

2.7.1 The following table shows the proposed savings and income for Adult Social Care, and the more significant areas are explained below:

SAVINGS, INCOME	**£000**
Transformation - Future Cost Increase Avoidance	-5,363.7
Transformation - Service Transformation	-55.2
Efficiency	2,081.7
Income	-8,000.2
Policy	-612.9
TOTAL SAVINGS & INCOME	**-11,950.3**

2.8 The table above is a net summary of savings to be delivered offset by budget realignment due to undelivered savings, the following table shows this separated out, which are explained in more detail below:

MEMORANDUM - SAVINGS:	
Removal of undelivered/temporary savings	18,004.7
New & FYE of existing Savings	-21,954.8
New & FYE of existing Income	-8,000.2
TOTAL SAVINGS & INCOME	**-11,950.3**

2.9 Removal of Undelivered and Temporary Savings - £18,004.7k - the budget is proposed to be realigned for those which were included in the 2025/2026 budget, and which are deemed as irretrievable over the medium term at the original estimated level and have now been replaced with the more rigorous process to manage spending growth. These comprise areas such as commissioning and contract savings in homecare, supported living, and community equipment - **£10,454.8k**; initial contact, reviews and other practice related areas - **£7,299.9k**, and planned removal of Public Health income - **£250k.**

2.10 New and Full Year Effect (FYE) of existing savings - £21,954.8k – comprise the following areas:

2.10.1 Transformation – Future cost increase avoidance - **£7,410k** – relates to the continuation of Enablement, Technology Enabled Lives, and Occupational Therapists into 2026/2027 which commenced in earlier years. These savings also over-achieved in 2025/2026 by **£5,253.6k**, which needs to be taken into account in the 2026/2027 budget

2.10.2 Efficiency - **£8,078.1k**:

- **£5,900k** relates to the joint funding of Section 117 Mental Health Act placements. Following the recommendations from recent mediation between the Integrated Care Board (ICB) and Kent County Council (KCC), it is now felt appropriate to negotiate with the NHS for them to fund a greater proportion to the care costs. The exact detail has to however be agreed with the ICB, so at this stage this is just an estimate.
- **£2,000k** relates to the full year effect of more stringent cost control at the point of new residential placements being made
- **£178.1k** relates to the over-achievement of an alternative saving relating to the cost of residential placements for the younger working age adults in 2025/2026.

2.10.3 Policy - **£1,157.9k**

- **£862.9k** relates to the full year effect of the review of the preventive services
- **£295k** relates to an increased Public Health contribution towards the Domestic Abuse Service
- Service Transformation - **£55.2k** relates to a council wide review of embedded staff.

2.11 It is important to note that most of the savings above with the expectation of Section 117 relate to existing plans and policies. This budget includes a new approach to managing growth provisions of both cost and demand.

2.12 New and Full Year Effect (FYE) of existing income- **£8,000.2k** – comprise the following areas

- £5,808k - Annual Uplift in social care contributions in line with estimated benefit and other income increases.
- £2,192.2k – Estimated Increase in Better Care Fund.

2.13 In addition to the savings outlined in the proposed 2026/2027 there is currently £10,019.9k of savings from 2025/2026 rolled forward.

3. Recommendations

3.1 Recommendations: The Adult Social Care and Public Health Cabinet Committee is asked to:
a) **NOTE** the draft capital and revenue budget proposals
b) **SUGGEST** any alternatives which should be considered related to the Cabinet Committee's portfolio, before the final draft budget is considered by Cabinet on 29 January 2026 and presented to Full County Council on 12 February 2026

4. Background Documents

https://www.kent.gov.uk/__data/assets/pdf_file/0003/225822/Draft-budget-report-January-2026.pdf

715c837011803df9f0d0cd2935ebc959_2026-27 Budget Consultation and Engagement Report Final.pdf

5. Appendices

Appendix 1 – Summary of Adult Social Care Draft 2026/2027 Budget Proposals

6. Contact details

Report Authors: Dave Shipton Head of Finance Policy, Planning and Strategy 03000 419418 dave.shipton@kent.gov.uk Cath Head Head of Finance Operations 03000 416934 Cath.Head@kent.gov.uk Michelle Goldsmith Finance Business Partner – Adult Social Care 03000 416159 Michelle.Goldsmith@kent.gov.uk	Director: Sarah Hammond Corporate Director – Adult Social Care and Health 03000411488 Sarah.Hammond@kent.gov.uk

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APPENDIX E - 2026-27 Budget

Directorate	**ASCH**
Cabinet Member	**Diane Morton**
	Core
	£000s
MTFP Category	
Original base budget	708,723.3
internal base adjustments	439.4
Revised Base	**709,162.7**
SPENDING	
Base Budget Changes	37,666.6
Reduction in Grant Income	756.1
Pay	15.6
Prices	9,917.3
Demand & Cost Drivers - Cost	15,778.7
Demand & Cost Drivers - Demand	25,285.2
Government & Legislative	0.0
Service Strategies & Improvements	385.0
TOTAL SPENDING	**89,804.5**
SAVINGS, INCOME & GRANT	
Transformation - Future Cost Increase Avoidance	-5,363.7
Transformation - Service Transformation	-55.2
Efficiency	2,081.7
Income	-8,000.2
Financing	0.0
Policy	-612.9
TOTAL SAVINGS & INCOME	**-11,950.3**
Increases in Grants and Contributions	0.0
TOTAL SAVINGS, INCOME & GRANT	**-11,950.3**
MEMORANDUM:	
Removal of undelivered/temporary savings & grant	18,004.7
New & FYE of existing Savings	-21,954.8
New & FYE of existing Income	-8,000.2
New & FYE of existing Grants	0.0
	-11,950.3
Prior Year savings rolling forward for delivery in 26-27 *	-10,019.9
TOTAL Savings for delivery in 2026-27	***-39,974.9***
* the prior year savings rolled forward for delivery in 2026-27 are based on the Qtr 3 monitoring and will be updated as part of the outturn report, and those updated figures will be used for the 2026-27 savings monitoring	
RESERVES	
Contributions to Reserves	0.0
Removal of prior year Contributions	0.0
Drawdowns from Reserves	0.0
Removal of prior year Drawdowns	0.0
TOTAL RESERVES	**0.0**
NET CHANGE (excl internal base adjustments)	**77,854.2**
NET BUDGET	**787,016.9**

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From: Linden Kemkaran, Leader of the Council
Brian Collins, Deputy Leader of the Council
Diane Morton, Cabinet Member for Adult Social Care & Public Health

To: Adult Social Care & Public Health Cabinet Committee 21 January 2026

Subject: **Draft Capital Programme 2026-36, Revenue Budget 2026-27 and Medium Term Financial Plan (MTFP) 2026-29**

Classification: **Unrestricted**

Summary:
This report outlines the key policy considerations within the draft capital and revenue budget proposals for the Cabinet portfolios and council departments relevant to this committee. This is a tailored report for each committee and should be considered within the context of the overall whole council budget proposals published separately to support the budget scrutiny process.

Recommendations:
The Adult Social Care & Public Health Cabinet Committee is asked to:
a) NOTE the draft capital and revenue budget proposals
b) SUGGEST any alternatives that should be considered related to the Cabinet Committee's portfolio before final draft budget is considered by Cabinet on 29th January 2026 and presented to Full County Council on 12th February 2026

1. Background and Context

1.1 The setting of the budget is a decision reserved for Full Council. The Council's Budget and Policy Framework requires that a draft budget is issued for consultation with the Cabinet and Scrutiny Committees to allow for their comments to be considered before the final budget proposals are made to Full Council.

1.2 The Council is under a legal duty to set a balanced and sustainable budget for the forthcoming year (2026-27) within the resources available from local taxation and central government grants, and to maintain adequate reserves. This duty applies to the final draft budget presented for Full Council approval at the annual budget meeting and does not necessarily apply the preceding drafts or plans for subsequent years. The overall strategy for the budget is to ensure that the Council continues to plan for revenue and capital budgets which are affordable, reflect the Council's strategic priorities, allow the Council to fulfil its statutory responsibilities and continue to maintain and improve the Council's financial resilience within the overall resource constraints.

1.3 A medium term financial strategy covering the entirety of the resources available to the Council is the best way that resource prioritisation and allocation decisions can be considered and agreed in a way that provides a stable and considered approach to service delivery and takes into account relevant risks and uncertainty. A report on the purpose of medium term financial planning was presented to Policy and Resources Committee on 8th July 2025 P&R MTFP Update. This report identified that the strategy should pull together in one place all known factors affecting the

financial standing and sustainability of the Council over the medium term. The draft budget publication sets out all this necessary information for the scrutiny process. The final draft will include all the necessary information for the approval process. These are not necessarily the same and the final draft will include supporting strategies e.g. treasury management strategy, necessary for final budget approval.

1.4 The primary focus within the capital programme must be to ensure that the Council has sufficient capacity to meet legal and regulatory requirements where there is risk of death or serious harm to residents and service users. This means first call on capital is to address "safety vital" works. The secondary focus is to reduce impact on revenue budget. This can be achieved through using the flexibility to use capital receipts to fund permitted revenue costs and reducing borrowing requirements. The capital programme will still include individual project schemes and rolling programmes funded from external sources.

1.5 The primary focus of the revenue budget must be to strike an appropriate balance between fulfilling the Council's statutory obligations on service provision and the administration's strategic priorities. However, these aims are not always compatible and involves difficult decisions about service levels and provision both for the forthcoming year and over the medium term. In reaching this balance the budget has to include provision for forecast spending growth (base budget changes to reflect full year impact of current variances, contractual price uplifts, staff pay awards, other cost drivers such as market availability, demand increases and service improvements). The revenue budget must also include planned efficiency, policy and transformation savings and plans to generate additional income necessary to balance any differences between spending growth and the available resources from central government and local taxation.

1.6 As part of budget scrutiny process it is worth clarifying that savings relate to reducing current recurring spend whereas bearing down on future growth is cost avoidance. Both amount to the same end outcome of reducing planned spending in the forthcoming year from what would otherwise have been needed without action and intervention. Both savings and cost avoidance are essential to ensure the statutory requirement for a balanced budget is met.

1.7 Fuller details of the budget plans are set out in the draft budget report published on 5th January 2026 to support the scrutiny process. This report is available here A separate report on responses to public consultation on the budget strategy has also been published and is available at: KCC Budget Consultation 2026-27

1.8 The report to this Cabinet Committee focuses on the key policy considerations within the draft budget proposals for the directorate/Cabinet portfolio(s) relevant to each committee. To assist this, a summary of the 2026-27 proposals for the relevant directorate/Cabinet portfolio is included as appendix E to this report. An interactive dashboard is also provided to Members, enabling the details of all proposals to be examined and scrutinised in depth.

1.9 Following the scrutiny process, a revised draft of the final budget proposals will be published in January for Cabinet consideration and approval at County Council in February 2026.

2. Key Policy Considerations

2.1 Public Health spending is fully externally funded through the Public Health grant and external income, with no contribution through core funding from general grants or local taxation. This means the net budget proposals from spending, savings, income and reserves must net to zero.

2.2 From 2026-27, Public Health specific grants for Drug and Alcohol Treatment & Recovery Improvement as well as Local Stop Smoking services have been consolidated into the Public Health grant, although conditions remain to ensure spending on these services is maintained. For 2026-27 the provisional PH grant settlement is:

	TOTAL	Stop Smoking Services ringfence	Drugs & Alcohol Treatment & Recovery ringfence
2026-27	£91,287,022	£4,054,765	£16,872,492

Capital Spending

2.3 There is no planned capital spending for Public Health in 2026-27.

Revenue Spending Growth

2.4 The draft budget for 2026-27 is based on the provisional grant announcement made in December 2025, which indicates a £2.35m increase overall in the newly consolidated Public Heath Grant compared to the core Public Health grant and other special grants included in the 2025-26 approved budget. It should be noted that £570k additional core Public Health grant was announced after the budget was approved in 2025-26, and minor changes were made to the special grant allocations in year, so the real increase in the total grant allocation for 2026-27 compared to final 2025-26 allocations is £1.75m.

2.5 An expected £243k reduction in external income is factored into the draft budget.

2.6 The 2026-27 spending proposals are funded from a combination of increased grant funding, unallocated grant from 2025-26, savings and Public Health reserves.

2.7 Spending proposals include increases to the costs of the Sexual Health contract (£264.9k) and School Health contract (£334.8k), other contract price uplifts (£141k), staffing changes including the impact of pay award and pay strategy (£678.5k) offset by reduction in pension contributions (-£106.8k), an increased contribution to Domestic Abuse services (£295k) and an additional £1m contribution to Children and Young People and Education (CYPE) for Family Hubs.

2.8 £4.7m is planned to be drawn down from reserves to fund additional, fixed term staffing (£994.9k), transformation transitional costs (£1.4m), NHS service improvements (£198.9k) a range of innovation projects (£1.4m), contribution to Live Well Kent (£500k) and other smaller investments for service improvement (£193.6k).

In addition to covering additional non-recurrent operational costs, service improvements and innovation projects, this is also part of a strategy to reduce Public Health reserves to a sustainable level.

Revenue Savings and Income

2.9 Transformation of the Healthy Lifestyles service has resulted in a saving of £406.8k which is reflected in this draft budget.

3. Contact details

Report Authors:

Dave Shipton (Head of Finance Policy, Planning and Strategy)
03000 419418
dave.shipton@kent.gov.uk

Cath Head (Head of Finance Operations)
03000 416934
Cath.Head@kent.gov.uk

Julie Samson (Strategic Financial Adviser – Public Health)
03000 416950
Julie.Samson@kent.gov.uk

Relevant Corporate Directors:

Dave Shipton (Acting Section 151 Officer)
03000 419418
dave.shipton@kent.gov.uk

Dr. Anjan Ghosh (Director of Public Health)
03000 412633
anjan.ghosh@kent.gov.uk

Background documents
Below are click-throughs to reports, more information, etc.
Click on the item title to be taken to the relevant webpage.

Explanatory note on funding simplification: consolidated grants and draft conditions - GOV.UK

APPENDIX E - 2026-27 Budget

Directorate	**Public Health**
Cabinet Member	**Diane Morton**
	External
	£000s
MTFP Category	
Original base budget	0.0
internal base adjustments	0.0
Revised Base	**0.0**
SPENDING	
Base Budget Changes	-317.2
Reduction in Grant Income	0.0
Pay	571.7
Prices	918.5
Demand & Cost Drivers - Cost	0.0
Demand & Cost Drivers - Demand	0.0
Government & Legislative	198.1
Service Strategies & Improvements	3,050.3
TOTAL SPENDING	**4,421.4**
SAVINGS, INCOME & GRANT	
Transformation - Future Cost Increase Avoidance	0.0
Transformation - Service Transformation	-406.8
Efficiency	0.0
Income	243.3
Financing	0.0
Policy	0.0
TOTAL SAVINGS & INCOME	**-163.5**
Increases in Grants and Contributions	-2,353.3
TOTAL SAVINGS, INCOME & GRANT	**-2,516.8**
MEMORANDUM:	
Removal of undelivered/temporary savings & grant	243.3
New & FYE of existing Savings	-406.8
New & FYE of existing Income	0.0
New & FYE of existing Grants	-2,353.3
	-2,516.8
Prior Year savings rolling forward for delivery in 26-27 *	0.0
TOTAL Savings for delivery in 2026-27	***-2,760.1***
RESERVES	
Contributions to Reserves	0.0
Removal of prior year Contributions	0.0
Drawdowns from Reserves	-4,700.0
Removal of prior year Drawdowns	2,795.4
TOTAL RESERVES	**-1,904.6**
NET CHANGE (excl internal base adjustments)	**0.0**
NET BUDGET	**0.0**

* the prior year savings rolled forward for delivery in 2026-27 are based on the Qtr 3 monitoring and will be updated as part of the outturn report, and those updated figures will be used for the 2026-27 savings monitoring process

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From:	Diane Morton, Cabinet Member for Adult Social Care and Public Health Dr Anjan Ghosh, Director of Public Health
To:	Adult Social Care and Public Health Cabinet Committee – 21 January 2026
Subject:	**Performance of Public Health Commissioned Services (Quarter 2 2025/2026)**
Classification:	Unrestricted
Previous Pathway of Paper:	None
Future Pathway of Paper:	None
Electoral Division:	All

Summary: This paper provides the Adult Social Care and Public Health Cabinet Committee with an overview of the activity and Key Performance Indicators for Public Health commissioned services.

In the latest available quarter, July to September 2025, of 14 Red-Amber-Green (RAG) rated quarterly Key Performance Indicators, **eight** were Green (met or exceeded target), **four** were Amber (below target but above the floor threshold), and **two** were Red (below the target and below the floor threshold). The two Red Key Performance Indicators are detailed below:

Number (%) of young people exiting specialist substance misuse services with a planned exit

Number (%) of clients currently active within One You Kent services being from the most deprived areas in Kent

Two Key Performance Indicators were not available at the time of writing this report. These are detailed below:

Number of people setting a quit date with smoking cessation services (cumulative)

Number (%) of clients quitting at 4 weeks, having set a quit date with smoking cessation services

There are also two Key Performance Indicators reported annually: the participation rate of Year R (4–5 year olds) pupils and the participation rate of Year 6 (10–11 year olds) pupils in the National Child Measurement Programme. Recently released data for the academic year 2024/2025 shows that both Key Performance Indicators are RAG rated Green.

Recommendation(s): The Adult Social Care and Public Health Cabinet Committee is asked to **NOTE** the performance of Public Health commissioned services in Quarter 2 (Q2) 2025/2026.

1. Introduction

1.1. A core function of the Adult Social Care and Public Health Cabinet Committee is to review the performance of services that fall within its remit. This paper provides an overview of the Key Performance Indicators (KPI) for the Public Health services commissioned by Kent County Council (KCC) and includes the KPIs presented to Cabinet via the KCC Quarterly Performance Report (QPR).

1.2. Appendix 1 contains the full table of KPIs and performance over the previous five quarters. This table includes benchmarking (England, region, nearest neighbour) where available.

2. Overview of Performance

2.1. Eight of the 14 quarterly KPIs remain above target and were RAG rated Green, four were below target although did achieve the floor standard (Amber), and two were below target and did not achieve the floor standard (Red). The Red (KPIs) were:

- Number (%) of young people exiting specialist substance misuse services with a planned exit
- Number (%) of clients currently active within One You Kent services being from the most deprived areas in Kent

2.2. Regarding the KPIs RAG rated Amber and Red, commissioners will continue to work with providers to improve performance.

2.3. Two KPIs were not available at the time of writing this report. These are detailed below:

- Number of people setting a quit date with smoking cessation services (cumulative)
- Number (%) of clients quitting at 4 weeks, having set a quit date with smoking cessation services

3. Health Visiting

3.1. In Quarter 2 2025/2026, the Health Visiting Service completed 16,994 out of 19,469 scheduled health and wellbeing reviews, achieving a completion rate of 87%. This means that 66,846 out of 76,127 (88%) were completed on a 12-month rolling basis, which meets the 86% target. The performance in the current quarter is consistent with performance in previous quarters, reflecting the continued stability and resilience of the service and highlighting the ongoing commitment to supporting families in the early years.

3.2. Four of the five mandated health and wellbeing reviews met or exceeded their respective targets. Antenatal contacts – delivered face-to-face, online, or by telephone, or via antenatal information letters – achieved 97%, meeting the 97% target. However, the proportion of antenatal contacts excluding antenatal information letters was 47%, below the 50% target. The antenatal contact serves as the initial touchpoint of the Healthy Child Programme, delivered through Health Visiting under the care of midwifery. The service takes a risk stratified approach, prioritising antenatal contacts for families assigned to a targeted or specialist caseload. Commissioners continue to monitor antenatal performance closely, with improvement action plans in place.

3.3. The Family Partnership Programme (FPP) is a targeted intervention that empowers parents and families who have experienced difficulties such as poverty, mental health issues, family problems, or domestic abuse, to lead happier, healthier lives. Service engagement remains strong, with 62% of families attending at least 80% of their scheduled contacts. While this is below the 75% target, the attendance achieved represents a positive outcome given that this cohort is traditionally considered hard to engage, and also indicates a strong level of commitment from families. In addition, some families may exit the programme early if they have achieved their goals.

3.4. Commissioners continue to work closely with Kent Community Health Foundation Trust (KCHFT) to improve antenatal contact performance. The Trust has successfully completed five key actions from its improvement plan, including a review of staffing levels, caseload management, and Kent-wide performance monitoring. It has also assessed the impact of recruitment and retention premiums in North Kent and West Kent and developed a proposal to centralise antenatal contacts to support delivery against the indicator.

3.5. Health Visiting workforce challenges are prevalent nationally. KCHFT is currently progressing a further five actions to address workforce challenges in Dartford, Gravesham, Sevenoaks, Tunbridge Wells, and Tonbridge and Malling. These efforts form part of the broader Public Health Service Transformation programme, which aims to enhance the antenatal offer and ensure equitable access and delivery across the county. The service has a strong track record of staff retention across Kent, which supports the sustainability of these improvements.

4. Adult Health Improvement

4.1. In Quarter 2 2025/2026, there were 6,998 NHS Health Checks delivered to the eligible population in Kent. This represents a decrease of 11% (-871) from the 7,869 checks that were delivered in the previous quarter. Due to the operational changes to the invitation process, delivery was expected to be lower in Quarter 2 than Quarter 1 whilst GPs transitioned from letter-based invitations to Short Message Service (SMS) invitations. KCC will continue to monitor delivery and the impact of SMS invitations on uptake. Previous pilot programmes have highlighted the importance of SMS message wording in influencing engagement. Should uptake not meet expectations, the SMS invitation wording will be reviewed and refined to improve effectiveness.

4.2. During the current quarter, a total of 23,046 first invitations were sent out, compared to 24,012 in the corresponding period of the previous year. In total, 45,944 (50%) of the eligible population have been invited to an NHS Health Check in the current year to date. Therefore, the programme is on track to invite the entire eligible population for 2025/2026. GPs continue to be supported to invite patients with mobile numbers via SMS instead of letter.

4.3. Following the key decision at the Adult Social Care and Public Health Cabinet Committee meeting in July 2025, the team has engaged with GPs and pharmacies – via the Local Medical Committee and Local Pharmaceutical Committee – to discuss the new model and contracting arrangements for delivering NHS Health Checks. The team is also working closely with Health Diagnostics, the digital system provider, to develop a new invitation model that prioritises inviting those at highest risk of cardiovascular disease.

4.4. The Stop Smoking Services data for Quarter 2 2025/2026 was not yet released at the time of writing this report. During this quarter, the service continued to support the Lung Cancer Screening Programme, which expanded in July to include Canterbury. This programme enables smoking advisors to be co-located alongside programme staff, providing prompt stop smoking interventions following a person's lung screening.

4.5. In addition, Everyone Health, the Outreach service provider, began planning a 12-month pilot programme within Accident and Emergency (A&E) departments, working closely with KCC commissioners. The pilot programme will place trained stop smoking advisors in A&E reception areas in three hospitals, working in partnership with Dartford, Gravesham and Swanley NHS Trust, and Maidstone and Tunbridge Wells NHS Trust. The programme is scheduled to begin delivery in Quarter 3 2025/2026.

4.6. In Quarter 2 2025/2026, the One You Kent (OYK) Lifestyle Service engaged with 1,769 people from Quintiles 1 & 2 (51%), which is below the 55% target and RAG rated Red. Providers are continuing to explore innovative ways to engage people in Quintiles 1 & 2, including working in partnership with primary health care settings and Family Hubs. Commissioners are also encouraging providers to consider collaborative approaches that can support innovation.

4.7. 59% of individuals on the weight management programme completed the programme in Quarter 1 2025/2026 (reported with a one-quarter lag). This figure is slightly below the target of 60% and therefore RAG rated Amber. Of those completing the programme, 91% achieved weight loss, and feedback continues to evidence the value of the support provided to those that complete the programme.

5. Sexual Health

5.1. KCC commissions several organisations to deliver statutory sexual health services, including free sexually transmitted infection (STI) testing and treatment, access to a broad range of contraception, and the provision of information and advice to support sexual health and wellbeing across Kent.

5.2. In Quarter 2 2025/2026, 98% of first-time patients were offered a full sexual health screen, and 63% accepted. This is below the 72% target, resulting in an Amber RAG rating. KCC has worked with providers to identify barriers to achieving this target, holding a dedicated workshop and collaborative meetings between providers. The outcome of this scrutiny is that this metric will be replaced with a revised metric from 1 April 2026, and the remainder of 2025/26 will be dedicated to the final stages of metric development.

5.3. During Quarter 2 2025/2026, 15,925 clinic appointments were attended, 11,501 home testing kits were ordered through the online STI testing service, and 2,815 packs of condoms were issued to under-25s through the Kent Condom Programme. In addition, 844 issuances of Emergency Oral Contraception for under-30s were processed through Community Pharmacies, and 2,095 Long Acting Reversible Contraception (LARC) procedures were reported by General Practice. This demonstrates the continued strong demand for sexual health services.

5.4. The Sexual Health service continues to develop its strategic approach, which will incorporate recommendations from the 2024 Kent Sexual Health Needs Assessment. Transformation of the Sexual Health services remains a key priority for the commissioning team. Short-term projects include the opening of a new sexual health clinic in Dover and the planning of a mobile sexual health clinic for west Kent.

6. Drug and Alcohol Services

6.1. In Quarter 2 2025/2026, the Community Drug and Alcohol Services supported 29% of people in structured treatment (1,673 of 5,774) to successfully complete treatment in the 12-month rolling period to September 2025, meeting the increased target (28%) and therefore RAG rated Green.

6.2. Regarding the substance groupings, the service is currently meeting the targets for successful completions among *alcohol only* users. The successful completion rate for *alcohol and non-opiate* users, *other non-opiate* users and *opiate* users are currently slightly below target. However, the substance group targets are ambitious, and were all increased for 2025/2026. In relation to each of the three pathways where Kent is missing its internal targets, both treatment progress and successful completions exceed national (England) and regional (South East) performance (Table 1).

Table 1. The successful completion rates for the substance groups

Substance Group	Target 24–25	Target 25–26	Q3 24–25	Q4 24–25	Q1 25–26	Q2 25–26	Benchmarking	
							England	Region
Opiate	8%	10%	8.5%	9.1%	9.2%	9.4%	5.8%	7.3%
Non-opiate	48%	39%	38.5%	36.0%	36.1%	37.4%	31.3%	32.2%
Alcohol	40%	39%	39.7%	40.3%	39.3%	39.2%	35.5%	36.7%
Alcohol & Non-opiate	33%	35%	32.8%	32.8%	34.0%	34.6%	28.2%	29.9%

6.3. In Quarter 2 2025/2026, the number of people accessing structured treatment (rolling 12-months) for the *alcohol and non-opiate*, *alcohol only*, and *non-opiate* pathways have met the respective targets. The *opiate* pathway is not meeting

the recently increased target. The number of people accessing opiate treatment continues to be an area of focus, which is addressed during contract monitoring meetings between commissioners and providers. Should the target continue not to be met, commissioners may look to implement improvement plans.

6.4. The services continue to conduct testing and support clients into treatment for hepatitis C. Micro-elimination of hepatitis C has now been achieved across Dover, Folkestone and Hythe and Ashford. Continued work will focus on sustaining the progress achieved to date, and undertaking an analysis of current data in order to identify the requisite level of investment and testing required to consistently achieve these outcomes across Kent.

6.5. In Quarter 2 2025/2026, the proportion of young people exiting treatment in a planned way was 74%, which is below the 85% target and therefore RAG rated Red. This represents 61 planned exits, 18 unplanned exits, and three transfers. There was a reduction in planned exits across both age groups this quarter, with under-18s decreasing by 3 percentage points (from 85% to 82%) and over-18s by 17 percentage points (from 81% to 64%). This is being addressed by the service, with an area for improvement focusing on closing cases in a timely way when treatment goals are complete. Commissioners will continue to monitor this and address any issues as required.

6.6. Every unplanned closure must be reviewed by a manager to ensure all available routes to re-engage the young person have been explored. This includes calls, texts, letters, and, where appropriate, discussion with the referrer.

6.7. Of those young people who exited treatment in a planned way, 16% reported abstinence. This is no longer a KPI for the service, as it is recognised that not all young people wish to achieve abstinence – some may only require harm reduction. Therefore, the service also monitors feedback from young people.

6.8. In Quarter 2 2025/2026, based on 59 responses:

- 96% rated the programme as ‘good’.
- 98% said the experience helped them learn more about drugs and alcohol.
- 100% would recommend the service.

6.9. In addition to structured treatment, in the current quarter the service also supported 118 young people through group work, 32 young people through the RisKit programme – a targeted, multi-component intervention for 14–16 year olds aimed at reducing risk-taking behaviours – and 30 young people through the Re-Frame diversion programme – a pre-arrest, psycho-educational scheme offering early support to 10–17 year olds found with Class B or C drugs.

7. Mental Health and Wellbeing Service

7.1. In Quarter 2 2025/2026, Live Well Kent and Medway received 1,978 referrals countywide, an increase of 8% compared to the same quarter last year. The

service remained responsive to demand, with 99% of eligible referrals contacted within two working days.

7.2. Exit survey completion rates also improved, and over 90% of respondents reported improvements with regard to their personal goals, demonstrating strong engagement with the service. Wellbeing outcomes remained high, with 90% of people showing improved or maintained wellbeing scores using the DIALOG Scale.

7.3. Employment support continued to deliver strong results, with job starts and sustained employment exceeding target in several areas. The network remains responsive to increasing complexity, as a growing proportion of people are presenting to the service with high needs.

8. National Child Measurement Programme

8.1. In 2024/2025, the mandated National Child Measurement Programme (NCMP) participation rate for Year R (aged 4−5 years) was 95% and Year 6 (aged 10−11 years) was 94%, both exceeding the target of 92% and therefore RAG rated Green. The service provider continues to work well with schools to maximise uptake and engagement whilst ensuring they meet school need and availability.

9. Conclusion

9.1. Eight of the 14 KPIs remain above target and were RAG rated Green, four were below target although did achieve the floor standard (Amber), and two were below target and did not achieve the floor standard (Red). Regarding the KPIs RAG rated Amber and Red, commissioners will continue to work with providers to improve performance.

9.2. Commissioners continue to explore other forms of delivery, to ensure the current provision is fit for purpose and are able to account for increasing demand levels and changing patterns of need. This will include ongoing market review and needs analysis.

10. Recommendation

10.1. **Recommendation(s):** The Adult Social Care and Public Health Cabinet Committee is asked to **NOTE** the performance of Public Health commissioned services in Quarter 2 2025/2026.

10. Background Documents

10.1. None

11. Appendices

11.1. Appendix 1: Public Health commissioned services KPIs and activity.

12. Report Author(s)

Victoria Tovey
Assistant Director of Integrated Commissioning
03000 416779
victoria.tovey@kent.gov.uk

Yozanne Perrett
Performance and Analytics Manager
03000 417150
yozanne.perrett@kent.gov.uk

Lead Director
Anjan Ghosh
Director of Public Health
03000 412633
anjan.ghosh@kent.gov.uk

Appendix 1: Public Health Commissioned Services: Key Performance Indicators Dashboard

Indicator Description		Target 24/25	Target 25/26	Q2 24-25	Q3 24-25	Q4 24-25	Q1 25-26	Q2 25-26	DoT	Benchmarking* England	Region	Neighbour
► Health Visiting												
PH29	No. (%) of mandated health and wellbeing reviews delivered by the health visiting service (12 month rolling)	86%	86%	66,746 87%	67,008 87%	66,696 87%	66,831 88%(G)	66,846 88%(G)	↔	-	-	-
PH30	No. (%) of pregnant women receiving an antenatal contact (face-to-face, online, telephone) by the health visiting service or an antenatal information letter	97%	97%	3,202 96%	2,986 96%	2,998 97%	3,325 98%(G)	3,492 97%(G)	↓	-	-	-
PH14	No. (%) of pregnant women receiving an antenatal contact (face-to-face, online, telephone) by the health visiting service	50%	50%	1,325 40%(R)	1,572 51%(G)	1,459 47%(A)	1,588 47%(A)	1,670 47%(A)	↔	-	-	-
PH15	No. (%) of new birth visits delivered by the health visitor service within 10–14 days of birth	95%	95%	3,860 94%(A)	3,630 94%(A)	3,489 94%(A)	3,663 94%(A)	3,840 95%(G)	↑	85%	84%	86%
PH31	Proportion (%) of families who attended at least 80% of Family Partnership Programme (FPP) contacts	75%	75%	42% -	58% -	70% -	78% (G)	62% (A)	↓	-	-	-
► Substance Misuse Treatment												
PH13	No. (%) of young people exiting specialist substance misuse services with a planned exit	85%	85%	43 75%(R)	54 75%(R)	56 74%(R)	89 83%(A)	61 74%(R)	↓	-	-	-
PH06	No. of adults accessing structured treatment substance misuse services (12 month rolling)	5,998	5,770	5,534 (A)	5,566 (A)	5,543 (A)	5,656 (A)	5,774 (G)	↑	-	-	-
PH03	No. (%) of people successfully completing drug and/or alcohol treatment of all those in treatment (12 month rolling)	25%	28%	1,519 27%(G)	1,570 28%(G)	1,573 28%(G)	1,608 28%(G)	1,673 29%(G)	↑	22%	24%	23%
► Lifestyle and Prevention												
PH01	No. of the eligible population aged 40–74 years old receiving an NHS Health Check (12 month rolling)	31,000	31,000	33,194 (G)	33,550 (G)	33,487 (G)	32,840 (G)	31,376 (G)	↓	-	-	-
PH26	No. of people setting a quit date with smoking cessation services (cumulative)	-	-	2,651	4,163	6,499	1,733	NCA	-	-	-	-
PH11	No. (%) of clients quitting at 4 weeks, having set a quit date with smoking cessation services	55%	55%	738 60%(G)	803 56%(G)	1,383 59%(G)	995 57%(G)	NCA	↓	53%	54%	53%
PH25	No. (%) of clients currently active within One You Kent services being from the most deprived areas in Kent	55%	55%	1,729 50%(R)	1,744 53%(A)	1,967 52%(A)	1,733 53%(A)	1,769 51%(R)	↓	-	-	-
PH27	No. (%) of clients that complete the Weight Loss Programme	60%	60%	370 57%(A)	238 70%(G)	505 61%(G)	428 59%(A)	NCA	↓	-	-	-
► Sexual Health												
PH28	No. (%) of all new first-time patients receiving a full sexual health screen (excluding online referrals)	72%	72%	3,577 65%(A)	3,469 65%(A)	4,035 67%(A)	3,635 63%(A)	3,891 63%(A)	↔	-	-	-
► Mental Wellbeing												
PH22	No. (%) of Live Well Kent and Medway clients who would recommend the service to family, friends, or someone in a similar situation	98%	98%	675 99.6%(G)	743 99%(G)	809 99.5%(G)	603 99%(G)	713 99.4%(G)	↔	-	-	-

* The benchmarking figures represent the latest available data and may not reflect the quarter reported in this paper. The 'Region' (South East) benchmark is determined from the Bracknell Forest, Brighton and Hove, Buckinghamshire, East Sussex, Hampshire, Isle of Wight, Kent, Medway, Milton Keynes, Oxfordshire, Portsmouth, Reading, Slough, Southampton, Surrey, West Berkshire, West Sussex, Windsor and Maidenhead, and Wokingham LAs. The 'Neighbour' benchmark reflects the statistical neighbours for Kent determined by NHS England Nearest Neighbour Model: Cheshire West and Chester, Essex, Gloucestershire, Hampshire, Hertfordshire, Kent, Lancashire, Leicestershire, Norfolk, Nottinghamshire, South Gloucestershire, Staffordshire, Suffolk, Warwickshire, West Sussex, Worcestershire.

Commissioned Services Annual Activity

Indicator Description		2019/20	2020/21**	2021/22	2022/23	2023/24	2024/25	DoT	Benchmarking England	Region	Neighbour
PH09	Participation rate of Year R (aged 4–5 years) pupils in the National Child Measurement Programme	95% (G)	85% (G)	88% (A)	93% (G)	96% (G)	95% (G)	↓	95%	95%	-
PH10	Participation rate of Year 6 (aged 10–11 years) pupils in the National Child Measurement Programme	94% (G)	9.8% (A)	87% (A)	90% (G)	95% (G)	94% (G)	↓	94%	94%	-
PH05	No. receiving an NHS Health Check over the 5-year programme (cumulative: 2018/19 to 2022/23, 2023/24 to 2027/28)***	76,093	79,583	96,323	121,437	31,379	64,866	-	-	-	-
PH07	No. accessing KCC-commissioned sexual health service clinics	71,543	58,457	65,166	58,012	61,508	61,360	↓	-	-	-

**In 2020/21 following the re-opening of schools, the Secretary of State for Health and Social Care via Public Health England (PHE) requested that local authorities use the remainder of the academic year to collect a sample of 10% of children in the local area. PHE developed guidance to assist local authorities in achieving this sample and provided the selections of schools. At the request of the Director of Public Health, Kent Community Health NHS Foundation Trust prioritised the Year R programme.

*** PH05 - This is an accumulative indicator over 5 years to measure the delivery of the NHS Health Check programme. Reset in 2023/24 to conclude in 2027/28

Key(s)

RAG Ratings

	(G) Green: Target has been achieved
	(A) Amber: Floor standard achieved but Target has not been met
	(R) Red: Floor standard has not been achieved
NCA	Not currently available

DoT (Direction of Travel) Alerts

↑	Performance has improved
↓	Performance has worsened
↔	Performance has remained the same
-	No performance direction

Relates to two most recent time frames

Date Quality Note

All data included in this report for the current financial year is provisional unaudited data and is categorised as management information. All current in-year results may therefore be subject to later revision.

DECISION REPORT TO CABINET COMMITTEE

From: Diane Morton, Cabinet Member for Adult Social Care & Public Health

Anjan Ghosh, Director Public Health

To: Adult Social Care & Public Health Cabinet Committee – 21st January 2026

Subject: Suicide & Self-Harm Prevention Strategy 2026-2030

Decision no: ***25/00105***

Key Decision :

- It affects more than 2 Electoral Divisions

Classification: Unrestricted

Past Pathway of report: N/A

Future Pathway of report: Cabinet Member Decision

Electoral Division: All

Is the decision eligible for call-in? *Yes*

Summary: The existing Suicide & Self-Harm Prevention Strategy for 2021-2025 is coming to an end. It has contributed to a situation where suicide rates locally are falling slightly, while national rates increase, and led to the work of the Kent & Medway Suicide Prevention Programme being nationally recognised as good practice.

To continue this vital work, a new Suicide & Self-Harm prevention strategy for 2026-2030 (appendix B) has been drafted and undergone public consultation, where it was met with wide approval. Although there will be some small amendments made (currently in progress) the draft strategy reflects the vision, mission, aims and priorities of the final version, which has been based upon the national suicide prevention strategy for England (2023-2028) and developed in conjunction with the Suicide Prevention Network. The Cabinet Member is asked to agree that the proposed strategy is adopted for 2026-2030.

Implementation of this strategy will sit with the Kent and Medway Suicide Prevention

Programme, which sits within Kent County Council's (KCC) Public Health division which is funded through the Kent & Medway Integrated Care Board (ICB) via an open-ended Memorandum of Understanding (MOU).

Recommendation(s):

The Adult Social Care & Public Health Cabinet Committee is asked to **CONSIDER** and **ENDORSE**, or **MAKE RECOMMENDATIONS** to the Cabinet Member for Adult Social Care & Public Health in relation to the proposed decision as detailed in the attached Proposed Record of Decision document (Appendix A).

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1. Introduction

1.1 Every suicide is a heartbreaking tragedy that profoundly affects the victim's loved ones and reverberates throughout the entire community.

1.2 To reduce the number of lives being lost in this devastating way, it is crucial that every area has its own suicide prevention strategy that can reflect the needs of its local area.

1.3 In Kent & Medway, the suicide and self-harm prevention strategy is overseen by the Suicide Prevention programme team, which sits within KCC Public Health but is funded by the Kent & Medway Integrated Care Board through an open-ended Memorandum of Understanding.

1.4 Since 2021, the work of the programme has been shaped by the existing suicide and self-harm prevention strategy for 2021-2025. This has contributed to a situation whereby local rates are falling slightly whilst national rates increase, and the work of the programme has been nationally recognised as best practice.

1.5 There is still, however, much work to be done. Between 2020-2024, 721 individuals died by suicide in Kent and Medway, according to the local Real Time Suicide Surveillance system.

1.6 Each of these deaths will have had devastating impacts on the communities around them. Evidence suggests up to 135 people can be impacted by an individual case of suicide (Cerel et al, 2018), and people bereaved by the sudden death of a friend or family member are also 65% more likely to attempt suicide if the deceased died by suicide than if they died by natural or accidental causes (Pitman et al, 2016).

1.7 Whilst the financial impact of suicide should not be prioritised above the emotional impact, it is still important to acknowledge that there is a substantial one. Each suicide is estimated to cost £1.46 million, rising to £2.85 million for children aged 10–14 (Samaritans, 2022).

1.8 To increase the likelihood of reducing the number of lives lost to suicide in Kent & Medway, it is essential to implement new strategy for 2026-2030 that uses data, evidence and established Networks to shape the future direction of this essential work.

2. Key Considerations

2.1 The existing strategy is in operation between 2021-2025. It has contributed to a situation whereby local rates have been falling slightly whilst national ones increase, however there has been a substantial amount of other key outcomes.

2.2 These have included the ongoing promotion of the Release the Pressure campaign, a service which supports tens of thousands of people each year, over 100 community grants being distributed to projects directly supporting those with suicidal ideation or who were self-harming, over 8000 individuals being trained in suicide prevention and mental health, and the commissioning of a specialist suicide bereavement support service so that bespoke support has been available to those impacted in this devastating way.

2.3 The programme has also developed a Real Time Suicide Surveillance system with Kent Police, which has enabled it to monitor for any patterns or trends as they emerge and intervene accordingly. This has included the identification of the link between domestic abuse and suicide, which led to this being recognised in the national strategy for the first time in 2023, with the research of the Kent & Medway Programme directly cited.

2.4 The new strategy for 2026-2030 combines all of the positive examples above and has been shaped and designed alongside key research, local data and evidence, and with the input of our wider stakeholders, including Network members.

2.5 It is essential to have a new strategy in place to help inform the effective direction of the programme.

3. Background

3.1 The Kent and Medway Suicide and Self-harm Prevention Strategy 2026-30 is the continuation of the work undertaken as a result of the 2021-2025 Kent and Medway Suicide Prevention Strategy and combines local data about who is dying by suicide in Kent and Medway with national research and policy direction.

3.2 Unlike the existing Strategy (2021-2025), the Suicide and Self-Harm Prevention Strategy for 2026-2030 encompasses both Adults, and Children and Young People (CYP) as opposed to creating a separate Strategy for both. The new Strategy sets the same eight priorities for both groups, but across two separate action plans, in recognition of the need for a slightly different approach for each.

3.3 The draft Suicide Prevention Strategy 2026-30 was developed by the Kent and Medway Suicide Prevention Programme, which is hosted by KCC's Public Health department and funded by the Kent and Medway Integrated Care Board. The strategy group also includes Medway Council Public Health Team and

representatives from the Integrated Care Board and the Kent and Medway Mental Health Trust.

3.4 The draft strategy was developed in conjunction with the Suicide Prevention Networks, which are well-established partnerships made up of over 250 agencies, including statutory and voluntary / community sector organisations as well as individuals living with experience of suicidal thoughts, self-harm or being bereaved by suicide. There is a Network focused on supporting adults, and a Network focused on supporting children and young people. These Networks will oversee the action plans set out for each as result of this Strategy.

3.5 The vision of the new strategy is that Kent and Medway becomes a place where the number of people dying by suicide is reduced as much as possible. Our aim is for the Kent and Medway suicide rate to be below the national average by 2030 (if not sooner).

3.6 The mission of this strategy is to make Kent and Medway a place where hope is always available to anyone, no matter what they are facing. Specifically, we would like to have achieved the following by 2030:

- Children and young people in Kent and Medway to be resilient enough to cope with life's normal ups and downs, but knowledgeable and confident enough to reach out for more support when they need it.
- Adults in Kent and Medway to know how to look after their own emotional wellbeing but to feel comfortable and able to seek more help when necessary.
- All agencies (statutory, voluntary, community) to work collectively to ensure support and help is available to those who need it.
- All agencies to share knowledge and support each other to learn what works in helping people get the support they need.

3.7 The draft Strategy went out for public consultation between 23rd July to 6th October 2025. A consultation report (appendix d) was produced and is published on the Let's Talk Kent website along with the You Said, We Did document (appendix e), which outlines the changes made to the Strategy post consultation, which are minimal, due to the support for the Strategy demonstrated during the consultation.

4. Options considered and dismissed, and associated risk

4.1 No other options were considered as the Strategy is necessary to the Kent & Medway Suicide Prevention Programme.

5. Financial Implications

5.1 The Suicide Prevention team and programme is funded via the NHS through the Kent and Medway Integrated Care Bboard (ICB), therefore there are minimal financial implications to KCC.

5.2 KCC funds the Programme Manager role and occasionally provides financial support to individual projects.

5.3 The Samaritans estimate that each individual suicide has associated costs of £1.46 million (consisting of lost employment productivity, healthcare costs and legal and administrative expenses). Suicide prevention activity plays an important role in mitigating these costs.

6. Legal implications

6.1 There are no legal implications for KCC, or its partners associated with the development of the strategy

7. Equalities implications

7.1 An equalities impact assessment (EqIA) has been completed as part of the strategy development process, the EqIA was reviewed and amended following the consultation. (see appendix c) It identifies that there are some groups at higher risk of suicide, which are reflected in the priorities of the new strategy. However, as this strategy seeks to serve all residents there is no potential for discrimination and all appropriate measures have been taken to advance equality and foster good relations between the protected groups.

8. Data Protection Implications

8.1 A Data Protection Impact Assessment (DPIA) is not required for the Strategy as the Programme does not deliver direct support to Kent residents. DPIAs will be implemented across commissioned services where identified as a requirement following screening.

9. Other corporate implications

9.1 The new Suicide & Self-Harm Prevention Strategy 2026-2030 clearly aligns with the commitment to work with our partners to hardwire a preventative approach into improving the health of Kent's population and narrowing health inequalities, improving safeguarding and preventing death. It aims to work with partners across the System to improve residents' mental health and reduce the risk of people dying by suicide.

9.2 The strategy will be overseen by the Kent & Medway Suicide Prevention Programme, which sits within KCC Public Health but works closely with other areas of the organisation as required, such as Children's & Young People.

10. Governance

10.1 Accountability of this strategy sits with the Director of Public Health. The Suicide Prevention Oversight Board which includes the ICB, who fund this programme, are fully supportive of this proposal.

11. Conclusions

11.1 Adoption of the 2026-2030 suicide and self-harm prevention strategy will shape the direction of the Kent & Medway Suicide Prevention Programme's work for the next five years.

11.2 The Suicide Prevention Oversight Board, which includes representatives from Medway Council, Kent and Medway Mental Health NHS Trust, and the ICB (who fund this programme) are fully supportive of this proposal.

Recommendation(s):

The Adult Social Care & Public Heath Cabinet Committee is asked to **CONSIDER** and **ENDORSE**, or **MAKE RECOMMENDATIONS** to the Cabinet Member for Adult Social Care & Public Health in relation to the proposed decision as detailed in the attached Proposed Record of Decision document (Appendix A).

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10. Background Documents

10.1 The Draft Suicide & Self-Harm Prevention Strategy 2026-2030 – Post Consultation Version 8

10.2 2026-2030 Data & Evidence Pack v7: **Documents | The Kent and Medway Suicide and Self-Harm Prevention Strategy 2026-2030 | Let's Talk Kent**

10.3 Equality Impact Assessment (pre-consultation): https://letstalk.kent.gov.uk/41977/widgets/127040/documents/88213

10.4 Equality Impact Assessment (post-consultation):

10.5 Consultation Questionnaire: **Documents | The Kent and Medway Suicide and Self-Harm Prevention Strategy 2026-2030 | Let's Talk Kent**

10.6 National Suicide Prevention Strategy for England : **Suicide prevention strategy for England: 2023 to 2028 - GOV.UK**

10.7 Suicide & Self-Harm Prevention Strategy 2026-2030 Consultation Report: **Available to download at: The Kent and Medway Suicide and Self-Harm Prevention Strategy 2026-2030 | Let's Talk Kent**

10.8 Suicide & Self-Harm Prevention Strategy 2026-2030 'You Said, We Did' document: **Available to download at: The Kent and Medway Suicide and Self-Harm Prevention Strategy 2026-2030 | Let's Talk Kent**

11. Contact details

Report Author: Sophie Kemsley Job title: Senior Project Officer Telephone number: 03000 411512 Email address:	Director: Dr Anjan Ghosh Job title: Director of Public Health Telephone number: 03000 412633 Email address: anjan.ghosh@kent.gov.uk

sophie.kemsley@kent.gov.uk	

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KENT COUNTY COUNCIL – PROPOSED RECORD OF DECISION

DECISION TO BE TAKEN BY:	DECISION NUMBER:
Diane Morton, Cabinet Member for Adult Social Care & Public Health	25/00105

Executive Decision – key

Kent & Medway Suicide And Self-Harm Prevention Strategy 2026-2030 (25/00105)

Decision:

As Cabinet Member for Adult Social Care and Public Health, I agree to:
APPROVE the adoption of the Suicide & Self-Harm Prevention Strategy 2026-2030

Reasons for decision:

The Suicide & Self-Harm Prevention Strategy 2026-2030 is a continuation of the existing strategy (2021-2025) and combines local data about who is dying by suicide in Kent and Medway with national research and policy direction.

To increase the likelihood of reducing the number of lives lost to suicide in Kent & Medway, it is essential to implement new strategy for 2026-2030 that uses data, evidence and established Networks to shape the future direction of this essential work.

The draft Strategy went out for public consultation between 23rd July to 6th October 2025. A consultation report was produced and is published on the Let's Talk Kent website along with the You Said, We Did document, which outlines the changes made to the Strategy post consultation, which are minimal, due to the support for the Strategy demonstrated during the consultation.

Adoption of the 2026-2030 suicide and self-harm prevention strategy will shape the direction of the Kent & Medway Suicide Prevention Programme's work for the next five years.

The Suicide Prevention Oversight Board, which includes representatives from Medway Council, Kent and Medway Mental Health NHS Trust, and the Integrated Care Board (ICB) (who fund this programme) are fully supportive of this proposal.

Financial implications:

The Suicide Prevention team and programme is funded via the NHS through the Kent and Medway ICB, therefore there are minimal financial implications to Kent County Council (KCC).

KCC funds the Programme Manager role and occasionally provides financial support to individual projects.

The Samaritans estimate that each individual suicide has associated costs of £1.46 million (consisting of lost employment productivity, healthcare costs and legal and administrative expenses). Suicide prevention activity plays an important role in mitigating these costs.

Legal implications:

There are no legal implications for KCC, or its partners associated with the development of the strategy

Equalities implications:

An Equality Impact Assessment (EqIA) was completed as part of the strategy development process. This was reviewed and amended following the consultation. It identifies that there are some groups at higher risk of suicide, which are reflected in the priorities of the new strategy. However, as this strategy seeks to serve all residents there is no potential for discrimination and all appropriate measures have been taken to advance equality and foster good relations between the protected groups.

Data Protection implications:

A Data Protection Impact Assessment (DPIA) is not required for the Strategy as the Programme does not deliver direct support to Kent residents. DPIAs will be implemented across commissioned services where identified as a requirement following screening**.**

Cabinet Committee recommendations and other consultation:

The proposed decision will be discussed at the Cabinet Committee member for Adult Social Care & Public Health on 21st January 2026

Any alternatives considered and rejected:

No other options were considered as the Strategy is necessary to the Kent & Medway Suicide Prevention Programme.

Any interest declared when the decision was taken and any dispensation granted by the Proper Officer:

No other interests declared.

.....	.....
Signed	Date

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The Kent and Medway Suicide and Self-Harm Prevention Strategy 2026-2030

January 2026

Visit: kent.gov.uk/suicideprevention

NHS
Kent and Medway

Medway Council
Serving You

Kent County Council
kent.gov.uk

“Hope is not a lottery ticket you sit on the sofa and clutch. It is an axe you break down doors with.”

