**Agenda Number: 14**
**Part B**

NHS Medway

**MEDWAY PRIMARY CARE TRUST**

# A REPORT ON THE ENGAGEMENT EXERCISE AND CONSEQUENT CHANGES TO LIVE IT WELL – A STRATEGY FOR IMPROVING THE MENTAL HEALTH AND WELLBEING OF PEOPLE IN KENT AND MEDWAY

## 1. Overview

1.1 As the lead commissioner for mental health and wellbeing across the Kent and Medway PCTs and both Local Authorities, NHS Medway committed last year to leading development of a joint five year strategy to improve the mental health and wellbeing of the Kent and Medway population.

Our joint strategy began with setting a vision for improving mental health and wellbeing, which is supported by ten explicit commitments (see Appendix 1).

The commitments cover very many needs:-

- The need to address mental health and wellbeing in a joined up way across government agencies
- Employers
- The voluntary sector and citizens themselves
- The need to reduce stigma
- Discrimination
- Suicide
- Inequality in provision
- The need to achieve specific