Rebecca Solnit

Any discussion of suicide is distressing. Please look after yourself. Help is available 24 hours a day by calling 0800 107 0160.
(https://www.kent.gov.uk/social-care-and-health/health/release-the-pressure)

Foreword

“In 2024, 5717 lives were lost to suicide in England, including 162 in Kent and Medway alone. Every one of these deaths represents a tragedy which would have had heartbreaking effects on those left behind, including families, friends and wider communities.

The mission is simple; we must do whatever we can to reduce the number of individuals in Kent and Medway who feel that suicide is their only option. We must do whatever is in both our individual and collective powers to instil hope across our communities and ensure that the experiences of those we have lost lead to visible actions that bring these statistics down.

The new Suicide and Self-Harm Prevention Strategy for 2026-2030 is our ongoing commitment to have the oversight on fulfilling this mission, it is not the job of any one agency, it needs to be everybody’s business.

We encourage all who read this strategy to think about the valuable role they can play within it, whether that be developing awareness of suicide and feeling more confident in holding conversations that could save somebody’s life, knowing which services are available to support or simply thinking about how to promote hope to those around us. It is also about improving services, better access to much needed support, and leadership to create healthy, strong and supportive communities.

Our new strategy builds on the previous strategies, the national strategy and comments from a wide variety of stakeholders and people with lived experience across Kent and Medway. Our new strategy wants a bolder approach to tackle self-harm, better access routes to support, and to empower people with lived experience and local communities to shape the changes needed to improve people’s lives and give hope. Together we will support those who are affected by suicide, whether personally or professionally. We will address stigma and fear of blame, through shared responsibility, collective action, listening and learning from each other to achieve suicide safer communities.

We all have an important role to play, and we look forward to working together to save lives and support those impacted by suicide.”

Anjan Ghosh (Director of Public Health) – Kent County Council
David Whiting (Director of Public Health) – Medway Council
Sheila Stenson (CEO) and Andy Cruickshank (Chief Nursing Officer) – Kent and Medway Mental Health NHS Trust
Name TBC - Kent and Medway Integrated Care Board –

Executive Summary

Current Context

As we come to the end of our current 2021-25 Suicide Prevention Strategy, the Kent and Medway Suicide Prevention Programme:

- Has contributed to a situation where suicide rates locally are falling slightly, while national rates increase.
- Is made up of three Networks with over 250 engaged Members who meet regularly to discuss major issues and shape local responses.
- Is nationally recognised as good practice.

However, there is much work still to be done:

- Every death is one death too many.
- Kent and Medway suicide rates still appear to be higher than the national average.

Vision

Our vision is that Kent and Medway becomes a place where the number of people dying by suicide is reduced as much as possible and our specific aim is for the Kent and Medway suicide rate to be below the national average by 2030 (if not sooner).

Mission

We will work to make Kent and Medway a place where hope is always available to anyone, no matter what they are facing.

By 2030 we would like:

- Children and young people in Kent and Medway to feel empowered and able to cope with life's normal ups and downs, but knowledgeable enough and confident enough to reach out for more support when they need it
- Adults in Kent and Medway to know how to look after their own emotional wellbeing but to feel comfortable and able to seek more help when necessary
- All agencies (statutory, voluntary, community) to work collectively to ensure support and help is available to those who need it
- All agencies to share knowledge and support each other to learn what works in helping people get the support they need.

Values

1. **Collaboration.** The power of the Suicide Prevention Programme comes from the hundreds of Members who all work towards the Vision.
2. **Hope.** Hope is extraordinarily powerful, yet without it, everything is extremely difficult. We will embed hope into everything that we do.
3. **Determination.** Suicide prevention is not an easy task, particularly in a population of nearly two million. We will undertake every action with fierce determination.
4. **Sensitivity.** We will work sensitively with everyone impacted by suicide to ensure we don't add to their trauma.

Strategic priorities – we will:

1. Make suicide everybody's business so that we can maximise our collective impact and support to prevent suicides.
2. Address common risk factors linked to suicide at a population level to provide early intervention and tailored support.
3. Tailor and target support to priority groups, including those at higher risk, to ensure there is bespoke action and that interventions are effective and accessible for everyone.
4. Provide effective crisis support across sectors for those who reach crisis point.
5. Improve data and evidence to ensure that effective, evidence-informed and timely interventions continue to be developed and adapted.
6. Reduce access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides.
7. Promote online safety and responsible media content to reduce harms, improve support and signposting, and provide helpful messages about suicide and self-harm.
8. Provide effective bereavement support to those affected by suicide.

Success measures – we will:

1. Monitor local and national suicide data.
2. Ensure every programme or project we deliver or invest in has tailored performance targets.
3. Complete monthly Action Plans that record progress and deliverables against our strategic priorities
4. Publish an annual impact report, which will be distributed widely through our suicide prevention network and newsletter and publicly available on our Padlet (Padlet (https://padlet.com/SuicidePrevention/suicide-prevention-team-resources-zuu4rhjasoll5b01) or upon request
5. Undertake regular engagement activities with Network Members to ensure there is collective agreement on our 5 year strategy and annual action plans.

Introduction

Every suicide is a heartbreaking tragedy that profoundly affects the victim's loved ones and reverberates throughout the entire community.

Every death is one too many, so this strategy sets our plan to reduce the numbers of people taking their own lives as much as possible.

But no single organisation, agency or individual can reduce suicide on their own. It needs to be everyone's business, everyone working together to harness our collective power.

We want this strategy to be a rallying cry, and a call to action to every organisation, agency and individual to join together and help prevent the needless deaths we see too often.

Above everything, we want the actions contained within this strategy to provide hope to those individuals who find themselves now, or maybe in the future, in a dark place. We want Kent and Medway to become a place where hope is always available to anyone, no matter what they are facing.

And finally, we know that for people who have already lost loved ones to suicide, no strategy, no collection of words, can ever bring their loved one back. For that we are truly sorry, but through these actions, we will do all we can to reduce the risk of other families experiencing the same pain.

Background

This Kent and Medway Suicide and Self-harm Prevention Strategy 2026-30 is the continuation of the work undertaken as a result of the 2021-2025 Kent and Medway Suicide Prevention Strategy.

This strategy combines local data about who is dying by suicide in Kent and Medway with national research and policy direction.

It has been developed by the Kent and Medway Suicide and Self-harm Networks (separate Networks focused on adults, and children & young people), which consist of over 250 partners working together.

Before coming into effect, this strategy will go out to public consultation, (featuring discussions with existing partnerships and a survey) to ensure that the widest number of individuals, people with lived experience and organisations have their chance to input into the plans.

To ensure that this strategy does not discriminate unfairly against any particular group within Kent and Medway, an equality impact assessment has also been undertaken and is available on the Let's Talk Kent website.

Strategy Development

Members of both the Adult Suicide Prevention Network, and the Children and Young People's Suicide Prevention Network fed into the draft strategy, including discussions at both recent Network meetings, the 2023 and 2024 annual conferences and a special workshop to review the new national suicide prevention strategy in 2024.

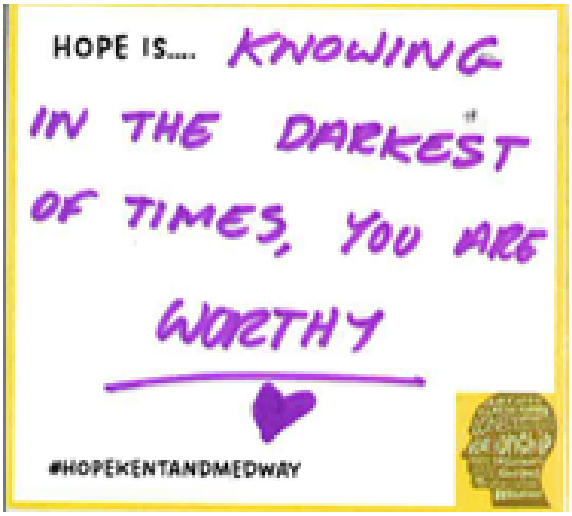
Public Consultation

The public consultation ran from 16 July to 6 October 2025 and was hosted on the Let's Talk Kent website: www.kent.gov.uk/suicideprevention . The consultation period was extended to allow additional time for responses after the school holidays and to give people the chance to take part after the Baton of Hope event which took place on 22 September 2025.

153 responses were received in total of which 149 responses were received through the online questionnaire. There were a further 2 responses received via email, and 2 further comments received via email.

Each of these responses and comments were analysed and used to produce the Consultation Report, which can be found on the Let's Talk Kent website. The findings from this report showed that the majority of respondents supported the draft Strategy: 89% agreed with the vision, 88% agreed with the mission, and 91% agreed with the values.

The key findings from the analysis report informed the production of the 'You Said, We Did' document, which is also available on the Let's Talk Kent website. This document highlighted and explained the changes which were then made to finalise the draft Strategy.



Statistical Snapshot

The latest data published by the Office of National Statistics (October 2025) shows that both Kent and Medway appear to have higher suicide rates than the national average. However rates in Kent are falling at a time when national rates are increasing.

Table 1 Suicide rate comparison, 3 year suicide rolling rates per 100,000

	2020 to 2022	2022 to 2024
England	10.3	10.9
Kent	12.1	11.3
Medway	10.6	10.3

Source – Office for National Statistics, 2025

By analysing the 721 records of people who have died in Kent and Medway between 2020 and 2024 (contained within the Real Time Suicide Surveillance system, delivered in partnership with Kent Police) we have uncovered more detail about the situation in Kent and Medway which then drives our programme's work.

Of those who have died by suspected suicide in Kent and Medway…	Implication for our work
75% were male	When designing our services and campaigns we try to ensure that men know they exist, and are confident and comfortable accessing them.
69% were not known to secondary mental health services	We focus heavily on support for communities and individuals not known to secondary mental health services (as well as working with partners to improve the quality and safety of secondary mental health services).
33% had been impacted by domestic abuse (either as victim or perpetrator)	We are leading the way nationally in researching this relationship and establishing ways to reduce the risk of domestic abuse victims taking their own lives.
21% were known to misuse alcohol or drugs	We support our substance misuse providers to recognise and respond to suicide risk.
14% were 25 or under	The number of years of life lost by each individual, and the fact that young people face many different issues mean that we have developed an additional Children and Young People Suicide Prevention Network and action plan

Source – Kent and Medway Real Time Suicide Surveillance 2020-2024

For an in-depth statistical analysis, please see the corresponding Data and Evidence Pack (available on the Let's Talk Kent website) which was produced to support the public consultation and the development of the strategy.

National Context

In 2023, the Government published the "Suicide Prevention Strategy for England". It contains eight priorities which we propose to follow in Kent and Medway. We will adapt each one to ensure local concerns and priorities are reflected.

Kent and Medway local context

This strategy fully aligns to the Kent and Medway Integrated Care Strategy which sets up how partners across the county will work together to tackle the full range of health determinants, improve health and address inequalities. This strategy's Vision (to reduce the Kent and Medway suicide rate to below the national average) is also within the Integrated Care Strategy ensuring cross-system support for our work.

Our suicide prevention programme is nationally recognised as best practice and we are often invited to present what we do to national and even international partners.

The core suicide prevention team is made up of four committed and passionate professionals, but the power of our programme is generated by the hundreds of individuals and organisations across the county who make up our Suicide Prevention Networks, who play a major part in the design and delivery of the programme.

Illustration – Kent and Medway Suicide Prevention Network Members

Alongside our Networks, the Suicide Prevention Strategic Oversight Board consists of senior Public Health colleagues from Kent County Council and Medway Council, Kent and Medway Mental Health NHS Trust and NHS Kent and Medway. The Strategic Oversight Board takes financial decisions and provides the formal pathway into KCC, Medway Council and NHS Kent and Medway governance structures.

Review of the 2021-25 Strategy

As we reach the end of the period covered by our previous strategy, local suicide rates have fallen by a small amount, at the same time as national rates increased. We believe that the funded projects we have supported, and the system leadership that we have provided over the last five years, have contributed to that decline.

To reduce the risk of suicide in key high-risk groups we…

- Promoted the Release the Pressure social marketing campaign and 24 hour services in a wide range of creative and effective ways. The helpline and text service supports tens of thousands of conversations every year.

"If it hadn't been for this helpline I wouldn't have coped one bit… I can't thank you enough."

"Without the service, I would not be here today. I wouldn't be talking to you now, I'd be six foot under."

- Supported Citizens Advice to support people with mental health and financial difficulties. An independent academic evaluation has found this service makes over £1 million of financial gain for clients every year and is directly responsible for saving people's lives.

To tailor approaches to improve mental health and wellbeing Kent we…

- Provided over 100 community grants to local grassroots projects who directly supported individuals who were suicidal or self-harming.
- Supported Mid Kent Mind to deliver over 8,000 places on Suicide Prevention, or Everyday Mental Health Training.

"The training came in useful on Friday evening when I spent an hour at xxx train station persuading a young man not to kill himself."

"The training has helped me support a family member whose child was feeling suicidal to get the right support."

To provide better information and support to those bereaved by suicide we…

"Amparo have been a lifeline for me during the most difficult time in my life."

"Without the weekly support {from Amparo}, I can't imagine where life may have taken me in the days after my parent's death."

- Commissioned the Amparo bereavement support service to support families and individuals who have been bereaved by suicide.

To support research, data collection and monitoring we…

- Established a Real Time Suicide Surveillance system to identify local trends, patterns and the details of what was happening in the lives of people in Kent and Medway before they died by suicide.
- Conducted nationally influential research into the links between domestic abuse and suicide, as well as separate research projects into the impact of debt on suicidality and the links between autism and suicide.

To reduce access to the means of suicide we…

- Analysed Real Time Suicide Surveillance data to identify high risk sites
- Worked closely with Network Rail, Highways England and other major landowners regarding those sites.

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.
- Promoted the Samaritans Media Guidelines to local journalists.

We will continue to fund many projects as well as driving change through system leadership during 2026-2030.

Population Groups of Concern for the 2026-2030 Strategy

One sad truth about suicide is that it doesn't discriminate. Over the course of the last five year strategy we have seen tragic deaths among virtually every population group imaginable. So over the course of the next strategy, we will ensure that we try to reduce the risk of suicide for everyone in Kent and Medway.

However when you look at population level statistics, there are some population groups which seem to be at greater risk than others. There are also some groups which may not have had historically high suicide rates but they are a concern because national evidence suggest that their rates are increasing.

The national strategy identifies the following high-risk groups as priorities for actions:

- Middle aged men
- Children and young people
- People with a history of self-harm
- People known to secondary mental health services
- People in contact with the justice system
- People affected by physical illness
- People affected by social isolation and loneliness
- People who are impacted by domestic abuse
- Pregnant women and new mothers
- Neurodivergent people (including those awaiting diagnosis)
- People affected by financial difficulty and economic adversity
- People affected by gambling harms
- People affected by drug and alcohol misuse

We have conducted deep dives into each of these groups in the Data and Evidence Pack that is published alongside this strategy, but rest assured that in addition to working to reduce the suicide risk in these groups, we will continue to work to reduce the suicide risk for everyone in Kent and Medway.

Suicide and Self-Harm Prevention Strategy 2026 – 2030

Our vision – that the Kent and Medway suicide rate falls below the national average by 2030.
Our mission – we will work to make Kent and Medway a place where hope is always available to anyone, no matter what they are facing.
Our values – Collaboration, Hope, Determination and Sensitivity.

Our strategic priorities - we will…

1. **Make suicide everybody's business so that we can maximise our collective impact and support to prevent suicides.**

- We will increase knowledge and awareness of suicide prevention techniques and tools by continuing to offer free to attend suicide prevention training for everyone.
- We will provide system leadership and quality improvement through our suicide prevention networks, annual conferences and relationships with individual services.

2. **Address common risk factors linked to suicide at a population level to provide early intervention and tailored support.**

- We will increase public awareness of 24-hour support services through the Release the Pressure social marketing campaign.
- We will deliver public facing initiatives such as the Baton of Hope to reduce the stigma of talking about suicide and accessing support.

3. **Provide tailored and targeted support to priority groups, including those at higher risk, to ensure there is bespoke action and that interventions are effective and accessible for everyone.**

- We will deliver targeted interventions to support people in higher risk groups including (but not limited to) people impacted by domestic abuse, neurodivergent people, people in contact with secondary mental health services, people in financial difficulty, and people with substance misuse issues.

4. **Provide effective crisis support across sectors for those who reach crisis point.**

- We will support efforts to improve support for those in crisis, including working with secondary mental health services and safe havens across Kent and Medway.

5. **Improve data and evidence to ensure that effective, evidence-informed and timely interventions continue to be developed and adapted.**

- We will conduct regular analysis of our Real Time Suicide Surveillance system to identify emerging trends and on-going patterns, and respond accordingly
- We will commission or conduct bespoke research into emerging or high risk topics.

6. **Reduce access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides.**

- We will monitor our Real Time Suicide Surveillance and work with partners such as Kent Police, Network Rail and National Highways to identify, intervene and respond to high risk locations or other means.

7. **Promote online safety and responsible media content to reduce harms, improve and signposting, and provide helpful messages about suicide and self-harm.**

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

8. **Provide effective bereavement support to those affected by suicide.**

- We will continue to commission a support service for people bereaved by suicide.

Children and Young People Suicide and Self-Harm Prevention Strategy 2026 – 2030

Our vision – that the Kent and Medway suicide rate falls below the national average by 2030.
Our mission – we will work to make Kent and Medway a place where hope is always available to anyone, no matter what they are facing.
Our values – Collaboration, Hope, Determination and Sensitivity.

Our strategic priorities - we will…

1. **Make suicide everybody's business so that we can maximise our collective impact and support to prevent suicides.**

- We will increase knowledge and awareness of suicide prevention techniques and tools by continuing to offer suicide prevention training targeted at those who support children and young people.
- We will provide system leadership through our children and young people suicide prevention network and our informal system leaders group.

2. **Address common risk factors linked to suicide at a population level to provide early intervention and tailored support.**

- We will produce versions of our Release the Pressure social marketing campaign specifically aimed at children and young people.

3. **Provide tailored and targeted support to priority groups, including those at higher risk, to ensure there is bespoke action and that interventions are effective and accessible for everyone.**

- We will deliver targeted interventions to support children and young in higher risk groups including (but not limited to) those impacted by domestic abuse, neurodivergent people, those in contact with secondary mental health services and those who self-harm.

4. **Provide effective crisis support across sectors for those who reach crisis point.**

- We will support efforts to improve support for those in crisis, including working with secondary mental health services.

5. **Improve data and evidence to ensure that effective, evidence-informed and timely interventions continue to be developed and adapted.**

- We will conduct regular analysis of our Real Time Suicide Surveillance system to identify emerging trends and on-going patterns, and respond accordingly
- We will commission or conduct bespoke research into emerging or high risk topics.

6. **Reduce access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides.**

- We will monitor our Real Time Suicide Surveillance and work with partners such as Kent Police, schools and social services to identify, intervene and respond to high risk locations or other means.

7. **Promote online safety and responsible media content to reduce harms, improve and signposting, and provide helpful messages about suicide and self-harm.**

- We will work with local, national and social media outlets to promote positive stories about mental health, hope and help seeking behaviours.

8. **Provide effective bereavement support to those affected by suicide.**

- We will ensure that our commissioned suicide bereavement service takes a whole family approach and continues to support children.
- We will ensure that support is available to schools, colleges and universities if they have a tragic suicide amongst their community.

EQIA Submission – ID Number
Section A

EQIA Title
The Kent and Medway Suicide and Self-Harm Prevention Strategies 2026-2030

Responsible Officer
Sophie Kemsley - AH Public Health

Approved by (Note: approval of this EqIA must be completed within the EqIA App)
Jessica Mookherjee - AH Public Health

Type of Activity

Service Change
No
Service Redesign
No
Project/Programme
Project/Programme
Commissioning/Procurement
No
Strategy/Policy
Strategy/Policy
Details of other Service Activity
No

Accountability and Responsibility

Directorate
Strategic and Corporate Services
Responsible Service
Public Health
Responsible Head of Service
Jessica Mookherjee - AH Public Health
Responsible Director
Anjan Ghosh - AH Public Health

Aims and Objectives

The new Suicide & Self Harm Prevention Strategy for 2026-2030 is a combined Strategy for both Adults and CYP.

The K&M Suicide Prevention Programme first developed a strategy in 2015 and made a commitment to review this every 5 years. We are currently in the final year of the existing 2021-2025 strategy and within this timeframe have also seen the publication of the new national suicide prevention strategy (2023-2028). Both our existing strategy and the one we are planning to implement from 2026 align with national strategy and its ultimate aims to reduce suicide and self-harm as much as possible, and to continue improving support to those who self-harm and those who have been bereaved by suicide.

The Kent and Medway Suicide and Self-Harm Prevention Strategy for 2026-2030 will continue to build upon the successes of the current strategy. It will not lead to significant changes within the Programme, but we have used the renewal process as an opportunity to confirm priorities and identify any gaps.

The Kent and Medway Suicide and Self-Harm Prevention Strategy for 2026-2030 sets out a multi-agency commitment and approach to reducing the number of people who lose their lives to suicide. Since anybody can be at risk, this is a strategy which will apply to all residents of Kent & Medway. The 2026-2030 strategy

is a continuation of the previous 2021-2025 strategy which is intended to impact Kent & Medway residents positively, and sets out high level objectives.

The Strategy has been designed to work for all residents in Kent and Medway. Although there are some groups of people identified as being a 'priority group' on the basis of data and evidence that suggests they may be at a higher risk, we know that suicide and self-harm do not discriminate.

There is no evidence to suggest that updating the Suicide Prevention and Self-harm Strategy will have an adverse/negative impact on protected groups.

The Strategy was out for Public Consultation between 23rd July 2025 and 6th October 2025. A summary of engagement can be found in Section B of this EQIA.

Respondents were asked their views on the EQIA as part of the consultation questionnaire. 43 respondents (29% of all consultation respondents) provided a comment to this question referencing a total of 17 themes. The most commonly observed theme was an approval of the EqIA (10 mentions). 9 voiced some scepticism of the EqIA, whilst 8 referenced neurodivergence and 5 referenced the LGBTQIA+ community. The main scepticisms were that the EQIA should not detract from the responsibility for the Strategy to focus on all individuals, on the basis that mental health does not discriminate. The comments relating to Neurodivergence and the LGBTQIA+ community were also cited elsewhere in the consultation responses, and have been addressed within the Consultation Report and 'You Said, We Did' document available on the Let's Talk Kent website. As part of our response to this we have changed 'Autistic people' to 'Neurodivergent people' on the basis of the overlaps between those who are Autistic and those with ADHD.

We have also re-asserted that an absence of a particular group within the 'Priority Groups' does not preclude them from our Strategy, and that we will respond to any emerging data and evidence around other groups as they emerge.

The pre-Consultation EQIA was reviewed following the Consultation and has now been updated into this version 2.

Analysis Outcome:

No change. The evidence suggests that there is no potential for discrimination and all appropriate measures have been taken to advance equality and foster good relations between the protected groups.

Section B – Evidence

Do you have data related to the protected groups of the people impacted by this activity?
Yes
It is possible to get the data in a timely and cost effective way?
Yes
Is there national evidence/data that you can use?
Yes
Have you consulted with stakeholders?
Yes
Who have you involved, consulted and engaged with?
The following engagement work was undertaken to develop the draft strategy:

- December 2023 - The SP Programme's adults and CYP conference included a table-top activity which asked stakeholders what they wanted to see in the new local strategy.
- April 2024 - A smaller workshop, with identified key stakeholders, took place to build on what was learned during the previous engagement activity. This was led by an independent facilitator and outcomes report produced.
- November 2024 – We used our annual conference to remind attendees that the new strategy was being put together in the year ahead.
- March 2025 - Adult Network meeting March 2024 – We gave an overview of the process at our Adult Network meeting and gave a further opportunity for stakeholders to provide thoughts on what they felt had worked well under the current strategy and what they would like to see in the new one.
- April 2025 –We will repeat this at the CYP Network meeting.

Engagement has taken place through the existing adult and CYP Suicide Prevention Networks. These Networks consist of representatives from a range of sectors and organisations including British Transport Police, Canterbury Christchurch University, Kent Coroners, Kent County Council, Kent Police, Kent and Medway HCPs, KMPT, Medway Council, Network Rail, NHS England, the Samaritans and carers. They are chaired by Public Health and Integrated Children's Services Kent County Council representatives

The Strategy was out for Public Consultation between 23rd July 2025 and 6th October 2025.

To raise awareness of the consultation and encourage participation from a number of groups, the following engagement was undertaken:

- Emails sent to stakeholders asking them to promote the consultation through their networks.
- Invites sent to people registered with Let's Talk Kent who had expressed an interest in relevant the topics (11,532 users).
- Article in the Better Mental Health Suicide Prevention newsletter (circulated to approx. 900 stakeholders across the county) requesting participation and for recipients to share with their wider networks and service users.
- Promotional materials distributed at event locations during the visit of the Baton of Hope to Kent and Medway on 22 September 2025.
- Key commissioned service providers, including Amparo, Mid Kent Mind and CANWK were asked to raise awareness of the consultation among service users and support them to participate.
- Children and young people engagement through the CYP Network and wider partners.
- Shared with KMPT service users and their Lived Experience Panel.
- Shared across KCC staff comms channels and with all Staff Groups to help capture input from a wide range of groups (including ethnic diversity, disability and LGBTQ+ groups).
- Joint media releases and communications with Medway Council and the Integrated Care Board.
- Social media posts on KCC's Facebook, X (formerly Twitter), Instagram, Nextdoor and LinkedIn channels. Mid-way through the consultation period, four posts were boosted to gain wider reach and engagement.
- Posters displayed in KCC buildings, including libraries, Gateways and country parks.
- Promotional banner on the Kent.gov.uk homepage during the consultation.
- Articles in the KCC's residents' e-newsletter.
- Articles were sent for inclusion in the KELSI Schools e-bulletin.
- Presented at internal and external meetings, including the ReferKent Network meeting, the Suicide-Safer Strategic meeting hosted by Canterbury Christ Church University, and the Community Safety information sessions.
- Promoted to town and parish councils through the Kent Association of Local Councils (KALC).
- Shared by KCC's Adult Social Care team with the Learning Disability Partnership Board, the People's Panel,

Your Voice network, and Carers Voice engagement group.
• Following a review of responses mid-way through the consultation, specific organisations were targeted in an efforts to increase the number of responses from underrepresented groups, such as middle-aged men and ethnic minorities.

Has there been a previous Equality Analysis (EQIA) in the last 3 years?

Yes

Do you have evidence that can help you understand the potential impact of your activity?

Yes

Section C – Impact

Who may be impacted by the activity?

Service Users/clients

Service users/clients

Staff

No

Residents/Communities/Citizens

Residents/communities/citizens

Are there any positive impacts for all or any of the protected groups as a result of the activity that you are doing?

Yes

Details of Positive Impacts

The Strategy is designed to have a positive impact on all residents of Kent and Medway, to cover all protected characteristics.

The Vision, Mission and Priorities of the Strategy are set out below:

Vision
Our vision is that Kent and Medway becomes a place where the number of people dying by suicide is reduced as much as possible and our specific aim is for the Kent and Medway suicide rate to be below the national average by 2030 (if not sooner).

Mission
We will work to make Kent and Medway a place where hope is always available to anyone, no matter what they are facing.

By 2030 we would like:
- Children and young people in Kent and Medway to feel empowered and able to cope with life's normal ups and downs, but knowledgeable enough and confident enough to reach out for more support when they need it
- Adults in Kent and Medway to know how to look after their own emotional wellbeing but to feel comfortable and able to seek more help when necessary
- All agencies (statutory, voluntary, community) to work collectively to ensure support and help is available to those who need it
- All agencies to share knowledge and support each other to learn what works in helping people get the support they need.

Values

1. Collaboration. The power of the Suicide Prevention Programme comes from the hundreds of Members who all work towards the Vision.
2. Hope. Hope is extraordinarily powerful, yet without it, everything is extremely difficult. We will embed hope into everything that we do.
3. Determination. Suicide prevention is not an easy task, particularly in a population of nearly two million. We will undertake every action with fierce determination.
4. Sensitivity. We will work sensitively with everyone impacted by suicide to ensure we don't add to their trauma.

Strategic priorities – we will:
1. Make suicide everybody's business so that we can maximise our collective impact and support to prevent suicides.
2. Address common risk factors linked to suicide at a population level to provide early intervention and tailored support.
3. Tailor and target support to priority groups, including those at higher risk, to ensure there is bespoke action and that interventions are effective and accessible for everyone.
4. Provide effective crisis support across sectors for those who reach crisis point.
5. Improve data and evidence to ensure that effective, evidence-informed and timely interventions continue to be developed and adapted.
6. Reduce access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides.
7. Promote online safety and responsible media content to reduce harms, improve support and signposting, and provide helpful messages about suicide and self-harm.
8. Provide effective bereavement support to those affected by suicide.

Negative impacts and Mitigating Actions

19.Negative Impacts and Mitigating actions for Age

Are there negative impacts for age?

Yes

Details of negative impacts for Age

Although people who die by suicide come from all age groups, data at both local and national levels indicate that some are more at risk than others. Middle-aged (men) and CYP are cited as two particular groups for whom there is considered to be a higher level of risk. In Kent & Medway there were 21 suspected suicides among those aged 18 and under between 2020-2024. Within the 16-25 year old age bracket there were 76 suspected suicides within the same timeframe. In males specifically, the most common age group for suspected suicides between 2020-2024 was 40-49, accounting for 107 (15%) of all suspected suicides.

Mitigating Actions for Age

The overall strategy will consist of a strategy for adults, and one aimed at CYP. This will ensure that targeted support is delivered in respect of risks relating to age.

Responsible Officer for Mitigating Actions – Age

Tim Woodhouse

20. Negative impacts and Mitigating actions for Disability

Are there negative impacts for Disability?

Yes

Details of Negative Impacts for Disability

Physical illness - including disabilities - is cited as a common risk factor in the national suicide prevention

strategy. Our own RTSS data suggests that 24% of those dying by suspected suicide between 2020-2024 had a physical health condition.

Mitigating actions for Disability

The new strategy will set out to continue exploring the links between key risk factors and suicide. This will include physical health and disability, and we will share the consultation survey with relevant groups, such as the KCC Level Playing Field Group. One of the strategy's aims will be to develop greater understanding and awareness that can be used to tailor effective suicide prevention activity. Neurodivergent people are cited as a priority group in the new Strategy.

Responsible Officer for Disability

Tim Woodhouse

21. Negative Impacts and Mitigating actions for Sex

Are there negative impacts for Sex

Yes

Details of negative impacts for Sex

Both sexes are at risk of suicide. Among males there is particular risk associated with those who are middle-aged, and among females there is particular risk associated with new mothers. In our local RTSS data, 75% of all suspected suicides between 2020-2024 were among males and 25% among females. This proportion aligns with a national proportion which is long established.

Mitigating actions for Sex

The new strategy will focus on risk factors that relate to sex and will seek to deliver targeted interventions as required.

Responsible Officer for Sex

Tim Woodhouse

22. Negative Impacts and Mitigating actions for Gender identity/transgender

Are there negative impacts for Gender identity/transgender

Yes

Negative impacts for Gender identity/transgender

There is a growing level of national research and evidence that suggests that those who are transgender or querying their gender are at heightened risk of suicide. The RTSS data set-up enables us to capture the impact of this in Kent & Medway although current levels of data are limited.

Mitigating actions for Gender identity/transgender

We have engaged with relevant stakeholders – such as the internal KCC staff group, Rainbow - and voluntary sector organisations - to capture the needs of these groups during the consultation period. Although there is not yet the same levels of data and evidence available for those listed as priority groups in the Strategy, the Strategy will retain the responsibility to respond to other risk factors as they emerge, including gender identity, and will seek to deliver targeted interventions as required.

Responsible Officer for mitigating actions for Gender identity/transgender

Tim Woodhouse

23. Negative impacts and Mitigating actions for Race

Are there negative impacts for Race

Yes

Negative impacts for Race

Ethnicity data is not always recorded by Kent Police on the RTSS or on death certificates meaning there has been a wider, long-standing difficulty in understanding the extent of the links between race and suicide. There is a significant amount of national research to suggest that suicide rates can vary between ethnic groups, and this is an area we will continue to explore as new data and evidence emerges.

Mitigating actions for Race

The new strategy will focus on a range of risk factors as they emerge, including race, and will seek to deliver targeted and tailored interventions as required. We shared the consultation with the KCC Staff Ethnic Diversity forum and among other relevant stakeholders, to help capture the needs of these groups.

Responsible Officer for mitigating actions for Race
Tim Woodhouse
24. Negative impacts and Mitigating actions for Religion and belief
Are there negative impacts for Religion and belief
Yes
Negative impacts for Religion and belief
Similarly to ethnicity, data and evidence on the link between religion and suicide is limited. This is not often captured within our local RTSS as the information is not always known to Kent Police. There is evidence to suggest that religion can be both a protective or a risk factor and this is an area which requires greater understanding.
Mitigating actions for Religion and belief
The new strategy will focus on a range of risk factors as they emerge, including religion, and will seek to deliver targeted interventions as required. We shared the consultation with the KCC Staff Ethnic Diversity forum and among other relevant stakeholders, to help capture the needs and thoughts of those belonging to a range of different faith groups.
Responsible Officer for mitigating actions for Religion and Belief
Tim Woodhouse
25. Negative impacts and Mitigating actions for Sexual Orientation
Are there negative impacts for Sexual Orientation
Yes
Negative impacts for Sexual Orientation
Wider national evidence suggests that sexual orientation may be a risk factor to suicide although the data available within our local RTSS is limited, as Kent Police do not always have access to this information.
Mitigating actions for Sexual Orientation
The new strategy will focus on a range of risk factors as they emerge, including sexual orientation, and will seek to deliver targeted interventions as required. The consultation was shared with the internal KCC Staffing Group, Rainbow, to capture the needs of these groups.
Responsible Officer for mitigating actions for Sexual Orientation
Tim Woodhouse
26. Negative impacts and Mitigating actions for Pregnancy and Maternity
Are there negative impacts for Pregnancy and Maternity
Yes
Negative impacts for Pregnancy and Maternity
Pregnant women and new mothers have been cited as a priority group in the 2023-2028 national strategy as there is evidence to suggest that they are at greater risk of suicide. A national report stated that 16% of deaths among women who died between 6 weeks and 1 year after the end of pregnancy between 2020-2022 were by suicide.
Mitigating actions for Pregnancy and Maternity
The new strategy will focus on risk factors that relate to pregnancy and maternity and will seek to deliver targeted interventions as required. The design and delivery of a new briefing paper which links the relationship between the perinatal period and suicide is currently in discussion and the aim of this paper will be to raise awareness and shape better support to those impacted by this.
Responsible Officer for mitigating actions for Pregnancy and Maternity
Tim Woodhouse
27. Negative impacts and Mitigating actions for Marriage and Civil Partnerships
Are there negative impacts for Marriage and Civil Partnerships
Yes
Negative impacts for Marriage and Civil Partnerships

Whilst marriage and civil partnerships in their own right are considered to be a protective factor, they can also be a risk factor where there are struggles in the relationship or domestic abuse. Current relationship struggles were cited in 20% of suspected suicides in Kent & Medway between 2020-2024.
Mitigating actions for Marriage and Civil Partnerships
The new strategy will focus on a range of risk factors as they emerge, including marriage and civil partnerships as part of a wider look at the impact of relationships, and will seek to deliver targeted interventions as required.
Responsible Officer for Marriage and Civil Partnerships
Tim Woodhouse
28. Negative impacts and Mitigating actions for Carer's responsibilities
Are there negative impacts for Carer's responsibilities
Yes
Negative impacts for Carer's responsibilities
Those with caring responsibilities are not necessarily considered to be at a greater risk of suicide, but they are at greater risk of being impacted by it, given the links between mental / physical health conditions and suicide.
Mitigating actions for Carer's responsibilities
The new strategy will have a key focus on providing support to those bereaved by suicide. It will also focus on a range of risk factors as they emerge, including carer's responsibilities, and will seek to deliver targeted interventions as required.
Responsible Officer for Carer's responsibilities
Tim Woodhouse

Kent and Medway Suicide and Self-Harm Prevention Strategy 2026-2030

Consultation Report November 2025

www.kent.gov.uk/suicideprevention

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Kent and Medway Suicide and Self-Harm Prevention Strategy 2026 - 2030

Consultation Report

Executive summary

How was the draft Strategy developed?

- The Strategy was developed by both Kent and Medway Suicide and Self-Harm Prevention Networks (for adults and children).
- The Networks are partnerships of over 250 organisations and individuals living with experience of suicidal thoughts, self-harm or bereavement by suicide.

How many people responded to the consultation?

- The consultation ran from 23 July to the 6 October 2025.
- 153 responses were received in total of which 149 responses were received through the online questionnaire.
- 2 questionnaire responses were received by email.
- 2 additional comments were received via email.

Who responded to the consultation?

- 80% of responses were from individual residents of Kent and Medway.
- 7% of responses were from voluntary sector organisations, 3% were from educational settings, and a further 3% were on behalf of a family member or friend.

What did respondents tell us?

- The majority of respondents supported the draft Strategy. 89% agreed with the vision, 88% agreed with the mission, and 91% agreed with the values.
- The majority of respondents (93%) also agreed with the priorities set out in the Strategy, which include making suicide everybody's business by maximising collective impact, and providing specialist suicide bereavement support.
- There was strong support for the identified high-risk groups within the Strategy, with 90% of respondents agreeing with the groups listed.
- Some respondents felt that other groups of individuals should be considered high risk, particularly the neurodivergent community as a whole (as opposed to only autistic people), the LGBTQIA+ community.
- Other respondents commented that focussing on a particular group(s) was inappropriate as anybody can be at risk of suicide. They emphasised the importance of a Strategy that works for all.

- For the purpose of the consultation report, we have highlighted the most prominent themes for each question in the analysis below.
- One of the key recurring themes advocated for suicide prevention training to equip as many people as possible with the skills required to identify when somebody may be at risk of suicide, and the actions to take accordingly.
- Another recurring theme was the need for the Strategy to be supported by available, accessible and robust mental health support services in addition to local community-based support, such as peer groups. The importance of multi-agency collaboration was frequently cited across the responses.
- It was suggested that these services should be supported by a range of visible and appropriate campaigns - particularly at high-risk locations - to enhance wider awareness and increase the likelihood of people taking up support when needed.
- Less frequent themes that occurred throughout the responses included the impact of intersectionality, the importance of involving those with lived experience, stigma, and the value of trauma-informed care.
- For children and young people (CYP) specifically, the role of schools and other education settings in suicide prevention was a consistent theme, as was the role played by friends, family and wider networks. Online harms and social media were highlighted as something as a particular risk to CYP.

What will change as a result of the consultation?

- The draft Strategy will be amended to take into account the feedback received. Details of what has been changed will be included in a 'You Said, We Did' document which will be made available on the Let's Talk Kent[1] webpage.
- An action plan will be developed which sets out the details of how the Suicide Prevention Programme will seek to fulfil its priorities.

[1] Let's Talk Kent website: https://letstalk.kent.gov.uk/kent-and-medway-suicide-and-self-harm-prevention-strategy-2026-2030

Kent and Medway Suicide and Self-Harm Prevention Strategy 2026 - 2030

Consultation Report

Contents

1. Introduction

This document provides a summary of the responses received through the public consultation on the draft Kent and Medway Suicide and Self-Harm Prevention Strategy 2026-2030.

The Kent and Medway Suicide and Self-harm Prevention Strategy 2026-30 is the continuation of the work undertaken as a result of the 2021-2025 Kent and Medway Suicide Prevention Strategy[2] and combines local data about who is dying by suicide in Kent and Medway with national research and policy direction.

Unlike the existing Strategy (2021-2025), the Suicide and Self-Harm Prevention Strategy for 2026-2030 encompasses both Adults, and Children and Young People (CYP) as opposed to creating a separate strategy for both. The new Strategy sets the same eight priorities for both groups, but across two separate action plans, in recognition of the need for a slightly different approach for each.

The draft Suicide Prevention Strategy 2026-30 was developed by the Kent and Medway Suicide Prevention Programme, which is hosted by KCC's Public Health department and funded by the Kent and Medway Integrated Care Board.

The draft Strategy was developed in conjunction with the Suicide Prevention Networks, which are well-established partnerships made up of over 250 agencies, including statutory and voluntary / community sector organisations as well as individuals living with experience of suicidal thoughts, self-harm or being bereaved by suicide. There is a network focused on supporting adults, and a network focused on supporting children and young people. These networks will oversee the action plans set out for each as a result of this Strategy.

The vision of the new Strategy is that Kent and Medway become a place where the number of people dying by suicide is reduced as much as possible. Our aim is for the Kent and Medway suicide rate to be below the national average by 2030 (if not sooner).

The mission of this Strategy is to make Kent and Medway a place where hope is always available to anyone, no matter what they are facing. Specifically, we would like to have achieved the following by 2030:

[2] The Kent and Medway Suicide Prevention Strategy 2021-2025: https://www.kent.gov.uk/about-the-council/strategies-and-policies/service-specific-policies/public-health-policies/suicide-prevention-strategy

- Children and young people in Kent and Medway to be resilient enough to cope with life's normal ups and downs, but knowledgeable and confident enough to reach out for more support when they need it.
- Adults in Kent and Medway to know how to look after their own emotional wellbeing but to feel comfortable and are able to seek more help when necessary.
- All agencies (statutory, voluntary, community) to work collectively to ensure support and help is available to those who need it.
- All agencies to share knowledge and support each other to learn what works in helping people get the support they need.

2. Consultation process

Pre-consultation engagement

In order to develop the draft Strategy for public consultation, the Kent and Medway Suicide Prevention Programme engaged with its wider networks on multiple occasions.

These included:

- A discussion at the Annual Kent & Medway Suicide & Self-Harm Prevention Conference in December 2023
- An in-person workshop in April 2024
- Opportunities for all to input during the Adult and CYP Suicide Prevention Network meetings in March and April 2025.

The draft Strategy was shared at network meetings in June and July 2025, prior to public consultation. The image below provides a small snapshot of some the partner organisations that sit within our networks:

The Kent & Medway Suicide Prevention Programme also oversees the Better Mental Health Network and has over 350 members. The Programme was made aware of the new draft Strategy at meetings throughout 2025.

Key updates across all three Networks are shared through the Better Mental Health monthly newsletter, which has over 900 subscribers.

In addition to engaging with Network members, the following internal actions took place:

- The consultation for the draft Strategy was featured in the Director of Public Health's verbal update at the Health Reform and Public Health Cabinet Committee on 1 July 2025.
- The draft Strategy and consultation was discussed at the Children & Young People's Departmental Management Team meeting on 14 May 2025.
- The draft Strategy, Data Pack and consultation updates were regularly shared with the Suicide Prevention Strategic Oversight Board (SPSOB), which includes colleagues from Medway Public Health, KMPT (now Kent and Medway Mental Health NHS Trust) and the Integrated Care Board.
- Engagement with the Cabinet Member for Social Care and Public Health prior to the consultation going live.

Public consultation

On the 23 July 2025, an 11-week consultation was launched and ran until the 6 October 2025. The consultation provided the opportunity for residents and other stakeholders to provide feedback on the draft Strategy. The key consultation documents included the draft Strategy and a supporting Data and Evidence Pack, which focused on key data and an analysis of the local real time suicide surveillance data from 2020-2024.

The consultation was hosted on Let's Talk Kent KCC's engagement website: https://letstalk.kent.gov.uk/kent-and-medway-suicide-and-self-harm-prevention-strategy-2026-2030 Feedback was captured via an online questionnaire which was available on the webpage. A Word version of the questionnaire was provided on the webpage for people who did not wish to complete the online version and hard copies were also available on request. Letters, emails were analysed and considered alongside the questionnaire responses.

All consultation material included details of how people could contact KCC to ask a question, request hard copies or alternative formats.

A consultation stage Equality Impact Assessment (EqIA) was carried out to assess the impact the Strategy could have on the protected characteristics. The EqIA was available as one of the consultation documents and the questionnaire invited respondents to comment on the assessment that had been carried out. An analysis of responses to this question can be found on page 75 of this report.

To raise awareness of the consultation and encourage participation, the following was undertaken:

- Emails sent to stakeholders asking them to promote the consultation through their networks.
- Invites sent to people registered with Let's Talk Kent who had expressed an interest in relevant the topics (11,532 users).
- Article in the Better Mental Health Suicide Prevention newsletter (circulated to approx. 900 stakeholders across the county) requesting participation and for recipients to share with their wider networks and service users.
- Promotional materials distributed at event locations during the visit of the Baton of Hope to Kent and Medway on 22 September 2025.
- Key commissioned service providers, including Amparo, Mid Kent Mind and CANWK were asked to raise awareness of the consultation among service users and support them to participate.

- Children and young people engagement through the CYP Network and wider partners.
- Shared with KMPT service users and their Lived Experience Panel.
- Shared across KCC staff comms channels and with all Staff Groups to help capture input from a wide range of groups (including ethnic diversity, disability and LGBTQ+ groups).
- Joint media releases and communications with Medway Council and the Integrated Care Board.
- Social media posts on KCC's Facebook, X (formerly Twitter), Instagram, Nextdoor and LinkedIn channels. Mid-way through the consultation period, four posts were boosted to gain wider reach and engagement.
- Posters displayed in KCC buildings, including libraries, Gateways and country parks.
- Promotional banner on the Kent.gov.uk homepage during the consultation.
- Articles in the KCC's residents' e-newsletter.
- Articles were sent for inclusion in the KELSI Schools e-bulletin.
- Presented at internal and external meetings, including the ReferKent Network meeting, the Suicide-Safer Strategic meeting hosted by Canterbury Christ Church University, and the Community Safety information sessions.
- Promoted to town and parish councils through the Kent Association of Local Councils (KALC).
- Shared by KCC's Adult Social Care team with the Learning Disability Partnership Board, the People's Panel, Your Voice network, and Carers Voice engagement group.
- Following a review of responses mid-way through the consultation, specific organisations were targeted in an efforts to increase the number of responses from underrepresented groups, such as middle-aged men and ethnic minorities.

A summary of interaction with the consultation website and documents can be found below:

- 3,276 visits to the consultation webpage by 2,887 visitors.
- 702 downloads of the draft Strategy and 225 of the Data and Evidence Pack.
- 66 downloads of the Word version of the consultation questionnaire.
- 30 downloads of the consultation stage Equality Impact Assessment.

Organic social media posts via KCC's corporate channels had a reach of 22,905 on Facebook. There were 53,127 impressions on Instagram, X (Twitter), LinkedIn, and Nextdoor. Reach refers to the number of people who saw a post at least once and impressions are the number of times the post is displayed on someone's screen. The posts generated 1,375 clicks through to the consultation webpage. (Not all social media platforms report the same statistics). Boosted Facebook posts had a reach of 50,223 and generated 847 clicks to the consultation webpage.

Figure 1. Examples of social media graphics

Points to note

- Respondents were given the choice of which questions they wanted to answer / provide comments. The number of respondents providing an answer for each question is provided throughout the report.
- The sum of individual percentages in any single choice question in this report may not sum to 100% due to rounding.
- Participation in consultations is self-selecting and this needs to be considered when interpreting responses.
- Response to this consultation does not wholly represent the individuals or practitioners the consultation sought feedback from and is reliant on awareness and propensity to take part based on the topic and interest.
- Respondents were asked to provide feedback in their own words throughout the questionnaire. Whilst this report includes thematic feedback received at these questions, specific feedback unique to particular organisations or

circumstances was also received. All feedback is being reviewed and considered.

- The presentation of thematic feedback in the main body of the report usually focuses on the 5 themes that were mentioned most frequently for each question, but in some questions this number will vary. This applies when there are more than 5 themes that have been raised by a similar number of respondents, or when there are fewer themes that have been mentioned more frequently than others.

3. Who responded to the consultation?

There were 149 questionnaire responses: 147 online and 2 via paper / email. An additional 2 emails / letters were received providing feedback. The content of these have been reviewed alongside open-ended feedback received within the consultation questionnaire.

This section details the profile of respondents who completed the consultation questionnaire. The first question asked respondents to select from a list the option that best described how they were responding to the consultation.

Are you responding as…? (Base – 148)	**Number of responses**	**Percentage**
A Kent or Medway resident	118	80%
On behalf of a family member or friend (please complete this questionnaire using their information)	4	3%
On behalf of a charity or Voluntary, Community or Social Enterprise (VCSE) organisation	10	7%
On behalf of a Parish / Town / Borough / District Council in an official capacity	2	1%
A Parish / Town / Borough / District / County Councillor	1	1%
On behalf of an educational establishment, such as a school or college	4	3%
On behalf of a business in Kent	3	2%
Something else	6	4%

Geographic profile

The following table shows how many people responded across each of the districts and boroughs in Kent and Medway.

Please tell us the first 5 characters of your postcode. (Base – 149)	**Number of responses**	**Percentage**
Ashford	13	9%
Canterbury	15	10%
Dartford	3	2%
Dover	10	7%
Folkestone & Hythe	8	5%
Gravesham	0	0%
Maidstone	11	7%
Medway	9	6%
Sevenoaks	8	5%
Swale	13	9%
Thanet	17	11%
Tonbridge & Malling	9	6%
Tunbridge Wells	5	3%
Did not provide postcode	28	19%

Demographics of respondents

The tables below show the demographic profile of individual respondents who completed the consultation questionnaire. Respondents were given the option to skip all or some of these questions and those responding on behalf of an organisation were advised not to answer them. The proportion who left these questions blank or indicated they did not want to disclose this information is not included in the statistics below.

What is your sex? (Base – 111)	**Number of responses**	**Percentage**
Female	87	76%
Male	24	21%
I prefer not to say	3	3%

Is the gender you identify with the same as your sex registered at birth? (Base – 112)	**Number of responses**	**Percentage**
Yes	110	98%
No	0	0%
I prefer not to say	2	2%

Which of these age groups applies to you? (Base – 114)	**Number of responses**	**Percentage**
18-25	4	4%
26-35	17	15%
35-45	19	17%
46-55	26	23%
56-65	26	23%
66-75	14	12%
76-85	7	6%
86 and over	1	1%
I prefer not to say	0	0%

Do you have a disability, health condition, physical or mental impairment that has a substantial and long-term negative effect on your ability to do normal daily activities? (Base – 114)	**Number of responses**	**Percentage**
Yes	50	44%
No	61	54%
I prefer not to say	3	3%

If you answered 'Yes' to Q21, please tell us if any of the following disabilities or health conditions apply to you. (Base – 50)	**Number of responses**	**Percentage**
Physical	22	44%
Sensory (hearing, sight or both)	1	2%
Longstanding illness or health condition, such as cancer, HIV/AIDS, heart disease, diabetes or epilepsy	14	28%
Mental health condition	30	60%
Learning disability	1	2%
Neurodivergent, such as ADHD, autism, dyslexia and dyspraxia	29	58%
I prefer not to say	2	4%
A different disability or health condition	2	4%

Please note, the total of the percentages above may exceed 100% on the basis that some respondents may experience multiple conditions.

What is your religion or belief? (Base – 112)	**Number of responses**	**Percentage**
No religion or belief	51	46%
Atheist	5	4%
Christian	37	33%
Buddhist	2	2%
Hindu	1	1%
Muslim	1	1%
A different religion or belief	9	8%
I prefer not to say	6	5%

Which of the following best describes your sexual orientation? (Base – 112)	**Number of responses**	**Percentage**
Heterosexual/Straight	94	84%
Bisexual	4	4%
Gay or Lesbian	6	5%
I prefer to define my own sexuality, please tell us:	4	4%
I prefer not to say	4	4%

Are you a Carer? (Base – 114)	**Number of responses**	**Percentage**
Yes	29	25%
No	81	71%
I prefer not to say	4	4%

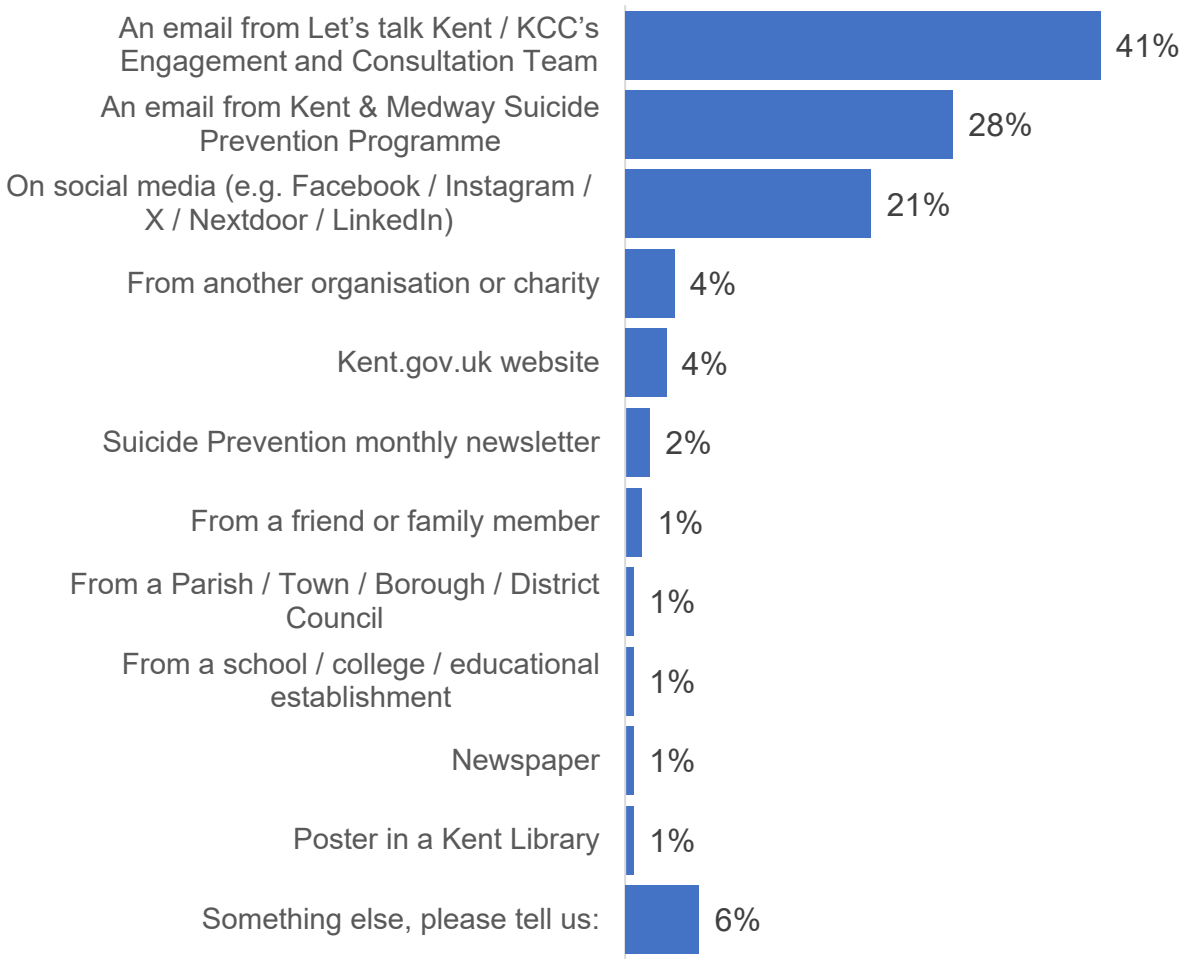
What is your ethnic group? (Base – 149)	**Number of responses**	**Percentage**
White	108	95%
Mixed or Multiple	2	2%
Asian or Asian British	2	2%
Black, Black British, Caribbean or African	2	2%

Which of the following best describes your working status? (Base – 114)	**Number of responses**	**Percentage**
Working full time	41	36%
Working part time	28	25%
Unemployed	4	4%
Retired	23	20%
Student	2	2%
I prefer not to say	3	3%
Something else, please tell us:	13	11%

Consultation awareness

The two most common means of finding out about the consultation were an e-mail from Let's Talk Kent / KCC's Engagement and Consultation Team (41%) and via e-mail from the Kent & Medway Suicide Prevention Programme (28%). 21% found out about the consultation through social media:

How did you find out about this consultation? Base: all providing a response 142



Supporting data table	Number of responses	Percentage
An email from Let's talk Kent / KCC's Engagement and Consultation Team	58	41%
An email from Kent & Medway Suicide Prevention Programme	40	28%
On social media (e.g. Facebook / Instagram / X / Nextdoor / LinkedIn)	30	21%
From another organisation or charity	6	4%
Kent.gov.uk website	5	4%
Suicide Prevention monthly newsletter	3	2%
From a friend or family member	2	1%
From a Parish / Town / Borough / District Council	1	1%
From a school / college / educational establishment	1	1%
Newspaper	1	1%
Poster in a Kent Library	1	1%
Something else, please tell us:	9	6%

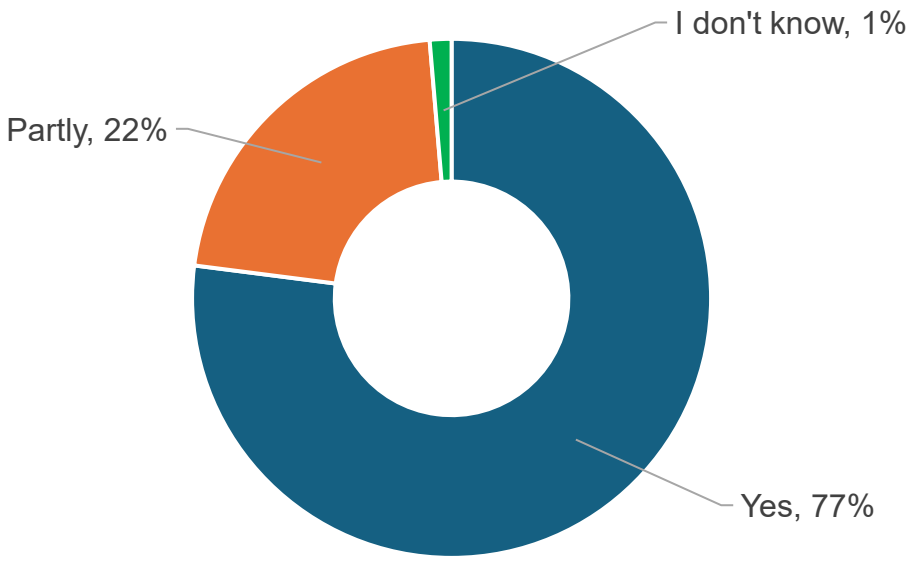
Please note, the total of the percentages above may exceed 100% on the basis that some respondents may have heard about the consultation through multiple channels

4. Feedback on the Strategy

Perceived ease of understanding of the Kent and Medway Suicide and Self-Harm Prevention Strategy

Over three quarters of respondents (77%) agreed that the Kent and Medway Suicide and Self-Harm Prevention Strategy is easy to understand. A further 21% indicated that it is partially easy to understand and 1% were not sure. No respondents stated that the draft Strategy is not easy to understand.

Chart 1. Is the draft Kent and Medway Suicide and Self-Harm Prevention Strategy 2026-2030 easy to understand? Base: 148



Supporting data table	Number of responses	Percentage
Yes	114	77%
Partly	32	21%
No	0	0%
I don’t know	2	1%

Respondent feedback on how the Strategy could be made easier to understand

Respondents were asked to detail how the Strategy could be made easier to understand. Respondent comments have been reviewed and grouped into themes.

In total, 18 different themes were raised, although several were not related to the ease of understanding the document. A number of respondents commented on the formatting of the document (11) and suggested increased use of spaces, bullets and visuals.

A further 10 stated that the Strategy required examples of specific interventions and actions needed to achieve the document aims, whilst 6 suggested that the Strategy needed to be more specific to particular demographics.

There were suggestions from 6 of respondents that an Easy Read version should have been available, and 5 suggested possible wording amendments.

The top 5 themes are included in the table below. A full analysis is provided in Appendix 2.

If you have any comments or suggestions on how to make the Strategy easier to understand, please tell us in the box below. Base:54

Themes	Number of respondents who raised this theme
Needs reformatting (e.g. space, bullets, visuals)	11
Needs specific examples of specific interventions / actions	10
Is too generalised / needs to be more demographic specific	6
Easy Read version required	6
Needs wording amends	5

Example quotes, in respondents own words, for the main themes can be found below:

Formatting of the draft Strategy

“The Strategy would benefit from more visual elements to improve accessibility.”

“Summary pages are particularly word-heavy and could be broken up with diagrams or infographics. Some sections felt generic and lacked specificity around domestic abuse and trauma-informed approaches.”

“The new information for the upcoming years is succinct and clear, but right at the end. The rest of the information is interesting but not necessarily needed ahead of the new idea's as that is what we are being asked to consult on. I understand why it’s been written that way but as an explanation of the new plan but it could be after the new plan as justification.”

“The formatting could be improved to make it easier to absorb the data at a glance.”

“Feels very repetitive, space writing out more to make it easier to differentiate sentences and sections.”

Need for specific examples of interventions and actions

“The reasoning and ideas are easy to understand and sufficiently detailed. However how the plan will be implemented is too vague, lacking detail about for example, timely and bespoke interventions for mental health support. What will this look like? What additional provisions will be made, will time frames will be introduced for those in need of services?”

“Feels like PR spin. Rhetoric is empty and irritating. It is not a Strategy, it is marketing. Simply Identify the issue, identify the goal, identify critical factors and then clearly demonstrate stress testing, factoring capacity, increased risks of developments known to perpetuate distress.”

“Provide specific details about what will actually be done - not broad statements that don't outline the exact strategies, resources, and support that will be available. For example, an increase in funding for mental health support, employing more therapists and counsellors, widening the range of therapies available - with specific numbers for finding and provision. Setting measurable and transparent goals.”

“Some is at the level of aspirations, impossible to evaluate.”

Need for the draft Strategy to be less generalised and more demographically specific

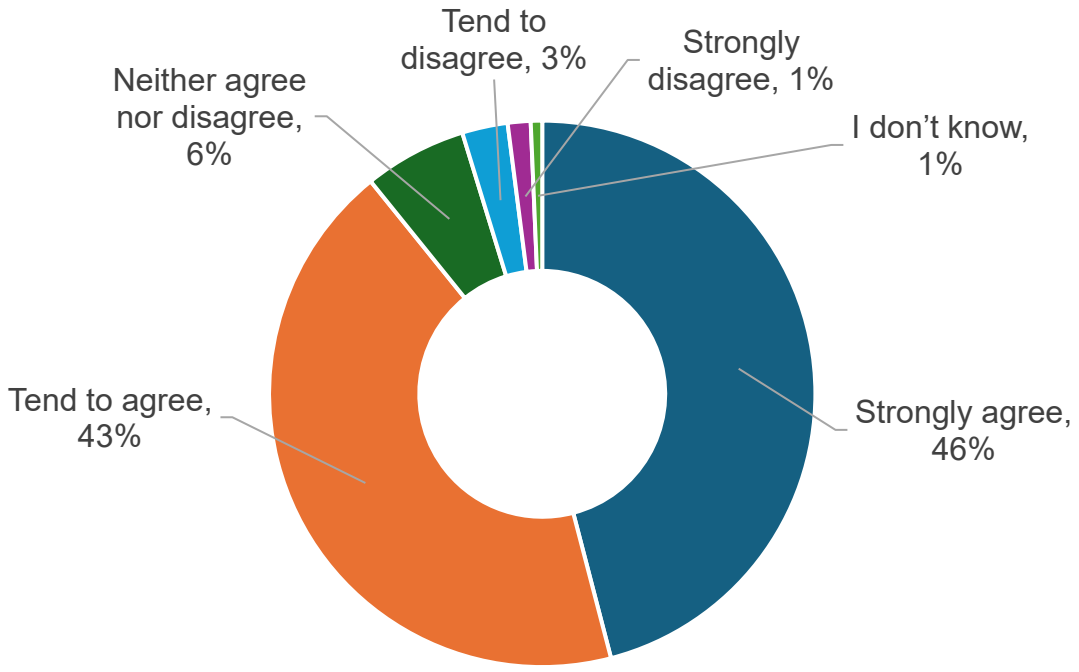
"Extremely generalised and most seems to be using the same stuff for the at risk groups rather than realising those things may not work for those groups and finding new things that might make a difference."

"Suggest you name the numerous voluntary organisations (eg Men's sheds, Allotment Societies, Sports Clubs), so that the professional organisations know where to focus training and assistance. Also needs stratification by age, lifestyle and gender of suicide rates. It's commonly thought that newly single older men are most at risk; is this true in Kent?"

Agreement with the proposed vision for the draft Strategy

In 89% of respondents agreed with the proposed vision of the Strategy, with,46% strongly agreeing and 43% tending to agree. 6% of respondents neither agreed or disagreed, 3% tended to disagree and 1% strongly disagreed.

Chart 2. How much do you agree or disagree with our proposed vision for the draft Strategy? Base:148



Supporting data table	Number of responses	Percentage
Strongly agree	68	46%
Tend to agree	64	43%
Neither agree nor disagree	9	6%
Tend to disagree	4	3%
Strongly disagree	2	1%
I don't know	1	1%

Respondent feedback on why they agree or disagreed with the proposed vision of the draft Strategy

Respondents were asked to provide more detail on why they agreed or disagreed with the proposed vision of the draft Strategy.

In total, 27 different themes were raised, covering a broad range of topics including the role of mental health support, neurodivergence and hope.

A number of respondents used this question as an opportunity to voice their approval and agreement of the vision (71).

35 respondents, including many who agreed with the vision of the Strategy, expressed scepticism around how effectively it could be put into practice.

14 respondents wanted to highlight the importance of good mental health support which should accompany this vision, and 8 advocated for the need to support children and young people. A further 7 stressed the importance of multi-agency collaboration to achieve the desired outcomes.

The top five themes are included in the table below. A full analysis is provided in Appendix 2.

Please tell us the reason for your answer in the box below: Base: 114

Themes	Number of respondents who raised this theme
Agreement with the vision	71
Scepticism over policy / needs focus on Strategy in practice	35
Importance of good mental health support	14
Support for young people	8
Multi-agency collaboration	7

Example quotes, in respondents own words, for the main themes can be found below:

Agreement with the vision

“I have lost many friends to suicide and very much view any death by suicide as one death too many and am pleased to see the desire to reduce deaths by suicide as much as possible”

“Seems like a balanced compromise as it doesn't rely on a huge injection of money which will never become available in the current state of the economy.”

“The aim is grounded, measurable, and time-bound—this makes it achievable. It’s a strategic and compassionate approach that focuses on progress, not perfection. “Below the national average” gives Kent and Medway a realistic benchmark. The decision not to say “zero suicides” reflects sensitivity, realism, and respect for the complexity of suicide.”

“We can't keep losing lives to suicide. People have to have hope in their lives, and your plans are great. Especially as you have linked up all the different groups and people. It is the saddest thing that people feel so overwhelmed, and I am glad to see that help is available for them.”

“Below the National Average is reasonable, as much as possible would be ideal. The only thing better would be more of a leaning toward 'as much as possible' for the specific aim, too, but there are limits on achievability and below the national average is an achievable and measurable goal.”

Scepticism of the vision – particularly in terms of how it will be put into practice

“The vision is great. You have identified high risk groups and wish to offer them better support. The plan to back it up with I have doubts about.”

“Pinning things to the "national average" is unfortunate and gives the impression that "some" suicides are not a problem as long as Kent is not notably an outlier in terms of cases. I don't for a moment think this is true, and I suspect this is just because it's a useful marker of progress but it gives the impression that the effort is a mainly bureaucratic one to improve the "optics" of the problem than an empathetic one to deal with the root causes. If the national average was 88% and Kent fell at 87% this would hardly be cause for celebration after all. At the same time, I do understand why it's presented the way it is.”

“I don't know how realistic it is without major transformation to the education system and relationship support. Also the lack of support services and ever changing research findings.”

“Focus entirely on suicide rate, not on self-harm and the poor state of mental health amongst the population in Kent and Medway.”

“Reduced as much as possible is meaningless. A clear Strategy sets out specific, measurable, and time-bound targets. The national average itself represents an unacceptable level of preventable deaths. Kent and Medway should aspire to be a leader in prevention, not just “less bad” than the rest of England.”

“I agree in principle, although coming at it from statistics depersonalises what is a very emotive issue. The indicator of success could be that the Kent and Medway suicide rate is below the national average by 2030, but I wonder if the start of the paragraph could be something like…

Our vision is that Kent and Medway becomes a place where people can access supportive services when they need to and that as far as possible, fewer die by suicide… Our specific aim is for the Kent and Medway suicide rate to be below the national average by 2030 (if not sooner).”

Need for good mental health support

“Most of it looks fine but we still need a proper NHS mental health service that offers continuous, joined-up care for as long as a person needs it.”

“It is important that as much support is put in place for vulnerable people no matter where they are from or what age group. Men often find it difficult to reach out so supporting them and letting them know its ok to feel vulnerable and reach for help is absolutely ok.... The crisis process needs to be made easier to access and people given more time before they are signed off.”

“I strongly agree with the Strategy topic but think it needs more detail , the mental health support from NHS is appalling in Kent and this needs a really strong focus to

help save people's lives . People are struggling and not knowing who to turn to . If you are on the waiting list for support from the NHS you are told if you go for counselling anywhere else the NHS will not help you . Yet you are put on a big waiting list with them. It's awful, school staff don't have a clue how to help either and pass mental health off as behaviour."

"I agree with all of the Strategic Objectives, and appreciate this is targeted towards those who are already suicidal, however I implore KCC to consider the bigger picture - if Mental Health Services and/or community support groups had more support (funding = recruiting more staff, providing more therapies, etc) we can prevent more people from getting to the suicidal point."

Support for young people

"You have included all relevant groups which can try to support vulnerable people and prevent suicide. However this assumes that (young) people will be correctly identified by e.g. their school or other education setting; or their employer, to name only 2. This requires a lot of support from these settings which I do not believe is in place at the moment. A lot of training will be required I believe."

"The priority around resilience for children needs rewording it is not fixed and not owned by an individual and sits with a context."

"Anything that helps to prevent youngsters from feeling that despondent that they feel they have no option but to self harm or commit suicide has to be a good thing"

"I think we have to take whatever initiatives we can to prevent the risk of suicide - especially in young people as today's world of social media bullying and harassment is seeing an increase in the number of young teens taking this route to end their suffering."

Need for multi-agency collaboration

"Seems KMPT are nowhere to be seen on this document which is very concerning considering it's the mental health trust. You need to be working closely with this trust to create better care for people with mental health."

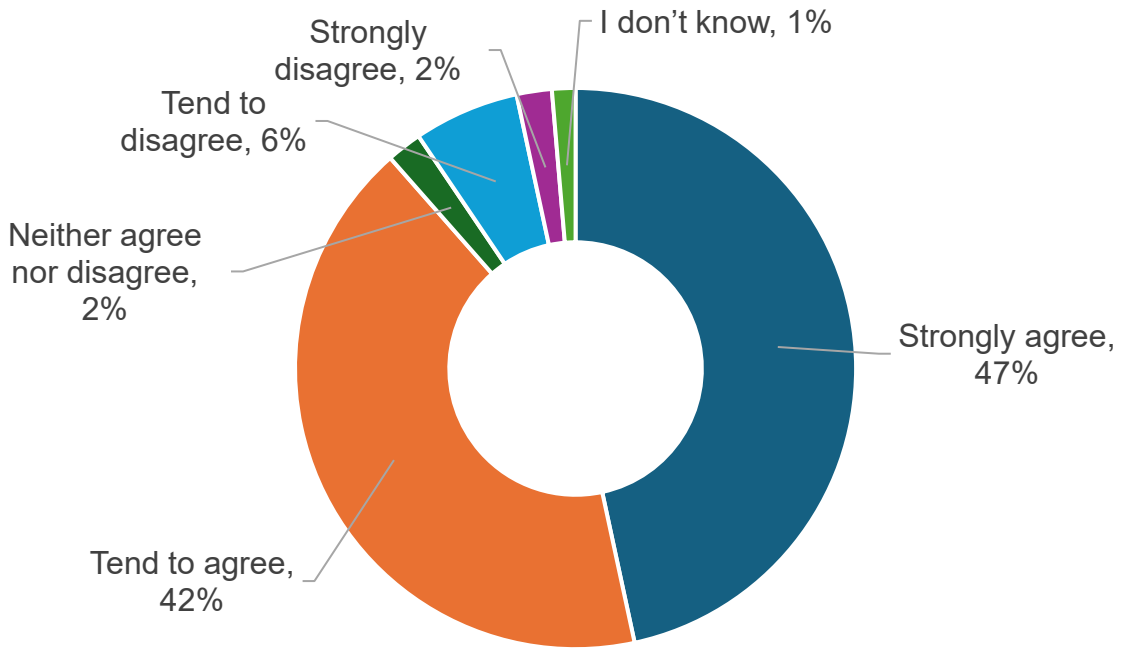
"Agencies don't work together, mental health provision extremely poor."

"Services working together. Professionals armed with evidence are crucial."

Agreement with the proposed mission

89% of respondents agreed with the proposed mission of the Strategy, either strongly (47%) or tended to agree (42%). 8% didn't agree with the mission, and 3% of respondents neither agreed or disagreed or weren't sure.

Chart 3. How much do you agree or disagree with our proposed mission for the draft Strategy? Base: 148



Supporting data table	Number of responses	Percentage
Strongly agree	69	47%
Tend to agree	62	42%
Neither agree nor disagree	3	2%
Tend to disagree	9	6%
Strongly disagree	3	2%
I don't know	2	1%

Respondent feedback on why they agreed or disagreed with the proposed mission of the draft Strategy

Respondents were asked to provide more detail on why they agreed or disagreed with the proposed mission of the draft Strategy.

In total, 29 different themes were raised, covering a broad range of areas including the importance of support for children and young people, service availability and standards, and resilience.

A number of respondents (37) used this question as an opportunity to voice their approval and agreement of the mission. 23 respondents used this question to express their thoughts on the availability and standards of mental health services.

21, including many who agreed with the mission of the Strategy, expressed scepticism around how effectively it could be put into practice.

Support for young people was referenced by 20 respondents, and multi-agency collaboration was again highlighted as an area of focus (16). 16 respondents had views – both positive and negative – of the use of the term, 'resilience'.

The top 6 themes are included in the table below. A full analysis is provided in Appendix 2.

Please tell us the reason for your answer in the box below. You can also let us know if you feel there is anything missing from the mission. Base: 108

Themes	Number of respondents who raised this theme
Agreement with mission	37
Service availability / standard	23
Scepticism of mission	21
Support for young people	20
Resilience	16
Multi-agency collaboration	16

Example quotes, in respondents own words, for the main themes can be found below:

Agreement with the mission

“I applaud the mission to restore in everyone the knowledge that life has its ups and downs. It is normal for levels of happiness and sadness to fluctuate. Children need to be reassured that is not abnormal to feel sad at times. They should not be labelled by others or label themselves as having mental health problems if things are not going well.”

“These strong aims don’t just clarify what needs to be achieved, they illuminate why it matters and how it fits into the bigger picture. This clarity fosters strategic coherence, boosts understanding, and empowers individuals to contribute with confidence and intent.”

“It has been developed collaboratively through ongoing engagement with relevant agencies.”

Service availability and standards

“Help needs to be available for those who need it, including lesser levels/early intervention options that enable people to get help before reaching crisis/suicidality. This is partially covered later on with mention of accessibility for all, but it should be noted that mental health teams refusing to take on autistic people is a very common problem, meaning autistic people may be denied the option of help when they do seek it.”

“Often onus is on the individual suffering to reach out for resources/self-refer which is very difficult at that point. Early intervention is key. Services in Kent are not interested unless a person have already planned their suicide.”

“Generally agree that opening up awareness and support across all agencies and populations is good as not everyone at risk will have the awareness, desire, or capability to access health services. However primarily mental health support (for those struggling) is a health and social care professional remit and the primary focus must be increased availability of professional services (specifically psychotherapy, and psychiatry access) at the point of needing it. Waiting weeks or months to be 'managed' by a basic Mental health practitioner is not adequate for those referred into MH services and more aligned to early intervention. We need more psychiatrists and advanced MH practitioners who can diagnose znx prescribe, and more specialised psychotherapists (trauma being a major cause of MH fragility) who can offer individualised therapy over for a satisfactory period.”

Scepticism of the mission – particularly in terms of how it will be put into practice

“The mission is a good one but I don't see how anything will be changed in practice and many professionals working in mental health for example don't want to help if someone is suicidal and other provisions to help certain at risk groups have been removed this year placing more people at risk.”

“I agree in principal I'm just not sure how this is achievable in the real world, having worked in mental health services and seeing the massive lack of collaboration between services (school, GP, MH services etc).”

“Again, not resolving the root cause of suicide. You will only fix the issue short term. More work with national rail is good but you cannot remove all methods of suicide, it would also be against human rights if you did.”

Support for children and young people

“Equipping youngsters to be masters of their own mental health should be encouraged.

“I applaud the mission to restore in everyone the knowledge that life has its ups and downs. It is normal for levels of happiness and sadness to fluctuate. Children need to be reassured that is not abnormal to feel sad at times. They should not be labelled by others or label themselves as having mental health problems if things are not going well.”

“There seems to be an implied “young people just need to toughen up” and their problems aren’t being taken seriously”

Use of the term ‘resilience’

“Putting emphasis on resilience for children and young people disregards the mental health crisis in this cohort and lack of support/access to CAMHS. Resilience is a problematic word and denies the social factors/lived experience of these individuals. Also adults looking after their own wellbeing places the onus on individuals and there is no support even when we do seek help.”

“I hate the use of the word 'resilient' as it is often tied to victim blaming, rather than accepting the huge pressures that someone is under. E.g. a young person who cannot attend school due to it causing actual sensory pain is often accused of being 'anxious' and not resilient in the face of challenges. It feeds into a sense of powerlessness and therefore more likely to lead someone to self-harm or suicidality.”

"I feel that working towards building resilience especially post covid & encouraging more children & adults to discuss their thoughts & feelings is a positive & necessary."

"The outlined points in the mission are all important. I think it is important to note that lasting resilience is built over time, with practice and with external support. People need to be taught how to maintain their wellbeing and not left to cope by themselves under the guise of building resilience, as this can affect both their self confidence in their skills and lengthen their distress."

Role of multi-agency collaboration

"There is no mention of adequately improving the communication link between Social care services and Community mental health services, the collaboration between these services is very broken."

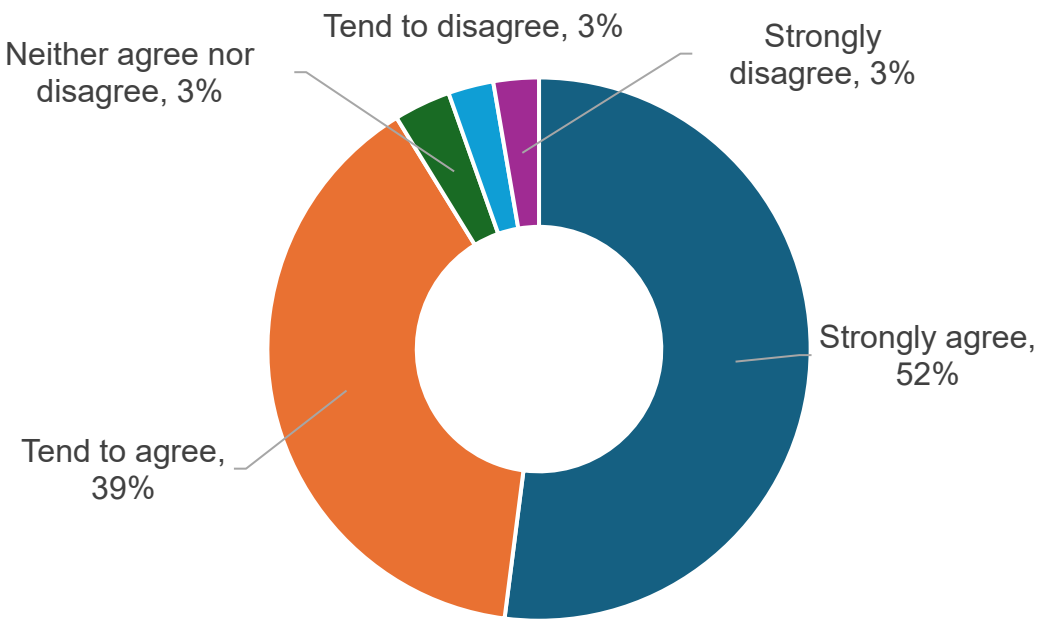
"I think working towards collaboration between all agencies, including charities, schools, police, workplaces and more, will be the key to this Strategy. This shared responsibility should be proactive and individuals need to be clear about the actions expected of them."

"Even when Social Services have significant concerns about the mental health care and treatment of a patient, they do not hold any power to press for care and treatment which has previously been proven to be effective. Support Services are ignored. Families are ignored. The idea of working together is a good one... in practice mental health services hold all the cards."

Agreement with the proposed values

91% of respondents agreed with the proposed values of the draft Strategy, 52% strongly so and 39% tending to. 3% of respondents neither agreed or disagreed, 3% tended to disagree and 3% strongly disagreed.

Chart 4: How much do you agree or disagree with our proposed values for the draft Strategy? Base: 148



Supporting data table	Number of responses	Percentage
Strongly agree	77	52%
Tend to agree	58	39%
Neither agree nor disagree	5	3%
Tend to disagree	4	3%
Strongly disagree	4	3%
I don't know	0	0%

Respondent feedback on why they agreed or disagreed with the proposed values of the draft Strategy

Respondents were asked to provide more detail on why they agreed or disagreed with the proposed values of the draft Strategy.

In total, 20 different themes were raised. These covered a broad range of topics, though there were clear parallels with those raised in previous questions, such as multi-agency collaboration and the availability and standards of services.

A number of respondents used this question as an opportunity to voice their approval and agreement of the values (49).

16 respondents, including some who agreed with the overall values of the Strategy, expressed scepticism. 16 spoke about the role of hope in a suicide and self-harm prevention strategy, and 15 raised the importance of multi-agency collaboration. Service availability and standards were once again raised as a key theme, this time by 13 respondents.

The top 5 themes are included in the table below. A full analysis is provided in Appendix 2.

Please tell us the reason for your answer in the box below: Base: 88

Themes	Number of respondents who raised this theme
Agreement with values	49
Scepticism of values	16
Hope	16
Agency collaboration	15
Service availability / standard	13

Example quotes, in respondents own words, for the main themes can be found below:

Agreement with the values

“I think these are great - avoiding the traditional values usually associated with MH gives the impression that there is some real "oomph" to this”

“The values are spot on - preventing harm is something any society that calls itself civilised should make a priority.”

“All vitally important, I love the use of the word 'determination' - When I think of the Suicide Prevention Team I also think of their passion and advocacy and would suggest these also feature in your values as it’s something the team embody strongly, and this is something I see being a big part of the Strategy's success”

“These values are important to make sure there is enough visibility at leadership level of this area of work.”

Scepticism of the values

“The. Values and direction is correct. But this should not rely on over using soundbites and generic terms as mental health information is very samey.”

“They sound nice but are quite vague. Anyone can claim these things, but what does e.g. determination actually translate into? Sensitivity is a good one to have in there though.”

“It’s probably best to omit the emotional stuff about hope and sensitivity etc - professionals should accept it”

Role of hope

“Hope and sensitivity is very important...”

“The inclusion of hope seems out of place among the other tenants”

“'Hope' as a concept needs definition. Hope of what, exactly?”

“Hope is empty without action. Hoping things improve simply won’t work. Tangible measurable and meaningful action groups and doing is what will make impact. Suicides are driven by a lack of acceptance, belonging and connection. This is Maslow basic human need above food and shelter. This is what will save lives. Not empty hope.”

Multi-agency collaboration

“These are perfectly acceptable motivations for the people who are working to prevent this. I do think that collaborative working is necessary, if only because the prevailing political winds have decided to strip back any funding and capacity for the NHS and local authorities to be leaders rather than "coordinators" in this. There are advantages to collaborative working, I wonder how much they are eclipsed by the difficulty of arranging so many disparate and separate groups - all well-intentioned. I realise this is beyond the remit of the Strategy to address.”

“Fine words but more targeted response needed, more collaboration with existing organisations within at risk groups like National Autistic Society. Self referral and wide advertising of what is accessible for individuals is definitely required.”

“Collaboration is vital for suicide prevention and when concerns are raised to secondary services about someone experiencing suicide ideation, haven't always been positive experiences and a lot more work is needed to ensure that other professionals views (like from voluntary organisations) and judgements are taken seriously.”

“Collaboration is really important and involving as many services, educational establishments and charities/community interest groups as possible will improve the likelihood of making meaningful and lasting changes.”

Availability and standards of services

“I agree but you have not included any drug or alcohol charities or organisations in the collaboration to put the draft Strategy together, including the organisation which primary carers refer to in Medway. As always mental health problems are treated as a cause and not a reason. The mental health system needs to get away from this and not be allowed to use these problems as a reason not to treat. You also don't really explain HOW you are going to improve service providers and their staff (currently abysmal).“

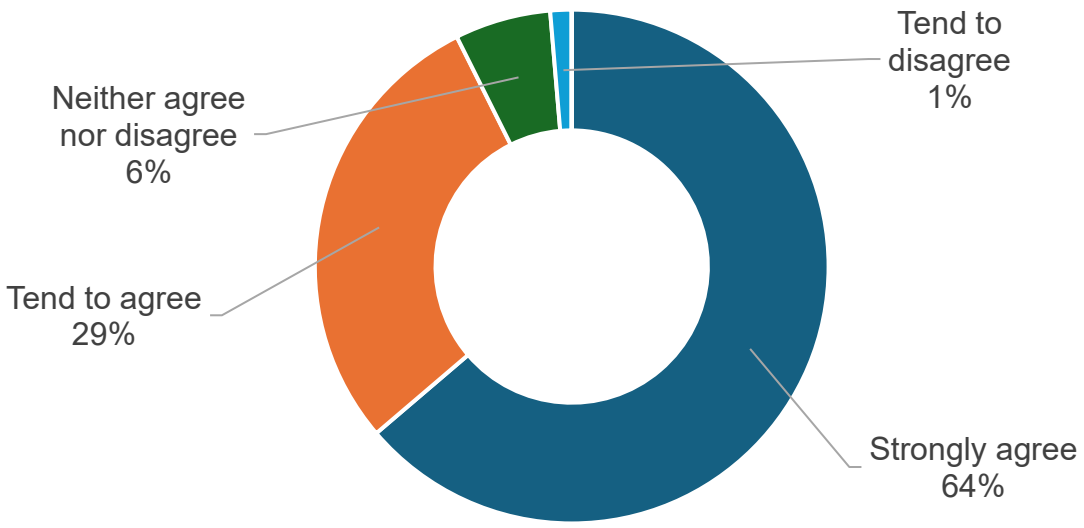
“Emphasis on hope can minimise risks. This Strategy should look beyond suicide to the state of mental health - eg numbers waiting for mental health treatment services and self-harm attendances at A&E”

“This is absolutely needed and urgent action needs to take place to minimise the negative impact the NHS and schools are having on young people who have suffered trauma and are struggling with their mental health . The provision is far from being adequate and sadly I feel there is a lot of work to be done in this area.”

Agreement with priorities

93% respondents agreed with the proposed priorities of the draft Strategy, 64% strongly so and 29% tending to. 6% of respondents neither agreed or disagreed, 1% tended to disagree and 0% strongly disagreed.

Chart 5. How much do you agree or disagree that we should continue to follow the above priorities? Base: 149



Supporting data table	Number of responses	Percentage
Strongly agree	95	64%
Tend to agree	43	29%
Neither agree nor disagree	9	6%
Tend to disagree	2	1%
Strongly disagree	0	0%
I don't know	0	0%

Respondent feedback on why they agreed or disagreed with the proposed priorities of the draft Strategy

Respondents were asked to provide more detail on why they agreed or disagreed with the proposed priorities within the new Strategy.

In total, 29 different themes were raised. The range of topics was again broad, though the majority of these were referenced in fewer than 5% of all responses. Such examples of these include neurodivergence, gambling harms, and personality disorders.

A number of respondents used this question as an opportunity to voice their approval and agreement of the priorities (29).

24 were keen to again highlight the importance of service availability and standards and 11 expressed scepticism of the priorities.

10 spoke about the role of training in suicide prevention, and online safety / social media and support for those left behind both saw reference from 8 and 7respondents.

The top 6 themes are included in the table below. A full analysis is provided in Appendix 2.

Please tell us the reason for your answer in the box below. You can also let us know if you feel there are any priorities missing. Base: 89

Themes	Number of respondents who raised this theme
Agreement with priorities	29
Availability and standards of services	24
Scepticism of priorities	11
Training	10
Social media / online safety	8
Support for those left behind	7

Example quotes, in respondents own words, for the main themes can be found below:

Agreement with the priorities

“I fully support these priorities - I think it captures everything well”

"I agree with all 8 priorities, I think it would be beneficial to try and obtain information from people with lived experience these are the people who will really know where the gaps in support are and what they needed at the time of what is likely to be one of the most difficult times of their lives. We need to learn lessons now not when it's too late."

"These priorities reflect best practice and continued commitment to them is essential if we are to reduce suicide rates and support those affected with dignity and care."

"Agree with aligning to the national Strategy. Priorities are clear and provide a good structure around which to develop further work."

Availability and standards of services

"As previously stated, crisis support is too late and poorly staffed. Sharing information is one thing, but getting professionals to read up on a case before an appointment would stop the regular re-traumatising which goes on over most services, where individuals have to explain themselves over and over!"

"Suicide prevention is everybody's business but this should be to add to services not excuse inadequate or insufficient professional services. Wait lists of months and years for psychiatrist and psychology assessments are not acceptable. Access to ADHD medications needs drastically improving. Crisis interventions should be continued until routine services have confirmed they have picked up the case not just to slightly reduce the escalating situation (or the patient yo-yos in and out of crisis management with no regular support or improvement."

"Clear pathways, transparency and accountability when suicidal thoughts are reported. I don't feel this is very standardised and you could get a different response from different people within the same service. Everyone judges risk differently. It feels a bit unclear and vague."

"We would like to see sustainable and consistent recovery services, in addition to crisis and prevention support. Crisis and prevention are vital, but sustainable recovery pathways are equally important. The Strategy should also address how trends will be identified and communicated. It would be good to state a focus on frequently overlooked groups."

Scepticism of the priorities

"I mostly agree that the above priorities should be continued. They reflect a multi-layered approach to suicide prevention and show a clear commitment to data, crisis support, and bereavement care. However, it's important that these priorities are enacted effectively. For example, making suicide "everybody's business" must be supported with access, training, and recognition of community labour."

“Again I agree wholeheartedly, but I do wonder how you will achieve these aims in practice.”

“So where do you think this tailored support is coming from? There is a lack of funding into mental health support, so getting tailored support would be impossible without extra funding. People don't even get tailored support in secondary mental health services due to the lack of funding.

You need to sort out the crisis teams as they are dangerous to anyone who is suicidal.

Providing in-depth training in Autism and ADHD, especially ADHD as many MH professionals have no clue how to support someone with it as theres no ADHD-Specific training by law unlike Autism.

Not sure how you would reduce the means of suicide, as this would be impossible to do unless you stopped all trains, buying ropes, paracetamol/Medications, closed all bridges etc. I mean that statement doesn't really make sense.

Online safety and responsibility definitely needs more attention especially for children and young people. However, no matter how much awareness is out there, new harmful content reappears. TikTok is a very dangerous place, where individuals will create content which makes out mental health issues, psych wards, running from police, etc is fun and exciting. Its wrong and something needs to be done to stop these people who constantly waste services time and end up bed blocking so people who actually need urgent MH support are pushed to the back because there’s no beds or support.”

“Agree with the priorities but would like to see more substance around “how” this is going to be achieved”

Role of training

“As before your message must be made public. Helping vulnerable people will probably involve a lot of organisations, many of them which are run by volunteers. This will require training, investment i.e. funding, and collaboration between different organisations.”

“I have an acquaintance who recently lost her partner to suicide. I felt really unsure about how to offer support because the circumstances were so traumatic. I did what I could, but would have liked some advice on how I could have helped more usefully. I was aware her trauma was publicly known, yet her grief was private, and was anxious about choosing the right line with sensitivity.”

“Stop medics CAUSING mental health issues by lack of compassion and training. I thought their motto was DO NO HARM.”

"Important to widely publicise the support available. Important to raise awareness. As a former advisor at *(voluntary sector organisation)* I was not trained to either spot suicidal tendencies nor how to deal with them if I did spot them and yet I had several clients who I suspect were suicidal."

Social media and online safety

"I think social media has been a serious issue. Now with AI and algorithms picking up our conversations and even thoughts, it is imperative that something is done!"

"Social media platforms need to be held accountable for their content on suicide and self harm"

"…Sometimes younger people stumble across these messages and then it seeds the idea of suicide as a concept or a possibility before any stimulus for negative feelings enters their mind"

"…Online safety and responsibility definitely needs more attention especially for children and young people. However, no matter how much awareness is out there, new harmful content reappears. TikTok is a very dangerous place, where individuals will create content which makes out mental health issues, psych wards, running from police, etc is fun and exciting. Its wrong and something needs to be done to stop these people who constantly waste services time and end up bed blocking so people who actually need urgent MH support are pushed to the back because theres no beds or support."

Importance of supporting those left behind

"Support for people who are left when a family member has died is so important."

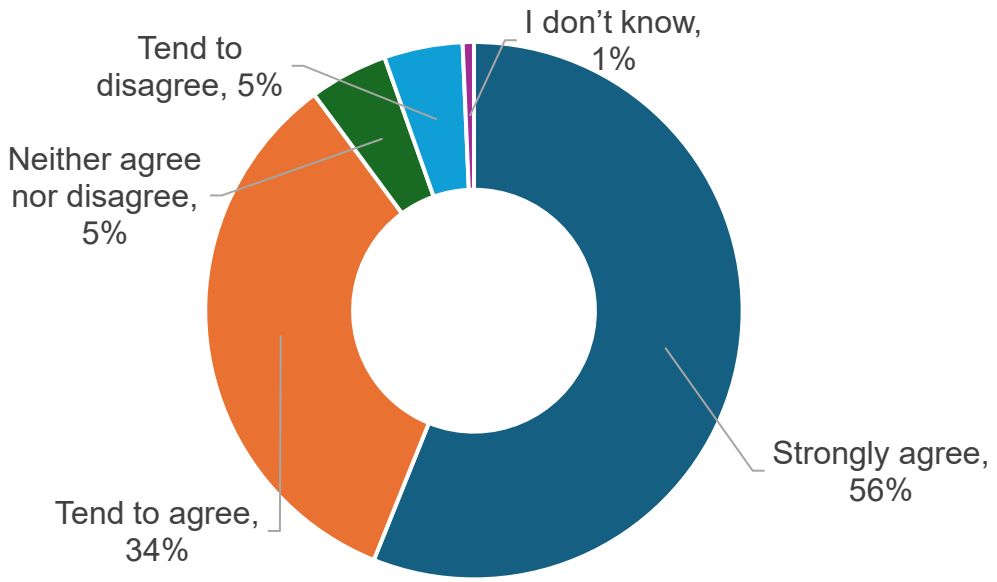
"I agree with all 8 priorities, I think it would be beneficial to try and obtain information from people with lived experience these are the people who will really know where the gaps in support are and what they needed at the time of what is likely to be one of the most difficult times of their lives. We need to learn lessons now not when it's too late."

"There needs to be support for families and this needs to have time measures in place - eg support will be within 24 hours / 2 weeks as timescales hold services to account and deliver support quickly for individuals"

Agreement with high-risk groups

90% of respondents agreed that the listed high-groups were the right ones to be prioritising, 56% strongly so and 34% tending to. 5% of respondents neither agreed or disagreed, 5% tended to disagree and 1% were not sure. No respondents strongly disagreed with the list.

Chart 6. How much do you agree or disagree that these are the right high-risk groups that we should be prioritising in the Kent and Medway Suicide and Self-Harm Prevention Strategy? Base: 148



Supporting data table	Number of responses	Percentage
Strongly agree	83	56%
Tend to agree	50	34%
Neither agree nor disagree	7	5%
Tend to disagree	7	5%
Strongly disagree	0	0%
I don't know	1	1%

Respondent feedback on why they agreed or disagreed with the high-risk groups cited as a priority in the draft Strategy

Respondents were asked to provide more detail on why they agreed or disagreed with the high-risk groups listed as a priority.

In total, 36 different themes were raised, with many of these being suggestions of other population groups which should be included in the proposed list.

A number of respondents used this question as an opportunity to voice their approval and agreement with the listed groups (30), compared to 11 who expressed scepticism.

Neurodivergence was referenced in 25 of the responses to this question and a notable proportion (12) were keen to highlight the LGBTQIA+ community as a suggested priority group.

The top 5 themes are included in the table below. A full analysis is provided in Appendix 2.

Please tell us the reason for your answer in the box below. You can also let us know if you feel there are any high-risk groups missing. Base: 109

Themes	Number of respondents who raised this theme
Agreement with groups	30
Neurodivergence	25
LGBTQIA+	12
Scepticism of selection	11
Children and young people	9

Example quotes, in respondents own words, for the main themes can be found below:

Agreement with the groups

“These groups are roughly in line with other evidence based research I have seen; as well as with what I have witnessed myself.”

“Important for common experiences of particular groups within society to be pooled and understood to support these vulnerable individuals”

"You have taken a data led approach. If other respondents feel there are any high-risk groups missing, I hope you will interrogate the data before adding them."

"I agree. It would be helpful to explore overlaps, eg autistic middle aged men known to secondary mental health services."

"There is good evidence to show that these groups are othered marginalised and excluded, alongside associated stigma and judgement. Acceptance, belonging and connection is the common most thematic missing for all of these groups."

Neurodivergence

"Individuals with ADHD (especially in Kent, as its the worse county in the UK for ADHD support, diagnosis and treatments)."

"Your focus should be on all neurodiverse individuals, not just those with Autism. However, getting a diagnosis for Autism or another neurodiverse condition is incredibly difficult so those who have self-diagnosed need support as well - if you only focus on those with a professional diagnosis then you will be ignoring hundreds of individuals who are probably at more risk because their lack of official diagnosis limits their access to support."

"I agree with prioritising these main groups but also people that may have autism but haven't been diagnosed when they were younger but clearly are struggling with a lot of the traits associated with it."

"I would strongly advocate for the Kent and Medway Strategy to reference 'neurodiverse' people rather than 'autistic' people. Further, "including those awaiting assessment". Whilst some of the data available to the SPN is not broken down enough to identify between e.g., autistic, or ADHD, or both in people who have died by suicide, we have seen in Kent practice reviews that ADHD can be specifically relevant in terms of impulsivity, for example. Given that the national priorities have already been adapted to meet local need, I think it is justified to be mindful of learning from Kent practice reviews and broaden the term. The reason I would suggest adding "including those awaiting assessment" is because we have also seen in reviews that where individuals are on a waiting list for neurodiversity assessment, sometimes their mental health needs are left unresponded to by virtue of the fact some symptoms may be ND related, rather than recognising a deterioration in mental health as something that needs an additional response."

LGBTQIA+ community

"LGBTQI+ people are a known risk group for suicide and I am really surprised that they are not included here. The Office of National Statistics calculates that LGB

people have a risk factor double that of heterosexual people for suicide. Studies suggest that the risk factor for transgender people may be as high as five times that of the general population."

"To NOT have LGBTQI+ in this list of groups of people is, quite incredible."

"As the data drives these results, then those groups are obviously the priority. I would also highlight LGBT+ people, particularly young Trans people as the literature suggests they are at a very high risk for suicide. See Shon Faye's 'The Transgender Issue' for great discussion of this."

"I agree with all the groups that you have included but i would add young men of early to mid twenties who are struggling with their sexual identity."

Scepticism of the groups

"This is definitely the case but care must be taken to not ostracise any group or individual. Suicide can be a split second negative thought and everyone is susceptible."

"I think there is always going to be people who don't fall into those categories who might slip through the net because they are the "unmet need".

"These are all higher risk groups but mental health does not discriminate and nor should we. It is good to focus targeted campaigns on these groups. However everyone regardless of age or gender or background should have equal timely access to bespoke mental health care when they request it. It must not be restricted to those deemed 'low risk' as if someone is requesting help, they have a need."

"I believe by using resources to address targeted groups, it is money wasted that could be available for anyone that requires support. This screams of hearing politicians that say they need to identify where an area needs improving rather than just getting on with it."

Children and young people

"Children should be made number 1 priority we need to shape their future one day they will be the ones running it the more we push them aside to deal with other categories the more they develop unhealthy mindsets and it will lead to larger issues in the future lets take children's mental illness and SEN children seriously."

"I would put children and young people at the top. Many people begin to have mental health problems in their early teens, so early intervention is crucial."

"Children and Young People feels too broad…"

"The overlaps between the different groups could be highlighted a bit more, especially for children and young people."

"Young people/secondary school age and neuro-divergent people should be a priority"

Suggestions for specific actions that could be taken to reduce the suicide risk for any of the high-risk priority groups

Respondents were asked if they had any suggestions for any specific actions that could be taken to reduce the suicide risk for any of the high-risk priority groups.100 respondents provided a response to this open-text question.

31 different themes were identified. The most prominent were around general access to support, making sure that services are visible and available to cater for peoples' needs. This was referenced in 28 responses.

Community cohesion, support groups and loneliness and isolation were themes that regularly came up with considerable overlap (20). Again, there was a considerable proportion of responses that made reference to the needs of the neurodivergent (16).

Other notable themes included the quality of available support (15), the needs of children and young people (12), and the role of schools and educational settings (12).

The top 6 themes are featured in the table below. A full analysis is provided in Appendix 2.

If you have any suggestions for any specific actions that could be taken to reduce the suicide risk for any of the high-risk priority groups, please tell us in the box below. Base: 100

Themes	Number of respondents who raised this theme
Availability / visibility / access to support	28
Community cohesion / support groups / loneliness and isolation	20
Neurodivergence	16
Quality of support	15
Children and young people	12
Schools / education	12

Example quotes, in respondents own words, for the main themes can be found below:

Availability, visibility or access to support

“I liked your introductory “poster” and would hope such information will be wildly available for all public areas where the vulnerable can see them with clear contact details given. I would also suggest areas such as churches, community halls, libraries, motorway service toilets, national trust at White Cliffs, Dartford bridge, etc.”

“Get out into community groups, have a presence, provide training and link up the signposting. People are always telling me "there is nothing out there" when there is - it's just not easy to link to it or obvious - make it widely known… Posters at railway stations, bus stations, community hubs, cafes, offices. Encourage conversations by providing information to key influencers. Also whilst secondary care is more and more difficult to access then there needs to be clear pathways to bridge the gap”

“Avoiding delays, wait lists, and having to see and disclose issues to multiple people. Direct appts with a psychiatrist or psychotherapist for MH referrals indicating this is needed and only initial assessments by general MH practitioners for lower level/more vague referrals so as not to waste time and risk reduction of engagement”

“There are helplines which are 24 hours such as Samaritans and shout which I think are helpful but know the demand for these is extremely high and can take hours to get support which again means that a difficult decision to reach out has been made but not got the timely support needed, could consideration be given to a local helpline? Especially outside of office hours. The safe havens are a great resource but know that people and organisations aren’t fully aware of these, they need to be publicised more effectively, as do many other supportive organisations in Kent and Medway, I think there is so much generalisation and a lack of specific actions in the Strategy overall.”

“Safe Havens and MH services are already overstretched. “Support efforts” is passive and meaningless. What additional crisis capacity will be funded? Where? When?”

Community cohesion, support groups and loneliness or isolation

“Loneliness and isolation among middle aged men is an invisible issue - it is hard to measure since they do not appear on many "radars" until it is too late… Perhaps some forms of interaction could be encouraged that could be engaged with remotely - Teams or Zoom clubs, meetings etc with options of in-person interaction, maybe arranged around certain themes. Even clubs to watch a football game with or to engage in gaming or Dungeons and Dragons etc.”

“More small casual groups in local areas so people can become passive friends with each other and become a natural support network”

“Making every contact count so that people feel confident to discuss their thoughts & feelings. Encouraging almost "whistleblowing" for friends, relatives & colleagues of those at risk.”

“Creating spaces across the county for men to meet and build community. Self sufficient communities are so integral to combating the loneliness epidemic.”

“Peer support groups, properly funded and led by lived experience will provide a sense of belonging and support, early support prevents escalation to more intense support and this is what is wanting. Whilst in the void many people escalate to higher need intervention when peer support would have prevented escalation and been a significantly cheaper option.”

Neurodivergence

“Many autistic adults find making phone calls or having contact with a stranger extremely difficult if not impossible so the generalised mental health matters number or similar they are never likely to contact or the text things like SHOUT as they are often misunderstood at a very vulnerable time and end up feeling worse due to hope being taken away even more so a specialist service is needed for that risk group and none appears to exist now”

“Support services for autistic people. The new KCHFT keyworker service won't help people in crisis. There will be no help for autistic people and mental health services are not neuroinclusive.”

“More ongoing support for autistic people following diagnosis. People are literally diagnosed and discharged with a leaflet.”

“With regard to those with Autism they need consistency in the Teams they work with and the specialist KCC Autism team should be re-instated. Mental health workers need a greater understanding of Autism as they try to get them to attend group therapy. People in Kent with Autism should not have to travel out of the area to get access to mental health services who understand Autism.”

Quality of support

“Improve Mental health services, properly funded and staffed. Let's see real action, rather talk”

“We need strong, robust and reliable crisis support - It's not good enough that people are being turned away from Safe Havens or can't get through on the phoneline. I know of people who have literally been crying out for help and have been turned away. This is so very sad and deeply concerning, it takes a lot for someone to reach out for help, so when they take that step they should be able to access it when they

need it, without the fear of being rejected when they are at such a low point in their lives."

"Avoiding delays, wait lists, and having to see and disclose issues to multiple people. Direct appts with a psychiatrist or psychotherapist for MH referrals indicating this is needed and only initial assessments by general MH practitioners for lower level/more vague referrals so as not to waste time and risk reduction of engagement."

"Better crisis support. GPs send people away to return for a later appointment. Crisis support stop checking if someone doesn't answer initial calls. Very difficult for people to get support from secondary care team, just a monthly call from primary care and phone numbers for self-referral. This is not good enough or sufficient to prevent suicides."

Children and young people

"For young people an app that sends supportive messages to them and where they can face time someone to talk to I think would make a huge difference."

"Children need safe spaces with trusted adults to be able to seek help and develop resilience. Short term interventions can be limited in impact."

"Ensure all staff looking after children and young people and vulnerable adults are educated to be able to support and refer people who are struggling with mental health and suicidal thoughts."

Schools and education

"I'm unsure how much power KCC has over school activities, but it may be worth considering bringing something into the PSHE syllabus - or have an outreach programme. I don't mean to talk about suicide with children - I mean to gently introduce them to the idea that something you might feel really bad, and you need to talk to someone about it. If possible get parents involved as well."

"The Strategy should also include "All secondary school pupils" from Yr 7 upwards, with definite attention to single sex schools (prevalent Self harm in Girls' only), private & Grammar schools"

"Effective support of PHSE leaders in co-design and delivery of suicide and self-harm in and across curriculum"

"More information and awareness sessions/workshops in schools and colleges."

Continuing to make suicide and self-harm prevention everybody's business

Respondents were asked how we could continue to make suicide and self-harm prevention everybody's business. This open-text question yielded a response from 113 out of 149 respondents (76%).

26 different themes were identified, with the main two being the importance of training (41), and the awareness and visibility of relevant campaigns (38).

The other top 5 themes in response to this question were; the roles of schools and education settings (15), the importance of community cohesion and local support groups (13), and the importance of conversation (10).

Examples of other themes, which did not fall into the top 5 for this question, included the role of the VCSE sector (7), the role of workplaces, friends and family in providing support (7) the importance of multi-agency collaboration (6), and the need to address stigma (4).

The top 5 themes are featured in the table below. A full analysis is provided in Appendix 2.

How can we continue to make suicide and self-harm prevention everybody's business? Base: 113

Themes	Number of respondents who raised this theme
Training	41
Awareness campaigns / communication	38
Schools / education	15
Community cohesion / support groups	13
Importance of conversation	10

Example quotes, in respondents own words, for the main themes can be found below:

Training

"As I answered earlier, having free or low cost training for interested individuals in suicide awareness and prevention would mean that more people in the community have the skills both to identify suicide risk and be confident about engaging in a conversation about this. Schools could adopt this training in an age and setting

appropriate manner for teenagers so that they know warning signs to look for in their friends and family."

"Make Suicide Prevention training a mandatory thing that everyone needs to do."

"Continue doing that training but remember not to just fob off the actual individual who is suicidal with a phone this helpline as that isn't possible for everyone and people aren't all the same"

"Conduct free community education sessions establish a DONT WALK BY Strategy where members of he public can help someone if they were to see someone in need of help."

"To make suicide and self-harm prevention everybody's business, we need to embed it across everyday settings. Normalising open conversations, training frontline staff, and promoting responsible media and online safety."

"Training on suicide prevention should be compulsory for business leaders, teachers, police officers and other people in positions of responsibility in Kent. Just offering the training isn't enough."

Awareness campaigns and other communications

"Create an awareness campaign (leaflets, for example) to explain the symptoms of suicidal thoughts. The majority of the people are not aware of the symptoms of suicidal thoughts."

"It's about publicity at its core I think. Each suicide is a tragedy but it's also a statistic. Everyone is used to euphemistic "person on the line" reports when commuting. There's never a story of that person, their name, who they were, the family they leave behind and so on. Suicides on railway property are literally the business of thousands of people and can provoke angry responses without much human empathy. I would favour a leaflet or display with some kind of memorial for those who died which is visible as people enter mainline stations. Just a moment's pause and reflection that this could be a family member or friend, and that having your journey disrupted is not the real story."

"The adverts need to be hard hitting but relatable. A man sitting quietly with his noose that he gets comfort from every night, knowing it is his only option for control. Someone playing with their special razor blade. When people are doing these things, and they do, they are already in crisis, they are the highest risk and yet they don't know that it is behaviour that others have had and got better from."

"Continue to provide messaging that help those dealing with thoughts of suicide and self-harm, including sign posting sources of support. Ensure everyone has

opportunities to access education that can help them reach out to others. Ensure messaging is well targeted and in places those who need it are most likely to find it."

"From my perspective the ad campaigns in public toilets and at petrol stations are particularly important, i have also heard students on construction industry courses discussing this."

Role of schools and education

"It starts with having an early years education Strategy building resilience in children from birth"

"Courses must be widely advertised and particular targets to school and college staff, youth leaders, those involved with vulnerable groups"

"Awareness, visiting schools, talking to pupils about how they access support."

Community cohesion and support groups

"Reach out to VCS groups who are well connected to their communities, particularly grassroots groups."

"It's important to recognise suicide prevention beyond formal training and settings. When people check in, share meals, or walk together, this can be a non-clinical lifeline for someone living with suicidal thoughts. Also, creative play like art and theatre offers ways for people to build community and experience joy beyond clinical settings. Recognising informal ways of preventing suicide and the importance of play for preventing suicide is very important."

"Use community hubs, like libraries, to offer support groups or places to access information - training individual staff at libraries so there is always at least one member of staff working who is able to react & respond appropriately to someone who may come in asking for support."

"Avoid the impression of top-down management of this issue. Run any training through local organisations that can be identified as coming from "my community" not some lofty County level. I need to feel that the issue is live and real on my street and that we, as a local community, are being empowered."

"Having your own resident group that rotates similar to jury service so people can offer insight from the local communities and how the Strategy is working."

Importance of conversation

"By bringing this topic into everyday life, normalising mental health as something that can affect anyone at any time, no stigma should be attached."

"Initiating cultures of speaking about feelings before they even get to the point of crisis."

"Give people the opportunity to talk about suicide in their workplace, at home, school etc. So many people suffer in silence, feel judged or ashamed."

"Promote bystander interventions. Promote open discussions about suicide and suicide prevention."

"By promoting, discussing the subject without fear but with care, love and support."

Reducing access to the means and methods of suicide in Kent and Medway

Respondents were asked how we could reduce access to the means and methods of suicide in Kent and Medway. This open-text question yielded a response from 96 out of 149 respondents (64%).

25 different themes were identified, with the main two being the need to focus on – and address - the risk at high risk locations (30) and the importance of visible, accessible and available support (22). The other top 4 themes included; some scepticism about how this priority could be achieved (17) and the role of awareness campaigns and other communications (17).

Examples of other themes, which did not fall into the top 4 for this question, included a suggestion to mitigate the risks of social media and other online platforms (10), increase the take-up of relevant training (10), and encourage greater multi-agency collaboration (11).

The top 4 themes are featured in the table below. A full analysis is provided in Appendix 2.

How can we reduce access to the means and methods of suicide in Kent and Medway? Please tell us the reason for your answer in the box below: Base:96

Themes	Number of respondents who raised this theme
Focusing on high risk locations	30
Availability / visibility / access to services	22
Scepticism of priority	17
Awareness campaigns / communication	17

Example quotes, in respondents own words, for the main themes can be found below:

Need to focus on high risk locations

“Put decent sized railings up at high-risk suicide spots (e.g. Car parks, tops of buildings, cliff edges & train tracks), to prevent people from taking the risk of ending their own lives and put a big sign on the railings to ask them if they've spoken to someone they trust about how they feel. Maybe put up a speaker at high-risk public places which plays a recorded message from different people's points of view (e.g. Children, parents, friends, partners), asking the person not to end their life and giving them reasons to stay. Above all, more should be put in place to break the stigma of asking for help with suicidal thoughts (be it going to the GP or talking to friends, loved ones or help services), in the first place, as people are ashamed to in this day & age due to unfair stigma around it being a weak thing to do.”

“Unfortunately the most successful form of suicide is hanging which can be accessed anywhere. However, I definitely think it’s a great idea to stop being able to get onto railway tracks, bridges - terrible for the driver and emergency services to deal with”

“I would think that having more police officers and other staff continually monitoring these locations would be a step in the right direction.”

“I’d suggest a change to the wording: Ensure that environments are as safe as possible by restricting access to common means of suicide where evidence shows this saves lives - alongside support for underlying distress.

You can’t police peoples every move so having support available in places that are a high suicide rate will be important.”

“Look to see how motorway bridges can be made safer or at least put information regarding support near hotspots.”

Availability, visibility or access to support

“To some extent its an impossible task as if the person is desperate enough they will find a way..... helping the individual before that point is the best solution”

“ Increase availability / timely screening and early identification Implement routine mental health screenings in schools and paediatric care. Ensure pathways for follow-up and treatment when risk is detected are timely - offer youth accessible & friendly services that offer flexible, confidential, and low-cost/no-cost options”

“Clear places to go in crisis with well trained staff”

“Continue with the work you’re doing; fund organisations like the Samaritans and MIND to do more sessions in the community where they can be visible.”

Scepticism towards this priority

“I think if people want to do it they will find a way.”

“To some extent it’s an impossible task as if the person is desperate enough they will find a way..... helping the individual before that point is the best solution.”

“In my experience we already do a lot. As long as the Internet is available new ways will be found.”

“Oh for heaven’s sake, people have access the drugs, alcohol, toxic mixes of everything. This is a stupid question.”

“Unfortunately we'll always find a way - from medication, to buying ropes or helium from Amazon.”

Need for awareness campaigns and communications

“Check rail hotspots (on the advice of the rail authorities and transport police) and display notices for Samaritans”

“Very difficult challenge, I think public awareness of odd behaviour, noticing distress and being compassionate, signs in high profile areas to make people think about these issues. Make it a really Kent wide aim to get these rates down and that it can only ever be achieved if every person living in Kent becomes alert and compassionate.”

“Providing more awareness to services at hot spots where suicide is more commonly tried. For example the Samaritan stickers on bridges etc..”

“Increase public awareness so eyes and ears are everywhere. Ensure information about missing people is communicated to the public sector support families of missing people to access information about organisations who can help support in the search before it is too late.”

Best way of providing information and support to those bereaved by suicide

Respondents were asked what the best way was to provide information and support to those bereaved by suicide. This open-text question yielded responses from 100 out of 149 respondents (67%).

23 different themes were identified, and the proportions of the ones referred to most frequently were significantly smaller compared to the proportions of the ones referred to most frequently in previous questions. The theme which was raised the most was

the need for appropriate awareness campaigns to support visibility of existing support services (mentioned 21 times).

The importance of early intervention (13), the need for a range of flexible support methods (14) and the availability and general accessibility of specialist bereavement services (14) completed the top 4 themes for this question.

Examples of other themes, which did not fall into the top 4, included a recommendation to make sure those with lived experience were included within the design and delivery of relevant services (9) and the importance of making sure frontline professionals such as the Police, GPs and coroners have the knowledge of specialist suicide bereavement services required to identify the need for – and make – a referral (9).

The top four themes are featured in the table below. A full analysis is provided in Appendix 2.

What is the best way of providing information and support to those bereaved or affected by suicide? Base: 100

Themes	Number of respondents who raised this theme
Awareness campaigns / visibility	21
Importance of early intervention	13
Range / flexibility of support methods	14
Accessibility / availability of services	14

Example quotes, in respondents own words, for the main themes can be found below:

Need for awareness campaigns to help promote the visibility of services

“Those directly involved in “giving the news” (police?) to provide clear advice as to support. In various forms - leaflet, contact cards, website details. A follow up visit, phone call. In my limited experience many will not immediately seek any support so something has to be provided long term”

“In a short, concise email or on a dedicated website which is concise and easy to navigate, or in webinars where others can share their stories in a non-judgemental space and receive support from peers who are all in the same boat.”

“Sometimes I think just knowing the support is there if required - comms, marketing, social media campaigns”

"Advertising in public and private sectors, social media and support groups shops etc . Ensure GP's , police , schools, hospitals and funeral homes, coroners are advertising the support available to people who have had a bereavement by suicide . Ensure other districts are aware of the offer and able to signpost residents when the suicide happens outside the area."

Importance of early intervention

"Rapid access: Families should be proactively contacted within 72 hours of a suspected suicide by a trained bereavement worker (not left to hunt for services themselves). Long-term, stable funding: Support must be ring-fenced and guaranteed, not precarious annual contracts. Suicide bereavement is lifelong; support should not be short-term."

"This should be directly offered through police/health care as these are the services people will be in contact with following a suicide death of a loved one. Ensure it is offered immediately."

"Those directly involved in "giving the news" (police?) to provide clear advice as to support. In various forms - leaflet, contact cards, website details. A follow up visit, phone call. In my limited experience many will not immediately seek any support so something has to be provided long term"

Need for a range of flexible support methods

"However the bereaved want it, by being flexible to accommodate what works best for them, not expecting them (or the MH patient) to have to always fit in to what works best for the service"

"I would say by recognising that individuals need support in differing ways so rather than have a blanket approach listen to the needs and be flexible with the support and how it is delivered."

"Depends what they want. Offer of free contact with a bereavement counsellor would be good"

Need for generally accessible and available suicide bereavement support services

"You need to provide support so that those bereaved by suicide don't become the next lot of people who commit suicide ..... making sure there's no grey areas anymore so those people don't fall through the gaps on services (eg the person can be viewed as too complex for normal bereavement services but CMHT won't see people for bereavement and person requires more immediate help than a GP can give them)"

"You should reach in, not expect people to reach out. Support should be instant and warm. Access to trained grief counsellors who understand the complexities of suicide loss (different from general grief). Services should be free, trauma-informed, and not time-limited. Ideally includes options for one-to-one support, family sessions, and children's grief specialists…Services must be culturally competent, LGBTQIA+ inclusive, and attuned to different family dynamics."

"I feel leaflets could be available for those affected at the time of the suicide but it's probably too early to have a conversation and proactively giving out leaflets may feel insensitive. But could there be a follow up call 1-2 weeks later, then again 6 weeks later? Check in points could be good. Ensure services like Cruse Bereavement counselling is funded, or perhaps provided a payment for someone to seek private counselling."

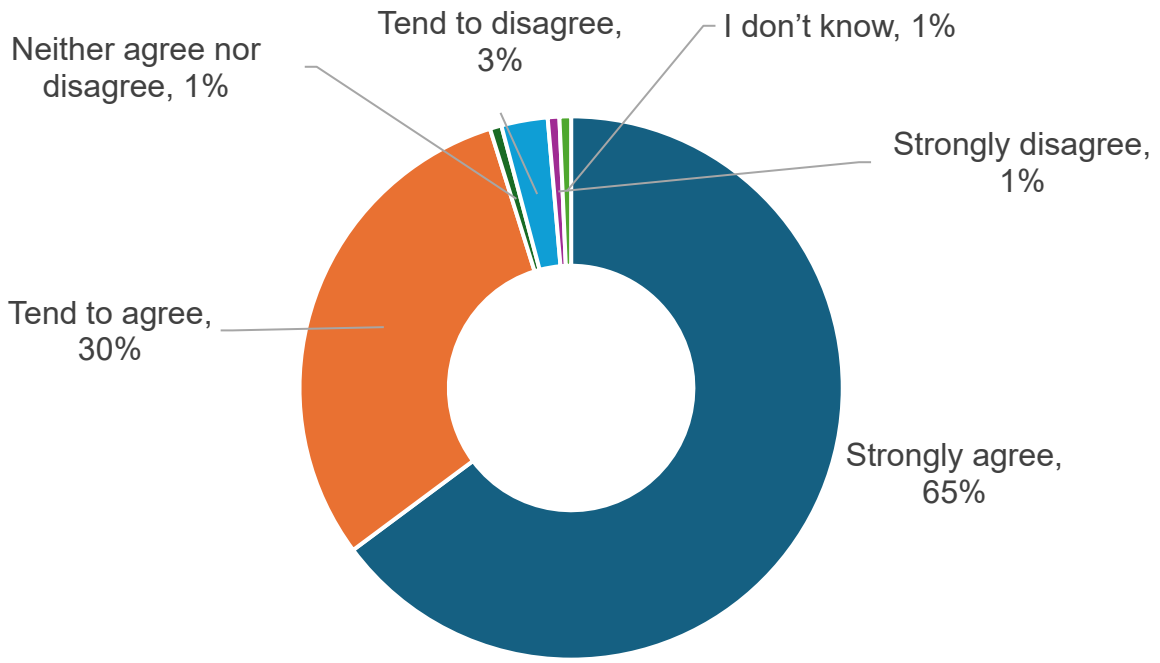
"I lost a friend and colleague to suicide prior to my own. Breakdown. I received no support from secondary care mental health services or IAPT. I was denied support to deal with my grief by 15 NHS and or voluntary services for various reasons including being too complex or no capacity within the service. Please provide a service for suicide bereavement that is accessible."

Children and Young People

Areas of focus that should be prioritised for children and young people

95% of respondents agreed with the areas of focus that should be prioritised for children and young people, (65% agreed strongly and 30% tended to agree). 1% of respondents neither agreed or disagreed, 4% disagreed (3% tended to disagree and 1% strongly disagreed) and 1% didn't know. 3% of all consultation respondents did not answer this question.

Chart 7. How much do you agree or disagree that these are the areas of focus that should be prioritised for children and young people in the Kent and Medway Suicide and Self-Harm Prevention Strategy? Base: 145



Supporting data table	Number of responses	Percentage
Strongly agree	94	65%
Tend to agree	44	30%
Neither agree nor disagree	1	1%
Tend to disagree	4	3%
Strongly disagree	1	1%
I don't know	1	1%

Respondent feedback on why they agreed or disagreed with identified areas of focus that should be prioritised for children and young people

Respondents were asked to provide more detail on why they agreed or disagreed with the identified areas of focus that should be prioritised.

In total, 33 different themes were raised, and once again there was a wide range of these.

The themes which featured the most were the role of schools and education settings, including universities (17), a general agreement with the priorities (16) and an urge for available and accessible support services (16). Each of these themes were expressed by 16-17% of all respondents who answered this question.

Other themes which saw considerable mention included concerns around the impacts of social media and online harms (9), and a need to better understand and tailor support to neurodivergent children and young people (9).

8 respondents stressed the need for smoother transitions between adolescent and adult mental health services, and several CYP specific risk factors were also referenced, including the impact of the care system (2) and 5 mentioned the unique challenges experienced by those not in education, employment or training (NEETs).

The top 5 themes are included in the table below. A full analysis is provided in Appendix 2.

Please tell us the reason for your answer. You can also let us know if you feel there are any areas of focus missing. Base: 99

Themes	Number of respondents who raised this theme
Schools / education (including universities)	17
Agreement with areas of focus	16
Accessibility / availability of services	16
Online / social media	9
Neurodivergence	9

Example quotes, in respondents own words, for the main themes can be found below:

Role of schools and education settings (including universities)

“The support in schools need to be taught in a way it is readily available for all students. The importance of telling someone if something is wrong or don’t feel right. All staff need adequate training in this just in case. Child does confide in them bout themselves or a peer or a family member.”

"Mental health support in schools, colleges and universities - this should be on the curriculum for PSHE - and all schools should have a wellbeing hub/wellbeing officer with training."

"Mental health support in education settings is vital but will need to be funded. It should be made a mainstream topic not one that has an air of embarrassment about it."

"You need to figure out just how much schools and universities themselves might be contributing to SEND suicide rates, such as with ever rising rates of homework. Some of the demands schools/universities try to make exceed those of an adult full-time job, which is wrong."

"I feel there is nothing about prevention, including education about how the mind works, what is depression and anxiety etc. Were schools linked in with? What is on the curriculum? Surely prevention and education at an early stage is key. Could there be a travelling assembly/show around schools in Kent/Medway to educate about these topics from an organisation that is passionate about the topic and has in depth knowledge?"

Agreement with the areas of focus

"This is clearly a high risk age group as the numbers are rising."

"The focus on the mental health of young people is understandable but many of the risk factors are mental health (eg autism, poverty, criminal justice). These other factors need focus too."

"Have to try to stop young people feeling that suicide is their only option."

"We should do all we can to inculcate a positive view of life and prospects."

General accessibility and availability of services

"Mental health support from medical/nursing is some counties has been very limited in the past. There must be a effective and fast referral to these people as waiting for help is not an option if you want to save lives."

"This is one of the most important steps in the process. Children should have access to mental health support the same way adults do, as they experience all the same emotions and sometimes struggles. The earlier children can be taught emotional regulation (when age appropriate), and about different cultures, families, brains, disabilities, the better the future will be."

"Mental health services in Kent are a joke. It is hard to get help and when it is offered it is limited A free counselling service for children would be extremely helpful but only

if provided by qualified counsellors. Free support for parents who are concerned about a child's mental health/behaviour could also make a difference. Opening the children's centres is helpful."

"It is notoriously difficult to access adequate or timely support from MH services or medication for this group, as primary care largely do not manage this group and MH referrals for this group are generally rejected, closed after minimal intervention, or left on long wait lists due to insufficient psychiatrist availability."

"Many children are denied support by CAMHS even following suicide attempts. Many vulnerable young people are NEET or EBSA so school and college support of no use to them."

"There are next to no effective and timely services. Those that exist are out dated. Cumbersome and the waits are huge. CAHMS is not fit for purpose with waits of up to two years for help and hugely excluding criteria. Escalation and harm ensues. Huge under investment year upon year given the rise in MH, understanding of SEND and neurodivergence."

Use and impact of social media and other online platforms

"Young people have things within their lives, phones, social media, pressure from peers which have not in previous generations been prevalent, and as such they need help to sort out disinformation from misinformation and seek genuine answers and truths rather than rely on technology to inform them."

"Concerns over cyber bullying. Never switching off from it and children looking at their phones too much."

"2025 has much different sources of bullying and harassment than in previous decades and this takes place in isolation now i/e behind closed doors in bedrooms rather than the school playground Young people have to not only have the tools and skills to be able to be robust enough to deal with this but also have a social environment where they can offload to their peers or support network."

"Areas missing - impact of social media on CYPs; and impact of family breakdown (system) on CYPs."

Neurodivergence

"Evidence may never help to understand. Young people are not as quickly diagnosed with SEND and are missed causing greater risk of self harm and suicide."

"Secondary MH services will actually refuse a referral if a patient has a primary diagnosis of Autism, learning disabilities or ADHD. No matter if they are struggling with their MH. This needs to change."

"The transition between child to adult mental health services can lead disabled and neurodivergent people without support, so it's really important that this group is prioritised. We also need to especially recognise young carers and those navigating the foster care system."

"I know people who have been turned away. I also know that the support provided has not taken into account the sensory needs of an autistic person. Neither was follow-up done or any other help offered. We should also identify individual patterns / flashpoints significant to the individual and provide more support around those times. We also need to make sure that the support offered is appropriate. Manualised CBT is not effective for autistic people, for example and runs the risk - especially in children - of adding yet another thing the think they have failed at."

Continuing to make suicide and self-harm prevention among children and young people everybody's business

Respondents were asked how can we continue to make suicide and self-harm prevention among children and young people everybody's business. This open-text question yielded 102 responses from 149 respondents (68%).

25 different themes were identified in the responses to this question. The theme raised the most was the need for appropriate training and education measures around suicide prevention (37). This was followed closely by mention of the roles that schools and other education settings can play (33), which included regular overlap with the training theme.

Raised awareness and relevant campaigns were mentioned in 21 responses, along with the role played by friends and family. The availability of – and general access to – relevant support services was highlighted in 11, along with themes around the use of social media and online harms (10).

Examples of other themes, which did not fall into the top 6 for this question, included the need for community support groups (8), the importance of early intervention (6), self-harm (6) and the need to ensure that all children and young people feel heard and believed (5).

The top 6 themes are featured in the table below. A full analysis is provided in Appendix 2.

How can we continue to make suicide and self-harm prevention among children and young people everybody's business? Base: 102

Themes	Number of respondents who raised this theme
Training / education	37
Schools / education settings	33
Raised awareness / campaigns	21
Role of friends / family	21
Availability / accessibility of services	11
Social media / online harms	10

Example quotes, in respondents own words, for the main themes can be found below:

Training and education

"Train as many teachers as possible in suicide prevention. Bring lessons into schools about talking! Make sure the MH campaigns make it to schools. Make sure schools have a suicide prevention policy."

"…having either internally or externally provided age and setting appropriate training in schools would seem to be a good way of increasing knowledge both among the target population and teachers. It could also be offered to parents through the school."

"Your current missing link is not delivering training and support direct to the young people themselves. Young people want to be empowered and this training not only enables them to support their peers but to directly improve their own resilience as well…"

"Make it mandatory in all people-facing roles to have some government provided training within the role."

"Encouraging conversations from all who have contact with children and young people, not specifically about self-harm or suicide but to forge relationships which could help to identify warning signs, also education and training and awareness including on social media as used extensively by young people on various platform"

"Embed suicide prevention into all youth-facing services. Include Youth Advisory Boards in Strategy development (e.g. feedback on page 12). Train professionals in

trauma-informed and DA-specific suicide risk. Ensure interventions are co-designed with young people."

"To make suicide and self-harm prevention among children and young people everybody's business, we must go beyond formal settings and ensure every adult who interacts with young people, including youth workers, sports coaches, community volunteers, and peer mentors has access to training and support."

Role of schools and other educational settings

"Education in schools and an officer they can turn to for their welfare needs. Like safeguarding."

"Be more proactive in schools and colleges by having a presence, demonstrating to everyone that feeling sad or upset is a normal process in life, not everyone is programmed to think like that."

"Start early with primary schools and continue to have open and honest conversations about feelings and emotions all the way through school."

"Make discussing everyone's wellbeing a common and regular topic in education and social settings. This could lead on to discussing self-harm - introduce an incident of self-harm to be discussed - e.g. what could have led up to this point? Why did they not ask for help? Why didn't anyone notice that they needed help? How could we prevent it happening to anyone else? This sort of discussion may not be successful in large groups. Small groups and single sex groups would probably be more successful."

"In use in the curriculum and have lived experiences talk to pupils. Many schools have archaic thinking as to not talk about suicide or they feel it will put ideas into pupils minds. This is utter rubbish and only perpetuates the stigma and inability to reach out for help or to talk about it. Children are also reluctant to tell adults but may confide in friends. Training needs to be levelled at peers ie what to do if they are worried about a friend. How can they flag this without going directly to a teacher or adult. How do they report this without seemingly betraying a confidence in their mind."

Need for raised awareness and specific campaigns

"Keep reporting and publishing key facts and figures, including what's going right, working well and improving as well as areas still needing improvement"

"Make role-play style adverts on social media, in cinemas & TV similar to the THINK Road Safety campaign that was on the radio, in cinemas and on TV a while ago."

"By increasing availability to more prevention and awareness of the many different services / supports already in place like youth groups, art, music , dance that increase community support and wellbeing rather than illness"

"Continue to provide messaging that help those dealing with thoughts of suicide and self-harm, including sign posting sources of support. Ensure everyone has opportunities to access education that can help them reach out to others. Ensure messaging is well targeted, in places young people who need it are most likely to find it, and uses language and imagery they can relate to."

"System leadership will be critical to ensure resources are in place to support this work, and to include this in occasional updates to joint Kent Chief Execs and Leaders to help raise the profile of this work. Build suicide prevention awareness around relevant activities within education settings – for instance ensuring posters/leaflets etc are displayed and talked about. Also that support services, such as Kooth and other YP mental health support, are known about and promoted"

Role friends and families can play

"Support for parents as to where to turn with direct contacts."

"Parents and peers need to know how to recognise the signs and need strategies to employ to support those they love."

"We need to expand responsibility beyond professionals and recognise suicide prevention as an everyday practice. That means recognising the role of peers, carers, and community members."

"Doesn't the buck stop with them and there family/friends rather than everyone's business. What if the individual doesn't want it to be everyone's business?"

"Run sessions for parents via schools"

Need for generally accessible and available support services

"Improve access to CAMS and mental health services - if someone is already self-harming or suicidal, prevention is too late, they need urgent help"

"Early diagnosis, banish waiting list, if people need help, should be provided immediately."

"More mental health professionals especially for younger age groups"

"More resources are needed for therapeutic interventions like DBT"

Use of social media and online harms

"…That means addressing all forms of bullying and social segregation - especially cyber bullying which adults often miss because of the new technology at play. Likewise, parents and teachers need to be aware of how predators groom youngsters online. This means identifying risky behaviours of youngsters - some of which openly invites predators into the online life. I've seen it first hand and it terrifies me how little adult understanding and safeguarding is in place. However bad you think it is - it is worse than that. If it does not give you nightmares, you have not seen the worst of it. Young people with suicidal thoughts are especially vulnerable and extremely hard to protect. Both the young people and the adults that care for them need a breadth of education and support about the risks that can precipitate suicidal inclination because at that stage most of the damage is done. There is a young person in my family in that exact situation and keeping their mental health stable and protecting them from online danger and "IRL" risky behaviours is a full time job for the entire extended family. The problem is real, deep, complex and poorly understood…"

"Being on top of social media and the challenges that go around ie holding your breath until you pass out. With knowledge of the 'in thing' awareness and discussing it and its dangers can dilute its appeal."

"Education about social media, particularly in group situations in school/colleges where things can be seen together as cause and effect."

"Reduce dependence on social media and peer pressure."

Reducing suicides in children and young people in Kent and Medway by controlling access to the means of suicide

Respondents were asked how we can reduce suicides in children and young people in Kent and Medway by controlling access to the means of suicide. This open text question yielded responses from 55 out of 149 respondents (37%).

22 different themes were identified in the responses to this question. The theme raised the most was around social media and online harms, which were mentioned 16 times.

10 respondents voiced scepticism around this priority and its achievability. 9 spoke about making physical adjustments, including at high-risk locations. The role of schools and other education settings were again identified as an important component (8) and the need for continued raised awareness and campaigns was also highlighted (7).

Examples of other themes, which did not fall into the top 5 for this question, included the role of parents and families (6), effective use of data and research (4) and youth / community groups (4).

The top 5 themes are featured in the table below. A full analysis is provided in Appendix 2.

How can we reduce suicides in children and young people in Kent and Medway by controlling access to the means of suicide? Base: 75

Themes	Number of respondents who raised this theme
Online / social media regulations	16
Scepticism of priority	10
Physical adjustments / high risk locations	9
Schools / education settings	8
Raised awareness / campaigns	7

Example quotes, in respondents own words, for the main themes can be found below:

Social media and online harms

“The internet can be an unsafe place and it is hard to police. Young people need to be protected regarding what sites they are visiting.”

“Social media and bullying online is a huge issue - monitoring platforms, calling out negative posts and rhetoric, encouraging parents to learn about apps, language changes, working on laws to stop parents posting their children online, will all be important steps.”

“Social media content is a way of accessing vulnerable youngsters so this requires far more rigorous control. There is talk of banning under 14s from using social media but it's probably not feasible as it already exists. Young people must be taught how to identify and question inappropriate content and seek advice. As before this will no doubt require training and funding.”

“Social media is a difficult area to tackle but people being aware of the law now around online crimes and the consequences is important educate up on this early.”

“There needs to be consequences for social media companies that allow their sites to publish suicide related materials - I think negligence in this area should be corporate manslaughter.”

Scepticism of this priority

“You cannot make everything in everyday life suicide proof, we need to program children to understand it is not a viable option in the first place.”

“Not sure this is possible. Better to take away the ideation.”

“Bluntly: this is a clear example of overreach. You cannot fence off every risk in a child’s life. The real task is making sure help is available, accessible, and timely — so that children are not left so desperate that access to means becomes the last resort. No more fat consultation process, just Guaranteeing rapid access to care: no child or young person in crisis should be left waiting months for CAMHS or safe-haven services.”

“Almost impossible to do that 100%. There are so many means that are available in everyday items. Trying to stop them wanting to do so by early intervention and help/therapy is the best way, plus monitoring their online activities if possible.”

Need for physical adjustments, including at high risk locations

“The adults where they live and visit should ensure that harmful substances and sharp implements are secured and not accessible.”

“Look at local area statistic as to where suicides are happening and get surveillance in these areas.”

“At-risk areas should include clear, youth-friendly signs pointing to local support, and digital access to help via QR codes or text services.”

Role of schools and education settings

“Work with schools and families to identify and restrict access to means of suicide.”

“Ensure schools are not able to give up on children and young people up to 25 who have difficulties in school that they have a duty of care until adequate and sustainable support is available and have taken over the duty of care.”

“Young people need safe spaces to talk long before they reach crisis, including access to peer-led groups in schools and communities.”

Need for raised awareness and campaigns

“Young people can be drawn to the taboo so true empirical information should be readily available”

“Increasing parental awareness of signs of mental distress in their children, as well as monitoring use of medication, etc.”

Best way of providing information and support to those children and young people bereaved or affected by suicide

Respondents were asked what the best way was to provide information and support to those children and young people bereaved or affected by suicide This open -text question yielded 85 out of 149 respondents (57%).

20 different themes were identified in the responses to this question. The theme observed most frequently was around the role of networks and communities, which was mentioned 21 times.

As has been consistent throughout the questions relating to children and young people, the important role of schools was also highlighted, and this was the second most frequent theme, mentioned in 16 responses.

13 respondents spoke about the need to ensure that there is a range of support methods available to children and young people. 10 referred to counselling and therapy specifically. A general need for available and accessible support was referenced by 10 of respondents.

The top 5 themes are featured in the table below. A full analysis is provided in Appendix 2.

What is the best way of providing information and support to those children and young people bereaved or affected by suicide? Base: 85

Themes	Number of respondents who raised this theme
Use of networks / community	21
Schools / education settings	16
Range of support methods	13
Therapy / counselling	10
Accessibility / availability of support	10

Example quotes, in respondents own words, for the main themes can be found below:

Roles of networks and communities

“This is where established communities, including schools, do best. It would be useful to look at house building here. New estates, and many older ones too, need facilities

such as community centres, shops, medical and other facilities which bring people together and create communities. Communities are the key to the sharing of information and mutual support."

"Create social groups so people can bond and learn together."

"Peer support - stories from those their own age that have experienced difficulty themselves and can share how they became strong enough to not give in."

"Support network with those who have experienced similar."

"Having groups that can proactively talk about issues, promoting projects and training for staff and parents and professionals (e.g. Stefan's Acts of Kindness)."

Role of schools and education settings

"Schools should have the capacity and sign posting ability here."

"Ensuring resources are available in education settings and other places where young people visit (e.g. family hubs, sports facilities, etc)."

"Schools, colleges and universities should have clear pathways to specialist bereavement services, and staff should be trained to respond with sensitivity. After initial support, young people should be offered the option of peer-led bereavement groups, where they can process their grief alongside others with shared experience in a safe, supported environment. Involving bereaved young people in shaping these services ensures they feel relevant, accessible, and genuinely helpful."

Need for a range of support methods

"Making sure there is a range of option both online face to face ,peer support those with lived experience."

"Supporting memorial/vigils etc can be helpful to families. Also ensuring there are a range of services on offer, in person online on the phone, individual and group etc"

"Offering consistent support for a period of time following the bereavement via a medium that they can choose and connect with (text, video chat, AI wellbeing app etc)"

"Through either online or face to face; dependent on requests 1 to 1 or group work, really depends on the child and context of the suicide. Also, in terms of children it may not be until they are older they are impacted by an historical suicide of a relative. (parent etc). needs to follow the need not the service."

"Everyone's needs are individual. Seek to establish those needs on a one-to-one basis and then provide the relevant information and support."

Need for therapy and counselling provisions

"Offer family counselling for bereavement. Explain the stages of loss the strong emotions to deal with such as anger , heartache, guilt 'duvet diving 'not being able to face the day."

"Don't think it will just go away. Provide support for those affected & make it easily accessible. Counselling online or a counsellor for each area of Kent to work with the school friends & relatives of school age. Allowing them the space to organise their thoughts & questions & often guilt. Just do so much more. educate their parents too."

"Professional help and therapy. Online support groups, such as The Compassionate Friends, who have advice for siblings affected by suicide, as well as support for the whole family."

Need for support which is generally accessible and available

"Be open, be available and most importantly be caring and not judging or opinionated"

"We could have information packs that are tailored to different age groups that are available in different formats (digital, physical, Braille, audio description, easy read). This could include practical guidance on grief, normalising feelings, how to ask for help, and contact information for support services."

"Timely support , relevant to them. The impact is huge and brings future issues around ACE's if not supported adequately. Increased services and timely, not 8 months down the line and to be fought for which was our experience and that of many."

"I felt supported but I still feel my remaining children were left to seek help themselves or see a school pastoral team member - they need specialist help to be brought into school to support them, not someone who has had half a day training"

"To make sure people are aware of all services and support available to them."

"Advertise! Ensure it is widely known that you offer this service and make sure it is easily and promptly accessible."

Feedback on any of the other priorities or actions for adults or children and young people in the Strategy

Respondents were asked if they would like to provide feedback on any of the other priorities or actions for adults or children and young people in the draft Strategy. This question yielded 30 responses out of 149 respondents (20%).

26 different themes were identified in the responses to this question, with the one observed most frequently being a general approval of the Strategy, which was voiced by 7 respondents.

The other top themes were neurodivergence (3), the importance of a wider mental health Strategy (3), and the importance of continued research to address risk factors 3().

The top four themes are featured in the table below. A full analysis is provided in Appendix 2.

If you would like to provide feedback on any of the other priorities or actions for adults or children and young people in the Strategy, please provide these below.
Base: 33

Themes	Number of respondents who raised this theme
Agreement / support of strategy	7
Wider mental health strategy	3
Neurodivergence	3
Importance of continued research / addressing risk factors	3

As the responses to this question were fewer in number, we have combined all 26 different themes for the purpose of supplying the example quotes below:

“Strategies are all well and good, totally pointless if mentally health provision not funded adequately.”

“There are so many deep seated root causes that the Strategy has not addressed. This is not a fault, these root causes are hidden and hard to find (until you find yourself in the middle of them). Every underlying and contributing factor that causes groups to be especially at risk must be addressed directly or you will forever be putting out fires that started a long time ago.”

“Stop doing a one size fits all approach such as mainly advertising one helpline and stop making it all about helplines as those do not suit everyone, not everyone is able to get to safe havens either and some people will already have loads of trauma associated with bad experiences of helplines and other services.”

“Please add support for people with ADHD. We are always being left out of documents and missed. Kent has already taken NHS referrals away and the real possibly the chance for any kind of assessment or diagnosis for those waiting due to only providing right to choose as the only option left which Kent only has two approved companies for right to choose.”

“Add more content about self-harm.”

“What’s missing throughout:

Accountability — who owns each action, and who is held responsible if targets aren’t met?
Capacity stress-testing — what happens when demand spikes or funding is cut?
Structural action — poverty, debt, housing insecurity, domestic abuse, and gambling are drivers of despair, yet they’re treated as footnotes.”

“We welcome the overall direction of the Strategy and are particularly supportive of its emphasis on hope, collaboration, and tailored support. However, we believe more emphasis should be placed on investing in regular, local peer support groups as a core intervention across all priorities not just as an add-on. Peer groups offer consistent, trusted, non-clinical support that can prevent crisis, reduce isolation, and help people manage their mental health independently over time.”

“Clarify what intersectionality looks like in practice for this Strategy. Include more detail on interventions for high-risk groups. Ensure Strategy is survivor-led and trauma-informed. Consider a programme for those with suicidal thoughts linked to domestic abuse.”

Any other comments on the draft Strategy

61 out of 149 respondents (41%) provided additional comments on the Strategy.

30 different themes were identified, with the most frequent a call for greater mental health support (15) followed closely by a general approval of the Strategy (14).

A small number of respondents (5) used this question to voice some scepticism of the Strategy, and other themes that saw similar proportions included the importance of multi-agency collaboration (4), neurodivergence (4), accountability (4) and the impact of the wider socio-economic environment (4).

The top 7 themes are featured in the table below. A full analysis is provided in Appendix 2.

If you would like to make any other comments on the draft Kent and Medway Suicide and Self-Harm Prevention Strategy, please tell us in the box below:
Base: 62

Themes	Number of respondents who raised this theme
Improving mental health provision / increased funding	15
Agreement with Strategy	14
Scepticism of Strategy	5
Multi-agency collaboration	4
Neurodivergence	4
Accountability	4
Wider socio-economic environment	4

Example quotes, in respondents own words, for the main themes can be found below:

Need for greater mental health support

“Capacity and resource , funding for all system partners to participate in MDTs , Holistic health and social care assessments should be a priority.”

“Improve existing mental health provision. Invest in services that cannot cope under existing demands.”

“I think that you have it about right...the only thing that bothers me is that if A and E are busy in hospitals, still suicides are turned away as you did it you sort it...this has to change, these people are crying out for help.”

“Please help people with PTSD. So many of us are expected to continue on without support because there isn't any NHS trauma therapists within our immediate area & that just leads to us being retraumatised constantly, making our condition worse. I have had complex PTSD for around five years & despite being under secondary mental health services, I still haven't received trauma-focused support. I have done everything right, I have tried so hard to get help so that I can try to return to some level of normality & all I get is doors shut in my face, constantly being told that my trauma is

not something that a particular organisation or mental health professional can help with…..

I have spent years advocating for myself, trying to get support so that I can start working again & be a productive member of society but the help I need isn't available - I go through stages of coping well, but I always swing back to being suicidal & my fear is that this will all end with me taking my own life when my symptoms are especially bad because there is no other option at this point. Every nightmare or triggered memory makes my trauma worse, & eventually I won't be able to continue to cope with it on my own. And I know I'm not the only person with PTSD living like this. Please help us. Please focus on supporting people who have been traumatised, as well as all the other at-risk groups, instead of leaving us to cope alone. We deserve better."

"Have you linked it up with the NICE guidelines on Self Harm and Suicide where it talks about making sure that services who use screening questionnaires don't filter out people who have low scores and don't give them an intervention eg in an IAPT service using a PHQ-9 or CORE 10 questionnaire as evidence suggests that people who do go on to take their lives can score low when they present to a service and then they may only be given text support rather than in person."

Agreement with the Strategy

"The Strategy looks fantastic and has clearly been created with care and sensitivity. Thank you."

"This is needed, our business is happy to be involved."

"It is an excellent and well-thought-out piece of work."

"Really robust, strongly support it"

Scepticism of the Strategy

"If "hope" and intent could prevent suicide, Kent and Medway would already have the lowest rates in the country."

"This Strategy is a performative measure with no thought as to the people behind the numbers. It is just another empty strategic piece of nonsense doomed to fail. There is no joined up thinking and linking into stakeholders in real terms and is standalone all but in words. Unless a concerted combined effort is made more lives will be lost, most of which are entirely preventable."

Importance of multi-agency collaboration

“The issue of sharing personal information on people at risk between different departments will always be a stumbling block. It could be made clear in the Strategy on how you manage this.”

Neurodivergence

“Kent needs more specialist support for Autistic young men. Currently there is nothing for them. The Beacon in Thanet has no understanding of Autism. We have lost the specialist KCC Autism team. You never see the same GP or Psychiatrist for proper medication reviews or constancy of care.”

“We should make sure disabled and neurodivergent people feel fully included. Support should be flexible and respectful of the different ways people show stress and ask for help. Many people, like carers or people supporting friends, help in ways that aren’t always obvious. Their work matters and it should be recognised.”

Need for accountability

“Having a Strategy is fine - but it is ACTION that is required.”

“Just as already stated I would like to see more specific actions, I appreciate this is a huge area to try and tackle so think specific actions which can be piloted, monitored and evaluated and then potentially rolled out further rather than putting a great deal of effort into a blanket approach which is maybe not as effective.”

Wider environment

“In the context of Local Government Reorganisation, what thoughts are being given to how this Strategy/area of work may be managed going forward?”

“There does seem to be a culture of I want, I ought to have, someone else should give me. I am ENTITLED to ... I think this isn't doing any of us any good. Opportunities should be given more status in the minds of people. Those receiving benefits ought to give what they can in return and thereby achieve a sense of purpose. On Sark in the Channel Islands once the tourist work closes down the residents who can fix the roads DO, in return for payment which is what gets them through to the summer again. I have considered suicide and believed removing myself would make life better for those around me. I don't know enough about this! Sorry.”

5. Responses to the equality analysis

Respondents were asked to provide their views on the Equality Impact Assessment (EqIA) for the Strategy in their own words. Respondent comments have been reviewed and example quotes have been provided below.

43 respondents (29%) provided a comment to this question referencing a total of 17 themes. The most commonly observed theme was an approval of the EqIA (10 mentions). 9 voiced some scepticism of the EqIA, whilst 8referenced neurodivergence and 5 referenced the LGBTQIA+ community.

A table showing all of the themes is provided in Appendix 2.

Example comments from across all themes are included below, in the respondents own words:

“The equality analysis highlighted the need to add information and Strategy for both sexual orientation and gender identification so I am not sure why this does not seem to have been done.”

“Get rid of it as it creates division where there was none”

“These tools are useful but unless you can see and talk to someone face to face, people are going to slip through the cracks, so to speak. It’s going to be a long, slow process to do this effectively.”

“Its a good analysis, I think it could be more detailed in places but recognise there are gaps in the data”

“What does mental health need EQIA, mental illness doesn't choose patient based on gender or race or disability it affects us all”

“It's great that you've done an EqIA - which seems to point out the comments I've made earlier in the survey. Would be good to include more proactivity in the Strategy around supporting the LGBTIA+ community in terms of suicide prevention and support, on the back of this.”

“This should only be considered if it is relevant to the learning from each suicide case or statistics otherwise treat all cases on their detail and all persons as a life and nothing different. I don't think this is a subject matter where being "PC" is more important than reducing the number of persons dying from suicide, unless of course the statistics dictate a particular group are susceptible and a dedicated approach is necessary.”

"You have no impact on staff - this does not take into account colleagues within health and care who may be affected by the Strategy"

"Look at women - suicide rate for autistic women is 13% more than the average."

"Just to focus on all groups - mental health and suicide is a human response which excludes no one."

"Please ensure "neurodivergent" is used instead of "autistic" to be inclusive of undiagnosed individuals. Include "children in care" as a distinct group. Clarify how intersectionality will be addressed in practice."

"From our experience supporting people across Kent and Medway, we believe it's vital that the Strategy actively considers intersectionality recognising how overlapping factors (e.g. race, disability, neurodivergence, and economic hardship) can increase risk and impact access to support. We suggest ensuring that support services, especially peer-led groups, are physically and culturally accessible, and that they are co-designed with people from marginalised communities. It's also important to consider barriers faced by neurodivergent individuals, such as sensory needs or social anxiety, which may prevent them from engaging with standard services."

"Currently mental health services in Kent do NOT want to utilise reasonable adjustments for those with autism. Royal College of Psychiatrists Report CR228 shows the need for robust direct questioning, points out masking etc. There needs to be an acceptance that people can look okay even when they are not."

6. Next steps

All of the responses to this consultation have been considered by the Suicide Prevention Programme team, and where possible they will be used to help finalise the Strategy and the Equality Impact Assessment (EqIA).

This consultation report will be published on the Let's Talk Kent consultation webpage, alongside a "You Said, We Did" document detailing the key changes made to the Strategy because of the consultation and explaining any areas that haven't been included.

This report, along with the EqIA and the final draft Strategy is expected to be presented at the Adult Social Care and Public Health Cabinet Committee in early 2026.

The final draft Strategy and consultation report will also be shared at the Adult Suicide Prevention Network and the Children & Young Peoples' Suicide Prevention Network meetings in early 2026. In addition, we will also be delivering an update at the Annual Suicide and Self-Harm Prevention Conference on 27 November, where we will have around 250 attendees.

If approved, a link to the final Strategy will be published on the consultation webpage.

7. Appendix 1. Consultation questionnaire

Consultation Questionnaire

The Kent and Medway Suicide Prevention Programme is creating a new suicide and self-harm prevention Strategy for adults and children and young people. The current Strategy finishes at the end of 2025. We have reflected on what has worked well and where the priorities should be for the next five years. We would like to hear from anybody who is interested in having their say around suicide and self-harm prevention. We will use this feedback to help finalise the Strategy.

We have provided this feedback questionnaire for you to give your comments. The questionnaire is split into five parts:

You can respond to all or as many of the sections/questions as you like. If you would rather not provide feedback on a section or question, just move on to the next one.

This questionnaire can be completed online at kent.gov.uk/suicideprevention.

Alternatively, fill in this paper form and return to:

Email: suicideprevention@kent.gov.uk

Address: Suicide Prevention Team, Public Health, Room G17 Sessions House, County Road, Maidstone, Kent ME14 1XQ

Please ensure your response reaches us by midnight on 6 October 2025.

What information do you need before completing the questionnaire?

We recommend that you view the consultation material, including the draft Strategy online at kent.gov.uk/suicideprevention before responding to this questionnaire.

If you have any questions about the Strategy or need any help taking part in the consultation, please email suicideprevention@kent.gov.uk.

Kent and Medway Suicide and Self-Harm Prevention Strategy 2026 - 2030

Consultation Report

Please do not include any personal information that could identify you or anyone else in any of your answers.

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.

Help and advice: If you are struggling to cope and would like free advice from a trained counsellor, you can call the Release the Pressure helpline on 0800 107 0160.

Visit www.releasethepressure.uk for full details.

If you have been bereaved by suicide and would like to access free emotional and practical support from a specialist trained Liaison Worker, you can contact the Amparo service online (https://amparo.org.uk) or by calling 0330 088 9255.

A range of other information on the help and support available in Kent and Medway can be found on the Mental Wellbeing Hub (www.kmhealthandcare.uk/mental-wellbeing-information-hub).

Part 1 – About you

Q1. **Are you responding as…?** Please select the option from the list below that most closely represents how you will be responding to this consultation. Please select **one** option.

☐	A Kent or Medway resident
☐	A resident from somewhere else
☐	A representative of a local community group or residents' association
☐	On behalf of a family member or friend (please complete this questionnaire using their information)
☐	On behalf of a charity or Voluntary, Community or Social Enterprise (VCSE) organisation
☐	On behalf of a Parish / Town / Borough / District Council in an official capacity
☐	A Parish / Town / Borough / District / County Councillor
☐	On behalf of an educational establishment, such as a school or college
☐	On behalf of a business in Kent
☐	Something else, please tell us:

Q1a. If you are responding on behalf of an organisation or business, please tell us the name of your organisation in the box below:

Q2. Please tell us the first 5 characters of your postcode:

Please do not reveal your whole postcode. If you are responding on behalf of an organisation, please use your organisation's postcode. If you are responding on behalf of someone else, please use their postcode. We use this to help us to analyse our data. It will not be used to identify who you are.

Q3. How did you find out about this consultation? Please select **all** that apply.

- [ ] An email from Kent & Medway Suicide Prevention Programme
- [ ] An email from Let's talk Kent / KCC's Engagement and Consultation Team
- [ ] A Parish / Town / Borough / District / County Councillor
- [ ] From a Parish / Town / Borough / District Council
- [ ] From a friend or family member
- [ ] From a school / college / educational establishment
- [ ] From another organisation or charity
- [ ] Kent.gov.uk website
- [ ] Newspaper
- [ ] On social media (e.g. Facebook / Instagram / X / Nextdoor / LinkedIn)
- [ ] Poster in a Kent Library
- [ ] Postcard at an event
- [ ] Suicide Prevention monthly newsletter
- [ ] Something else, please tell us:

Part 2 – Feedback on the Strategy

Q4. **Is the draft Kent and Medway Suicide and Self-Harm Prevention Strategy 2026-2030 easy to understand?** Please select **one** option.

- ☐ Yes
- ☐ Partly
- ☐ No
- ☐ I don't know

Q4a. **If you have any comments or suggestions on how to make the Strategy easier to understand, please tell us in the box below.** If your suggestion relates to a specific section/page, please provide details.

Our **vision** is that Kent and Medway becomes a place where the number of people dying by suicide is reduced as much as possible and our specific aim is for the Kent and Medway suicide rate to be below the national average by 2030 (if not sooner).

Q5. How much do you agree or disagree with our proposed vision for the draft Strategy? Please select **one** option.

- ☐ Strongly agree
- ☐ Tend to agree
- ☐ Neither agree nor disagree
- ☐ Tend to disagree
- ☐ Strongly disagree
- ☐ I don't know

Q5a. Please tell us the reason for your answer to Q5 in the box below:

Our **mission** is to work towards making Kent and Medway a place where hope is always available to anyone, no matter what they are facing. By 2030 we would like:

- Children and young people in Kent and Medway to be resilient enough to cope with life's normal ups and downs, but knowledgeable enough and confident enough to reach out for more support when they need it.
- Adults in Kent and Medway to know how to look after their own emotional wellbeing but to feel comfortable and able to seek more help when necessary.
- All agencies (statutory, voluntary, community) to work collectively to ensure support and help is available to those who need it.
- All agencies to share knowledge and support each other to learn what works in helping people get the support they need.

Q6. How much do you agree or disagree with our proposed mission for the draft Strategy? Please select **one** option.

☐	Strongly agree
☐	Tend to agree
☐	Neither agree nor disagree
☐	Tend to disagree
☐	Strongly disagree
☐	I don't know

Q6a. Please tell us the reason for your answer to Q6 in the box below. You can also let us know if you feel there is anything missing from the mission.

Our **values** for suicide and self-harm prevention are:

1. **Collaboration.** The power of the Suicide Prevention Programme comes from the hundreds of network members who all work towards the Vision.
2. **Hope.** Hope is extraordinarily powerful, yet without it, everything is extremely difficult. We will embed hope into everything that we do**.**
3. **Determination.** Suicide prevention is not an easy task, particularly in a population of nearly two million. We will undertake every action with fierce determination.
4. **Sensitivity.** We will work sensitively with everyone impacted by suicide to ensure we don't add to their trauma.

Q7. How much do you agree or disagree with our proposed values for the draft Strategy? Please select **one** option.

- ☐ Strongly agree
- ☐ Tend to agree
- ☐ Neither agree nor disagree
- ☐ Tend to disagree
- ☐ Strongly disagree
- ☐ I don't know

Q7a. Please tell us the reason for your answer to Q7 in the box below:

To reduce suicide and self-harm as much as possible, we are proposing to adopt the **eight priorities** from the National Suicide Prevention Strategy[3] and adapting them for our local circumstances. The proposed priorities are:

1. Make suicide everybody's business so that we can maximise our collective impact and support to prevent suicides.
2. Address common risk factors linked to suicide at a population level to provide early intervention and tailored support.
3. Tailor and target support to priority groups, including those at higher risk, to ensure there is bespoke action and that interventions are effective and accessible for everyone.
4. Provide effective crisis support across sectors for those who reach crisis point.
5. Improve data and evidence to ensure that effective, evidence-informed and timely interventions continue to be developed and adapted.
6. Reduce access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides.
7. Promote online safety and responsible media content to reduce harms, improve and signposting, and provide helpful messages about suicide and self-harm.
8. Provide effective bereavement support to those affected by suicide.

Q8. How much do you agree or disagree that we should continue to follow the above priorities? Please select **one** option.

- ☐ Strongly agree
- ☐ Tend to agree
- ☐ Neither agree nor disagree
- ☐ Tend to disagree
- ☐ Strongly disagree
- ☐ I don't know

[3] Suicide Prevention Strategy 2023 to 2028 : https://www.gov.uk/government/publications/suicide-prevention-Strategy-for-england-2023-to-2028

Q8a. Please tell us the reason for your answer to Q8 in the box below. You can also let us know if you feel there are any priorities missing. If your response is about a specific priority, please make it clear in your answer.

Our Strategy is for everyone, and the actions set out are designed to support as many people as possible. However, there are some groups who have higher suicide rates than the general population. Others may not have high rates but are of particular concern, such as children and young people, because national rates have increased in recent years despite being low overall. It is therefore crucial that organisations and individuals tailor and target resources and services to support these groups. The national Strategy identifies the following high-risk groups as priorities for actions:

- Middle aged men.
- Children and young people.
- People with a history of self-harm.
- People known to secondary mental health services.
- People in contact with the justice system.
- Autistic people.
- People affected by social isolation and loneliness.
- People who are impacted by domestic abuse.
- Pregnant women and new mothers.
- People affected by physical illness.
- People affected by financial difficulty and economic adversity.
- People affected by gambling harms.
- People affected by drug and alcohol misuse.

Q9. How much do you agree or disagree that these are the right high-risk groups that we should be prioritising in the Kent and Medway Suicide and Self-Harm Prevention Strategy? Please select **one** option.

- ☐ Strongly agree
- ☐ Tend to agree
- ☐ Neither agree nor disagree
- ☐ Tend to disagree
- ☐ Strongly disagree
- ☐ I don't know

Q9a. Please tell us the reason for your answer to Q9. You can also let us know if you feel there are any high-risk groups missing. If your response is about a specific high-risk group(s), please make it clear in your answer.

Pages 11 and 12 of the Strategy give an overview of the **key actions** that will be undertaken for each of the priorities for adults and children and young people. The Strategy does not break these down into individual tasks for each high-risk priority group.

Q10. If you have any suggestions for any specific actions that could be taken to reduce the suicide risk for any of the high-risk priority groups, please tell us in the box below. If your response is about a specific high-risk priority group(s), please make that clear in your answer.

We would like to ask you some questions about some of the **priorities and actions** in the Strategy. There will be an opportunity later in the questionnaire to comment specifically on some of the priorities for children and young people (Q14 to Q17). If you would like to make any comments on the other priorities and actions you can do this in Q18.

Priority 1. Make Suicide everybody's business so that we can maximise our collective impact and support to prevent suicides.

- We will increase knowledge and awareness of suicide prevention techniques and tools by continuing to offer free to attend suicide prevention training for everyone.
- We will provide system leadership and quality improvement through our suicide prevention networks, annual conferences and relationships with individual services.

Q11. How can we continue to make suicide and self-harm prevention everybody's business? Please write in below:

Priority 6. Reduce access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides.

- We will monitor our Real Time Suicide Surveillance and work with partners such as Kent Police, Network Rail and National Highways to identify, intervene and respond to high-risk locations or other means.

Q12. How can we reduce access to the means and methods of suicide in Kent and Medway? Please write in below:

Priority 8. Provide effective bereavement support to those affected by suicide.

- We will continue to commission a support service for people bereaved by suicide.

Q13. What is the best way of providing information and support to those bereaved or affected by suicide? Please write in below:

Key areas of focus for children and young people

The National Strategy has identified the following areas of focus as being crucial to suicide prevention in children and young people:

- Children and young people known to mental health services, including the 18 to 25 transition to adult mental health services for young people with Special Educational Needs and/or Disabilities (SEND).
- Mental health support in schools, colleges and universities.
- Improving evidence to better understand the experience of children and young people.

Q14. How much do you agree or disagree that these are the areas of focus that should be prioritised for children and young people in the Kent and Medway Suicide and Self-Harm Prevention Strategy? Please select **one** option.

☐	Strongly agree
☐	Tend to agree
☐	Neither agree nor disagree
☐	Tend to disagree
☐	Strongly disagree
☐	I don't know

Q14a. Please tell us the reason for your answer to Q14. You can also let us know if you feel there are any areas of focus missing. If your response is about a specific area(s) of focus, please make it clear in your answer.

We believe it is necessary to have a separate set of key actions in relation to children and young people because of the different risk factors that they face. These actions can be found on page 12 of the Strategy.

We would like to ask you some questions about some of the priorities and actions for children and young people in the Strategy. If you would like to make any comments on the other priorities and actions you can do this in Q15.

Priority 1. Make Suicide everybody's business so that we can maximise our collective impact and support to prevent suicides.

- We will increase knowledge and awareness of suicide prevention techniques and tools by continuing to offer suicide prevention training targeted at those who support children and young people.
- We will provide system leadership through our children and young people suicide prevention network and our informal system leaders group.

Q15. How can we continue to make suicide and self-harm prevention among children and young people everybody's business? Please write in below.

Priority 6. Reduce access to the means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides.

- We will monitor our Real Time Suicide Surveillance and work with partners such as Kent Police, Network Rail and National Highways to identify, intervene and respond to high-risk locations or other means.

Q16. How can we reduce suicides in children and young people in Kent and Medway by controlling access to the means of suicide? Please write in below:

Priority 8. Provide effective bereavement support to those affected by suicide.

- We will ensure that our commissioned suicide bereavement service takes a whole family approach and continues to support children.
- We will ensure that support is available to schools, colleges and universities if they have a tragic suicide amongst their community.

Q17. What is the best way of providing information and support to those children and young people bereaved or affected by suicide? Please write in below:

Q18. If you would like to provide feedback on any of the other priorities or actions for adults or children and young people in the Strategy, please provide these below. If your response is about a specific priority or action, please make it clear in your answer.

Part 3 – Is there anything else you would like to tell us about the draft Strategy?

Q19. If you would like to make any other comments on the draft Kent and Medway Suicide and Self-Harm Prevention Strategy, please tell us in the box below:

Part 4 – Equality analysis

To help ensure that we are meeting our obligations under the Equality Act 2010 we have prepared an Equality Impact Assessment (EqIA) for the Strategy.

An EqIA is a tool to assess the potential impact any proposals or strategies could have on the protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation. At KCC we also include carer's responsibilities.

The EqIA is available online at kent.gov.uk/suicideprevention or in paper copy on request.

Q20. We welcome your views on our equality analysis, including suggestions for anything else we should consider relating to equality and diversity. Please add your comments below. Please do not include any personal information that could identify you or anyone else in your answer.

Part 5 – 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 equality monitoring questions. This information really helps us to understand how different people could be affected by our strategies and proposals, but 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.

If you are responding **on behalf of someone else**, please answer using their details.

Q21. What is your sex? A question about gender identity will follow. Please select **one** option.

- ☐ Female
- ☐ Male
- ☐ I prefer not to say

Q22. Is the gender you identify with the same as your sex registered at birth? Please select **one** option.

- ☐ Yes
- ☐ No, please tell us your gender identity: ☐
- ☐ I prefer not to say

Q23. Which of these age groups applies to you? Please select **one** option.

☐ 0-17	☐ 18-25	☐ 26-35	☐ 36-45	☐ 46-55
☐ 56-65	☐ 66-75	☐ 76-85	☐ 86 and over	☐ I prefer not to say

Q24. Do you have a disability, health condition, physical or mental impairment that has a substantial and long-term negative effect on your ability to do normal daily activities? Please select **one** option.

- ☐ Yes
- ☐ No
- ☐ I prefer not to say

Q24a. If you answered 'Yes' to Q21, please tell us if any of the following disabilities or health conditions apply to you.
You may have more than one, so please select **all** that apply. If none of these applies to you, please select 'A different disability or health condition' and give brief details.

- ☐ Physical
- ☐ Sensory (hearing, sight or both)
- ☐ Longstanding illness or health condition, such as cancer, HIV/AIDS, heart disease, diabetes or epilepsy
- ☐ Mental health condition
- ☐ Learning disability
- ☐ Neurodivergent, such as ADHD, autism, dyslexia and dyspraxia
- ☐ I prefer not to say
- ☐ A different disability or health condition

If you have selected 'A different disability or health condition', please tell us:

Q25. What is your religion or belief? Please select **one** option.

- ☐ No religion or belief
- ☐ Atheist
- ☐ Christian
- ☐ Buddhist
- ☐ Hindu
- ☐ Jewish
- ☐ Muslim
- ☐ Sikh
- ☐ A different religion or belief, please tell us: _____
- ☐ I prefer not to say

Q26. Which of the following best describes your sexual orientation? Please select **one** option.

- ☐ Heterosexual/Straight
- ☐ Bisexual
- ☐ Gay or Lesbian
- ☐ I prefer to define my own sexuality, please tell us: _____
- ☐ I prefer not to say

A Carer is someone who gives unpaid care or help to anyone because they have a long-term physical or mental health condition or illness, or problem related to old age. Both children and adults can be Carers.

Q27. Are you a Carer? Please select **one** option.

- ☐ Yes
- ☐ No
- ☐ I prefer not to say

Q28. What is your ethnic group? Please select **one** option.

White

- ☐ English, Scottish, Welsh, Northern Irish or British
- ☐ Irish
- ☐ Gypsy or Irish Traveller
- ☐ Roma
- ☐ Any other White background, please tell us: ☐

Mixed or Multiple

- ☐ White and Black Caribbean
- ☐ White and Black African
- ☐ White and Asian
- ☐ Any other Mixed or Multiple background, please tell us: ☐

Please see over the page for more ethnic groups.

Asian or Asian British

- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Chinese
- ☐ Any other Asian background, please tell us: ☐

Black, Black British, Caribbean or African

- ☐ Caribbean
- ☐ African background, write in below
- ☐ Any other Black, Black British, or Caribbean background, please write in below:

☐

Another ethnic group

- ☐ Arab
- ☐ Roma
- ☐ Any other ethnic group, please tell us: ☐

Q29. Which of the following best describes your working status? Please select **one** option.

- [ ] Working full time
- [ ] Working part time
- [ ] Unemployed
- [ ] Retired
- [ ] Student
- [ ] I prefer not to say
- [ ] Something else, please tell us:

Thank you for taking the time to complete this questionnaire; your feedback is important to us. All feedback received will be reviewed and considered in the development of the Strategy.

We will report back on the feedback we receive, but details of individual responses will remain anonymous, and we will keep your personal details confidential.

Closing date for responses: 6 October 2025.

8. Appendix 2. Full list of themes for each question

Making the Strategy easier to understand

Q4a. If you have any comments or suggestions on how to make the Strategy easier to understand, please tell us in the box below.

Themes	Number of respondents who raised this theme
Needs reformatting (e.g. space, bullets, visuals)	11
Needs specific examples of specific interventions / actions	10
Approval of written format	7
Is too generalised / needs to be more demographic specific	6
Easy Read version required	6
Needs wording amends	5
Document is too long	3
Needs to raise awareness of available support	2
Needs alternative versions (e.g. Braille, BSL)	2
Needs to be more organisation specific	1
Needs more information about educating GPs	1
Too much emphasis on self-sufficiency	1
Institutional phrasing	1
Should include hyperlinks to resources	1
Not enough reference to self-harm	1
Needs more detail on how it was written / who with	1
Needs lived experience voice	1
Unable to download document	1
Schools	1

Vision, mission and values

Q5a. Please tell us the reason for your answer to Q5. (How much do you agree or disagree with our proposed vision for the draft Strategy?)

Themes	Number of respondents who raised this theme
Agreement with objectives	71
Scepticism over policy/ needs focus on strategy in practice	35
Importance of good mental health support	14
Support for young people	8
Agency collaboration	7
More support for community groups	4
ADHD / Autism	4
Crisis support	4
Support for those left behind	3
Need for training	3
Support for males	3
Hope	3
Costs of service	2
Inclusivity	2
Follow up	1
Readability of the Strategy	1
Support for women	1
Support for LGBTQIA+	1
Longer term support / therapy	1
Self-harm	1
Addiction	1
Access to resources	1
Medway	1
Needs less focus on numbers	1
Domestic abuse	1
Those known to justice system	1
Investigating deaths by misadventure	1

Q6a. Please tell us the reason for your answer to Q6. (How much do you agree or disagree with our proposed mission for the draft Strategy? You can also let us know if you feel there is anything missing from the mission.

Themes	Number of respondents who raised this theme
Agreement with mission	37
Service availability / standard	23
Scepticism of mission	21
Support for young people	20
Resilience	16
Collaboration between agencies	16
Autism / ADHD	7
Training	5
Stigma	4
Crisis support	4
Social media	4
Hope	4
Community cohesion	3
Support for males	3
Importance of listening	3
Language of mission	3
Costs	2
Trauma-informed care	2
Carers support	1
Need for research	1
Signage near hotspots	1
Support for women	1
Self-harm	1
Gambling	1
Support for older adults	1
Employer support	1
Needs information on support	1
Knowing how to support others	1
Visibility of services	1

Q7a. Please tell us the reason for your answer to Q7. (How much do you agree or disagree with our proposed values for the draft Strategy?)

Themes	Please tell us the reason for your answer
Agreement with values	49
Scepticism of values	16
Hope	16
Agency collaboration	15
Service availability / standard	13
Wording	6
Support for CYP	3
Accountability	3
Autism / ADHD	2
Use of data and research	2
Substance misuse	1
Support for those left behind	1
Community cohesion	1
Training and awareness	1
Support for older people	1
Justice	1
Accessibility	1
Stigma	1
Trauma-informed care	1
Involving family	1

Proposed priorities

Q8a. Please tell us the reason for your answer to Q8. (How much do you agree or disagree that we should continue to follow the above priorities? You can also let us know if you feel there are any priorities missing.)

Themes	Number of respondents who raised this theme
Agreement with priorities	29
Availability and of services / standards	24
Scepticism of priorities	11
Training	10
Social media / online safety	8
Support for those left behind	7
Costs	6
Use of data and research	6
Autism / ADHD	6
Suicide is everyone's business	5
Socio-economic / deprivation	4
Agency collaboration	4
Lived experience	4
Access to means	3
Self-harm	3
Support for CYP	3
Domestic abuse	3
Localised approaches	3
Prevention	3
Community cohesion	2
Accountability	2
Support for those who have experienced ideation / attempts	1
Personality disorders	1
Gambling harms	1
Needs more detail	1
Needs to focus on everybody, not just priority groups	1
Relationship breakdowns	1
Contact with justice system	1

High risk groups

Q9a. Please tell us the reason for your answer to Q9. (How much do you agree or disagree that these are the right high-risk groups that we should be prioritising in the Kent and Medway Suicide and Self-Harm Prevention Strategy? You can also let us know if you feel there are any high-risk groups missing.)

Themes	Number of respondents who raised this theme
Agreement with groups	30
Neurodivergence	25
LGBTQIA+	12
Scepticism of selection	11
CYP	9
People awaiting mental health treatment / support / not known to services	6
Loneliness / isolation	6
Asylum seekers	5
Women	4
Males (general)	4
Mental health conditions / personality disorders	4
Availability / visibility of services	4
Older males / females	3
Co-occurring conditions / substance misuse	3
People affected by financial adversity	3
Carers	3
Ethnic minorities	2
Veterans	2
Agency collaboration / signposting	2
Cuckooing	2
Gambling harms	2
People bereaved by suicide	2
Care leavers	2
Farmers	2
People in contact with justice system / family courts	2

Themes	Number of respondents who raised this theme
Trauma / ACEs	2
Students	1
Costs / funding	1
Homeless	1
Health conditions (physical)	1
UASC	1
Needs to be available to all	1
Domestic abuse	1
Relationship breakdown	1
Perinatal mental health	1

Key priorities and actions

Q10. If you have any suggestions for any specific actions that could be taken to reduce the suicide risk for any of the high-risk priority groups, please tell us.

Themes	Number of respondents who raised this theme
Availability / visibility / access to support	28
Community cohesion / support groups / loneliness and isolation	20
Neurodivergence	16
Quality of support	15
Schools / education	12
CYP	12
Training	11
Multi-agency collaboration	8
Co-occurring conditions / substance misuse	6
Support from friends / relatives	6
Data and research	5
Online / social media	5
Engagement with lived experience	5
Financial concerns / debt	4
Engagement with priority groups	3
Domestic abuse	3

Themes	Number of respondents who raised this theme
Primary care	2
Adequate support for self-harm	2
NHS	1
Support for those awaiting treatment	1
Carers	1
Benefits / universal credit	1
Physical adjustments (barriers etc)	1
Accessing confidential support	1
A sense of purpose	1
Workplace support	1
Support for peri / menopausal women	1
Housing	1
Accountability	1
Improved risk assessments	1

Q11. How can we continue to make suicide and self-harm prevention everybody's business?

Themes	Number of respondents who raised this theme
Training	41
Awareness campaigns / communication	38
Schools / education	15
Community cohesion / support groups	13
Importance of conversation	10
Availability / visibility / access to services	7
VCSE sector	7
Role of friends / family	7
Workplace / employer role	7
Multi-agency collaboration	6
System accountability	6
Scepticism of statement	5
High risk locations	4

Themes	Number of respondents who raised this theme
Quality of support	4
Lived experience	4
Stigma	4
Agreement with statement	3
Costs	2
Data and research	2
Leadership and accountability	2
Bystander interventions	2
Wider determinants / prevention	1
Self-harm	1
Sharing best practice	1
Online safety	1
Substance misuse	1

Q12. How can we reduce access to the means and methods of suicide in Kent and Medway?

Themes	Number of respondents who raised this theme
High risk locations	30
Availability / visibility / access to services	22
Scepticism of priority	17
Awareness campaigns / communication	17
Multi-agency collaboration	11
Training	10
Online / social media	10
Early intervention	6
Quality of support	6
Making it everyone's business	4
Use of data and research	4
Agreement with priority	3
Funding / costs	3

Themes	Number of respondents who raised this theme
Monitoring of high risk means	3
Importance of conversation	2
Schools / education	2
Lived experience involvement	2
Restricting medications	2
Stigma	1
Rural locations	1
Addressing socio-economic issues	1
Help for loved ones	1
Substance misuse	1
Importance of listening	1
Trauma-informed care	1

Q13. What is the best way of providing information and support to those bereaved or affected by suicide?

Themes	Number of respondents who raised this theme
Awareness campaigns / visibility	21
Range / flexibility of support methods	14
Accessibility / availability of services	14
Importance of early intervention	13
Involving lived experience	9
Frontline service role	9
Community cohesion / support groups	8
Role of family / friends	7
Multi-agency collaboration	7
Funding / VCSE sector	7
SOBS / peer led support	5
Scepticism of priority	3
3 month window	3
Role of schools	3

Themes	Number of respondents who raised this theme
Advice on how to share news	2
Online / social media	2
Amparo	2
System leadership / commitment to services	1
Service user identification	1
Physical goods	1
Counselling	1
System change	1
Support for those affected by attempted suicide	1

Areas of focus for children and young people

Q14. Please tell us the reason for your answer to Q14. (How much do you agree or disagree that these are the areas of focus that should be prioritised for children and young people in the Kent and Medway Suicide and Self-Harm Prevention Strategy? You can also let us know if you feel there are any areas of focus missing.)

Themes	Number of respondents who raised this theme
Schools / education	17
Agreement with focus	16
Accessibility / availability of services	16
Online / social media	9
Neurodivergence	9
Transition between CYP and adult services	8
Resilience	7
Raised awareness / training	6
Quality of services	6
Students / universities	5
NEETS / not in mainstream education	5
Impact of changes to wider living environment (e.g. political, technological)	4
Self-harm	4
Role of social environment	4

Themes	Number of respondents who raised this theme
Bullying	4
Scepticism of focus	3
Early intervention	3
CYP and parent insights	3
Understanding difference between standard emotions and suicide risk	3
LGBTQI+	2
Impact of services / stigma	2
Children in care	2
Workplace support	1
ACEs	1
Communication	1
Immigrants	1
Young carers	1
Youth groups	1
Educational pressures	1
Requires more detail	1
Trauma-informed care	1
Support for CYP bereaved by suicide	1
Role of CYP services	1

Q15. How can we continue to make suicide and self-harm prevention among children and young people everybody's business?

Themes	Number of respondents who raised this theme
Training / education	37
Schools / education settings	33
Raised awareness / campaigns	21
Role of friends / family	21
Availability / accessibility of services	11
Social media / online harms	10
Community support / groups	8

Themes	Number of respondents who raised this theme
Multi-agency collaboration	7
Early intervention	6
Self-harm	6
Scepticism of priority	5
Making CYP feel heard / believed	5
Stigma	3
System leadership	3
Lived experience	3
Sharing best practice	1
Addressing bullying	1
Empathy	1
Flexible approach	1
Substance misuse	1
Workplace	1
Quality of services	1
Trained advocates	1
Understanding wider factors	1
CYP-targeted resource e.g. books	1

Q16. How can we reduce suicides in children and young people in Kent and Medway by controlling access to the means of suicide?

Themes	Number of respondents who raised this theme
Online / social media regulations	16
Scepticism of priority	10
Physical adjustments / high risk locations	9
Schools	8
Raised awareness / campaigns	7
Parents / families	6
Training	5
Listening to CYP	5

Themes	Number of respondents who raised this theme
Youth clubs / community groups	4
Strengthening emotional development	4
Effective use of data and Research (including AI)	4
Access / visibility / availability of services	4
Multi-agency collaboration	4
Better quality support / services	2
Early intervention / identifying CYP who are at risk	2
Agreement with priority	1
Self-harm	1
Substance misuse	1
Educating the press / media	1
CYP suicide bereavement support	1
Role of friends	1

Q17. What is the best way of providing information and support to those children and young people bereaved or affected by suicide?

Themes	Number of respondents who raised this theme
Use of networks / community	21
Schools	16
Range of support methods	13
Therapy / counselling	10
Accessibility / availability of support	10
Involvement of those working with CYP	8
Use of lived experience	8
Visibility / awareness campaigns	8
Timeliness of support	6
Family Involvement	5
Agreement with priority	4
24/7 support	4
Social media	4
Books / films	3

Themes	Number of respondents who raised this theme
Funding	2
Memorials / vigils	1
Scepticism of priority	1
Training	1
Mentoring	1
Support for suicide attempts	1

Feedback on other priorities

Q18. If you would like to provide feedback on any of the other priorities or actions for adults or children and young people in the Strategy, please provide these below.

Themes	Number of respondents who raised this theme
Agreement / support of strategy	7
Importance of continued research / addressing risk factors	3
Wider mental health strategy	3
Neurodivergence	3
Importance of individualised approach	2
Accountability	2
Accessibility / visibility of support	2
Increased use of lived experience	2
Funding	1
Over-reliance on helplines	1
Isolation	1
Timespan of Strategy	1
Pressures on CYP	1
Self-harm	1
Education	1
Outdoor activities and therapies	1
Stress-testing	1
Structural action	1
Social media / online harms	1

Themes	Number of respondents who raised this theme
Needs more detail around intersectionality	1
Needs more details around interventions	1
Domestic abuse	1
Trauma-informed care	1
Increase peer support groups	1
Importance of early intervention	1
Role of schools	1

Anything else?

Q19. If you would like to make any other comments on the draft Kent and Medway Suicide and Self-Harm Prevention Strategy, please tell us:

Themes	Number of respondents who raised this theme
Improving mental health provision / increased funding	15
No / agreement with Strategy	14
Scepticism of Strategy	5
Multi-agency collaboration	4
Neurodivergence	4
Wider environment	4
Accountability	4
Continued research of risk factors	3
Importance of mental health support	2
Involvement of lived experience	2
Crisis teams / crisis support	2
Increased awareness / campaigns	2
RNLI / other organisations	1
Middle aged women / menopause	1
Timespan of Strategy	1
Role of family / friends	1
Asylum seekers / immigrants	1
PTSD	1
Self-harm	1

Themes	Number of respondents who raised this theme
Community / social groups	1
Where to find further info	1
Education / training	1
Use of green / blue spaces	1
Stigma	1
Intersectionality	1
Needs more detail around interventions	1
Trauma-informed care	1
Domestic abuse	1
Increase peer support groups	1

Equality analysis

Q20. We welcome your views on our equality analysis, including suggestions for anything else we should consider relating to equality and diversity.

Themes	Number of respondents who raised this theme
Agreement with EqIA	15
Scepticism of EqIA	9
Neurodivergence	8
LGBTQI+	5
Co-production with experts	3
Intersectionality	2
Hope	1
Housing	1
Employment	1
GP access	1
Women	1
Social media	1
Use of green and blue spaces	1
Resilience	1
Children in care	1
Ethnicity	1
Gender	1

Kent and Medway Suicide and Self-Harm Prevention Strategy 2026-2030

You Said, We Did: How your views have shaped the new Strategy

December 2025

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Kent and Medway Suicide and Self-Harm Prevention Strategy 2026 - 2030

You Said, We Did

1. Introduction

From the 23 July to 6 October 2025, KCC's Suicide Prevention Programme undertook an 11-week public consultation on the draft Kent and Medway Suicide and Self-Harm Prevention Strategy for 2026-2030. The consultation provided the opportunity for residents and other stakeholders to provide feedback on the draft Strategy.

The draft Strategy was developed in conjunction with the Suicide Prevention Networks, which are well-established partnerships made up of over 250 agencies, including statutory and voluntary / community sector organisations as well as individuals living with experience of suicidal thoughts, self-harm or being bereaved by suicide. There is a network focused on supporting adults, and a network focused on supporting children and young people. These networks will oversee the Action Plans set out for each as a result of the Strategy.

In total there were 153 responses to the consultation. 149 of these were received through the online questionnaire, two questionnaire responses were received by email and a further two comments were received via email.

The majority of these were from Kent or Medway residents (80%), with 7% on behalf of voluntary sector organisations, 3% from educational settings and 3% on behalf of a family member.

We would like to thank everyone who took part in and helped to promote this consultation. A Consultation Report, providing a full summary of the responses received through the public consultation, is available on the consultation webpage: https://letstalk.kent.gov.uk/kent-and-medway-suicide-and-self-harm-prevention-strategy-2026-2030 or in paper copy on request.

2. You Said, We Did

The table below sets out our responses to key themes raised in the consultation. In our responses, we set out how we intend to – or are already – responding to the themes raised.

The vision of the Strategy

You Said	We Did
The vision looks to reduce suicide rates across the County by 2030. Many respondents used this question to highlight a general need for the Strategy to be supported by available, accessible and robust mental health support services in addition to local community-based support, such as peer groups. The importance of multi-agency collaboration was frequently cited across the responses.	We agree that multi-agency collaboration is essential, and it is already a key part of our work. We will continue to work closely with the Kent & Medway Mental Health Trust, who are members of the multi-agency Oversight Board which governs our Programme and meets monthly. These meetings are also attended by representatives from the Integrated Care Board (ICB) and Medway Council. We will be adding a joint Foreword into the Strategy that highlights this close working connection and shared commitment to reducing the number of people dying by suicide in Kent and Medway by 2030 (if not sooner). We will also continue to host our multi-agency Suicide Prevention Networks – one for those working with adults, and the other for those working with children and young people. These networks consist of members from across the System, including professionals and those with lived experience. They meet quarterly and are an opportunity for members to understand more about the work taking place locally, including available services.

You Said	We Did
Continued.	With regards to available, accessible and robust mental health support services, we will continue to promote and raise awareness of local offers – such as Release the Pressure and the Kent and Medway Mental Wellbeing Hub - as part of our campaigns and advocate to System partners if we identify any gaps in existing provisions. In terms of local community-based support and peer groups, the Programme intends to continue hosting its annual 'Community Fund' each year which is an opportunity for smaller, local projects that support suicide prevention to apply for small funding grants. Around 10-15 projects across Kent and Medway have been supported through this scheme in previous years. Furthermore, as suicide prevention leads within the Integrated Care System, we are well-positioned to advocate and advise other organisations on the risk factors associated with suicide and what could be done to address these. This is often done using the data available on our Real Time Suicide Surveillance system and other available research.
The Strategy should be accompanied by clear, accountable targets.	We will work with the ICB to develop Key Performance Indicators (KPIs) which monitor the impact of the Programme where appropriate, whilst allowing the flexibility to adapt our work in response to emerging patterns, trends or new research.

You Said	We Did
Continued.	As a Programme we will continue to work to Action Plans which are based on the priorities we have set out. As a team, we will review these Action Plans monthly as a way to review and record our progress in each of the priority areas. We will continue to produce our annual impact report which is published onto our Padlet (https://padlet.com/SuicidePrevention/suicide-prevention-team-resources-zuu4rhjasoll5b01) an online gallery of all our resources. It will be available for public viewing at any time.

The mission of the Strategy

You Said	We Did
Some respondents felt that the use of the term 'resilience' when talking about children and young people was inappropriate as it could be considered as 'victim blaming' and not considering wider societal pressures, which are out of an individual's control. Others agreed that self-resilience is crucial to good mental health.	Our mission does not hold an expectation that children and young people are resilient to cope with life's normal ups and downs. We are ambitious for them to develop resilience as a result of the work and actions from this Strategy. We acknowledge the concerns around this terminology and will amend it to "feel empowered and able".

Kent and Medway Suicide and Self-Harm Prevention Strategy 2026 - 2030

You Said, We Did

The values of the Strategy

You Said	We Did
Some respondents felt that the inclusion of 'Hope' was out of place and meaningless without actions.	Although we understand these concerns, we will retain 'Hope' as a value. This is because it underpins everything that we are trying to do. Hope can be the difference between somebody choosing the end of their lives or not, and so our role – as a Programme, and in this Strategy, is to help create hope universally through the actions that we have set out.

The priorities of the Strategy

You Said	We Did
A number of respondents voiced concerns around the availability and standards of existing mental health provisions, in particular, crisis support.	These concerns will feed into the ongoing work we will be doing against our fourth priority – to provide effective crisis support across sectors. The fact that this has been identified as a theme within the consultation responses, demonstrates the importance of having this listed as a priority.

High risk groups

You Said	We Did
Focussing on a particular group(s) is inappropriate as anybody can be at risk of suicide. It is important that the Strategy works for all.	We know that anybody can be at risk of suicide, including those who do not belong to any of the listed priority groups. The list of priority groups has been designed to mirror those in the National Suicide Prevention Strategy 2023-2028.These have been identified on the basis of wider evidence and research. This is why we have designed a strategy that has the flexibility to work for all.

You Said	We Did
Continued.	That being said, we have a responsibility to listen and act upon the data, evidence and research that suggests particular groups may be at a higher risk than others. Therefore, we will retain the inclusion of priority groups as areas of particular focus.
The list of high-risk priority groups is missing some groups (e.g. LGBTQIA+ and older people).	As mentioned above, our list of priority groups is based upon those set out in the National Suicide Prevention Strategy. We acknowledge that there may be a number of other groups who may be at a higher risk, such as the LGBTQIA+ community and older people, yet there is not currently the same level of evidence and research available as there are for those currently listed. Fundamentally though, this Strategy does not preclude any group and has been designed to work for all. We have an ongoing commitment and responsibility to respond to any new evidence and research as it emerges, about any particular group, including those not currently listed as a priority. This is one of the most crucial roles of our Real Time Suicide Surveillance data.
Those with ADHD and other forms of neurodivergence should be considered as a high-risk priority group alongside autistic people.	Our priority groups mirror those in the National Suicide Prevention Strategy. These groups are based on extensive evidence and research, which is why it makes sense for our local approach to follow this. We have listened to the views in the consultation and feel that given the well documented overlaps with autism and other neurodivergent conditions such as ADHD, our local Strategy should seek to encompass the wider spectrum in one priority group, while retaining an understanding of the differences.

Kent and Medway Suicide and Self-Harm Prevention Strategy 2026 - 2030

You Said, We Did

Reducing the risk in high priority groups

You Said	We Did
Many respondents spoke about the availability and visibility of support and referenced campaign materials such as posters as a way to achieve this.	The Suicide Prevention Programme is committed to funding the Release the Pressure campaign, a free helpline for those experiencing concerns with their mental health. We consistently seek to make this campaign visible across a range of environments. Recent examples include linking up with local football stadiums to install signage and branded coffee cup sleeves for distribution in country parks. We also work closely with our Communications team to promote this campaign through social media and the radio. Additionally, we work with a third party to deliver geo-targeted campaigns so that information about the support available is visible on the phones of those who have been identified as being most at risk.

Making suicide everybody's business

You Said	We Did
Respondents voiced throughout the consultation questionnaire that there was a need for specialist suicide prevention training to be available.	We are committed to continue providing free to access suicide prevention training and plan to recommission this. We will continually work towards ensuring these training opportunities are visible to all, including not just professionals but those who want to develop these skills on a personal level to help support those around them. This is a standard part of our public facing campaigns and promotions.

Kent and Medway Suicide and Self-Harm Prevention Strategy 2026 - 2030

You Said, We Did

Reducing access to means and methods

You Said	We Did
Many respondents spoke of a need to focus on high-risk locations, such as cliffs and railways, when considering suicide prevention activity.	Our Real Time Suicide Surveillance system helps us to identify where high-risk locations are. We have established partnerships with those working in these areas, such as Southeastern and Network Rail. These partnerships enable us to ensure that the right messages are available in the right places and to coordinate actions that mitigate future risks. This work will continue as part of our sixth priority, to reduce access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides.

Providing effective support to those bereaved by suicide

You Said	We Did
Specialist suicide bereavement support should be visible and offered in a timely way, acknowledging that people may not feel ready to take this up in the immediate aftermath of a death.	Specialist support is already available to anybody bereaved by suicide in Kent and Medway, and in this Strategy we have made a commitment to continue delivering this. We will continue promoting this service to our System partners and working with our colleagues in Kent Police and the Coroners service to ensure that this information is provided to those who may need this support at the earliest opportunity. We will also continue to promote the fact that it can be accessed at any time, ensuring that that individuals know they can wait until they are ready before engaging with the service.

Kent and Medway Suicide and Self-Harm Prevention Strategy 2026 - 2030

You Said, We Did

Children and young people

You Said	We Did
Many respondents voiced the need to pay particular attention to children and young people (CYP).	Our Strategy clearly sets out a commitment to address suicide prevention in both adults, and children and young people, and this is reflected in the strategic priorities. Our dedicated Children and Young Persons Suicide Prevention Network will continue to meet to focus on risk, including responding to new patterns as they emerge. We will also commit to engaging with regional colleagues in order to help access best practice.
The use and impact of social media was cited as a particular cause for concern.	Our seventh priority promotes online safety and responsible media content to reduce harms. It also aims to improve signposting and provide helpful messages about suicide and self-harm. We fully agree that inappropriate use or access to social media is a significant risk factor. However, as a local programme with limited powers, we cannot oversee or regulate individuals' use of social media. Our role is to provide guidance and raise awareness, rather than to monitor/enforce social media use. This is a wider issue that needs to be – and is - being looked at nationally and considered in legislations such as the Online Safety Act, which seeks to reduce the risks associated with harmful content. Where we can, we will contribute to these national conversations in meaningful ways to advocate for the needs of people in Kent and Medway. What we can also do, more locally, is promote positive stories about mental health and hope that can be shared on social media to help counteract harmful content.

Other feedback

You Said	We Did
Throughout the responses, the role and importance of lived experience was cited as being crucial to suicide prevention activity	We will continue to encourage those with lived experience to join our Networks – where they can help shape future services - and become involved with our campaigns. As part of our second priority – to address common risk factors linked to suicide at a population level to provide early intervention and tailored support - we will also continue to support the delivery of public facing initiatives. In 2025, we hosted the Baton of Hope in Kent and Medway. Over 120 people with lived experience took part as Baton Bearers. We aim to ensure this event leaves a lasting legacy.
Although not a top theme for any question, the importance of breaking down the stigma of suicide and self-harm was referenced at various stages throughout the responses, particularly in terms of acting as a barrier to asking for help	We agree that stigma can be a significant barrier in accessing the support available, whether that's support for poor mental health or accessing specialist suicide bereavement support following the suicide of a loved one. All of our campaigns are designed to encourage people to speak out about how they feel and to know that they are not alone. Most recently the Baton of Hope events and campaign actively encouraged people in Kent and Medway to share their experiences openly with others. This helped the wider community understand that their feelings are not unusual or anything to feel ashamed of. We will continue to keep this message at the heart of everything that we do, including future campaigns.

You Said	We Did
Although Trauma-informed care (an approach that recognises the widespread impact of trauma on a person's life and promotes a culture of safety and trust) did not emerge as a key theme, its importance was highlighted at multiple points throughout the responses.	We will continue to use our position as suicide prevention leads within the Integrated Care System to raise awareness across the System of all risk factors - including adverse childhood experiences and other historic traumas - which can be linked to suicide. This is an ongoing piece of work that draws upon regular analysis of our Real Time Suicide Surveillance System as well as other forms of local and national research. The intention of this is to help promote wider understanding of the many different circumstances experienced by those with suicidal thoughts and ideations, so that these can be factored into sensitive service delivery.

3. Next Steps

The final draft of the Strategy is expected to be presented at the Adult Social Care and Public Health Cabinet Committee in early 2026, along with presentations at Medway Council and the Kent and Medway Integrated Care Board (ICB). It will also be shared at the Adult Suicide Prevention Network and the Children & Young Peoples' Suicide Prevention Network meetings in early 2026.

In addition, we will also be delivering an update at the Annual Suicide and Self-Harm Prevention Conference on 27 November 2025, where we will have around 250 attendees.

If approved, a link to the final Strategy will be published on the consultation webpage and Kent.gov.uk website.

CABINET COMMITTEE DECISION REPORT

From: Diane Morton, Cabinet Member for Adult Social Care and Public Health

Dr Anjan Ghosh, Director of Public Health

To: Adult Social Care and Public Health Cabinet Committee, 21 January 2026

Subject: Recommission the Kent Drug and Alcohol Inpatient Detoxification Service

Decision no: 25/00106

Key Decision : Yes - it involves expenditure or savings of more than £1m

Classification: Unrestricted

Past Pathway of report: N/A

Future Pathway of report: Cabinet Member Decision

Electoral Division: All

Is the decision eligible for call-in? Yes

Summary:

Kent Drug and Alcohol Services aim to reduce the harm caused by drugs and alcohol and improve the health and wellbeing of the people of Kent. The local authority's Public Health Grant requires the Authority to "have regard to the need to improve the take up of, and outcomes from, its drug and alcohol misuse treatment services."

The funding for the Kent Drug and Alcohol Inpatient Detoxification Service comes directly via the Office for Health Improvement and Disparities (OHID)'s Drug and Alcohol Treatment and Recovery Improvement Grant (DATRIG), which has recently been confirmed until 31 March 2029; the funding will be consolidated into the Public Health Grant from 01 April 2026, but will still be ringfenced solely for the use of drug and alcohol support. A key decision is now being sought to map out clear next steps to secure detoxification services for Kent residents.

Following an options appraisal and business case development, the recommendation is to recommission the Kent Drug and Alcohol Inpatient Detoxification Service in its current format, with the scope for the expansion of the number of bed nights purchased, should demand/funding allow.

Following approval of the key decision, a procurement process will be run, which will follow the Provider Selection Regime legislation that applies to health care services. We will aim to ensure this approach will support continuity of service, minimise risks such as destabilisation of the workforce and support spending of additional Office for

Health Improvement and Disparities (OHID) funding which is designed to boost numbers in treatment and improve quality. The service will align to the national drugs strategy, to the Kent Drug and Alcohol strategy and also to Kent County Council's strategic plan.

Recommendation(s):

The Cabinet Committee is asked to **CONSIDER** and **ENDORSE** or make **RECOMMENDATIONS** to the Cabinet Member for Adult Social Care and Public Health on the proposed decision as set out in the Proposed Record of Decision. (Appendix A).

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1. Introduction

1.1 KCC commissions drug and alcohol services as part of its statutory responsibilities and as a condition of its Public Health Grant. Kent Drug and Alcohol Services aim to reduce the harm caused by drugs and alcohol and improve the health and wellbeing of Kent's population. The local authority's Public Health grant requires the Authority to "have regard to the need to improve the take up of, and outcomes from, its drug and alcohol misuse treatment services."

1.2 This report seeks approval of the proposal to recommission the Kent Drug and Alcohol Inpatient Detoxification Service from April 2026 to ensure continuity of care for Kent residents.

1.3 In the context of drug and alcohol treatment, Inpatient Detoxification (IPD) refers to medically managed services where individuals with substance dependence undergo supervised withdrawal in a residential setting. These services are essential for people with complex physical or mental health needs, or those at high risk during detoxification. IPD units provide 24-hour care, often led by consultant addiction psychiatrists, and are considered Tier 4 specialist services within the treatment pathway.

1.4 The availability of such IPD services in England has significantly declined in recent years. As of 2025, only five NHS inpatient detox units remain operational across the country.

2. Strategic alignment and background

2.1 Professor Dame Carol Black's Review of Drugs (2021) was commissioned by the Home Office and the Department of Social Care to inform government thinking on what more can be done to tackle the harm that drugs and alcohol cause, underpinning a ten-year drug strategy.

2.2 Nationally, The provision of Inpatient Detoxification will help achieve the ambitions as set out in the national Drug Strategy[1] (2021). "From harm to hope:

[1] https://www.gov.uk/government/publications/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives

A 10-year drugs plan to cut crime and save lives". The Strategy outlines the concept of recovery from drugs and alcohol dependence into policy with clear practice outcomes, namely:

- Freedom from dependence on drugs or alcohol
- Prevention of drug-related deaths and blood borne viruses
- A reduction in crime and re-offending
- Sustained employment
- The ability to access and sustain suitable accommodation
- Improvement in mental and physical health and wellbeing
- Improved relationships with family members, partners and friends
- The capacity to be a caring and effective parent.

2.3 As a result of the additional investment from Central Government to sustain these national strategic objectives, Kent is in receipt of £33,685,188 investment via a number of OHID grants over the period April 2022 to March 2029, of which, up until 31 March 2026, Kent has spent £217,771 to fund the Kent Drug and Alcohol Inpatient Detoxification Service (£656,013.20 has been spent across the consortium in this time period). This additional funding compels the council to maintain the level of investment from the Public Health Grant and to the commitment of successfully achieving established local targets.

2.4 The provision of the Kent Drug and Alcohol Inpatient Detoxification Service aligns with the local and national strategies. Locally, the service is designed to achieve best value and align to the Council's Strategic Statement, supporting residents that need help, working with care providers and the NHS to ensure that the care system is more sustainable.

2.5 The IPD service also supports delivery of the Kent Drug and Alcohol Strategy, 2023-2028 'Better Prevention, Treatment and Recovery and Community Safety', which identifies 13 strategic priorities across three main areas: Prevention, Improving Treatment and Recovery and Community Safety.

3. Current contract

3.1 The Kent Drug and Alcohol Inpatient Detoxification Service is currently formed of a contract delivered via Bridge House, which is one of the few remaining NHS-funded IPD units. Operated by the Kent and Medway Mental Health Trust (KMMHT), formerly the Kent and Medway NHS and Social Care Partnership Trust (KMPT), Bridge House is a nine-bed facility located in Maidstone.

3.2 It provides high-quality, medically-assisted detoxification for individuals dependent on alcohol, opiates, stimulants, and other substances. The service is known for its holistic approach, co-production with people who use the service, and emphasis on harm reduction and relapse prevention.

3.3 Kent County Council currently acts as the lead banker for a consortium arrangement comprising Medway, Surrey, and Oxfordshire Councils. KCC

purchases bed nights at Bridge House utilising funding provided by each Local Authority and oversees the delivery of the contract on behalf of the consortium. These arrangements are overseen by the Kent's Combatting Drugs Partnership (CDP). The current contract is due to come to an end on 31 March 2026.

3.4 Benefits of a being consortium member include priority access to available beds, (where there is a wait list from spot purchasing authorities, authorities in the consortium have access to the bed before the spot purchasing authority up until the total number of bed nights within the allocation has been reached), meaning reduced waiting lists, and level tariffs across consortium members, resulting in fair access.

3.5 In the first full year of the contract, the consortium purchased 307 bed nights at a cost of £164,625. The number of bed nights has steadily increased over the life of the contract, with 407 bed nights being purchased in 2025/26 at a cost of £233,125.

3.6 Prices reflect an increase from £536 per bed night to £573 (6.9%) over the life of the four-year contract. Given the scarcity of provision the price is very much dictated by the market. Commissioners have validated that any price increases are in line with legitimate market factors such as an increase in utility costs to run the facility, NHS salary uplifts, and increased National Insurance costs. As services are delivered by NHS organisations, they are not driven by maximising profit.

3.7 Each consortium member is responsible for their own arrangements locally once their bed night allocation is used. Kent devolves a Public Health Grant-funded tier 4 budget to commissioned community drug and alcohol providers, who purchase bed nights using their own framework. An additional 748 bed nights were purchased in 2024/25 (535 of which were purchased by Kent). This demonstrates increasing demand for the service, precipitating a need to build flexibility into the contract going forward.

4. Commissioning service model

4.1 The aim of the proposed Service is to:

- provide an inpatient detoxification service that complies with available best practice, that is in line with national /local guidance and relevant guidelines in clinical practice.
- Provide people who need the service with access to effective and evidence based harm reduction and prevention strategies to improve their health and wellbeing, whilst being supported to achieve their personal recovery outcomes and goals.
- support those entering inpatient detoxification to overcome current problems and to develop strategies for dealing with future challenges and to live healthy and fulfilling lives as equal standing members of the community.
- build on existing pathways following the completion of inpatient detoxification into other drug and alcohol treatment services.

4.2 The service delivers interventions through a variety of methods:

- Assessment of substance use, physical and mental health and social issues (including any safeguarding concerns)
- Management of drug and/or alcohol withdrawals
- Stabilisation of prescription/or substitute medication and screening
- Supporting those with co-morbidities to safely meet their recovery aims
- Preventing harm and supporting the wider public health agenda
- Engagement and partnership working with other agencies to re-connect service users to wider health services.
- Promoting long term, sustainable abstinence from all mood-altering substances
- Promoting the successful social integration of individuals and enable them to live as independently as possible.
- Improving the overall wellbeing of service users and their carers and dependants
- Providing recovery focussed support packages tailored to meet individual needs and preferences.
- Ensuring smooth and effective service user pathway flow.

4.3 Expected outcomes of the Kent Drug and Alcohol Inpatient Detoxification Service include:

- Preventing people from dying prematurely
- Enhancing quality of life for people with long-term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

4.4 A long list of options was explored in order to identify potential changes to the existing delivery model. Options considered but rejected included:

- Let the contract come to an end when it expires on 31 March 2026 and return to commissioned community drug and alcohol providers using their devolved budgets to purchase bed nights. This was not considered a viable option as OHID grant conditions state that Local Authorities MUST be part of an IPD Consortium in order to receive the IPD element of the DATRIG funding. Whilst Kent is also part of the Hampshire Consortium, access to a facility only in Hampshire is not considered practical. Devolved purchasing of beds also means the council would no longer have priority access to local beds, which is likely to result in longer waiting times for Kent residents.

- Discontinue the current arrangement and instead purchase additional bed-nights as part of the existing Hampshire Consortium (this is a separate consortium arrangement, led by Hampshire County Council, of which Kent County Council is already a member). This would require patients to travel to Fareham and would mean there is no local inpatient detoxification provision.

- Join another Consortium nearby, such as West Sussex. Whilst this would provide an option closer than that offered through the Hampshire Consortium, it would not offer the convenience of a Kent-based facility, or support the sustainability of a local service.

4.5 The preferred option identified was to recommission the Kent Drug and Alcohol Detoxification Service with refinements to the specification as a result of learning from the current arrangement.

4.6 Key benefits of this are:

- Local provision, meaning improved accessibility and availability of ongoing aftercare support

- Supporting sustainability of local provision by purchasing a set amount of bed nights in advance

- Priority access to available beds, (where there is a wait list from spot-purchasing authorities, authorities in the consortium have access to the bed before the spot purchasing authority up until the total number of bed nights within the allocation has been reached)

- Reduced waiting lists as a result of priority access

- Level tariffs across Local Authorities, resulting in fair access.

5. Local Government Reorganisation

5.1 As the consortium is made up of four different Local Authorities, it will be important to consider the implications of Local Government Reorganisation (LGR) in relation to the delivery and sustainability of this contract.

5.2 Should LGR arrangements precipitate any change, a contract variation can be used to amend the contract. Standard KCC terms and conditions stipulate KCC is able to terminate the contract under the break clause, giving six months' notice.

6. Financial implications

6.1 The funding for this contract would be exclusively from OHID additional grant funding, the Drug and Alcohol Treatment and Recovery Improvement Grant (DATRIG), which will be consolidated into the Public Health Grant from 01 April 2026. The funding is linked to the 10-year national drug and alcohol strategy 'From Harm to Hope' and would constitute a continuation of the activity currently funded by the existing OHID grant.

6.2 The financial commitment for the Kent Drug and Alcohol Inpatient Detoxification Service will be circa £2,452,191 for a 5-year contract over an initial period from

1 April 2026 to 31 March 2029. The cost includes an option to extend for up to two additional one-year periods, ending no later than 31 March 2031, however, the contract will reflect only the money available through known grant funding at that time. The annual contract value will be circa £293,288 in the first year.

6.3 The above values reflect the potential for a year-on-year increase in the cost of bed nights (set by the provider) and the potential to increase the number of bed nights each consortium member may purchase. Annual allocations will be agreed subject to availability of the grant and in line with demand.

7. Commercial implications

7.1 Initially, commissioners conducted a make or buy assessment to establish whether it is possible to deliver the services in-house. KCC currently lacks the specialism, clinical governance and infrastructure required to deliver specialist drug and alcohol interventions.

7.2 Market analysis has been carried out which found that the availability of IPD services in England has significantly declined in recent years. As of 2025, only five NHS inpatient detox units remain operational across the country, which means there is a limited available market to engage with. There is only one provider available to deliver IPD in Kent (Bridge House), they are also the only local provider that has the specialism to deliver the level of care required.

7.3 The Health Care Services (Provider Selection Regime) Regulations 2023 (PSR) is a set of rules for procuring health care services in England (this includes substance misuse services) and must be followed by organisations termed ‘relevant authorities’. The relevant authorities to which the PSR applies are NHS England, NHS trusts and foundation trusts, Integrated Care Boards, and local and combined authorities.

7.4 The services will be procured in line with the above legislation and will follow appropriate governance routes, including obtaining the relevant approvals from the Commercial and Procurement Oversight Board.

8. Equalities Implications

8.1 An Equality Impact Assessment (EQIA) has been completed for the service. Current evidence suggests there is no negative impact and this recommendation is an appropriate measure to advance equality and create stability for vulnerable people.

8.2 Providers are required to conduct annual EQIAs as per contractual obligations.

9. Data Protection Implications

9.1 General Data Protection Regulations are part of current service documentation for the contract and there is a Schedule of Processing, Personal Data and Data Subjects confirming who is data controller/ processor. There is also an existing Data Protection Impact Assessment (DPIA) relating to the data that is shared between Kent County Council, the provider and the Office for Health Improvement and Disparities (previously named Public Health England) and the services.

9.2 The DPIA will be updated following contract award to ensure it continues to

have the most up-to date information included and reflect any changes to data processing.

10. Legal Implications

10.1 Under the Health and Social Care Act 2012, Directors of Public Health in upper tier and unitary local authorities have a duty to take such steps as they consider appropriate for improving the health of people in their area and such steps can include providing services or facilities designed to promote healthy living (whether by helping individuals to address behaviour that is detrimental to health or in any other way).

10.2 Kent Drug and Alcohol Services aim to reduce the harm caused by drugs and alcohol and improve the health and wellbeing of the people of Kent. The local authority's Public Health Grant requires the Authority to "have regard to the need to improve the take up of, and outcomes from, its drug and alcohol misuse treatment services."

10.3 The recommissioning of this service will fall under the Provider Selection Regime (PSR) 2023 introduced under the Health and Care Act 2022. Appropriate legal advice will be sought in collaboration with the Governance, Law and Democracy team and will be utilised to ensure compliance with relevant legislation; the Provider Selection Regime is still in its infancy and so commissioners will be working closely with this team as well as the Commercial and Procurement Team.

11. Governance

11.1 The delegations authorised via the proposed key decision are limited to the scope of the recommissioning and exercising any pre-approved extensions of the Kent Drug and Alcohol Inpatient Detoxification Service contract. Any contractual extensions beyond March 2029 will be contingent on confirmation of continued OHID funding and will be exercised in line with the agreed governance framework.

11.2 A key decision (22/00041) has already been taken to accept and deploy the additional OHID grant money received, therefore a further decision would not be required for deployment of further OHID funding, provided it is received on similar terms and conditions.

12. Conclusions

12.1 Approval is sought to proceed with the proposal to recommission the Kent Drug and Alcohol Detoxification Service from April 2026, in line with the Provider Selection Regime.

12.2 Key benefits of this are:

- Local provision, meaning improved accessibility and availability of ongoing aftercare support
- Supporting sustainability of local provision by purchasing a set amount of bed nights in advance

- Priority access to available beds, (where there is a wait list from spot-purchasing authorities, authorities in the consortium have access to the bed before the spot purchasing authority up until the total number of bed nights within the allocation has been reached)
- Reduced waiting lists as a result of priority access
- Level tariffs across Local Authorities, resulting in fair access.

12.3 This approach has been endorsed by the Commercial Procurement and Oversight Board and outcome of the procurement process will be presented prior to award in line with KCCs formal governance and decision-making requirements.

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13. Recommendation(s):

13.1 The Cabinet Committee is asked to **CONSIDER** and **ENDORSE** or make **RECOMMENDATIONS** to the Cabinet Member for Adult Social Care and Public Health on the proposed decision as set out in the Proposed Record of Decision (Appendix A).

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14. Background Documents

14.1 HM Government (2021) From Harm to Hope - A Ten Year Drugs Plan to Cut Crime and Save Lives
14.2 Department of Health & Social Care (2021) Dame Carol Black's Independent Review of Drugs https://www.gov.uk/government/publications/review-of-drugs-phase-two-report/review-of-drugs-part-two-prevention-treatment-and-recovery
14.3 Kent Drug and Alcohol Strategy 2023-2028 (Kent Drug and Alcohol Strategy 2023-2028)
14.4 2022 Kent Drug Needs Assessment Drug Needs Assessment (kpho.org.uk)
14.5 2021 Alcohol Needs Assessment Alcohol needs Assessment 2021 (kpho.org.uk)
14.6 2022 Kent Rough Sleepers Needs Assessment - Search - Kent Public Health Observatory (kpho.org.uk)
14.7 Drug & Alcohol Needs Assessment for Children and Young People CYP-Substance-Misuse-Final-Draft-July2016-v2.0.pdf (kpho.org.uk)
14.8 Public Health Indicators – PHOF Public Health Outcomes Framework - GOV.UK (www.gov.uk)

15. Contact details

Report Authors:

Rebecca Eley
Senior Commissioner (Integrated Commissioning)

Relevant Director:

Dr. Anjan Ghosh
Director of Public Health
03000 412633

03000 418777 Anjan.Ghosh@kent.gov.uk
Rebecca.Eley@kent.gov.uk

Victoria Tovey
Assistant Director of Integrated Commissioning
03000 416779
Victoria.Tovey@kent.gov.uk

Jessica Mookherjee
Consultant in Public Health
03000 416493
Jessica.Mookherjee@kent.gov.uk

Appendix A: Proposed Record Of Decision
Appendix B: Equality Impact Assessment (EqIA)

KENT COUNTY COUNCIL – PROPOSED RECORD OF DECISION

DECISION TO BE TAKEN BY:	DECISION NUMBER:
Diane Morton, Cabinet Member for Adult Social Care and Public Health	25/00106

Executive Decision – key

25/00106 Recommission the Kent Drug and Alcohol Inpatient Detoxification Service

Decision:

As Cabinet Member for Adult Social Care and Public Health I agree to:

I. **APPROVE** the recommissioning of the Kent Drug and Alcohol Inpatient Detoxification Service for an initial period from 1 April 2026 to 31 March 2029 with the option to extend for up to two additional one-year periods, ending no later than 31 March 2031, subject to confirmation of OHID funding

II. **DELEGATE** authority to the Director of Public Health to take relevant actions, including but not limited to, entering into, finalising, and varying the terms of relevant contracts or other legal agreements, as necessary, to implement the above decision

III. **DELEGATE** authority to the Director of Public Health, in consultation with the Cabinet Member for Adult Social Care and Public Health, the exercise of any extensions permitted in accordance with the extension clauses within the contract, subject to confirmation of OHID funding

IV. **CONFIRM** that, in accordance with Key Decision 22/00041, the Director of Public Health, following consultation with the Cabinet Member and Corporate Director of Finance, retains delegated authority to accept and deploy any future OHID grant funding on similar terms to support this area of work under the national Harm to Hope strategy

Reasons for the decision:
Kent County Council has statutory responsibility as a condition of its Public Health Grant to provide specialist Substance Misuse Services aimed at reducing the harm caused by drugs and alcohol and to improve the health and wellbeing of the people of Kent.

The current contract for the Kent Drug and Alcohol Inpatient Detoxification Service is due to expire on 31 March 2026 and a key decision is required to plan for beyond this date.

In the context of drug and alcohol treatment, Inpatient Detoxification (IPD) refers to medically managed services where individuals with substance dependence undergo supervised withdrawal in a residential setting. These services are essential for people with complex physical or mental health needs, or those at high risk during detoxification. IPD units provide 24-hour care, often led by consultant addiction psychiatrists, and are considered Tier 4 specialist services within the treatment pathway.

The availability of such IPD services in England has significantly declined in recent years. As of 2025, only five NHS inpatient detox units remain operational across the country, one of which is Bridge House. Operated by the Kent and Medway Mental Health Trust (KMMHT), formerly the Kent and Medway NHS and Social Care Partnership Trust (KMPT), Bridge House is a nine-bed facility located in Maidstone.

Kent County Council currently acts as the lead banker for a consortium arrangement comprising Medway, Surrey, and Oxfordshire Councils. KCC purchases bed nights at Bridge House utilising funding provided by each Local Authority and oversees the delivery of the contract on behalf of the consortium. These arrangements are overseen by the Kent's Combatting Drugs Partnership (CDP).

Financial implications:
The funding for the Kent Drug and Alcohol Inpatient Detoxification Service comes directly via the Office for Health Improvement and Disparities (OHID)'s Drug and Alcohol Treatment and Recovery Improvement Grant (DATRIG), which will be consolidated into the Public Health Grant from 01 April 2026 and has been confirmed until 31 March 2029. This would constitute a continuation of the activity currently funded by the existing OHID grant.

The financial commitment will be circa £2,452,191 for a 5-year contract for the Kent Drug and Alcohol Inpatient Detoxification Service for an initial period from 01 April 2026 to 31 March 2029 with the option to extend for up to two additional one-year periods, ending no later than 31 March 2031, however, the contract will reflect only the money available through known grant funding at that time.

The above values reflect the potential for a year-on-year increase in the cost of bed nights (set by the provider) and the potential to increase the number of bed nights each consortium member may purchase. Annual allocations will be agreed subject to availability of the grant and in line with demand.

A key decision (22/00041) has already been taken to accept and deploy the additional OHID grant money received, therefore a further decision would not be required for deployment of further OHID funding, provided it is received on similar terms and conditions.

Legal implications:
Under the Health and Social Care Act 2012, Directors of Public Health (DPH) in upper tier (UTLA) and unitary (ULA) local authorities have a duty to take such steps

as they consider appropriate for improving the health of people in their area and such steps can include providing services or facilities designed to promote healthy living (whether by helping individuals to address behaviour that is detrimental to health or in any other way).

Kent Drug and Alcohol Services aim to reduce the harm caused by drugs and alcohol and improve the health and wellbeing of the people of Kent. The local authority's Public Health Grant requires the Authority to "have regard to the need to improve the take up of, and outcomes from, its drug and alcohol misuse treatment services."

The recommissioning of this service will fall under the Provider Selection Regime (PSR) 2023 introduced under the Health and Care Act 2022. Appropriate legal advice will be sought in collaboration with the Governance, Law and Democracy team and will be utilised to ensure compliance with relevant legislation; the Provider Selection Regime is still in its infancy and so commissioners will be working closely with this team as well as the Commercial and Procurement Team.

Equalities implications:
An Equality Impact Assessment (EQIA) has been completed for the service. Current evidence suggests there is no negative impact and this recommendation is an appropriate measure to advance equality and create stability for vulnerable people.

Providers are required to conduct annual EQIAs as per contractual obligations.

Data Protection implications:
General Data Protection Regulations are part of current service documentation for the contract and there is a Schedule of Processing, Personal Data and Data Subjects confirming who is data controller/ processor. There is also an existing Data Protection Impact Assessment (DPIA) relating to the data that is shared between Kent County Council, the provider and the Office for Health Improvement and Disparities (previously named Public Health England) and the services.

The DPIA will be updated following contract award to ensure it continues to have the most up-to date information included and reflect any changes to data processing.

Cabinet Committee recommendations and other consultation:

The proposed decision will be discussed at the Adult Social Care and Public Health Cabinet Committee on 21 January 2026.

Committee Feedback Phase:

Any alternatives considered and rejected:

- Let the contract come to an end when it expires on 31 March 2026 and return to commissioned community drug and alcohol providers using their devolved

budgets to purchase bed nights. This was not considered a viable option as OHID grant conditions state that Local Authorities MUST be part of an IPD Consortium in order to receive the IPD element of the DATRIG funding. Whilst Kent is also part of the Hampshire Consortium, access to a facility only in Hampshire is not considered practical. Devolved purchasing of beds also means the council would no longer have priority access to local beds, which is likely to result in longer waiting times for Kent residents.

- Discontinue the current arrangement and instead purchase additional bed-nights as part of the existing Hampshire Consortium (this is a separate consortium arrangement, led by Hampshire County Council, of which Kent County Council is already a member). This would require patients to travel to Fareham and would mean there is no local inpatient detoxification provision.

- Join another Consortium nearby, such as West Sussex. Whilst this would provide an option closer than that offered through the Hampshire Consortium, it would not offer the convenience of a Kent-based facility, or support the sustainability of a local service

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Any interest declared when the decision was taken and any dispensation granted by the Proper Officer:

....

Signed Date

EQIA Submission – ID Number
Section A

EQIA Title
Re-commissioning of Kent Drug and Alcohol Inpatient Detoxification Service

Responsible Officer
Becks Eley - AH AIC

Approved by (Note: approval of this EqIA must be completed within the EqIA App)
Jessica Mookherjee - AH Public Health

Type of Activity

Service Change
No

Service Redesign
No

Project/Programme
No

Commissioning/Procurement
Commissioning/Procurement

Strategy/Policy
No

Details of other Service Activity
No

Accountability and Responsibility

Directorate
Adult Social Care and Health

Responsible Service
Integrated Commissioning

Responsible Head of Service
Jessica Mookherjee - AH Public Health

Responsible Director
Anjan Ghosh - AH Public Health

Aims and Objectives

The aim is to re-commission the Kent Drug and Alcohol Inpatient Detoxification (IPD) Service as part of the Kent Consortium. The objective is to build sustainability into the local system and speed up access to IPD, by ensuring bed nights are purchased in advance and priority access is given to residents within consortium member local authorities (Kent, Medway, Surrey, and Oxfordshire).
Current evidence suggests there is no negative impact and this recommendation is an appropriate measure to advance equality and create stability for vulnerable people.

Section B – Evidence

Do you have data related to the protected groups of the people impacted by this activity?
Yes

It is possible to get the data in a timely and cost effective way?
Yes

Is there national evidence/data that you can use?
Yes

Have you consulted with stakeholders?
Yes

Who have you involved, consulted and engaged with?
Consortium Members

Drug and Alcohol Providers
Public Health Consultant
Office for Health Improvement and Disparities (OHID) regional leads
Reach Out and Recover (ROAR) - Kent's Lived Experience Recovery Organisation (LERO)

Has there been a previous Equality Analysis (EQIA) in the last 3 years?

No

Do you have evidence that can help you understand the potential impact of your activity?

Yes

Section C – Impact

Who may be impacted by the activity?

Service Users/clients
Service users/clients

Staff
Staff/Volunteers

Residents/Communities/Citizens
Residents/communities/citizens

Are there any positive impacts for all or any of the protected groups as a result of the activity that you are doing?

Yes

Details of Positive Impacts

1. Age
Young adults: Improved access to specialist detox services can prevent long-term substance misuse and associated harms.
Older adults: Tailored support for age-related health conditions and poly-substance use, improving quality of life and reducing hospital admissions.

2. Disability
Mental health conditions: Enhanced therapeutic alliances and trauma-informed care can improve engagement and outcomes.
Physical disabilities: Accessible facilities and support services ensure equitable treatment experiences.

3. Gender Reassignment
Services can be designed to be inclusive and sensitive to the needs of trans and non-binary individuals, reducing stigma and improving engagement.

4. Marriage and Civil Partnership
Support for family and relationship dynamics during recovery can strengthen social networks and reduce relapse risk.

5. Pregnancy and Maternity
Specialist pathways for pregnant individuals with substance misuse issues can reduce risks to both parent and child, improving maternal and neonatal outcomes.

6. Race
Culturally competent care and targeted outreach can address disparities in access and outcomes for ethnic minority groups.

7. Religion or Belief
Respect for religious practices (e.g. dietary needs, prayer times) within inpatient settings can enhance comfort and engagement.

8. Sex
Gender-specific services (e.g. women-only groups) can provide safer spaces for recovery, especially for those with histories of trauma.

9. Sexual Orientation
LGBTQ+ inclusive services can reduce barriers to access and improve trust in healthcare providers.

Negative impacts and Mitigating Actions

19.Negative Impacts and Mitigating actions for Age

Are there negative impacts for age?

No

Details of negative impacts for Age

Not Applicable

Mitigating Actions for Age

Not Applicable

Responsible Officer for Mitigating Actions – Age

Not Applicable

20. Negative impacts and Mitigating actions for Disability

Are there negative impacts for Disability?

No

Details of Negative Impacts for Disability

Not Applicable

Mitigating actions for Disability

Not Applicable

Responsible Officer for Disability

Not Applicable

21. Negative Impacts and Mitigating actions for Sex

Are there negative impacts for Sex

No

Details of negative impacts for Sex

Not Applicable

Mitigating actions for Sex

Not Applicable

Responsible Officer for Sex

Not Applicable

22. Negative Impacts and Mitigating actions for Gender identity/transgender

Are there negative impacts for Gender identity/transgender

No

Negative impacts for Gender identity/transgender

Not Applicable

Mitigating actions for Gender identity/transgender

Not Applicable

Responsible Officer for mitigating actions for Gender identity/transgender

Not Applicable

23. Negative impacts and Mitigating actions for Race

Are there negative impacts for Race

No

Negative impacts for Race

Not Applicable

Mitigating actions for Race

Not Applicable

Responsible Officer for mitigating actions for Race
Not Applicable
24. Negative impacts and Mitigating actions for Religion and belief
Are there negative impacts for Religion and belief
No
Negative impacts for Religion and belief
Not Applicable
Mitigating actions for Religion and belief
Not Applicable
Responsible Officer for mitigating actions for Religion and Belief
Not Applicable
25. Negative impacts and Mitigating actions for Sexual Orientation
Are there negative impacts for Sexual Orientation
No
Negative impacts for Sexual Orientation
Not Applicable
Mitigating actions for Sexual Orientation
Not Applicable
Responsible Officer for mitigating actions for Sexual Orientation
Not Applicable
26. Negative impacts and Mitigating actions for Pregnancy and Maternity
Are there negative impacts for Pregnancy and Maternity
No
Negative impacts for Pregnancy and Maternity
Not Applicable
Mitigating actions for Pregnancy and Maternity
Not Applicable
Responsible Officer for mitigating actions for Pregnancy and Maternity
Not Applicable
27. Negative impacts and Mitigating actions for Marriage and Civil Partnerships
Are there negative impacts for Marriage and Civil Partnerships
No
Negative impacts for Marriage and Civil Partnerships
Not Applicable
Mitigating actions for Marriage and Civil Partnerships
Not Applicable
Responsible Officer for Marriage and Civil Partnerships
Not Applicable
28. Negative impacts and Mitigating actions for Carer's responsibilities
Are there negative impacts for Carer's responsibilities
No
Negative impacts for Carer's responsibilities
Not Applicable
Mitigating actions for Carer's responsibilities
Not Applicable
Responsible Officer for Carer's responsibilities
Not Applicable

Cabinet Committee Decision Report

From: Diane Morton, Cabinet Member for Adult Social Care and Public Health

Dr Anjan Ghosh, Director of Public Health

To: Adult Social Care and Public Health Cabinet Committee – 21 January 2026

Subject: Extension of Support Service for People Bereaved by Suicide (SC20060 – Lot 2)

Decision no: 25/00107

Non-Key Decision

Classification: Unrestricted

Past Pathway of report: N/A

Future Pathway of report: Cabinet Member Decision

Electoral Division: All

Is the decision eligible for call-in? Yes

Summary: The contract for a Support Service for People Bereaved by Suicide, known as Amparo (which means shelter or safe haven in Spanish), is currently delivered by Listening Ear and due to expire 31 July 2026. A review of the service has been conducted, and options beyond July 2026 have been explored. This includes recommissioning via an open procurement, which is not preferred at this time due to instability from organisational reforms and risk of service disruption. Implementing an eight-month contract extension (from 1 August 2026 until 31 March 2027) is proposed to maintain continuity of service and allow time to consider options for future commissioning and longer-term security of finances. The funding for this contract is expected to be fully secured through the Kent and Medway Integrated Care Board (ICB).

Recommendation(s):

The Adult Social Care and Public Health Cabinet Committee is asked to CONSIDER and ENDORSE or MAKE RECOMMENDATIONS to the Cabinet Member for Adult Social Care and Public Health in relation to the proposed decision as detailed in the attached Proposed Record of Decision document (Appendix A).

1. Introduction

1.1 In 2019, the NHS committed £36 million over a period of 10 years to support the roll out of suicide bereavement support services across England. This funding is received by Kent and Medway Integrated Care Board (ICB) to deliver the core Kent and Medway Suicide Prevention Programme. A Memorandum of Understanding (MoU) sets out the financial relationship between KCC and the ICB for this programme, which is hosted by KCC. This means that the outputs of the Programme, including commissioned services must align with not only with the priorities and requirements of KCC, but also with those of the NHS and deliver against the multi-agency Suicide Prevention Strategy. The MoU will be refreshed in 2026-27.

1.2 Between 2022-2024, there was an average of 144 suspected suicides per year in Kent and Medway, according to the Real Time Suicide Surveillance System (RTSS).

1.3 Specialist suicide bereavement support has been delivered in Kent and Medway by Listening Ear's Amparo service since 2021. The service provides timely emotional and practical support to anyone affected by suicide, an experience which differs to bereavement through natural or accidental means as it usually comes with senses of guilt and stigma, which often leads to social isolation and the increased risk of suicide mentioned above.

1.3 Support is delivered by trained Liaison Workers and can include providing emotional support and assisting with a range of practical matters, such as dealing with the police and coroners, helping with media enquiries, preparing for (and attending) inquests and helping individuals to access any other relevant services. Support is delivered both in person and on the phone.

1.4 The service provides support to individuals living in Kent or Medway, and targets:

- Close family members of the individual who died
- Friends, colleagues, witnesses, and other people affected by a suicide
- People who are working to support, or who are spending time with, people bereaved by suicide

1.5 The need for such support is backed by evidence that suggests up to 135 people can be impacted by an individual case of suicide (Cerel et al, 2018). People bereaved by the sudden death of a friend or family member are also 65% more likely to attempt suicide if the deceased died by suicide than if they died by natural or accidental causes (Pitman et al, 2016).

2. Key Considerations

2.1 The contract for Amparo, is due to expire 31 July 2026 and has been live for five years (as per key decision 20/00132). There is still a consistently high need for specialist support to people bereaved by suicide, and a recent review of Amparo to date demonstrated the value and impact of the service which supports delivery of both the National Suicide Prevention Strategy (2023–2028) the current and the draft Kent and Medway Suicide and Self-Harm Prevention Strategy (2026–2030).

2.2 Options have been considered for beyond July 2026 and conclude that recommissioning via open procurement is not recommended at this time due to ongoing Integrated Care Board (ICB) reforms. These organisational changes create instability and risk service disruption, making continuity during transition uncertain.

2.3 Maintaining continuity and stability is critical, therefore an eight-month extension (from 1 August 2026 until 31 March 2027) is proposed to allow time to consider options for future commissioning. This period will also allow for discussions with the ICB, which fully funds the service, to secure a long-term financial commitment. At present, formal clarity on the budget cannot be provided due to timing of organisational redesign, not unwillingness to commit.

2.4 Legal advice has been sought and extending the current contract by 8 months is legally viable. Any decision on the long-term arrangements, from April 2027, will be subject to a future Key Decision through the appropriate governance process.

3. Background

3.1 The Amparo service was commissioned by Kent County Council (KCC) on behalf of the Integrated Care Board (ICB) and began operating in August 2021. For 2025/26, the Amparo service cost is £127,616, fully funded by the ICB.

3.2 Because suicide prevention is a public health responsibility, KCC leads the suicide prevention programme, including commissioning services, even though the funding originates from NHS budgets. KCC's established relationships with voluntary and community sector providers enable a collaborative approach that avoids duplication and ensures alignment with the Kent and Medway Suicide Prevention Strategy.

3.3 Outcomes for the beneficiaries of the service include:

- Feel supported during Police and Coroner investigations
- Feel less lonely and isolated
- Improve day to day social functioning and ability to function in work, education or care giving role
- Improve psychological health.

3.4 A comprehensive review of the service has been undertaken to shape options for delivery beyond July 2026. This process included an analysis of performance data, case studies and feedback from beneficiaries. A summary can be found in Appendix B.

3.9 The review concluded that over the past five years, the service has provided free, timely, compassionate, and tailored support to individuals and communities affected by suicide, consistently achieving positive outcomes and high levels of client satisfaction. The service has remained responsive and adaptable and its ability to deliver both practical and emotional support, alongside advocacy and partnership working, has been crucial in reducing isolation, stigma, and risk among those bereaved by suicide.

4. Options considered and dismissed, and associated risk

4.1 The following options have been explored, with Option 2 being preferred;

Option	Summary
Option 1: Do nothing - allow the contract for suicide bereavement support in Kent and Medway to come to an end 31 July 2026.	This option is not preferred as it would mean bereaved families and individuals would be unable to access practical and emotional support. This option is not in line with the NHS Long Term Plan and the new K&M Suicide and Self-Harm Prevention Strategy for 2026-2030. This option would also not utilise the funding that is dedicated to this area of work and may result in higher longer-term costs including new service set up.
Option 2: Extend current contract with Listening Ear.	**This is the preferred option and proposal being taken forward.** This will maintain continuity of care for individuals bereaved by suicide and avoids disruption during a critical time for stakeholders as the NHS and Local Authority undergo reforms. Amparo has demonstrated positive outcomes and responsiveness over the past five years and continuing this service will build on established relationships, referral pathways, and community trust and allow time for longer-term planning and stakeholder engagement to gain longer term future funding commitments.
Option 3: Recommission via open procurement.	This option is not preferred at this time. Current changes within the Integrated Care Board (ICB) creating uncertainty, making it difficult to guarantee continuity during transition. A procurement process can take several months, risking gaps in provision for bereaved families and existing referral pathways and trust built by Listening Ear could be disrupted. This option would also require significant commissioning capacity and stakeholder engagement during a period of organisational reform.
Option 4: Bring service in-house.	This option is not preferred at this time due to service disruption and lack of specialist knowledge and experience in suicide bereavement support. This will be revisited during future recommissioning activity.

5. Financial Implications

5.1 A Memorandum of Understanding (MoU) is in place between KCC and the ICB for the Suicide Prevention programme. This outlines the ongoing arrangement including financial contribution from the ICB to support this programme, which is hosted by KCC.

5.2 The cost to implement an extension of the councils Support Service for people bereaved by suicide (SC20060) from 1 August 2026 until 31 March 2027 (8

months) totals £85,078. The funding to extend for this contract is expected to be fully secured through the Kent and Medway Integrated Care Board (ICB) in line with current arrangements.

5.3 While formal budget confirmation is pending due to the ongoing organisational redesign, funding for the extension is anticipated and the MoU will be refreshed to support longer-term planning for this programme of work.

6. Legal implications

6.1 To enable this extension, legal advice has been sought. The extension of the contract for a further period of 8 months, from 1 August 2026 until 31 March 2027, is permissible, under public contract regulations (PCR), Regulation 72.

7. Equalities implications

7.1 An Equalities Impact Assessment (EqIA) (appendix c) identifies that implementation of this eight-month extension will have no negative impacts. The service ensures that individuals affected by suicide, regardless of age, gender, ethnicity, disability, or sexual orientation, receive equitable support and services can be adapted for those with disabilities or language needs, reducing barriers to engagement.

8. Data Protection Implications

8.1 A Data Protection Impact Assessment (DPIA) is in place for the Suicide Bereavement Support Service. This identifies and addresses all relevant data protection risks through agreed controls. It will be kept under continuous review and updated to reflect any changes to data processing that may be implemented during the life of the contract.

9. Other corporate implications

9.1 Maintaining a support offer for individuals bereaved by suicide supports KCC's Reforming Kent 2025-28 commitments through the delivery of preventative well-being support. This can avoid escalation into more intensive, expensive care and foster stronger, more resilient communities.

9.2 The management and implementation of the proposed contract extension will be delivered by KCC Public Health and Integrated Commissioning teams with input from other teams such as Legal and Commercial & Procurement. Progress will be monitored through internal governance arrangements.

10. Governance

10.1 Accountability for this service and contract sits with the Director Public Health. The Suicide Prevention Steering group which includes the ICB, who fund this service, are fully supportive of this proposal.

10.2 Delegated authority will be granted to the Director of Public Health to take all necessary steps to implement the contract extension and to enter into any required contracts and legal agreements to give effect to the decision, including

entering into a refreshed Memorandum of Understanding (MoU) with the Kent & Medway Integrated Care Board.

11. Conclusions

11.1 The review of the service shows that Amparo has demonstrated positive outcomes and responsiveness over the past five years. Continuing this service will build on established relationships, referral pathways, and community trust. It will maintain continuity of care for individuals bereaved by suicide and avoid disruption during a critical time for stakeholders as the NHS and Local Authority undergo reforms.

11.2 Implementing the proposed contract extension will allow time for longer-term planning and stakeholder engagement to gain longer term future funding commitments. The Suicide Prevention Steering group which includes the ICB, who fund this service, are fully supportive of this proposal.

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12. Recommendation(s):

12.1 The Adult Social Care and Public Health Cabinet Committee is asked to CONSIDER and ENDORSE or MAKE RECOMMENDATIONS to the Cabinet Member for Adult Social Care and Public Health in relation to the proposed decision as detailed in the attached Proposed Record of Decision document (Appendix A).

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13. Appendices

- Appendix A – Proposed Record of decision
- Appendix B – Summary of review findings
- Appendix C – Equality Impact Assessment

14. Contact details

Report Author: Rachel Westlake **Job title:** Senior Commissioner **Telephone number:** 03000 413106 **Email address:** Rachel.westlake@kent.gov.uk **Name:** Vicky Tovey **Job title:** Assistant Director Integrated Commissioning **Telephone number:** 03000 416779 **Email address:** victoria.tovey@kent.gov.uk **Name:** Jess Mookherjee **Job title:** Consultant in Public Health **Telephone number:** 03000 416493 **Email address :** jessica.mookherjee@kent.gov.uk	**Director:** Dr Anjan Ghosh **Job title:** Director of Public Health **Telephone number:** 03000 412633 **Email address :** anjan.ghosh@kent.gov.uk

KENT COUNTY COUNCIL – PROPOSED RECORD OF DECISION

DECISION TO BE TAKEN BY:	DECISION NUMBER:
Diane Morton, Cabinet Member for Adult Social Care & Public Health	25/00107

Executive Decision –non-key

25/00107 Extension of Support Service for People Bereaved by Suicide (SC20060 – Lot 2)

Decision:
As Cabinet Member for Adult Social Care & Public Health, I agree to:

1. **APPROVE** implementation of an extension to the council's Support Service for people bereaved by suicide (SC20060) delivered by Listening Ear, from 1 August 2026 until 31 March 2027 (8 months).

2. **DELEGATE** authority to the Director of Public Health, in consultation with the Cabinet Member for Adult Social Care & Public Health to take relevant actions including but not limited to awarding, finalising the terms of and entering into the relevant contracts or other legal agreements, as necessary, to implement the decision.

Reasons for decision:
The contract for a Support Service for People Bereaved by Suicide, known as Amparo (which means shelter or safe haven in Spanish), which is currently delivered by Listening Ear, is due to expire 31 July 2026. This contract has been live for five years (as per key decision 20/00132).

There is still a consistently high need for specialist support to people bereaved by suicide, and a recent review of Amparo to date clearly demonstrated the value and impact of the service, highlighting its responsiveness, effectiveness and positive outcomes that it delivers for individuals and communities affected by suicide. This service supports delivery of both the National Suicide Prevention Strategy (2023–2028), the current and the draft Kent and Medway Suicide and Self-Harm Prevention Strategy (2026–2030), which recently underwent public consultation.

Options have been considered for beyond July 2026 and conclude that recommissioning via open procurement is not recommended at this time due to ongoing Integrated Care Board (ICB) reforms. These organisational changes create instability and risk service disruption, making continuity during transition uncertain.

Therefore, an eight-month extension (from 1 August 2026 until 31 March 2027) is proposed to maintain continuity of service and allow time to consider options for future commissioning. Legal advice has been sought and extending the current contract by 8 months is legally viable.

This decision also delegates authority to the Director of Public Health to take all necessary steps to implement the contract extension and to enter into any required contracts and legal agreements to give effect to the decision, including entering into a refreshed Memorandum of Understanding (MoU) with the Kent & Medway Integrated Care Board.

Any decision on the long-term arrangements, from April 2027, will be subject to a future Key Decision through the appropriate governance process.

Financial implications:
A Memorandum of Understanding (MoU) is in place between KCC and the ICB for the Suicide Prevention programme. This outlines the ongoing arrangement including financial contribution from the ICB to support this programme, which is hosted by KCC.

The cost to implement an extension of the councils Support Service for people bereaved by suicide (SC20060) from 1 August 2026 until 31 March 2027 (8 months) totals £85,078. The funding to extend for this contract is expected to be fully secured through the Kent and Medway Integrated Care Board (ICB) in line with current arrangements**.**

Legal implications:

Legal advice has been sought and extending the current contract by 8 months is legally viable. The extension of the contract for a further period of 8 months, from 1 August 2026 until 31 March 2027, is permissible, under public contract regulations PCR, Regulation 72.

Equalities implications:
An equalities impact assessment (EqIA) identifies that implementation of this 8-month extension will have no negative impacts. The service ensures that individuals affected by suicide, regardless of age, gender, ethnicity, disability, or sexual orientation, receive equitable support and services can be adapted for those with disabilities or language needs, reducing barriers to engagement.

Data Protection implications:
A data protection impact assessment (DPIA) is in place for the Suicide Bereavement Support Service. This identifies and addresses all relevant data protection risks through agreed controls. It will be kept under continuous review and updated to reflect any changes to data processing that may be implemented during the life of the contract.

Cabinet Committee recommendations and other consultation:

The proposed decision will be considered at the Adult Social care and Public Health Cabinet Committee on 21 January 2026. A public consultation into the new Suicide & Self-Harm Prevention Strategy 2026-2030 recently took place and 93% of 149 respondents agreed with the drafted eight priorities, one of which was around providing effective bereavement support to those affected by suicide. **The Kent and Medway Suicide and Self-Harm Prevention Strategy 2026-2030 | Let's Talk Kent**

Committee Feedback Phase:

Any alternatives considered and rejected:
The following options have been explored

- Do nothing - allow the contract for suicide bereavement support in Kent and Medway to come to an end 31 July 2026 – This option is not preferred as it would mean bereaved families and individuals would be unable to access practical and emotional support. This option is not in line with the NHS Long Term Plan and the new K&M Suicide and Self-Harm Prevention Strategy for 2026-2030. This option would also not utilise the funding that is dedicated to this area of work and may result in higher longer-term costs including new service set up.

- Recommission via open procurement – This option is not preferred at this time. Current changes within the Integrated Care Board (ICB) creating uncertainty, making it difficult to guarantee continuity during transition. A procurement process can take several months, risking gaps in provision for bereaved families and existing referral pathways and trust built by Listening Ear could be disrupted. This option would also require significant commissioning capacity and stakeholder engagement during a period of organisational reform.

- Bring service in-house – This option is not preferred at this time due to service disruption and lack of specialist knowledge and experience in suicide bereavement support. This will be revisited during future recommissioning activity.

Any interest declared when the decision was taken and any dispensation granted by the Proper Officer:

....

Signed Date

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Adult Social Care and Public Health Cabinet Committee – 21 January 2026

Extension of Support Service for People Bereaved by Suicide (SC20060 – Lot 2)

Appendix B – Summary of review findings

The Amparo service was commissioned by Kent County Council (KCC) on behalf of the Integrated Care Board (ICB) and began operating in August 2021. For 2025/26, the Amparo service cost is £127,616, fully funded by the ICB.

The service aligns with the Kent and Medway Suicide Prevention Strategy. Outcomes for the beneficiaries of the service include:

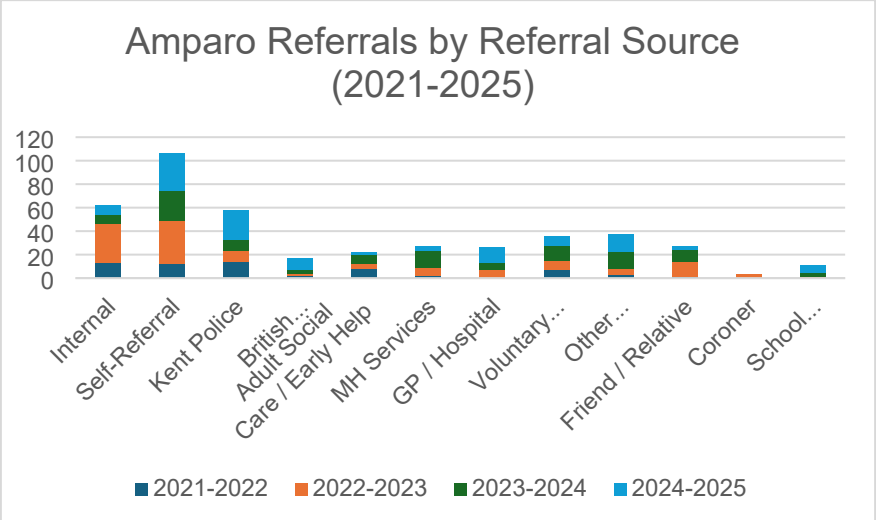
- Feel supported during Police and Coroner investigations.
- Feel less lonely and isolated.
- Improve day to day social functioning and ability to function in work, education or care giving role.
- Improve psychological health.

A comprehensive review of the service has been undertaken to shape options for delivery beyond July 2026.

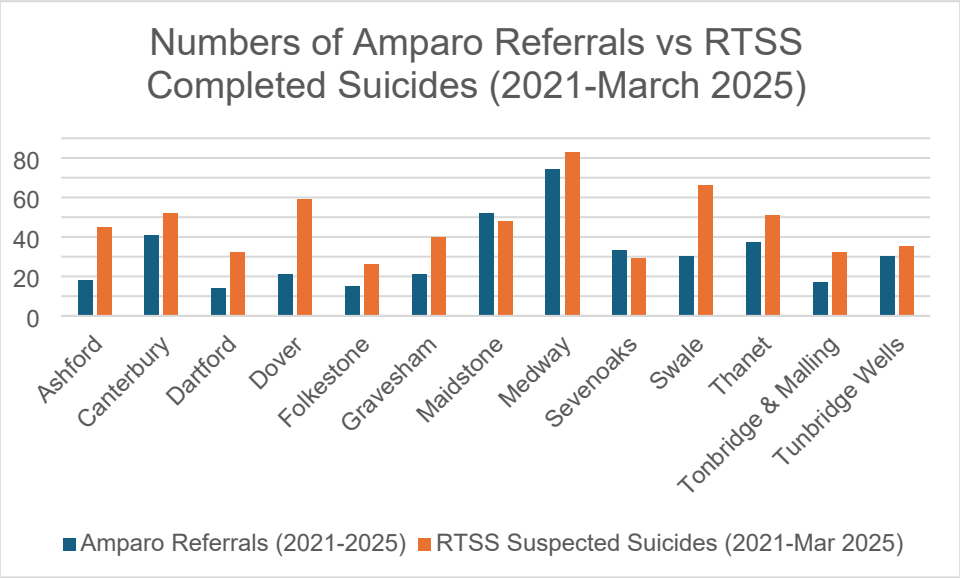
From April 2022 until March 2025 a total of 370 individuals were referred and 339 individuals (beneficiaries) received support.

Contractual Year (full)	Referrals	Beneficiaries
2022/23	**129**	**126**
2023/24	**115**	**106**
2024/25	**126**	**107**
TOTAL	**370**	**339**

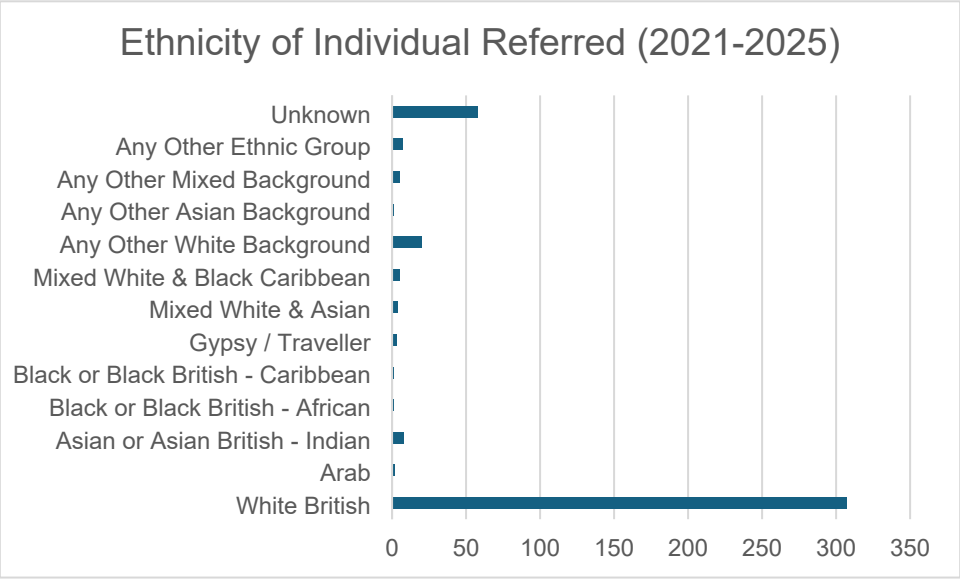
The most common source of referrals were ‘self-referrals’ followed by ‘internal referrals. These typically occur when the Suicide Liaison Worker identifies additional beneficiaries during contact with existing service users, such as wider relatives or friends of the deceased.



The area where referred individuals reside was spread across all Kent districts and Medway (Chart 1). The districts with the highest and lowest number of referrals aligned to RTSS area data between 2021-March 2025.



The majority of Amparo service users were female and White British. This may reflect the fact that approximately 75% of suspected suicides in Kent and Medway involve men. The data also however demonstrates that there was a wide range in ethnicities among those accessing.



Data shows that the service is responsive with an average waiting time in 2024-25 of 0.5 days from referral to first contact.

Amparo uses the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS) to collect paired outcomes among beneficiaries. These assessments are conducted at the start and end of support - provided the final session is meaningful - or at any other point when the SLW identifies that there has been a significant change to mental wellbeing.

Analysis of paired outcomes since 2022 shows consistently high volumes of positive outcomes, with the lowest recorded rate at 67% during the initial phase of contract delivery. Since then, positive outcome rates have ranged between 80% and 100%, with 7 out of 12 quarters showing rates above 90%.

Service user feedback includes;

- *"I truly don't know where I would've ended up without the support, I received it helped both myself and my family."*
- *"I have signposted other bereaved friends and family as I cannot fault my experience with them."*
- *"Extremely valuable service, helped at an extremely difficult time. Felt very supported at a very scary time."*
- *"Amparo have been a lifeline for me during the most difficult time in my life."*

The review identified that between April 2022 and March 2025 the cost of delivering Suicide Bereavement Support equated £1,105 per person and the cost per beneficiary per week was approximately £33. This demonstrates that Amparo provides sustained, specialist support at a relatively low weekly cost. Each suicide is estimated to cost £1.46 million, rising to £2.85 million for children aged 10–14 (Samaritans, 2022). By supporting those bereaved by suicide, who are at higher risk of suicidal behaviour, Amparo helps prevent future suicides and their associated economic and social costs.

A 2025 report by the Support Against Suicide Partnership (SASP) indicates that the average specialist suicide bereavement service costs the NHS around £85,000 per year. Given Kent's position as the 7th largest population in England (ONS Census 2021), its higher overall cost is proportionate.

Listening Ear (Amparo) have provided added value through:

- The delivery of multiple Community Response Plans where required. These are bespoke group support sessions aimed at particular communities where there has been a death by suicide.
- Delivery of specialist workshops and provision of emotional support to attendees at the annual K&M Suicide Prevention & Self-Harm conferences.
- Delivering in-person training to staff at the Coroner's Office - ensuring all staff have sufficient awareness of the service to pass on to affected next of kin during contact.
- Key partner in delivering the visit of the Baton of Hope to Kent and Medway in September 2025 including providing emotional support on the day.

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EQIA Submission – ID Number
Section A

EQIA Title
Extension of Amparo service

Responsible Officer
Rachel Westlake - AH AIC

Approved by (Note: approval of this EqIA must be completed within the EqIA App)
Victoria Tovey - AH AIC

Type of Activity

Service Change
No
Service Redesign
No
Project/Programme
No
Commissioning/Procurement
Commissioning/Procurement
Strategy/Policy
No
Details of other Service Activity
No

Accountability and Responsibility

Directorate
Adult Social Care and Health
Responsible Service
Integrated Commissioning
Responsible Head of Service
Victoria Tovey - AH AIC
Responsible Director
Anjan Ghosh - AH Public Health

Aims and Objectives

The contract for a Support Service for People Bereaved by Suicide, known as Amparo (which means shelter or safe haven in Spanish), is currently delivered by Listening Ear and due to expire 31 July 2026. This support has been delivered in Kent and Medway by Listening Ear's Amparo service since 2021. The service provides timely emotional and practical support to anyone affected by suicide, an experience which differs to bereavement through natural or accidental means as it usually comes with senses of guilt and stigma, which often leads to social isolation and the increased risk of suicide mentioned above.

Support is delivered by trained Liaison Workers and can include providing emotional support and assisting with a range of practical matters, such as dealing with the police and coroners, helping with media enquiries, preparing for (and attending) inquests and helping individuals to access any other relevant services. Support is delivered both in person and on the phone.

The service provides support to individuals living in Kent or Medway, and targets:

- Close family members of the individual who died
- Friends, colleagues, witnesses, and other people affected by a suicide
- People who are working to support, or who are spending time with, people bereaved by suicide

An 8-month extension (from 1 August 2026 until 31 March 2027) is proposed to maintain continuity of service and allow time to consider options for future commissioning. This period will also allow for discussions with the ICB, which fully funds the service, to secure a long-term financial commitment.

Section B – Evidence

Do you have data related to the protected groups of the people impacted by this activity?

Yes

It is possible to get the data in a timely and cost effective way?

Yes

Is there national evidence/data that you can use?

Yes

Have you consulted with stakeholders?

Yes

Who have you involved, consulted and engaged with?

The proposed extension of Support Service for People Bereaved by Suicide (Amparo) has been discussed and endorsed at the Suicide Prevention Steering Group. Statutory members include ICB, KCC, Medway, KMPT and Kent Police.

This has also been endorsed by the Integrated Commissioning Advisory Group which is led by the Director of PH (KCC).

A public consultation has been delivered to shape the new Kent and Medway Suicide & Self-Harm Prevention Strategy with support given to commit to the provision of support for people bereaved by suicide.

Has there been a previous Equality Analysis (EQIA) in the last 3 years?

Yes

Do you have evidence that can help you understand the potential impact of your activity?

Yes

Section C – Impact

Who may be impacted by the activity?

Service Users/clients

Service users/clients

Staff

Staff/Volunteers

Residents/Communities/Citizens

Residents/communities/citizens

Are there any positive impacts for all or any of the protected groups as a result of the activity that you are doing?

Yes

Details of Positive Impacts

Continuing to deliver support services for people bereaved by suicide can have significant positive impacts for individuals with protected characteristics.
Disability - Bereavement by suicide is linked to higher risk of depression, anxiety, and suicidal ideation. Accessible, inclusive support reduces these risks and promotes recovery for vulnerable groups, including those with disabilities or mental health conditions.
Race, Sexual orientation - People from minority ethnic backgrounds, LGBTQ+ communities, or older adults may face stigma and isolation after a suicide loss. Targeted support groups and culturally competent services foster connection and belonging.
Sex - Support can prevent job loss or educational disruption for those affected, particularly women, carers, and people with caring responsibilities.

Negative impacts and Mitigating Actions
19.Negative Impacts and Mitigating actions for Age
Are there negative impacts for age?
No. Note: If Question 19a is "No", Questions 19b,c,d will state "Not Applicable" when submission goes for approval
Details of negative impacts for Age
Not Completed
Mitigating Actions for Age
Not Completed
Responsible Officer for Mitigating Actions – Age
Not Completed
20. Negative impacts and Mitigating actions for Disability
Are there negative impacts for Disability?
No. Note: If Question 20a is "No", Questions 20b,c,d will state "Not Applicable" when submission goes for approval
Details of Negative Impacts for Disability
Not Completed
Mitigating actions for Disability
Not Completed
Responsible Officer for Disability
Not Completed
21. Negative Impacts and Mitigating actions for Sex
Are there negative impacts for Sex
No. Note: If Question 21a is "No", Questions 21b,c,d will state "Not Applicable" when submission goes for approval
Details of negative impacts for Sex
Not Completed
Mitigating actions for Sex
Not Completed
Responsible Officer for Sex
Not Completed
22. Negative Impacts and Mitigating actions for Gender identity/transgender
Are there negative impacts for Gender identity/transgender
No. Note: If Question 22a is "No", Questions 22b,c,d will state "Not Applicable" when submission goes for approval
Negative impacts for Gender identity/transgender
Not Completed
Mitigating actions for Gender identity/transgender
Not Completed
Responsible Officer for mitigating actions for Gender identity/transgender
Not Completed
23. Negative impacts and Mitigating actions for Race
Are there negative impacts for Race
No. Note: If Question 23a is "No", Questions 23b,c,d will state "Not Applicable" when submission goes for approval
Negative impacts for Race
Not Completed
Mitigating actions for Race
Not Completed
Responsible Officer for mitigating actions for Race

Not Completed
24. Negative impacts and Mitigating actions for Religion and belief
Are there negative impacts for Religion and belief
No. Note: If Question 24a is "No", Questions 24b,c,d will state "Not Applicable" when submission goes for approval
Negative impacts for Religion and belief
Not Completed
Mitigating actions for Religion and belief
Not Completed
Responsible Officer for mitigating actions for Religion and Belief
Not Completed
25. Negative impacts and Mitigating actions for Sexual Orientation
Are there negative impacts for Sexual Orientation
No. Note: If Question 25a is "No", Questions 25b,c,d will state "Not Applicable" when submission goes for approval
Negative impacts for Sexual Orientation
Not Completed
Mitigating actions for Sexual Orientation
Not Completed
Responsible Officer for mitigating actions for Sexual Orientation
Not Completed
26. Negative impacts and Mitigating actions for Pregnancy and Maternity
Are there negative impacts for Pregnancy and Maternity
No. Note: If Question 26a is "No", Questions 26b,c,d will state "Not Applicable" when submission goes for approval
Negative impacts for Pregnancy and Maternity
Not Completed
Mitigating actions for Pregnancy and Maternity
Not Completed
Responsible Officer for mitigating actions for Pregnancy and Maternity
Not Completed
27. Negative impacts and Mitigating actions for Marriage and Civil Partnerships
Are there negative impacts for Marriage and Civil Partnerships
No. Note: If Question 27a is "No", Questions 27b,c,d will state "Not Applicable" when submission goes for approval
Negative impacts for Marriage and Civil Partnerships
Not Completed
Mitigating actions for Marriage and Civil Partnerships
Not Completed
Responsible Officer for Marriage and Civil Partnerships
Not Completed
28. Negative impacts and Mitigating actions for Carer's responsibilities
Are there negative impacts for Carer's responsibilities
No. Note: If Question 28a is "No", Questions 28b,c,d will state "Not Applicable" when submission goes for approval
Negative impacts for Carer's responsibilities
Not Completed
Mitigating actions for Carer's responsibilities
Not Completed
Responsible Officer for Carer's responsibilities

Not Completed

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From:	Diane Morton, Cabinet Member for Adult Social Care and Public Health Sarah Hammond, Corporate Director, Adult Social Care and Health
To:	Adult Social Care and Public Health Cabinet Committee – 21 January 2026
Subject:	**Kent Carers' Support Service**
Key Decision :	It affects more than 2 Electoral Divisions and it involves expenditure over £1m
Decision no:	**25/00116**
Classification:	Unrestricted
Past Pathway of report:	N/A
Future Pathway of report:	Cabinet Member decision
Electoral Division:	All

Is the decision eligible for call-in? *Yes*

Summary: Kent County Council has statutory responsibilities under The Care Act 2014 which include assessing the needs of any adult (cared for or carer) with an appearance of need for care and support, and arranging services where appropriate to meet the unmet eligible needs of adults living in Kent. The 'Community Navigation Services (Part B)' and 'Carers' Short Breaks' Contracts support the council to meet this duty.

The new Kent Carers' Support Service Contract is split into two Lots, Lot 1 for East Kent and Lot 2 for West Kent.

Procurement for the Carers' Support Service was undertaken following formal evaluation of the bids procurement for Lot 2 (West Kent) was successful and procurement for Lot 1 (East Kent) was deemed not successful.

This decision seeks to award contracts to successful providers for Lot 2 and extend the current contractual arrangements for Community Navigation Services (Part B) and Carers' Short Breaks for up to four months (from 1 April 2026 to 31 July 2026) to allow a further procurement exercise to be undertaken for Lot 1 (East Kent) and award contracts to the successful providers for Lot 1, following completion of the procurement exercise.

Recommendation(s): The Adult Social Care and Public Health Cabinet Committee is asked to **CONSIDER** and **ENDORSE** or make **RECOMMENDATIONS** to the Cabinet Member for Adult Social Care and Public Health on the proposed decision as detailed in the attached Proposed Record of Decision document (Appendix A)

1. Introduction

1.1 Kent County Council (KCC) has statutory responsibilities under The Care Act 2014 which include assessing the needs of any adult (cared for or carer) with an appearance of need for care and support and arranging services where appropriate to meet the unmet eligible needs of adults living in Kent.

1.2 Following the decision to procure a new Carers' Support Service (decision 24/00113), extensive engagement and co-design work has been undertaken with carers and carers organisations. This work had informed a revised model for a Carers' Support Service which promotes choice and ensures equity of provision

1.3 This paper considers the outcome of the procurement activity for the new Kent Carers' Support Service Contract.

2. Key Considerations

2.1 In Kent, there are an estimated 148,341 adults providing unpaid care each week. KCC aim to support carers to maintain their own identity and live a full life. The support provided by carers can prevent, reduce and delay the need for care and support from both health and social care.

2.2 KCC has statutory responsibilities under the Care Act 2014, which includes assessing the needs of any adult with a need for care and support and arranging services where appropriate to meet the needs of eligible adults living in Kent. The Community Navigation Services (Part B) and Carers' Short Breaks Contracts support the council to meet this duty. In fulfilling these responsibilities, the council recognises the vital role of unpaid carers. Without the unpaid carer, the council would be required to arrange and deliver support for the person requiring care.

2.3 The new Kent Carers' Support Service directly supports the Care Act's core principles, including the promotion of individual wellbeing, the prevention of escalating care needs, and the provision of timely assessments and support for carers. The Kent Carers' Support Service will offer a range of support such as a carers' assessment, information and advice, support with accessing activities, peer support, training, and both planned and unplanned breaks to help carers in their caring role.

2.4 This aligns with Priority 5 of Reforming Kent – the Council's Strategic Statement by recognising and supporting the needs of carers and engaging with carers' support groups around the support and recognition carers can be provided

3. Background

3.1 In January 2025 approval was sought for a 12 month extension period for the Community Navigation Service (Part B) Contract and a direct award for the Carers' Short Breaks Contract from 1April 2025 to 31March 2026. This was to allow for the new service to be co-produced with stakeholders and people with lived experience, with a procurement exercise to follow.

3.2 At present the Community Navigation (Part B) contract is delivered geographically amongst three providers. Community Navigators work with the adult carers to identify needs and to offer support to ensure that carers have a balance between their caring responsibilities and a life outside of caring. The Carers' Short Breaks Contract is delivered by a sole provider across Kent.

3.3 The specification for the new Carers' Support Service was co-designed using carer feedback and based on the principles of the Kent Adult Carers' Strategy. Carers told us that they wanted a single point of access for carers' support services which is well promoted and marketed and has a wide reach into all parts of the community across Kent. This will ensure a greater focus on the benefits of completing a carers' assessment so the service can better understand the needs of carers.

3.4 A procurement process was designed which was proportionate to the requirement, clear and adhered to the updated 2023 Procurement Act regulations. The procurement plan and approach to the market was agreed by the Commercial and Procurement Oversight Board. Carers were involved in developing the award criteria; by creating a question which would encapsulate what they wanted from the service and allowing carer representatives to see how providers responded to their question by being part of the evaluation panel. The Carers' Support Service was procured through a competitive tendering process.

3.5 The table below sets out the procurement timetable-

Procurement Timetable	
Publication of advert and Invitation to Tender documentation on the Kent Business Portal	30 June 2025
Deadline for Tender responses	1 August 2025
Tender evaluation and governance procedures	4 August- 12November 2025
Contract award notice	25 November 2025
Contracts issued	8 December 2025
Contract commencement	1 April 2026

3.6 The evaluation of tenders was completed by a team consisting of officers and managers from the Adults and Integrated Commissioning Team, Adult Social Care Assistant Directors, Finance Officers, Social Value Officers and Carer representatives.

3.7 Under the new contact there are two Lots with one Lot for each geographical area (East Kent and West Kent) and the same service provider cannot deliver both Lots. The Lots are aligned with the Health and Care Partnership boundaries, as set out below:

- Lot 1 – East Kent (Ashford, Canterbury, Dover, Thanet, Folkestone and Hythe).
- Lot 2 – West Kent (Dartford, Gravesham, Sevenoaks, Maidstone, Tonbridge and Malling, Tunbridge Wells and Swale).

3.8 The evaluation method used was lowest cost above a minimum quality threshold.

3.9 Two bids were evaluated for Lot 1 but neither tenderer met the individual minimum thresholds required for specific quality-related questions. These thresholds were established to ensure higher standards. As a result, Lot 1 will not be awarded to any of the tenderers.

3.10 Imago Community were the winning bidder for Lot 2, having passed all the minimum quality thresholds and having submitted the lowest net price

3.11 An short term extension to the current contracts, of up to four months, is required to allow sufficient time to resolve the unsuccessful procurement for Lot 1.

3.12 The short term extension will mitigate any loss in the provision of service while the re-procurement is underway and will also enable ample mobilisation time for the winning bidder.

4. Options considered and dismissed, and associated risk

4.1 Following the unsuccessful procurement for Lot 1 the following options were considered

4.1.1 Do nothing

The option of 'doing nothing' was considered, however it was quickly dismissed. Without a new contract in place to support carers across the county it will have a negative impact on carers and put the council at risk on both a financial basis and with regard to meeting its statutory duties.

4.1.2 Undertake a negotiation and direct award for Lot 1 with one of the bidders for Lot 2 who met the minimum quality threshold

This would take less time to complete than undertaking a procurement exercise but may not achieve best value and would restrict competition. Advice from the council's Commercial and Procurement division is that a further procurement exercise will need to be undertaken for Lot 1.

4.1.3 Undertake a competitive process, in the form of a procurement exercise, for Lot 1.

Cabinet Office guidance states that contracting authorities may re-run a competition where no acceptable tender is received, provided the process is transparent and the relevant notices are published. Completing a procurement exercise will ensure the council is achieving best value and the required level of quality for this contract.

4.2 To enable a further procurement exercise to be undertaken the current contracts will need to be extended up to four months from 1 April 2026 to 31 July 2026, on the same terms and conditions at the same contract price. This will allow sufficient time to complete the procurement exercise and mobilise the new service.

4.3 Currently the Community Navigation (Part B) contract is delivered geographically amongst three providers and The Carers' Short Breaks Contract is delivered by a sole provider across Kent. The new Kent Carers' Support Service will consist of two contracts covering east and west Kent which will combine community navigation and breaks for carers. For this reason it is not possible to mobilise the service, for the successful Lot 2, until the procurement for both contracts has concluded.

5. Financial Implications

5.1 The four month extension to the existing contracts would be on the same terms and conditions at the same price. Therefore, no increase in cost for the extension period.

5.2 The annual price for Lot 2 is £2,647,176 which is below the maximum value set for this Lot £3,385,400. The total value for this Lot will be up to £18,530,235 over the lifetime of the contract (initial three years including the two-two year extension options).

5.3 The annual price for Lot 1 will not exceed the maximum value of £3,360,400 and will be up to £23,522,800 over the lifetime of the contract. The combined lifetime contract value will not exceed £42,053,035. Through the procurement exercise for Lot 1 the new contract value may be lower.

5.4 The Integrated Care Board (ICB) contributes £1,252,704 to the Community Navigation (Part B) contracts and £779,681 to the Carers' Short Break Service. ICB have committed to continue funding the service. Contribution to be agreed when the final contract prices are known.

5.5 This is a fixed price contract to ensure budget predictability and prevents overspend. KCC will pay 1/12 of the budget each month to avoid large upfront payments, which is also in line with other prevention contracts. Providers are encouraged to use resources efficiently to meet the high demand for services, ensuring value for money.

5.5 The use of the Supplier Incentive Programme has been utilised in this procurement.

6. Legal implications

6.1 <u>Care Act Implications</u>

6.1.1 KCC has statutory responsibilities under The Care Act 2014 include assessing the needs of any adult (cared for or carer) with an appearance for care and support and arranging services and where appropriate meeting the unmet eligible needs of adults living in Kent. Where it appears to the local authority that a carer may have needs for support (whether currently or in the future), a carer's assessment must always be offered.

6.1.2 In summary, the services are necessary and will allow KCC to meet these duties through a new carers offer which better meets the needs of carers.

6.2 Procurement Regulations Implications

6.2.1 A short term contract extension will be awarded to the incumbent providers of the Carers' Short Breaks Contract, and Community Navigation (Part B) Contract for a period of up to four months. The short term extensions will enable KCC to complete the re-procurement of a joint service. By awarding the short term extension, it mitigates any loss in the provision of service while the re-procurement is underway. In addition, it will also enable ample mobilisation time for the winning bidder.

6.2.2 A contract extension of the Carers' Short Break contract for a period of up to four months from 1 April 2026 to 31 July 2026 is in accordance with the relevant justifications set out in Regulation 72(1)(b)(c) of the Public Contract Regulations 2015.

6.2.3 A contract extension of the Community Navigation (Part B) contract for a period of up to four months from 1 April 2026 to 31 July 2026 is in accordance with the relevant justifications set out in Regulation 72(1)(b)(c) of the Public Contracts Regulations 2015

6.2.4 Regulation 72 (3) of PCR2015, requires Contracting authorities which have modified a contract in either of the cases described under Regulation (1)(b) and (c), as is recommended in this paper, should send a notice to that effect for publication, in accordance with Regulation 51. The risk to the council is that an alternate service provider may bring a legal challenge, arguing that the modification of the services does not satisfy Regulation 72. Officers will mitigate the risk of such a challenge by publishing a VEAT Notice on the central government "Find a Tender Service". This will notify the market of the council's intention to extend these contracts under Regulation 72 while a re-procurement for the failed lot is carried out. A 10 day standstill period will then commence before formally awarding the contract extensions.

6.2.5 Officers will follow the procurement regulations and Spending the Council's Money in relation to any procurement that is undertaken.

7. Equalities implications

7.1 An Equality Impact Assessment (EQIA), attached as Appendix 1, has been completed for the activity of recommissioning the service. The aim of the new service offer will be to deliver a service which is more is identifiable to carers, able to reach a greater number of carers from different communities and with different protected characteristics. The EQIA for the new service will look at all areas and in particular the issue of 'intersection' of different characteristics on people who may be impacted by more than two protected characteristics at the same time.

8. Data Protection Implications

8.1 A Data Protection Impact Assessment (DPIA) initial screening has been completed. No personal identifiable information will be collected for the extension. A full DPIA will be completed for the new service.

9. Governance

9.1 The Corporate Director, Adult Social and Health will inherit delegated authority to take relevant actions to finalise the required contractual and legal agreements necessary to implement the decision.

10. Conclusions

10.1 Kent County Council has a statutory duty to under The Care Act 2014 which include assessing the needs of any adult (cared for or carer) with an appearance of need for care and support, and arranging services and where appropriate meeting the unmet eligible needs of adults living in Kent.

10.2 Putting in place contractual arrangements for Carers' Support Services will meet those statutory duties.

10.3 Following the completion of a comprehensive and transparent procurement process, it is recommended to award the contract for the Kent Carers' Support Service to the successful provider identified as part of the procurement process and extend the existing contracts to allow for a procurement exercise to be undertaken for the unsuccessful Lot.

11. Recommendation(s): The Adult Social Care and Public Health Cabinet Committee is asked to **CONSIDER** and **ENDORSE** or make **RECOMMENDATIONS** to the Cabinet Member for Adult Social Care and Public Health on the proposed decision: as detailed in the attached Proposed Record of Decision document (Appendix A).

12. Background Documents

None

13. Appendices

Appendix 1 – Equality Impact Assessment

14. Contact details

Report Author	Director:
Ben Campbell	Helen Gillivan
Commissioning Manager	Director Adults and Integrated Commissioning
03000 417581	03000 410077
Ben.campbell@:kent.gov.uk	Helen.gillivan@kent.gov.uk

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KENT COUNTY COUNCIL – PROPOSED RECORD OF DECISION

DECISION TO BE TAKEN BY:	DECISION NUMBER:
Diane Morton, Cabinet Member for Adult Social Care and Public Health	25/00116

Executive Decision – key

25/00116 – Kent Carers' Support Service

Decision: As Cabinet Member for Adult Social Care and Public Health, I propose to:

a) **APPROVE** the contract award for the Kent Carers' Support Service;
b) **APPROVE** a direct award of the Carers' Short Breaks contract, for a period of up to four months, from 1 April 2026 to 31 July 2026, in accordance with the relevant justifications set out in Regulation 32(2)(c) of the Public Contract Regulations 2015; and
c) **APPROVE** a modification in the form of an extension of the contract for a period of up to four months for Community Navigation Services (Part B), from 1 April 2026 to 31 July 2026, in accordance with the relevant justifications set out in Regulation 72 of the Public Contract Regulations 2015; and
d) **DELEGATE** authority to the Corporate Director, Adult Social Care and Health to take other relevant actions including, but not limited to finalising the terms of and entering into required contracts or other legal agreements, as necessary to implement the decision; and
e) **DELEGATE** authority to the Corporate Director, Adult Social Care and Health, in consultation with the Cabinet Member for Adult Social Care and Public Health and the Corporate Director, Finance, to agree the relevant contract extensions for the Kent Carers' Support Service Contract as required.

Reasons for decision: A key decision (decision number 24/0113) was taken on 31 January 2025 to start the procurement exercise for a new Carer's Support Services Contract, combining the current Carers' Short Breaks and Community Navigation (Part B) services.

The new Carers' Support Service Contract is split into two Lots – Lot 1 for East Kent and Lot 2 for West Kent.

Procurement for the Carers' Support Service was undertaken and tenders were given from 30 June and 1 August to submit. Following formal evaluation of the bids submitted as part of the procurement exercise identified neither tenderer met the individual minimum thresholds required for specific quality-related questions

submitted for Lot 1 (East Kent), therefore Lot 1 was deemed not successful. Procurement for Lot 2 (West Kent) was successful.

Following advice from the council's Commercial and Procurement division a further procurement exercise will need to be undertaken for Lot 1.

Kent County Council has statutory responsibilities under The Care Act 2014 which include assessing the needs of any adult (cared for or carer) with an appearance of need for care and support, and arranging services where appropriate to meet the unmet eligible needs of adults living in Kent. Currently the Community Navigation Services (Part B) and Carers' Short Breaks contracts support the council to meet this duty until 31 March 2026.

This decision seeks to:

- award contracts to successful providers for Lot 2;
- extend the current contractual arrangements for Community Navigation Services (Part B) and Carers' Short Breaks for up to four months (from 1 April 2026 to 31 July 2026) to allow a further procurement exercise to be undertaken for Lot 1 (East Kent); and
- award contracts to successful providers for Lot 1 following completion of procurement exercise.

Financial implications:
The four month extension to the existing contracts will be on the same terms and conditions at the same price. Therefore, no increase in cost.

The annual price for Lot 2 is £2,647,176 and will be up to £18,530,235 over the lifetime of the contract (initial three years including the two-two year extension options).
The annual price for Lot 1 will not exceed the maximum value of £3,360,400 and will be up to £23,522,800 over the lifetime of the contract. The combined lifetime contract value will not exceed £42,053,035.

This is a fixed price contract to ensure budget predictability and prevents overspend. KCC will pay 1/12 of the budget each month to avoid large upfront payments, which is also in line with other prevention contracts. Providers are encouraged to use resources efficiently to meet the high demand for services, ensuring value for money.

The use of the Supplier Incentive Programme has been utilised in this procurement.

Legal implications:
KCC has statutory responsibilities under The Care Act 2014 include assessing the needs of any adult (cared for or carer) with an appearance for care and support and arranging services and where appropriate meeting the unmet eligible needs of adults living in Kent. Where it appears to the local authority that a carer may have needs for support (whether currently or in the future), a carer's assessment must always be offered.

In summary, the services are necessary and have allowed KCC to recommission a new carers offer that better meets the needs of carers.

A short term contract extension will be awarded to the incumbent suppliers of the Carers Short Breaks contract, and Community Navigation (Part B) contract for a period of 4 months. The short term extensions enable KCC to complete the re-procurement of a joint service. By awarding the short term extension, it mitigates any loss in the provision of service while the re-procurement is underway. In addition, it will also enable ample mobilisation time for the winning bidder.

A contract extension of the Carers Short Break contract for a period of 4 months from 01 April 2026 to 31 July 2026 is in accordance with the relevant justifications set out in Regulation 72(1)(b)(c) of the Public Contract Regulations 2015.

A contract extension of the Community Navigation (Part B) contract for a period of 4 months from 01 April 2026 to 31 July 2026 is in accordance with the relevant justifications set out in Regulation 72(1)(b)(c) of the Public Contracts Regulations 2015

Procurement Regulations Implications
Regulation 72 (3) of PCR2015, requires Contracting authorities which have modified a contract in either of the cases described under Regulation (1)(b) and (c), as is recommended in this paper, should send a notice to that effect for publication, in accordance with Regulation 51. The risk to the council is that an alternate service provider may bring a legal challenge, arguing that the modification of the services does not satisfy Regulation 72. Officers will mitigate the risk of such a challenge by publishing a VEAT Notice on the central government "Find a Tender Service". This will notify the market of the council's intention to extend these contracts under Regulation 72 while a re-procurement for the failed lot is carried out. A 10 day standstill period will then commence before formally awarding the contract extensions.

Commissioners will follow the procurement regulations and Spending the Council’s Money in relation to any procurement that is undertaken.

Equalities implications:

An Equality Impact Assessment has been completed for the activity of recommissioning the service. The aim of the new service offer will be to deliver a service which is more is identifiable to carers, able to reach a greater number of carers from different communities and with different protected characteristics. The Equality Impact Assessment for the new service will look at all areas and in particular the issue of ‘intersection’ of different characteristics on people who may be impacted by more than two protected characteristics at the same time.

Data Protection implications:

A DPIA initial screening has been completed. No personal identifiable information was collected for the procurement process. The full DPIA will be completed once the successful bidders have been identified.

Cabinet Committee recommendations and other consultation: The proposed decision will be considered at the Adult Social Care and Public Health Cabinet Committee on 21 January 2026 and the outcome included in the decision paperwork which the Cabinet Member will be asked to sign.

Any alternatives considered and rejected:

Following the unsuccessful procurement for Lot 1 the option of 'doing nothing' was considered, however it was quickly dismissed. Without a new contract in place to support carers across the county it will have a negative impact on carers put the council at risk on both a financial basis and with regard to meeting statutory duties.

- Option 1

Undertake a negotiation and direct award for Lot 1 with one of the bidders for Lot 2 who met the minimum quality threshold. This would be a short process.

- Option 2

Undertake a competitive process, in the form of a procurement exercise, for Lot 1.

Option 2 is the preferred option as it will ensure KCC is achieving best value and the required level of quality for this contract.

Any interest declared when the decision was taken and any dispensation granted by the Proper Officer:

…….. ……

Signed Date

EQIA Submission – ID Number
Section A

EQIA Title
Carers Support and Assessment

Responsible Officer
Ben Campbell - AH AIC

Approved by (Note: approval of this EqIA must be completed within the EqIA App)
Simon Mitchell - AH AIC

Type of Activity

Service Change
No
Service Redesign
No
Project/Programme
No
Commissioning/Procurement
Commissioning/Procurement
Strategy/Policy
No
Details of other Service Activity
No

Accountability and Responsibility

Directorate
Strategic and Corporate Services
Responsible Service
Commissioning
Responsible Head of Service
Simon Mitchell - AH AIC
Responsible Director
Helen Gillivan - AH CD

Aims and Objectives

Background

The Care Act describes a carer as 'somebody who provides support or who looks after a family member, partner or friend who needs help because of their age, physical or mental illness, or disability. This would not include someone paid or employed to carry out that role, or someone who is a volunteer.'

A core purpose of KCC as an adult social care organisation is to carry out duties according to the law by supporting carers. This means helping them feel empowered to lead the lives they want to live in a place they call home - essentially, putting carers at the heart of everything we do.

This includes, planning and funding carers' support, promoting carers' wellbeing, preventing, reducing, and delaying the need for support.

The Kent Adult Carers Strategy 2022 to 2027 was developed in partnership with carers, people who draw on care and support, NHS partners, carers organisations, staff, and county councillors. The strategy describes how we will work with partners to make changes that improve the experiences of adult carers in Kent. The Kent Adult Carers Strategy is closely aligned with 'Making a difference every day: our strategy for

adult social care.

The Kent Adult Carers Strategy vision: 'Making a difference every day by supporting and empowering you to live a fulfilling life whilst being a carer, as long as you are willing and able'

Commissioning a New Service
Existing services to support carers are offered via the Kent County Council Community Navigation Services contracts (Part B) and the Carers Short Breaks contract.

A range of pre-procurement activity and engagement has taken place. Carers Involvement meetings have taken place with carers to better understand how the offer can be improved. Co-production with carers will continue throughout the commissioning process.

We will shortly be going to market to procure a new Carers Support Service.

The information within this document relates to existing evidence and analysis. Gaps and areas for improvement will be covered within the new specification and service offer.

Section B – Evidence

Do you have data related to the protected groups of the people impacted by this activity?

Yes

It is possible to get the data in a timely and cost effective way?

Yes

Is there national evidence/data that you can use?

Yes

Have you consulted with stakeholders?

Yes

Who have you involved, consulted and engaged with?

Unpaid Carers and those who use existing carers services
Service Providers
Public Health
ICB

Has there been a previous Equality Analysis (EQIA) in the last 3 years?

Yes

Do you have evidence that can help you understand the potential impact of your activity?

Yes

Section C – Impact

Who may be impacted by the activity?

Service Users/clients
Service users/clients

Staff
Staff/Volunteers

Residents/Communities/Citizens

Residents/communities/citizens

Are there any positive impacts for all or any of the protected groups as a result of the activity that you are doing?

Yes

Details of Positive Impacts

In Kent, an estimated (2021 census) 158,512 adults aged 16 or over provide hours of unpaid care each week.

- 94,640 provide 1-19 hours of care a week
- 18,131 provide 20-49 hours of care a week
- 35,570 provide 50 hours of care or more a week.

15,252 unpaid carers live in Canterbury and its surroundings, making it the place with the highest total number of carers in Kent. This makes up 12% of the people that live there. The area that has the highest proportion of carers compared to the number of people that live there, is Thanet. Around 14% of people (15,150) in Thanet are unpaid carers.

Kent Adult Carers Strategy sets out the vision: 'Making a difference every day by supporting and empowering you to live a fulfilling life whilst being a carer, as long as you are willing and able'.

This ambition will be achieved by focusing on the following areas:

• Supporting you to be you - to live a full life, carers have told us that they need the right support so they can make time to get everyday tasks done.

• Providing the best support possible - carers have been clear that they, and the people they look after, need to be treated with respect and supported through every stage of their journey - not just during a crisis.

• Positive outcomes - everything we do alongside providers and partner organisations should focus on what makes a real difference and leads to positive change in carers' experiences

Building on the Kent Adult Carers Strategy we intend to commission an improved offer for carers. We have been developing proposals for a future model with carers and through engaging with the market

Leading from what carers told us we will introduce a single point of access for carers support services that is well promoted and marketed. We will ensure a greater focus on the benefits of completing a carers assessment so we can better understand the needs of carers. We will introduce a more local community-based approach ensure the service has a wider reach into all parts of the community across Kent. This should result in better outcomes and positive impact for protected groups.

We will use a range of methods for ensuring the new service offer is reaching and supporting the diverse range of carers in Kent.

Through the procurement exercise we will require bidders to describe how they will engage with and reach out to the underrepresented and ethnically diverse groups of carers including those who do not identify as carers.

The evaluation will include questions designed by carers and evaluated by carers.

The service specification has been co-produced and will ensure the service is positively supporting those with protected characteristics.

When the contract is mobilised we will be collecting a broader range of data and KPIs on those accessing the service. This will help determine 'intersection' of different characteristics on people who may be impacted by more than two protected characteristics at the same time.

The service will require carers to be part of ongoing development and there will be regular surveys and feedback to understand who is accessing the service and how it is performing.

Through contract monitoring we will continue to regularly collect equalities data on those accessing the

service from protected groups.

Negative impacts and Mitigating Actions

19.Negative Impacts and Mitigating actions for Age

Are there negative impacts for age?

Yes

Details of negative impacts for Age

Changes to the service may have a negative impact for this protected characteristic

A large proportion of unpaid carers over 65. Census data shows us Kent has more older unpaid carers living in coastal deprived areas.
Between 2010-2020, people aged 46-65 were the largest age group to become unpaid carers. 41% of people who became unpaid carers were in this age group (Petrillo and Bennett, 2022)

The data from April 2023 to March 2024 and is attached as evidence in the supporting documents:

This shows us the largest number proportion of carers are in the age group 25-59 and 60-79. Therefore both working age adults and older adults will be impacted by changes to the service.

Mitigating Actions for Age

The new services will be required to provide support, or work with appropriate sub-contracted services to deliver the support required for all age groups, with a particular focus on the growing needs of working age adults and older carers. The service specification will require providers to operate in full compliance with the Equality Act 2010 and that providers will be regularly monitored. Performance data relating to the age of people using the services will be collected and analysed over the life of the contract to understand gaps or barriers to access and work with providers to respond appropriately.

Through the procurement bidders will be asked to explain how they will tailor the service to meet the needs of the people within the geographical area they are bidding for. This will include using different communication methods to reach different age groups and ensuring there is access to support at different times of day to fit with those who are working.

We will place a greater focus on equality data through contract monitoring and have as a standing item on agenda.

There will also be a requirement put in place for the provider to conduct an annual survey for those that use that service so that we can monitor protected characteristics and ensure that there is equity of service.

Carers will be involved in mobilising and monitoring the service to ensure it is meeting the diverse needs of carers.

Responsible Officer for Mitigating Actions – Age

Lisa Rogers

20. Negative impacts and Mitigating actions for Disability

Are there negative impacts for Disability?

Yes

Details of Negative Impacts for Disability

Changes to the service may have a negative impact for this protected characteristic

Public Health data tells us 0.83% of carers had a learning disability, compared to 0.46% of the population aged 40+. 1.49% had a mental health issues compared to 1.23% of the population 40+.

The data from April 2023 to March 2024 is evidenced in the supporting documents.

This shows us the most common carer disability is long standing health condition and physical / mobility impairment.

Mitigating actions for Disability

We will ensure that a clear service mobilisation plan will support transition for existing carers, including those with a disability.
A requirement to collect carer disability information will be included in the service specification in order to better monitor and therefore ensure that for disabled carers, their needs and requirements are considered and met. The aim is to deliver a more equitable service across the whole county. This will ensure that those carers with a disability are not missing out because of where they live.
In order to mitigate any potential impacts, as part of the procurement process, interested bidders will be asked how they will engage with and reach out to underrepresented protected characteristic groups- ensuring that we are able to evaluate providers based on how well they plan to address these issues.

There will also be a requirement put in place for the provider to conduct an annual survey for those that use that service so that we can monitor protected characteristics and ensure that there is equity of service.

We will place a greater focus on equality data through contract monitoring and have as a standing item on agenda.

Carers will be involved in mobilising and monitoring the service to ensure it is meeting the diverse needs of carers.

Responsible Officer for Disability

Lisa Rogers

21. Negative Impacts and Mitigating actions for Sex

Are there negative impacts for Sex

Yes

Details of negative impacts for Sex

Changes to the service may have a negative impact for this protected characteristic

The Census found that in England and Wales, women are more likely to provide care than men. 59% of unpaid carers are female.

The data from April 2023 to March 2024 is evidenced in supporting documents attached.

This shows us a larger proportion of carers receiving support are female between 67% and 68%

Mitigating actions for Sex

Providers of the new service will be required to actively promote their services and find innovative ways to ensure services are targeted at both male and female carers.
Performance data relating to the gender of people using the services will be collected and analysed over the life of the contract to understand gaps or barriers to access and work with providers to respond appropriately.

In order to mitigate any potential impacts, as part of the procurement process, interested bidders will be asked how they will engage with and reach out to underrepresented protected characteristic groups- ensuring that we are able to evaluate providers based on how well they plan to address these issues.

There will also be a requirement put in place for the provider to conduct an annual survey for those that use that service so that we can monitor protected characteristics and ensure that there is equity of service

We will place a greater focus on equality data through contract monitoring and have as a standing item on agenda.

Carers will be involved in mobilising and monitoring the service to ensure it is meeting the diverse needs of carers.

Responsible Officer for Sex

Lisa Rogers

22. Negative Impacts and Mitigating actions for Gender identity/transgender

Are there negative impacts for Gender identity/transgender

Yes

Negative impacts for Gender identity/transgender

Through the current services we have in sufficient data for this protected characteristic.
The data from April 2023 to March 2024 is evidenced in supporting documents attached.

Mitigating actions for Gender identity/transgender

We require better data to understand the issues for this protected characteristic. When mobilising the new service this issue will be highlighted so plan can be developed to improve data in this area.

In order to mitigate any potential impacts, as part of the procurement process, interested bidders will be asked how they will engage with and reach out to underrepresented protected characteristic groups- ensuring that we are able to evaluate providers based on how well they plan to address these issues.

There will also be a requirement put in place for the provider to conduct an annual survey for those that use that service so that we can monitor protected characteristics and ensure that there is equity of service

We will place a greater focus on equality data through contract monitoring and have as a standing item on agenda.

Responsible Officer for mitigating actions for Gender identity/transgender

Lisa Rogers

23. Negative impacts and Mitigating actions for Race

Are there negative impacts for Race

Yes

Negative impacts for Race

Changes to the service may have a negative impact for this protected characteristic.

Analysis by University College London of Understanding Society data found that Pakistani and Bangladeshi carers were more likely to be living with the person they provided care for (70.1% and 74.8% respectively) in comparison with White carers (39.7%).

Carers UK research found that ethnic minority carers were more likely to be struggling financially, and more likely to have concerns around services not meeting their needs, in comparison with White British carers

The service data from April 2023 to March 2024 is evidenced in supporting documents attached. This data aligns with ONS analysis which found that the ethnicity of unpaid carers largely follows the ethnic-group distributions in the whole population.

In people who identified as unpaid carers and non-carers, the most common ethnic group identified with was "White: English, Welsh, Scottish, Northern Irish or British" in both England (78.3% and 73.8% in unpaid carers and non-carers, respectively) and Wales (92.9% and 90.2% in unpaid carers and non-carers, respectively)

Mitigating actions for Race

A requirement to collect carer ethnicity will be included in the service specification in order to better monitor and therefore ensure that services are reaching all communities and meeting their needs. The aim is to deliver a more equitable service across the whole county.

In order to mitigate any potential impacts, as part of the procurement process, interested bidders will be asked how they will engage with and reach out to underrepresented protected characteristic groups- ensuring that we are able to evaluate providers based on how well they plan to address these issues.

There will also be a requirement put in place for the provider to conduct an annual survey for those that use that service so that we can monitor protected characteristics and ensure that there is equity of service.

We will place a greater focus on equality data through contract monitoring and have as a standing item on agenda.

Carers will be involved in mobilising and monitoring the service to ensure it is meeting the diverse needs of different communities

Responsible Officer for mitigating actions for Race

Lisa Rogers

24. Negative impacts and Mitigating actions for Religion and belief

Are there negative impacts for Religion and belief

Yes

Negative impacts for Religion and belief

Changes to the service may have a negative impact for this protected characteristic.

In England and Wales, ONS analysis found that the most common religion carers identified with is Christian (48.7% of carers in England are Christian, and 45.5% of carers in Wales). In both countries, there has been an increase in the proportion of carers identifying with 'no religion' (35% in England, and 45.4% in Wales)

compared with 2011. This pattern has also been seen in the wider population.

Service data from April 2023 to March 2024 is evidenced in supporting documents attached. This shows similar pattern to the national data with less the 1% of carers from religions that are not Christian.

Mitigating actions for Religion and belief

Providers of the new service will be required to actively promote their services and find innovative ways to ensure services are targeted at different religions

Performance data relating to the religion of people using the services will be collected and analysed over the life of the contract to understand gaps or barriers to access, and work with providers to respond appropriately.

In order to mitigate any potential impacts, as part of the procurement process, interested bidders will be asked how they will engage with and reach out to underrepresented protected characteristic groups- ensuring that we are able to evaluate providers based on how well they plan to address these issues.

There will also be a requirement put in place for the provider to conduct an annual survey for those that use that service so that we can monitor protected characteristics and ensure that there is equity of service

We will place a greater focus on equality data through contract monitoring and have as a standing item on agenda.

Carers will be involved in mobilising and monitoring the service to ensure it is meeting the diverse needs of different communities

Responsible Officer for mitigating actions for Religion and Belief

Lisa Rogers

25. Negative impacts and Mitigating actions for Sexual Orientation

Are there negative impacts for Sexual Orientation

Yes

Negative impacts for Sexual Orientation

Changes to the service may have a negative impact for this protected characteristic.

ONS analysis of Census data in England and Wales found that a higher proportion of unpaid carers aged 16 and over are lesbian, gay, bisexual or other compared with non-carers. In England, 3.9% of unpaid carers are LGB+ compared with 3% of non-carers, and 4% of carers in Wales are LGB+ compared with 3% of non-carers

The service data from April 2023 to March 2024 is evidenced in supporting documents attached. This shows that less than 1% of those accessing services are lesbian, gay, bisexual or other sexual orientation. Therefore this group may be under accessing current services.

Mitigating actions for Sexual Orientation

We require better data to understand the issues for this protected characteristic. When mobilising the new service this issue will be highlighted so plan can be developed to improve data and take up in service for those who are lesbian, gay, bisexual or other sexual orientation.

In order to mitigate any potential impacts, as part of the procurement process, interested bidders will be

asked how they will engage with and reach out to underrepresented protected characteristic groups- ensuring that we are able to evaluate providers based on how well they plan to address these issues.

There will also be a requirement put in place for the provider to conduct an annual survey for those that use that service so that we can monitor protected characteristics and ensure that there is equity of service

We will place a greater focus on equality data through contract monitoring and have as a standing item on agenda

Carers will be involved in mobilising and monitoring the service to ensure it is meeting the diverse needs of the lesbian, gay and bisexual community.

Responsible Officer for mitigating actions for Sexual Orientation

Lisa Rogers

26. Negative impacts and Mitigating actions for Pregnancy and Maternity

Are there negative impacts for Pregnancy and Maternity

No

Negative impacts for Pregnancy and Maternity

Not Applicable

Mitigating actions for Pregnancy and Maternity

Not Applicable

Responsible Officer for mitigating actions for Pregnancy and Maternity

Not Applicable

27. Negative impacts and Mitigating actions for Marriage and Civil Partnerships

Are there negative impacts for Marriage and Civil Partnerships

No

Negative impacts for Marriage and Civil Partnerships

Not Applicable

Mitigating actions for Marriage and Civil Partnerships

Not Applicable

Responsible Officer for Marriage and Civil Partnerships

Not Applicable

28. Negative impacts and Mitigating actions for Carer's responsibilities

Are there negative impacts for Carer's responsibilities

Yes

Negative impacts for Carer's responsibilities

Feedback from carers suggests the current service is not known to some carers and is not accessible to all communities across the county.

The current service supports approximately 41,000 carers.

Mitigating actions for Carer's responsibilities

Following feedback and discussion with carers and carer service providers the new service will:

- introduce a single point of access for carers support services, that is well promoted and marketed.
- place a greater focus on the benefits of completing a carers assessment so we can better understand the needs of carers.
- develop a local community-based approach to ensure the service has a wider reach into all parts of the community across Kent.

This should result in better outcomes and positive impact for protected groups

We will use a range of methods for ensuring the new service offer is reaching and supporting the diverse range of carers in Kent.

Through the procurement exercise we will require bidders to describe how they will engage with and reach out to the underrepresented and ethnically diverse groups of carers including those who do not identify as carers.

The evaluation will include questions designed by carers and evaluated by carers.

The service specification has been co-produced and will ensure the service is positively supporting those with protected characteristics.

When the contract is mobilised we will be collecting a broader range of data and KPIs on those accessing the service. This will help determine 'intersection' of different characteristics on people who may be impacted by more than two protected characteristics at the same time.

The service will require carers to be part of ongoing development and there will be regular surveys and feedback to understand who is accessing the service and how it is performing.

Through contract monitoring we will continue to regularly collect equalities data on those accessing the service from protected groups.

Responsible Officer for Carer's responsibilities
Lisa Rogers

From:	Diane Morton, Cabinet Member for Adult Social Care and Public Health Sarah Hammond, Corporate Director, Adult Social Care and Health
To:	Adult Social Care and Public Health Cabinet Committee – 21 January 2026
Subject:	**Learning Disability, Physical Disability and Mental Health Needs Residential Care Contract**
Decision number:	**25/00117**
Key decision:	Yes – it involves expenditure of mote than £1m and affects more than two electoral divisions
Classification:	Unrestricted
Past Pathway of report:	N/A
Future Pathway of report:	Cabinet Member decision
Electoral Division:	All

Is the decision eligible for call-in? Yes

Summary The Learning Disability, Physical Disability and Mental Health Needs Residential Care Contract commenced in June 2020, for an initial period of four years, with two x two-year options to extend. In February 2024 the first of the two year extensions was utilised (Decision Number 24/00004) to extend the contract to 14 June 2026.

This decision seeks extend the current contract for a further two yeas, using the permissible contract extensions. The extension will maintain service continuity for people with learning disabilities, physical disabilities and mental health needs while the Council undertakes recommissioning to implement a more integrated and sustainable model of care. This approach avoids disruption, supports value for money, and provides flexibility during the transition.

Recommendation(s): The Adult Social Care and Public Health Cabinet Committee is asked to **CONSIDER** and **ENDORSE** or make **RECOMMENDATIONS** to the Cabinet Member for Adult Social Care and Public Health in relation to the proposed decision as detailed in the attached Proposed Record of Decision document. (Appendix A).

Introduction

1.1 Work is underway to commission a Supported Accommodation and Residential Living Service which encompasses both residential and supported living options for people with learning disabilities, physical disabilities and mental health needs, to allow a flexible transitional pathway to support people to maximise their independence.

1.2 The current Learning Disability, Physical Disability and Mental Health Needs (LDPDMH) Residential Care Contract commenced in June 2020, for an initial period of four years, with two x two-year extension options. In February 2024 the first of the two year extensions was utilised (Decision Number 24/00004) to extend the contract to 14 June 2026.

1.3 The current Supported Living Contract is due to end on 14 June 2026 and in order to align the recommissioning activity and support development of the new Supported Accommodation and Residential Living Service, this decision seeks to extend the LDPDMH Residential Care Contract for a further two years from 15 June 2026 to 14 June 2028, using the permissible contract extensions. The extension will maintain service continuity for people with learning disabilities, physical disabilities and mental health needs while the Council undertakes recommissioning to implement a more integrated and sustainable model of care. This approach avoids disruption, supports value for money, and provides flexibility during the transition

1.4 The new Supported Accommodation and Residential Living Service Contract is expected to commence by June 2027. On this basis, it is anticipated that only one year of the proposed two year extension for the LDPDMH Residential Care Contract will be required.

1.5 However, approval of a two-year extension provides the necessary assurance and flexibility, ensuring continuity of care in the event of any delays to the implementation of the new contract. This approach mitigates the risk of service disruption and avoids the need for a further key decision, while supporting a stable and well-managed transition to the new Supported Accommodation and Residential Living model.

2. Background

2.1 The Care Act 2014 gave local authorities in England, the NHS and the Care Quality Commission (CQC) clear legal responsibilities for managing different elements of the adult social care market that include considering need, provider sustainability, value for money and integration.

2.2 *Reforming Kent 2025-2028* identifies Supporting Residents that Need Help as one of its key priorities by recognising the importance of health and social care integration, building effective strategic partnerships with our providers through coproduction whilst being innovative in the way we look to redesign services, to improve quality and importantly respond to budget constraints.

2.3 A robust commissioning exercise for the Supported Accommodation and Residential Living Service has commenced and will include extensive engagement with people who use care and support services to inform and develop a new specification which ensures high quality and cost effective services in the future.

2.4 The initial costs for the LDPDMH Residential Care Contract are set out below along with the current costs. The reduction in residential spend correlates with the increase in supported living services. This is in line with the Council's vision to ensure people's independence is maximised through the least restrictive support options.

Contract	Initial contract cost advertised (per annum)	2025 - 2026 Spend
Residential Care Home Services (Learning Disability, Physical Disability & Mental Health) Framework SC19 012 Mosaic and Controcc	£108m (Source: Award Report 18 01 2022)	£85,949,076.20
Non Framework Placements - Mosaic		£22,584,443.98
Non Framework Placements – Controcc (18-25 year olds)		£1,374,510.80
Total spend		£109,908,030.98

2.5 There are currently 894 people placed in a residential care home settings through this contract, and a further 356 people placed in residential care homes on individual contracts both in Kent and out of county.

2.6 External and internal pressures have significantly changed from when the contracts were initiated in 2019.

2.7 Pressures include:

- The demand for care and support for people with a greater level of complexity of need.
- Inflationary pressures and financial sustainability issues.
- Increased placement costs seen across Kent and nationally.
- Workforce pressures and the recruitment and retention of high quality staff
- Quality issues resulting in poor CQC rating and contract suspensions.

3. Options considered and dismissed, and associated risk

3.1 The Council can choose not to extend the current contract. However, there are significant risks to choosing this option which have been identified and set out below

- The contract would need to be recommissioned on a like for like basis with no changes to the delivery model. There will be no opportunity to include residential care homes within the new contractual framework if the additional two year extension is not utilised.

- A lack of robust fee setting mechanisms and contractual leverage may result in a significant increase in placement costs, which will be challenging to control. Savings targets set out by the Council and to be met through greater partnership working and negotiation will be difficult to achieve through spot purchasing agreements, and providers will be within their right to give notice on individual placements that may be hard to source at an affordable price.

- Reputational: A shift to partnership working with providers will be challenged as the expectation is that the contractual arrangements with the authority will be maintained due to the mutual benefits to both parties. People using this service expect a robust oversight of the contract and the perception will be that this is not the case if the service is not part of a Kent County Council (KCC) contractual framework.

- Resource Implications: If the contract ends there will be a requirement for the review, renegotiation and repurchasing of all individual placements with new contract and terms and conditions established. This will also require significant system and process updates.

4. Financial Implications

4.1 The annual cost of the contract is £86,505,815 per annum and for the proposed two year extension the cost will be £173,011,630.

4.2 All placements are funded from the adult social care budget.

4.1 Cost analysis needs to be undertaken to overcome the challenges of determining the full cost of the contract i.e., breakdown of placement costs, budget contributions and system errors. Adequate finance advice and resource is required to ensure a collaborative approach to determine a robust fee model and pricing guide with the identification of any financial risk.

4.2 A new model for commissioning residential placements will be developed. This will inform the maximisation of support delivery from shared hours within the residential home, reducing the need to commission personalised one to one hours. This will support a sustainable model for both the provider and the Council. The extension will allow this activity to be completed.

4.3 These are demand driven services and due to increases in complexity, demand and inflation, requests for higher rates have increased. It is recognised that during the contract extension period, mitigations will be put in place to help halt the increased spend to the service through the development of a robust savings action plan. This will require a collaborative approach across KCC and NHS Kent and Medway Integrated Care (ICB) colleagues and proactively engaging with providers to determine fair costs for both legacy and new placements.

5. Legal implications

5.1 The Council commissions services from the independent sector to meet the needs of individuals deemed to be eligible in accordance with and following a Care Act assessment. If the contract ends the Council will be pressured to fully meet its statutory obligation under the Care Act with regards to providing a high quality, safe service at an affordable price.

5.2 The additional extension is available to be utilised within this contract. The additional extensions were included in the Contract / PIN Notice advertising the original procurement of these services, and therefore the extensions are permissible and are compliant under the PCR 2015 regulations.

5.3 The Council is required to adhere to the Procurement Act 2023 with the requirement to use framework contracts, limiting the use of individual spot contracts.

5.4 A clause will be written into the LDPDMH Residential Care Contract extension to allow the Council to terminate the contract when appropriate and to fit in with the mobilisation of the new Supported Accommodation and Residential Living Service Contract.

6. Equalities implications

6.1 An Equality Impact Assessment (EQIA) was completed as part of the original tender exercise. The EQIA (attached as Appendix 1) has been reviewed and is still relevant as no changes to the contract are being made during the further extension period.

7. Data Protection Implications

7.1 A Data Protection Impact Assessment (DPIA) was completed at the time of tender and there are no new data protection implications to be considered.

8. Governance

8.1 The Corporate Director, Adult Social and Health will inherit delegated authority to take relevant actions to finalise the required contractual and legal agreements necessary to implement the decision.

9. Conclusions

9.1 Work is underway to commission a Supported and Residential Living Service which encompasses both residential and supported living options for people with learning disabilities, physical disabilities and mental health needs, to allow a flexible transitional pathway to support people to maximise their independence.

9.2 The current Learning Disability, Physical Disability and Mental Health (LDPDMH) Residential Care Contract commenced in June 2020, for an initial

period of four years, with two x two-year extension options. In February 2024 the first of the two year extensions was utilised (Decision Number 24/00004) to extend the contract to 14 June 2026.

9.3 The current Supported Living Contract is due to end on 14 June 2026 and in order to align the recommissioning activity and support development of the new Supported Accommodation and Residential Living Service, this decision seeks to extend the LDPDMH Residential Care Contract for a further two years from 15 June 2026 to 14 June 2028, using the permissible contract extensions. The extension will maintain service continuity for people with learning disabilities, physical disabilities and mental health needs while the Council undertakes recommissioning to implement a more integrated and sustainable model of care. This approach avoids disruption, supports value for money, and provides flexibility during the transition.

9.4 The Council can choose not to extend the current contract. However, there are significant risks to choosing this option which have been identified and detailed in Section 3 of this report.

9.5 it is anticipated that only one year of the proposed two year extension for the LDPDMH Residential Care Contract will be required. However, approval of a two-year extension provides the necessary assurance and flexibility, ensuring continuity of care in the event of any delays to the implementation of the new contract. This approach mitigates the risk of service disruption and avoids the need for a further key decision, while supporting a stable and well-managed transition to the new Supported Accommodation and Residential Living Service model.

9.6 A clause will be written into the LDPDMH Residential Care Contract extension to allow the Council to terminate the contract when appropriate and to fit in with the mobilisation of the new Supported Accommodation and Residential Living Service Contract.

10. Recommendations

Recommendation(s): The Adult Social Care and Public Health Cabinet Committee is asked to **CONSIDER** and **ENDORSE** or make **RECOMMENDATIONS** to the Cabinet Member for Adult Social Care and Public Health in relation to the proposed decision as detailed in the attached Proposed Record of Decision document. (Appendix A).

11. Background Documents

24/00004 - Learning Disability, Physical Disability and Mental Health Residential Care Home Services - Contract Extension
https://democracy.kent.gov.uk:9071/ieDecisionDetails.aspx?ID=2821

12. Appendices

Appendix 1 – Equality Impact Assessment

13. Contact Details

Report Author Marie Hackshall System Programme Lead Kent and Medway – Learning Disability, Autism and ADHD 03000 411161 Marie.hackshall@kent.gov.uk	Director Helen Gillivan Director Adults and Integrated Commissioning 03000 410180 Helen.gillivan@kent.gov.uk

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KENT COUNTY COUNCIL – PROPOSED RECORD OF DECISION

DECISION TO BE TAKEN BY:	DECISION NUMBER:
Diane Morton, Cabinet Member for Adult Social Care and Public Health	25/00117

Executive Decision – key

25/00117 – Learning Disability, Physical Disability and Mental Health Needs Residential Care Contract

Decision: As Cabinet Member for Adult Social Care and Public Health, I propose to:
a) **EXTEND** the Learning Disability, Physical Disability and Mental Health Needs Residential Care Contract for a period of two years from 15 June 2026 to 14 June 2026; and
b) **DELEGATE** authority to the Corporate Director, Adult Social Care and Health to take other relevant actions, including but not limited to finalising the terms of and entering into required contracts or other legal agreements, as necessary to implement the decision

Reasons for decision: The Learning Disability, Physical Disability and Mental Health (LDPDMH) Residential Care Contract commenced in June 2020, for an initial period of four years, with two x two-year options to extend. In February 2024 the first of the two year extensions was utilised (Decision Number 24/00004) to extend the contract to 14 June 2026.

This decision seeks extend the current contract for a further two yeas, using the permissible contract extensions. The extension will maintain service continuity for people with learning disabilities, physical disabilities and mental health needs while the Council undertakes recommissioning to implement a more integrated and sustainable model of care. This approach avoids disruption, supports value for money, and provides flexibility during the transition.

Approval of a two-year extension provides the necessary assurance and flexibility, ensuring continuity of care in the event of any delays to the implementation of the new model of care. This approach mitigates the risk of service disruption and avoids the need for a further key decision, while supporting a stable and well-managed transition to the new Supported Accommodation and Residential Living Service model.

Financial implications: The annual cost of the contract is £86,505,815 per annum and for the proposed two year extension the cost will be £173,011,630.

All placements are funded from the adult social care budget.

Cost analysis needs to be undertaken to overcome the challenges of determining the full cost of the contract i.e., breakdown of placement costs, budget contributions and system errors. Adequate finance advice and resource is required to ensure a collaborative approach to determine a robust fee model and pricing guide with the identification of any financial risk.

A new model for commissioning residential placements will be developed. This will inform the maximisation of support delivery from shared hours within the residential home, reducing the need to commission personalised one to one hours. This will support a sustainable model for both the provider and the Council. The extension will allow this activity to be completed.

These are demand driven services and due to increases in complexity, demand and inflation, requests for higher rates have increased. It is recognised that during the contract extension period, mitigations will be put in place to help halt the increased spend to the service through the development of a robust savings action plan. This will require a collaborative approach across KCC and NHS Kent and Medway Integrated Care (ICB) colleagues and proactively engaging with providers to determine fair costs for both legacy and new placements.

Legal implications: The Council commissions services from the independent sector to meet the needs of individuals deemed to be eligible in accordance with and following a Care Act assessment. If the contract ends the Council will be pressured to fully meet its statutory obligation under the Care Act with regards to providing a high quality, safe service at an affordable price.

The additional extension is available to be utilised within this contract. The additional extensions were included in the Contract/PIN Notice advertising the original procurement of these services, and therefore the extensions are permissible and are compliant under the PCR 2015 regulations.

The Council is required to adhere to the Procurement Act 2023 with the requirement to use framework contracts, limiting the use of individual spot contracts.

A clause will be written into the LDPDMH Residential Care Contract extension to allow the Council to terminate the contract when appropriate and to fit in with the mobilisation of the new Supported Accommodation and Residential Living Service Contract.

Equalities implications: An Equality Impact Assessment (EQIA) was completed as part of the original tender exercise. The EQIA has been reviewed and is still relevant as no changes to the contract are being made during the further extension period.

Data Protection implications: A Data Protection Impact Assessment (DPIA) was completed at the time of tender and there are no new data protection implications to be considered.

Cabinet Committee recommendations and other consultation: The proposed decision will be considered at the Adult Social Care and Public Health Cabinet Committee on 21 January 2026 and the outcome included in the decision paperwork which the Cabinet Member will be asked to sign.

Any alternatives considered and rejected:
The Council can choose not to extend the current contract. However, there are significant risks to choosing this option which have been identified and set out below

- The contract would need to be recommissioned on a like for like basis with no changes to the delivery model. There will be no opportunity to include residential care homes within the new contractual framework if the additional two year extension is not utilised.
- A lack of robust fee setting mechanisms and contractual leverage may result in a significant increase in placement costs, which will be challenging to control. Savings targets set out by the Council and to be met through greater partnership working and negotiation will be difficult to achieve through spot purchasing agreements, and providers will be within their right to give notice on individual placements that may be hard to source at an affordable price.
- Reputational: A shift to partnership working with providers will be challenged as the expectation is that the contractual arrangements with the authority will be maintained due to the mutual benefits to both parties. People using this service expect a robust oversight of the contract and the perception will be that this is not the case if the service is not part of a Kent County Council (KCC) contractual framework.
- Resource Implications: If the contract ends there will be a requirement for the review, renegotiation and repurchasing of all individual placements with new contract and terms and conditions established. This will also require significant system and process updates

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Any interest declared when the decision was taken and any dispensation granted by the Proper Officer:

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Signed Date

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KENT COUNTY COUNCIL
EQUALITY ANALYSIS / IMPACT ASSESSMENT (EqIA)

This document is available in other formats, please contact Jennie.kennedy@Kent.gov.uk if you require this in another format or telephone 03000 415380.

Directorate:
Adult Social Care and Health

Name of policy, procedure, project or service
Recommissioning of Residential Care Home services for People with a Learning Disability, People a Physical Disability and people with Mental Health Needs.

What is being assessed?
This EqIA assesses the impact of the new tendered contract on residents who are living in residential care homes, either on a long or short term basis.

Responsible Owner/ Senior Officer
DMT representative, Penny Southern, Interim Corporate Director
Senior Responsible Officer, Clare Maynard, Head of Commissioning Portfolio– Communities, Older and Vulnerable People
Commissioning Lead, Paula Watson, Senior Commissioner

Date of Initial Screening
06 June 2018.

Date of Full EqIA: 8 February 2016

Version	Comments/ Author	Date	Comment
1	Paula Watson	06/6/18	First draft
	A Agyepong	20/6/18	Comments for review

Characteristic	Could this policy, procedure, project or service, or any proposed changes to it, affects this group less favourably than others in Kent? YES/NO If yes how?	Assessment of potential impact HIGH/MEDIUM LOW/NONE UNKNOWN		Provide details: a) Is internal action required? If yes what? b) Is further assessment required? If yes, why?	Could this policy, procedure, project or service promote equal opportunities for this group? YES/NO - Explain how good practice can promote equal opportunities
		Positive	Negative	Internal action must be included in Action Plan	If yes you must provide detail
Age	NO, 1)The project applies to people with a learning disability, physical disability or people with mental health needs over 18 years and therefore this age group will be the only one which is impacted by the letting of the contract. 2) If the current care home provider chooses not to tender or is unsuccessful in their tender or they decide they no longer wish to do business with KCC, they may give notice to current residents. A small number of residents may be required to move to another residential care home. By definition, as this client group have a disability there will be a disproportionate impact on them compared to other residents of the County.	Medium	High for the small number who could be affected. But this will be only in limited cases, if at all.	a) Internal action is required. All providers with existing KCC placements will be encouraged and supported to tender for the new contract. 2) Where current providers choose not to tender, negotiation will take place with the provider to agree a service continuity plan. Only in exceptional circumstances will residents be moved. In the event that a move is required, an action plan will be drawn up for each of the residents affected by this decision. The risk of anxiety for residents, relatives and carers will be minimised by providing appropriate assurances and through involving affected residents in action planning. This process will be managed by Care Managers who have a good knowledge of their clients' needs and a dedicated team of purchasers and commissioners who have knowledge and understanding of the average price of care in that area and will know the market. It is not intended that there be any impact on new people going into residential	Yes. 1) The intention of the letting the new contract to ensure there is more equitable provision of residential care across Kent at an affordable price. The relet also aims to commission services where there are gaps in current provision for certain specialist needs. Both these actions will result in a positive impact for people over 18 years with disabilities and mental health needs. An online Care Directory has been developed for this purpose and will provide information, advice and guidance on all available services, both those contracted and those who choose not to tender for a contract.

	However**, the intention is that moves will only happen in exceptional circumstances,** but this could cause anxiety and disruption. No change will arise if the existing residential provider is successful in their bid.			care. This EqIA will be updated if the proposed service is amended in a way that could affect this group. b) No further assessment is required.	Promotion of equality, human rights and equal opportunities will be reflected in the new contract service specification and terms and conditions that will ensure that this group of service users receive services dedicated to their needs. Quality of care and good practice can be monitored and improved through regular monitoring of all care homes. Service users, their families and carers should have better information about the contracted and non-contracted homes being commissioned on their behalf. It is expected that quality will improve through making price reviews more robust and transparent. Price reviews will allow providers to identify financial difficulties and consideration of price reviews will take place when it is clear that quality and cost issues are directly linked. Based on the implementation of the pricing decision the EqIA will be kept under review.
Disability	See above	Medium	Medium	Action will be taken when there are challenges in communicating with family members as well as residents who have learning disabilities, physical disabilities, mental health needs, sensory impairments, appropriate communication methods will be	Yes. It is expected that people with greater physical disability and people with Challenging behaviour are likely to be placed in newer homes or purpose built accommodation. There are a number of care homes that are

				used for all.	converted dwellings which have smaller corridors and stairs/steps and therefore people will struggle to mobilise or use the environment effectively in some of the older care homes. It is also known that the use of specialist equipment in smaller homes is more difficult to use.
Sex	No	Low	Low	The tender will not impact on the availability of services across Sex.	Yes – equalities must be promoted through ensuring that care providers comply with the contract specification for ensuring equality on the basis of Sex.
Gender identity	No.	Low	Low	No.	Yes – equalities must be promoted through ensuring that care providers comply with the contract specification for ensuring equality for all gender groups.
Race	No.	Low	Low	Action will be taken when there are challenges in communicating with people for whom English is not their first language or those whose knowledge of English is limited.	Yes – equalities must be promoted through ensuring that care providers comply with the contract specification for ensuring equality for all races.
Religion or belief	No.	Low	Low	No.	Yes – equalities must be promoted through ensuring that care providers comply with the contract specification for ensuring equality for all religious or belief groups.
Sexual orientation	No.	Low	Low	No.	Yes – equalities must be promoted through ensuring that care providers comply with the contract specification for ensuring equality for all sexual orientations.
Pregnancy and maternity	No.	Low	Low	No.	Not applicable
Marriage and Civil Partnerships	No.	Low	Low	No.	Yes – equalities must be promoted through ensuring that care providers comply with the contract specification for ensuring equality for marriage and civil

					partnerships.
Carer's responsibilities	No	Low	Low		Improved commissioning of residential services across Kent may benefit carers as identifying a home for the cared for should improve and there will be more equitable provision of services across the county. The new contract aims to commission residential respite services which will potentially have a positive impact on carers as it will improve the availability of respite care.

Part 1: INITIAL SCREENING

Proportionality - Based on the answers in the above screening grid what weighting would you ascribe to this function – see Risk Matrix

Low	Medium	High
Low relevance or Insufficient information/evidence to make a judgement.	Medium relevance or Insufficient information/evidence to make a Judgement.	High relevance to equality, /likely to have adverse impact on protected groups

State rating & reasons
Medium – because the potential impact for the vast majority of people living in residential care homes will have a limited impact on them. Assessed as medium, as there may be a limited number of cases where discussion and negotiation would need to take place with residential providers who are not awarded a contract or did not tender.

Context
The tender of the Residential Care Contract for people with LDPDMH supports local and national strategies as follows:

The Accommodation Strategy
The Strategy was developed launched in July 2014. It clearly articulates the agreed direction of travel in relation to residential care home provision. The conclusion of the Strategy for people with LDPHMH is to:

- Increase the provision of specialist and specialist plus homes and reduce the provision of standard Mid and high category residential homes.
- Remodel services to be better geared up to accommodating people with specialist needs.

The new tender is in line with the Authority's responsibilities under the Care Act 2014 and strategic drives as set out the KCC Strategic Vision published in March 2015 in and contributes to one of the key strategic outcomes of 'Older and vulnerable residents feel socially included, residents have greater choice and control over the health and social care they receive'.
Commissioning were tasked to review these services as part of the Accommodation Strategy.

Aims and Objectives
The aim of this tender is to have the new Residential Care Home contract for People with LDPDMH in place by April 2019, with the objectives of:

- Providing good outcomes for residents.
- Achieving enough capacity and coverage.
- Ensuring a consistent and quality service countywide.
- Delivering value for money.

Beneficiaries
The Residential Care Home service for people with a Learning Disability, people with a Physical Disability and people with Mental Health needs is available to people who are assessed as requiring this type residential care by the local authority.

Carers and families will also benefit from these residential care services by knowing that their family members are well cared for and being able to see far more transparency in the information collected and provided.

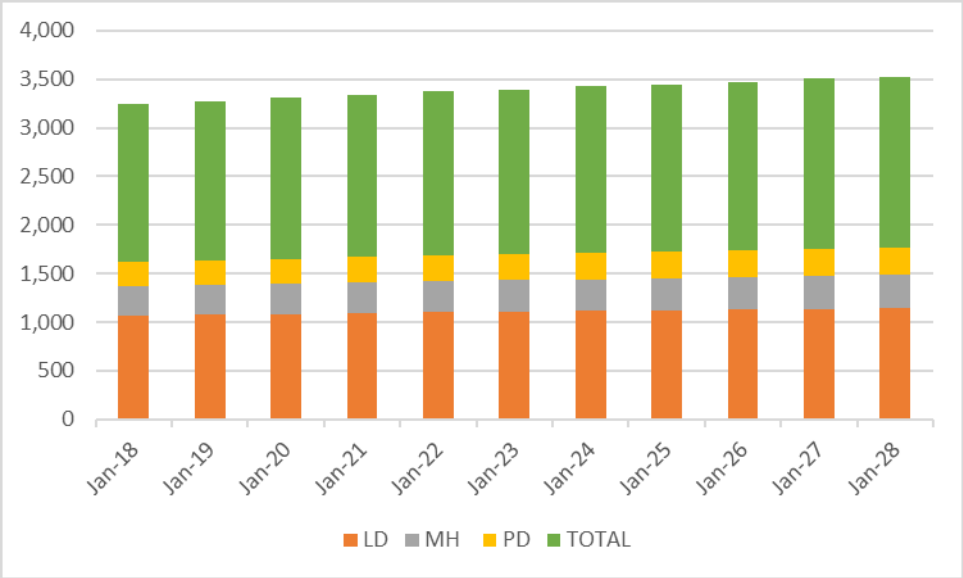
Information and Data
All KCC funded service users must meet the eligibility criteria to receive a residential care service.

Age profile of current placements

Age Range	LD	PD	MH
18-24	70	10	2
25-34	160	20	15
35-44	188	28	29
45-54	260	60	61
55-64	196	100	90
65-74	119	45	71
75Plus	42	17	18
	1035	280	286

Average length of stay in residential services	Years
LD	10
PD	7
MH	6

Trend based with mitigation scenario forecast by client group by year



Increase in overall placements over a 10-year period 139
69 LD, 31 PD, 39 MH

Current number of residential beds available in Kent

	LD	PD	MH	Total
Existing Residential Homes	2038	222	428	2688

The majority of residential care clients are people with a learning disability. There are around 1,600 people with LDPDMH who are in residential care in Kent.

LD clients make up the majority of placements, but as age increases the proportion of clients with physical disability or mental health increases. Some of this movement is a movement of clients from one category to another, with a higher proportion of LD clients aged 55 and over. The number of PD clients in residential care peaks in the age range 55-64 and drops sharply in the age range 65-74.

But also, in line with KCC's strategy, residential care is considered the last resort and the Social Care, Health & Wellbeing Directorate aims is to keep people at home and independent for as long as is possible.

Therefore, in line with KCC's strategy, if the need for residential care placements can reduce through prevention and policies. If future demand by 2028 is 10% less across all client groups and all ages up to age 65. This leads to an increase of 139 overall placements over a 10-year period up to 2028.

Detailed data on the LDPDMH care home market is set out in Kent's Accommodation Strategy. The evidence indicates there is sufficient alternative supply of residential care available across Kent for the homes that may close.

The EQiA for the Accommodation Strategy can be found via the following link:

http://www.kent.gov.uk/__data/assets/pdf_file/0015/14460/Accommodation-Strategy-equality-analysis-impact-assessment.pdf

Scope

The current contracts for residential care services for people with a physical disability, people with learning disabilities and people with mental health needs were last let in 2002 for the Disabilities contract and 2004 for the Mental Health contract.

The market for residential care services within Kent is disparate and as the existing contracts have not been let for over 14 years, the sector may not be familiar with tendering for services within Kent. The introduction of the Care Act 2014 in April 2015 brought a number of historic laws into one Act. Therefore, the contracts are no longer fit for purpose or meet the needs of the Council.

The new contract will procure both long and short term residential care provision and will be in place for a period of 4 years with an option to extend the contract for a further two years and after that, another two years.

Involvement and Engagement

There needs to be a commitment to involving those who use these services in planning, commissioning and delivery. Engagement is required with both internal and external; stakeholders. Those that are internal need to be aware and understand all of the relevant changes to ensure the new contract is implemented efficiently and effectively.

Those that are external and connected to the Council will include the providers of care themselves. It is vital that engagement is conducted prior to the tender exercise for this contract and throughout the contract term. Early engagement will allow providers the time to prepare for the necessary tender submission and ask any questions of the Council to remove all ambiguity. This will also allow the benefits to be promoted to encourage providers to join the contract. Furthermore, feedback can be collected and, if necessary, implemented before anything is formally published.

Strategic Commissioning will hold market events in 2018. These market events will introduce the tender which will include the timescales, expectations and requirements to strengthen the relationship with the market and continue to collaborate on emerging issues.

Service User engagement – plans include service user engagement through; Healthwatch, the Learning Disability Partnership Board and District Partnership Groups. PD and MH forums

To avoid anxiety and concern for current residents, consultation with them will take place when it is appropriate and when the likely impact on residents is known.

During the tender period, residents will continue to receive the same service. Where, as a result of this tender, there is a financial impact on residents, engagement will take place with those affected and their families at the most appropriate time and at a localised level.

Throughout the engagement process where equality issues have been raised they either have or will be added to this EqIA. As it stands, there have been no equality issues raised as part of the engagement process.

Potential Impact
For the vast majority of current residents, this tender will have no material impact on them at all. But it is anticipated that the new contract will have a positive impact and given the population of the residential market it will have a greater impact in relation to Disability groups. This new contract points to KCC's commitment to transform the service over coming years.

Adverse Impact
In very exceptional circumstances a small number of residents may lose continuity of care in the event that their current provider does not tender or is not awarded a contract or refuses to accept the terms and conditions of KCC. A change of this kind and/or an amendment to the contribution that they pay may cause anxiety and disruption to existing relationships. This will be addressed by the development of an individual service continuation plan to help minimise disruption and offer a number of options. It is not expected that this will affect a large number of residents.

In the unlikely event that, following discussions, a home does decide that it will not continue to provide a service for existing (current) residents, KCC will work closely with the resident, their carers and relatives and the home, to ensure there is a smooth transition to a home which meets their needs.

Positive Impact
The tender provides the opportunity to review and update the contract documentation to place more emphasis on:

- Equality and the minimisation of discrimination;

- Protecting the service user's Human Rights; and
- Reinforcing provider responsibility.

These positive impacts will contribute to raise the quality and standard of service delivery to the benefit of all service users.

It is anticipated that there will be a more equitable provision of services across the county and services here gaps in provision have been identified.

The impact will be evidence through performance monitoring through key performance indicators.

JUDGEMENT

Option 2 – Internal Action Required

There is potential for adverse impact on particular groups.

The tender of the Residential Care Home Contracts for people with LDPDMH is not a complete redesign of service and does not directly impact on the protected characteristics of individuals.

Given the population of residential care homes, there will be an impact on people with disabilities and people with mental health needs. There could be some providers choosing to leave the market and in these circumstances, KCC would find the most appropriate alternative care provision for them and following assessment, a different service may be required.

Action Plan
The Action Plan indicates a requirement to develop service continuation plans to minimise any disruption and to offer a choice of options for affected individuals.

Monitoring and Review
The development of an exit strategy has been identified on the Risk Log for this tender and will be built into the implementation timetable to ensure this occurs. Monitoring and review requirements will be developed as part of the exit strategy.

The working group allocated to this project will regularly review this EqIA and agree further actions as required.

Attestation
I have read and paid due regard to the Equality Analysis/Impact Assessment concerning the Recommissioning of Residential Care Home services for People with a Learning Disability, People a Physical Disability and People with Mental Health Needs.
I agree with risk rating and the actions to mitigate any adverse impact(s) that has /have been identified.

Signed: **Name:** Clare Maynard

June 2018

Job Title: Head of Commissioning Portfolio– Communities, Older and Vulnerable People

Date:

DMT Member

Signed: **Name*:*** Penny Southern

Job Title: Interim Corporate Director

Date:

Equality Impact Assessment Action Plan

Protected Characteristic	Issues identified	Action to be taken	Expected outcomes	Owner	Timescale	Cost implications
Age, Disability and Race	Current service users may see a change to either their care provider or cost which may cause anxiety and disruption to existing relationships. It is not intended that people will move, however if the provider requests that the individual moves there will be little option	A service continuation plan will be developed for service users affected. Assurances will be provided and impact will be discussed. All service users affected will be fully engaged in any move on plans, as will relatives. Communication will be provided in a range of texts, formats suitable for people with a disability or sensory impairments or for those whose first language is not English or if this is limited.	Work towards minimising disruption to service users. Service users and their family carers will be informed and have the opportunity to influence changes that affect them.	DCALDMH / Assistant Directors	Development is in progress.	Adult Purchasing Team already in place. Care Management time.
Age and Disability	New service users will be better supported to secure	Yes, the purchasing process will offer equal opportunities	It is intended that this process will be managed by a	DCALDMH / Assistant Directors	Development is in progress.	Adult Purchasing Team is already in place.

	residential care placements. This will allay fears and provide support at a difficult time.	for all providers.	dedicated team of purchasers who have knowledge and understanding of the average price of care in that area and will know the market. It is not intended that there be any impact on new people going into residential care.			

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From:	Diane Morton, Cabinet Member for Adult Social Care and Public Health Sarah Hammond, Corporate Director Adult Social Care and Health
To:	Adult Social Care and Public Health Cabinet Committee – 21 January 2026
Subject:	**Potential Fee Uplifts for Adult Social Care Providers for 2026/2027**
Decision no:	**25/00118**
Key Decision :	It affects more than 2 Electoral Divisions It involves expenditure or savings of maximum £1m – including if over several phases
Classification:	Unrestricted Report – Exempt Appendix
Past Pathway of report:	N/A
Future Pathway of report:	Cabinet Member Decision
Electoral Division:	All

Is the decision eligible for call-in? *Yes*

Summary: This report sets out the proposed approach to any, potential fee uplifts for Adult Social Care providers for 2026/27, reflecting the requirement for the Council to meet its statutory duties.

The Adult Social Care and Public Health Cabinet Committee is asked to **CONSIDER** and **ENDORSE** or make **RECOMMENDATIONS** to the Cabinet Member for Adult Social Care and Public Health in relation to the proposed decision as detailed in the attached Proposed Record of Decision document (Appendix A) but subject to the Council completing its market analysis in compliance with its Statutory Duties as detailed in the report.

1. Introduction

1.1 This report sets out the proposed approach to fee uplifts for Adult Social Care providers for 2026/2027.

1.2 The Council has the following statutory duties under The Care Act 2014 (together defined as its “Care Act Duties”) which require local authorities to have regard to the sustainability of the social care market. Those duties underpin and must inform any decision of the Council in respect of uplifts applicable to its social care contracts.

1.2.1 Legal Duty

The duties described below outline the legal context relevant to the Council's consideration of fee setting for adult social care.

Statutory duties under the Care Act 2014

The Care Act 2014 provides the legal framework for adult social care in England. When considering fee uplifts and wider commissioning decisions, the Council must have regard to a number of statutory duties.

1. The wellbeing principle (section 1)

The Council must promote individual wellbeing when carrying out its functions under the Act. This includes matters such as personal dignity, health and emotional wellbeing, protection from abuse and neglect, family and personal relationships, suitability of accommodation and the individual's control over day to day life.

2. Duty to provide information and advice (section 4)

The Council must ensure that people can access clear, impartial information and advice about care and support. This includes information about available services, how to access them, and how the local care market operates.

3. Market shaping and sustainability duty (section 5)

Section 5 places a strategic duty on the Council to support a care market that is diverse, sustainable and able to offer high quality services. In meeting this duty, the Council must have regard to:

- the effective and efficient operation of the local care market
- the sustainability of the market as a whole
- the availability of a variety of providers and services
- the promotion of choice, control and independence
- the need for a capable, appropriately rewarded workforce
- the role of innovation and community based provision
- the need for fee levels that enable providers to meet statutory requirements and deliver safe, good quality care.

This duty applies to services for adults with care and support needs and for carers.

1.3 The Council has carried out and continues to carry out market analysis in line with its mandatory duties (Chapter 4 of the Care and Support Statutory Guidance explains how local authorities must meet their duty under section 5 of the Care Act 2014 to promote the efficient and effective operation of the adult social care market). In order to comply with its Care Act duties, the Council is currently engaged in that process although it is not yet completed. The Council had monthly meetings with the market in 2025 and the Council met with the market in December 2025 specifically in relation to uplifts. The market has requested a further meeting with the Council, which given the Council's committee time tabling will necessarily be held after this report is published on 13 January 2026.

1.4 Compliance with its Care Act duties underpins and is integral to any decision of the Council regarding uplifts. Necessarily the recommendations that are made to the Cabinet Member for Adult Social Care and Public Health will only be drafted and finalised once the Council has completed its market analysis exercise and following agreement of the budget at County Council on 12 February 2026. Depending on the conclusion of the market analysis exercise, the recommendations set out in this report as of 13 January 2026 therefore may change.

1.5 The recommendations set out in this report as at 13 January 2026 are made on the basis of the information obtained and market analysis conducted as at and to that date. Any percentage uplifts proposed are therefore provisional. Any consideration, endorsement and recommendations of the Adult Social Care and Public Health Cabinet Committee to the Cabinet Member for Adult Social Care and Public Health are therefore made in the context of the information available on 13 January 2026 and should only be considered in that context.

1.6 The Council has engaged and continues to engage in conducting market analysis and notes that adult social care providers continue to experience rising employment and operating costs, including increases to the National Living Wage, employer National Insurance contributions, and wider inflationary pressures. The Council recognises that these pressures result from policy and funding changes announced in the 2024 Government budget and has engaged with providers to understand their impact on service sustainability.

1.7 The Council is experiencing continued growth in demand for care and support, alongside increasing complexity and cost of individual packages. Between 2021/2022 and 2025/2026 the adult social care (ASC) budget has increased by £250m, increasing from 40.6% of Kent County Council's total budget to 46.3%. Over the same period the specific funding for adult social care through the additional 2% ASC council tax precept and government grants for social care in the Local Government Finance Settlement have increased by £207m (of which £98m is through the Social Care Grant which is intended to support spending pressures in both Adults and Children's social care). Despite these substantial increases in funding allocated to adult social care the budget has overspent each year since 2022/2023 with the overspend increasing from £29m (5.7% of the ASC budget) to £50m forecast for 2025-26 (7.1% of ASC budget).

1.8 These overspends have had to be covered from the Council's reserves. The most significant increases to the ASC budget, and the majority of the overspends, have been required to support the rising cost of placements in Older Persons' Residential and Nursing (OPRN) Care.

1.9 The provisional local government finance settlement 2026/2027 to 2028/2029 settlement was published on 17 December 2025 and includes some significant changes following consultation on fundamental reforms to local authority funding (Fair funding 2.0) over the summer. In regard to adult

social care, the reforms include consolidating the Social Care Grant and Market Sustainability and Improvement Fund into the Revenue Support Grant with funding allocated according to new and updated formulas for relative need and revised/updated adjustment for relative resources. The Local Authority Better Care Grant remains at the same level as 2025/2026 in cash terms and is paid as a separate Section 31 grant to be pooled with health. Reforms to Better Care Fund pooling will not be introduced until 2027/2028 alongside changes to the Better Care grant. These changes mean it will in future be no longer possible to separately identify the additional government funding for adult social care, although a ”notional adult social allocation” will be published (to date this has not yet been provided for 2026/27) which should be used as a reference point for budget setting alongside local priorities

1.10 In light of these factors, it is not affordable to apply full inflationary uplifts across all service areas without materially impacting the Council’s ability to meet its statutory duties. The proposed approach therefore represents a balanced and proportionate exercise of commissioning judgement, targeting limited resources where they deliver the greatest strategic benefit, while managing and mitigating risks to continuity of care and in accordance with the Council’s Care Act duties.

1.11 The Adult Social Care and Public Health Cabinet Committee is asked to consider and endorse the proposed, in principle provisional approach, recognising it involves difficult but necessary choices in order to protect service continuity, meet statutory obligations, and maintain the long-term sustainability of the adult social care system.

2. Background

2.1 Over recent years, the Council has made sustained investment in adult social care fee rates, including above-inflation uplifts in some years and targeted interventions to support and improve market stability. As a result, fee levels in a number of service areas are comparatively high when benchmarked against other local authorities.

2.2 The Council has applied differentiated approaches across service areas in response to market conditions in accordance with its Care Act Duties and affordability when considering further market investment. In 2024/2025, the Council applied a flat 4% uplift for framework providers and made additional provision to manage exceptional sustainability and continuity risks within the market.

2.3 In 2025/2026, the Council applied a differentiated approach to fee uplifts across adult social care services, including variable uplift rates for OPRN provision, a 4% uplift across other commissioned services, and increases to sleep-night payments in line with the National Minimum Wage (NMW). While sleep-in arrangements are subject to complex employment law considerations and are not uniformly required to be paid at National Living Wage (NLW) rates, the Council chose to reflect NLW increases in sleep-night

payments in recognition of workforce pressures and market stability considerations.

2.4 These decisions reflected the Council's ongoing commitment to market stability and investment in the market within the resources available at that time. The Department for Health and Social Care publishes comparative fee information. This shows that the provisional 2025 average fee Kent County Council (KCC) pays to external providers for residential care excluding nursing is £1,186.81 compared to a national average of £955.56. This represents an increase in Kent of 11.6% over the comparable figure for 2024 compared to a national average increase of 4.9%. This is on top of an increase in care fees in Kent of 20.2% between 2023 and 2024 compared to a national average of 8.5%. The fees for external providers including nursing care show similar increases with the provisional fee level for 2025 increasing in Kent by 11.2% on 2024 (compared to a national average of 4.9%), on top of increases between 2023 and 2024 of 14.7% (compared to national average of 7.0%)

2.5 Consultation and engagement with provider representative organisations, including the Kent Integrated Care Alliance (KICA) and the National Care Association (NCA) in November 2025, has highlighted significant concern regarding the cumulative impact of rising employment and operating costs. Providers have indicated that Consumer Price Index (CPI) -level uplift would represent a minimum position to maintain financial sustainability, with higher uplifts required in some service areas.

2.6 The Council recognises that ongoing cost pressures may increase financial strain for some providers and could, if unmanaged, affect capacity and choice within parts of the market. The Council has well-established arrangements to manage provider failure and ensure continuity of care and will continue to actively monitor market conditions and intervene where there is demonstrable risk to service continuity, subject to affordability and available resources.

2.7 Any such intervention will be targeted, proportionate and time-limited, and will be considered alongside alternative commissioning and operational mitigations to ensure the needs of people who draw on care and support continue to be met.

2.8 ASC remains a priority for the Council. Notwithstanding National funding has not kept pace with the scale of demand and cost pressures facing local authorities, limiting the Council's ability to fully absorb inflationary increases, the Council must nevertheless continue to comply with its Care Act duties. The Cabinet Member for Adult Social Care and Public Health will continue to work with provider representatives in lobbying the Government to address these risks.

2.9 Alongside the Council's Care Act Duties, the Council's contracts contain terms related to uplifts which also need to be applied. Contract terms vary across service areas. Any uplifts necessary to comply with the Council's

statutory duties will be applied to contracts but would not be in addition to an uplift that may be applied as part of the contract terms.

2.10 Fee uplifts need to be finalised by 1 March 2026 to enable implementation within the Council's Adult Social Care case management system in time for providers to submit invoices for revised rates from April 2026. The proposals set out in this report are subject to approval of the budget by the County Council on 12 February 2026.

3. Options Considered

3.1 The Council must comply with its Care Act Duties before considering applying (or not applying as the case may be) any uplifts. These options have been considered on the basis of the information available to the Council at 13 January 2026 but are subject to amendment following completion of the Council's market analysis in accordance with its Care Act Duties. Any percentage uplifts proposed are therefore provisional.

3.2 Apply no fee uplifts across all adult social care services

3.2.1 This option was considered but discounted. This approach would not align with the Council's Care Act Duties to have regard to market sustainability, nor with its commissioning intention to prioritise prevention, independence, and demand management.

3.3 Apply a single standard percentage uplift across all services

3.3.1 This option was also considered but rejected on the basis of the conclusions of the market analysis as of 13 January 2026.

3.4 Apply differentiated uplifts (if any) aligned to Care Act Duties (Recommended)

3.4.1 Under this option, fee uplifts (if any) are applied in accordance with the Council's Care Act Duties. This could result in differentiated uplifts across contract types, reflecting the fact that cost pressures, market conditions, and strategic importance are not uniform across the adult social care market. The continuing market analysis will inform and shape this.

3.4.2 In particular, the proposed approach:

- prioritises investment in care at home services, reflecting their role in supporting people to remain independent and in managing demand for higher-cost care;
- proposes to apply more modest uplifts in residential and supported living services for working age adults, recognising the significant existing investment in these services, the bespoke nature of provision, and the need to balance market sustainability and continuity of care; and
- retains targeted, proportionate and time-limited mitigations to manage clear and evidenced risks to continuity of care.

3.4.3 This approach enables the Council to meet its statutory duties and acknowledges that it is not affordable to fully meet provider expectations for inflationary uplift across all services beyond consideration of its Care Act Duties.

3.4.4 Non framework placements are commissioned on an individual basis, with pricing agreed at the point of placement to reflect the assessed needs of the individual and the specific service requirement. Subject to the completion of the market analysis and ensuring compliance with its statutory duties no general uplift is proposed for non framework provision.

3.5 Proposed Approach and Rationale by Contract Type

3.5.1 **Care and Support in the Home Services**
Proposed uplift: CPI as of December 2025 (framework providers only) subject to contract terms and statutory duties, as applicable.

Care and support in the home is a central component of the Council's commissioning strategy and plays a critical role in supporting people to remain independent, preventing escalation of need, and managing demand for higher-cost residential and nursing care. Investment in this service supports hospital discharge, reablement, and early intervention, and is therefore prioritised within the available resources.

Applying a proposed uplift through the framework reflects both the strategic importance of care at home services and the need to maintain capacity and workforce stability in a highly competitive labour market. Targeting investment through the framework supports agreed standards of quality, availability, and performance, and reinforces the integrity and effectiveness of the Council's commissioning arrangements.

3.5.2 **Residential Care (Learning Disability, Physical Disability and Mental Health)**
Proposed uplift: 2% (framework providers only)

Residential provision for working age adults supports individuals with complex needs and typically involves intensive staffing models and long-term placements where stability and continuity of care are critical.

The proposed 2% uplift represents a proportionate response that recognises the need to balance market sustainability and continuity of care. It supports stability within the commissioned market and enables the Council to continue actively reviewing placements to ensure care remains outcomes-focused, proportionate, and aligned with individual need.

3.5.3 **Supported Living Services**
Proposed uplift: 2% and an additional element to fund the increase in NLW for sleep-night provision only (framework providers only) subject to contract terms and statutory duties, as applicable.

Under the terms of the framework contract KCC is required to pay an uplift in sleep-night payments in line with the National Living Wage. However, the courts have ruled that National Living Wage requirements do not apply to sleep nights and therefore KCC contractual uplifts have been more generous than statutory wage requirements for this element of provision.

Supported living services are designed to promote independence, flexibility and community inclusion, and are typically commissioned on a bespoke basis to reflect individual outcomes and support models. Pricing is influenced by individual support design staffing resulting in variation across packages In recognition of specific employment cost pressures, sleep-night payments will be uplifted in line with the NLW. This ensures that providers are supported to meet statutory wage requirements for this element of provision.

3.5.4 **Older Person's Residential and Nursing Care**
Proposed uplift: No general uplift subject to contract terms and statutory duties, as applicable.

The Council is currently procuring a new Older Person's Residential and Nursing Care contract, with updated pricing informed by market analysis and commissioning intentions. The new contract is expected to be implemented from Summer 2026 and will apply to new placements.

Current market analysis indicates that there is a sustainable market to meet the care needs of individuals through the market as a whole.

3.5.5 **Everyday Life Activities:** Proposed: No general uplift - subject to contract terms and statutory duties, as applicable.

Everyday Life Activities services are commissioned to provide flexible, short-term and preventative support, with pricing that reflects local delivery models and lower workforce intensity than other regulated care services. Current market analysis indicates that there is a sustainable market to meet the care needs of individuals through the market as a whole.

3.5.6 **Other Adult Social Care Service Lines subject to contract terms and statutory duties, as applicable.**
Proposed uplift: 2%, subject to contract terms and statutory duties, as applicable.

Other adult social care service lines not specifically referenced elsewhere in this report cover a range of lower-volume or specialist services, a 2% uplift is proposed for these services.

3.5.7 **Direct Payments**
Proposed approach: provision for individual increases (no general uplift) subject to statutory duties, as applicable.

Direct Payments are designed to provide individuals with flexibility and choice in arranging their own care and support. The proposed provision of £2.2 m

enables the Council to respond to individual circumstances, including increases required to reflect NLW changes or changes in assessed need. Direct Payment rates will continue to be reviewed on an individual basis through care and support planning and review processes to ensure they remain sufficient to meet assessed needs, in line with the Care Act duties.

3.5.8 Non framework placements are commissioned on an individual basis, with pricing agreed at the point of placement to reflect the assessed needs of the individual and the specific service requirement. Subject to the completion of the market analysis and ensuring compliance with its statutory duties no general uplift is proposed for non framework provision. that all non-framework placements are subject to ongoing care and support planning, review and contract management.

4. Financial Implications

4.1 Current Financial Context

4.1.1 The Council continues to face significant and sustained financial pressure, driven by increasing demand for adult social care and rising complexity of need. Within this context, the Council has identified £9.917.3k as the provisional amount for adult social care fee uplifts and Direct Payment increases for 2026/2027. This reflects the application of the Council's statutory duties alongside its wider financial and governance responsibilities, ensuring that available resources are deployed in a way that prioritises the delivery of assessed needs and the sustainability of care provision.

4.2 Price Uplift Proposal

4.2.1 These proposals allow for differentiated uplifts across the main areas of adult social care provision, ascertained in accordance with the Council's Care Act duties.

4.2.2 The proposed uplifts across the main social care contract areas are as follows subject to contract terms and statutory duties, as applicable.

- Care and Support in the Home Service – CPI as of December 2025. (framework providers only)
- Supported Living Services– 2% and an additional element to fund the increase in NLW for sleep-night provision only (framework providers only)
- Residential Care (Learning Disability, Physical Disability and Mental Health) –2% (framework providers only)
- Older Person's Residential and Nursing Care – 0%
- Everyday Life Activities – 0%

4.2.3 Non framework placements are commissioned on an individual basis, with pricing agreed at the point of placement to reflect the assessed needs of the individual and the specific service requirement. Subject to the completion of the market analysis and ensuring compliance with its statutory duties no general uplift is proposed for non framework provision. that all non-framework placements are subject to ongoing care and support planning, review and contract management.

4.3 Budget Impact

4.3.1 Table 1 below sets out the proposed allocation of the uplift budget and its financial impact.

Table 1 – Price Uplift: Budget Impact 2026/2027

Summary - Price Uplift Proposal	%
Care and Support in the Home Services	CPI
Supported Living Services	2% and an additional element for sleep nights
Residential Care (Learning Disability, Physical Disability and Mental Health)	2.0%
Older Person's Residential and Nursing	0.0%
Everyday Life Activities	0.0%
Other Service Lines	2.0%
Total	£7.7m
Provision for Direct Payments	£2.2m
Overall Total	£9,917.3

5. Legal implications

5.1 The Courts have confirmed that decisions which engage the section 5 market shaping duty may be subject to public law challenge, and that fee setting decisions form part of this framework where they have a direct effect on the sustainability and functioning of the care market. Recent case law, *R (SARCP) v Stoke on Trent City Council [2025],* has highlighted the importance of ensuring that decisions are supported by a clear and sufficiently complete evidential basis.

5.2 In making these decisions the Council must have regard to the Care and Support statutory guidance.

5.3 Additional confidential legal advice is attached as exempt Appendix 1

6. Equalities Implications

6.1 The Council must have regard to its Public Sector Equality Duty, and an Equalities Impact Assessment (EQIA) has been produced and is attached as Appendix 1. This is a live document and will continue to be updated as required.

7. Data Protection Implications

7.1 A Data Protection Impact Assessment is not required as there are no material changes to the way in which personal data is handled, nor the way in which it is used. Similarly, this work does not involve data profiling or changes to the way in which special category data is handled.

8. Conclusions

8.1 The Council recognises the very real pressures facing providers and has engaged, and continues to engage, with the sector to understand the impact of rising employment and operating costs. Providers have been clear that full inflationary uplifts would be their preferred position. However, it is not affordable for the Council to make additional investment in the sector beyond compliance with its statutory duties without materially undermining its ability to meet its wider statutory duties as a Council and manage demand across the wider system.

8.2 The provisional proposed approach to fee uplifts for 2026/2027, to apply any uplift determined in accordance with statutory duties (which includes market sustainability), is a balanced and evidence-based exercise which is ongoing. In developing these proposals, the Council has considered its duties under the Care Act 2014, including responsibilities in relation to market sustainability and continuity of care. While the Council cannot guarantee the financial sustainability of individual providers, it will continue to monitor market conditions and manage any risks to continuity of care and market stability through existing commissioning, contract management and operational arrangements, within the overall resources available.

8.3 Taken together, the provisional proposals set out in this report provide a reasonable and evidence-based framework for managing any fee uplifts in 2026/2027.

9. Recommendations

The Adult Social Care and Public Health Cabinet Committee is asked to **CONSIDER** and **ENDORSE** or make **RECOMMENDATIONS** to the Cabinet Member for Adult Social Care and Public Health in relation to the proposed decision as detailed in the attached Proposed Record of Decision document (Appendix A) but subject to the Council completing its market analysis in compliance with its Statutory Duties as detailed in the report.

10. Background Documents

None

11. Appendices

Appendix 1 Equality Impact Assessment
Exempt Appendix 1 – Confidential Legal Advice

12. Contact details

Report Author: Helen Gillivan Director of Adults and Integrated Commissioning 03000 417156 Helen.gillivan@kent.gov.uk	Director: Sarah Hammond Corporate Director, Adult Social Care and Health 03000 411488 Sarah.hammond@kent.gov.uk

KENT COUNTY COUNCIL – PROPOSED RECORD OF DECISION

DECISION TO BE TAKEN BY:	DECISION NUMBER:
Diane Morton, Cabinet Member for Adult Social Care and Public Health	25/00118

Executive Decision – key

25/00118 – Fee Uplifts for Adult Social Care Providers for 2026/2027

Decision: As Cabinet Member for Adult Social Care and Public Health, I propose to:

a) **APPROVE** the fee uplifts for Adult Social Care Providers for 2026/2027; and
b) **DELEGATE** authority to the Corporate Director Adult Social Care and Health, in consultation with the Cabinet Member for Adult Social Care and Public Health to take all necessary actions within the approved budget allocation to implement the decision.

Reasons for decision: The Council has statutory duties under The Care Act 2014 (together defined as its "Care Act Duties") which require local authorities to have regard to the sustainability of the social care market. Those duties underpin and must inform any decision of the Council in respect of uplifts applicable to its social care contracts

Consultation and engagement with provider representative organisations, including the Kent Integrated Care Alliance (KICA) and the National Care Association (NCA) in November 2025, has highlighted significant concern regarding the cumulative impact of rising employment and operating costs. Providers have indicated that Consumer Price Index (CPI) level uplift would represent a minimum position to maintain financial sustainability, with higher uplifts required in some service areas.

The proposed approached for 2026/2027 is to apply differentiated uplifts Under this option, fee uplifts (if any) are applied in accordance with the Council's Care Act Duties. This could result in differentiated uplifts across contract types, reflecting the fact that cost pressures, market conditions, and strategic importance are not uniform across the adult social care market. The continuing market analysis will inform and shape this.

The Council must comply with its Care Act Duties before considering applying (or not applying as the case may be) any uplifts. These options have been considered on the basis of the information available to the Council at 13 January 2026 but are subject to amendment following completion of the Council's market analysis in accordance with its Care Act Duties. Any percentage uplifts proposed are therefore provisional.

Fee uplifts need to be finalised by 1 March 2026 to enable implementation within the Council's Adult Social Care case management system in time for providers to submit invoices for revised rates from April 2026. The proposals set out are subject to approval of the budget by the County Council on 12 February 2026.

Financial implications: The Council continues to face significant and sustained financial pressure, driven by increasing demand for adult social care and rising complexity of need. Within this context, the Council has identified £9.917.3k as the provisional amount for adult social care fee uplifts and Direct Payment increases for 2026/2027.

Legal implications: The Courts have confirmed that decisions which engage the section 5 market shaping duty may be subject to public law challenge, and that fee setting decisions form part of this framework where they have a direct effect on the sustainability and functioning of the care market.

Recent case law, *R (SARCP) v Stoke on Trent City Council [2025]* has highlighted the importance of ensuring that decisions are supported by a clear and sufficiently complete evidential basis.

In making these decisions the Council must have regard to the Care and Support statutory guidance.

Equalities implications: The Council must have regard to its Public Sector Equality Duty, and an Equalities Impact Assessment (EQIA) has been produced. This is a live document and will continue to be updated as required.

Data Protection implications: A Data Protection Impact Assessment is not required as there are no material changes to the way in which personal data is handled, nor the way in which it is used. Similarly, this work does not involve data profiling or changes to the way in which special category data is handled.

Cabinet Committee recommendations and other consultation: The proposed decision will be considered at the Adult Social Care and Public Health Cabinet Committee on 21 January 2026 and the outcome included in the decision paperwork which the Cabinet Member will be asked to sign.

Any alternatives considered and rejected:

- **Apply no fee uplifts across all adult social care services** - This option was considered but discounted. This approach would not align with the Council's Care Act Duties to have regard to market sustainability, nor with its commissioning intention to prioritise prevention, independence, and demand management.

- **Apply a single standard percentage uplift across all services -** This option was also considered but rejected on the basis of the conclusions of the market analysis as of 13 January 2026.

Any interest declared when the decision was taken and any dispensation granted by the Proper Officer:

.....	.....
Signed	Date

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From:	Diane Morton, Cabinet Member for Adult Social Care and Public Health Dr Anjan Ghosh, Director of Public Health
To:	Adult Social Care and Public Health Cabinet Committee – 21 January 2026
Subject:	Exercise Pegasus – Summary of Exercise
Classification:	Unrestricted
Past Pathway of Paper:	None
Future Pathway of Paper:	None

Summary: This report summarises the phases of Exercise Pegasus a four nations 'Tier 1' exercise to test the UK's preparedness for a future pandemic. The Kent and Medway Resilience Forum coordinated the local participation in the exercise. A full report will be published by the Government in 2026.

Recommendation(s): The Adult Social Care and Public Health Cabinet Committee is asked to **NOTE** and **COMMENT** on the content of this report.

1. Introduction

1.1 Exercise Pegasus, the 'Tier 1' national (four nations) pandemic preparedness exercise led by the Department of Health and Social Care (DHSC) with the UK Health Security Agency (UKHSA), concluded live participation in November 2025. The exercise has been designed to assess the progress since Covid-19 and test the UK's preparedness and capabilities arrangements to response to future pandemics.

1.2 Exercise Pegasus has been the largest simulation of a pandemic in UK history, involving every government department, the devolved governments, representation from arms-length bodies, Local Resilience Fora, and the engagement of businesses, academics, and external stakeholders.

1.3 In Kent and Medway, the Exercise was coordinated by the Kent and Medway Resilience Forum (KMRF) on behalf of participating system partners.

2 Definition of Pandemics

2.1 Pandemics are the emergence of a novel pathogen (virus, bacteria, fungi or other organisms that cause disease) that is spreading quickly around the world due to lack of population immunity.

2.2 Previous pandemics include:

- 1918 - Spanish flu

- 1957 - Asian flu
- 1968 - Hong Kong flu
- 2009 - H1N1 swine flu
- 2020 - COVID-19

2.3 A pandemic remains the top risk of the UK's National Risk Register, and experts are clear that it is a case of 'when' and not 'if' the UK will experience another pandemic.

3. National Pandemic Response Plan

3.1 The Department of Health and Social Care are leading overall on the Pandemic Preparedness Programme, in partnership with the NHS, UKHSA, Cabinet Office, and other Arm's Length Bodies.

3.2 Work is underway to develop a national Pandemic Response Plan which will set out national roles and responsibilities, and how the health and social care system will respond to a pandemic occurring and for different routes of transmission. A date for the publication of a national Pandemic Response Plan has not been set yet.

4. Exercise Pegasus Core Objectives

4.1 Exercise decision making processes for measures to contain, control or mitigate the impact of a pandemic including how relevant priority lessons from previous civil emergency exercises and outbreaks of disease have been embedded.

4.2 Exploring the impact of inequalities, and their consideration within pandemic decision making.

4.3 Investigate likely impacts of government decision on the health and care system, local responders, communities, businesses, civil society and the general public.

4.4 Examine processes for the scaling up of relevant capabilities that would be needed as part of a cross-government pandemic response.

4.5 Investigate the effectiveness of coordination, including the exchange of information flows, between different tiers in the UK response.

4.6 Test the strategic response to disinformation and misinformation.

4.7 Enable and support local exercising of selected capabilities and response issues.

4.8 Identify and report on relevant areas of learning to impact future pandemic preparedness.

5. Stages of Exercise Pegasus and Scenarios

5.1 Across three phases, held in September, October and November, participants were challenged to respond across the key phases of a pandemic - emergence, containment and mitigation. A fourth phase (recovery) is planned for 2026.

- Phase 1 Emergence – cases detected globally and initial assessment of a few 'hot spots' within UK.
- Phase 2 Containment – disease continues to spread globally with several large ‘hot spots’ in the UK that impact social behaviour.
- Phase 3 Mitigation - there is widespread impact across the UK which causes significant impact on ‘normal life’ and public services.

5.2 Exercise Pegasus was based on a novel enterovirus originating from a fictional island. Enteroviruses are a group of viruses that usually cause mild illnesses but can lead to serious conditions such as meningitis or acute flaccid paralysis. Whilst the exercise used a single disease to drive the scenario, learning will be applicable across a range of diseases and modes of transmission. The government continues to plan and prepare for a range of pandemic and emerging infectious disease scenarios.

5.3 Local Resilience Fora, including the KMRF were requested to participate in the exercise through completion of a workbook for each of the exercise phases.

6. Next Steps

6.1 KCC Public Health are leading on the development of a KMRF Pandemic Response Framework. The Framework will supplement the KCC Emergency Response Framework.

6.2 The draft Framework will undergo a consultation process led by the KMRF in early 2026.

6.3 The UK Government will publish a report on Exercise Pegasus in 2026.

6.4 A date for the completion of the national Pandemic Response Plan is not yet known.

7. Conclusions

7.1 Exercise Pegasus, a national exercise to test the UK’s preparedness for a future pandemic was run in the autumn of 2025. The Kent and Medway Resilience Forum coordinated the participation of local system partners. A full report by the UK Government will be published in 2026.

7.2 KCC Public Health are leading on the development of a KMRF Pandemic Response Framework that will supplement the KCC Emergency Response Framework.

8. Recommendation

8.1 The Adult Social Care and Public Health Cabinet Committee is asked to **NOTE** and **COMMENT** the content of this report.

9. Report Author

Dr Ellen Schwartz
Deputy Director of Public Health
Ellen.schwartz@kent.gov.uk

Relevant Director

Dr Anjan Ghosh
Director of Public Health
03000 412633
anjan.ghosh@kent.gov.uk

ADULT SOCIAL CARE & PUBLIC HEALTH CABINET COMMITTEE
WORK PROGRAMME 2024/25

	21 January 2026 at 2pm		
1	Intro/ Web announcement	Standing Item	
2	Apologies and Subs	Standing Item	
3	Declaration of Interest	Standing Item	
4	Minutes	Standing Item	
5	Cabinet Member, Corporate Director and Director of Public Health Verbal Updates	Standing Item	
6	Draft Revenue and Capital Budget and MTFP	Bi-Annual item	
7	Performance Dashboard	Bi-Annual item	
8	**25/00096 Kent Carers' Support Service Contract Award - Key Decision**	**Key Decision**	
9	**25/00105 Suicide and Self Harm Prevention Strategy 2026-20230 - Key Decision**	**Key Decision**	
10	**25/00106 Kent Drug & Alcohol Service – Key Decision**	**Key Decision**	
11	**25/00117 Learning Disability / Physical Disability and Mental Health Contract Extension – Key Decision**	**Key Decision**	
12	**25/00118 Adult Social Care Provider Fee Uplifts 2026/2027 – Key Decision**	**Key Decision**	
13	25/00107 Suicide Bereavement Service (Non-Key Decision)	**Non Key Decision**	
14	Exercise Pegasus Update		
15	Work Programme	Standing Item	

	11 March 2026 at 2pm		
1	Intro/ Web announcement	Standing Item	
2	Apologies and Subs	Standing Item	
3	Declaration of Interest	Standing Item	
4	Minutes	Standing Item	

5	Cabinet Member, Corporate Director and Director of Public Health Verbal Updates	Standing Item	
6	Performance Dashboard ASC & PH	Quarterly Item	
7	Risk Management	Annual	
8	Kent Pandemic Plan		
9	**Peoples' Voice Activity (including Healthwatch Kent) Contract – Key Decision**	**Key Decision**	
10			
11	Work Programme	Standing Item	

ASC Item	**Cabinet Committee to receive item**
Work Programme 2025	Standing Item
Key Decision Items	
Adult Social Care & Health Pressures	Annual Item
Performance Dashboard	September, November, March and May
Draft Revenue and Capital Budget and MTFP	November and January
Risk Management: Adult Social Care	March
Annual Complaints Report	November
PH Item	**Cabinet Committee to receive item**
Work Programme 2025	Standing Item
Key Decision Items	
Performance Dashboard	January, March, July, September
Update on Public Health Campaigns/Communications	Bi-Annually (January and July)
Draft Revenue and Capital Budget and MTFP	Bi-Annually (November and January)

Annual Report on Quality in Public Health, including Annual Complaints Report	Annually (November)
Risk Management report (with RAG ratings)	Annually (March)

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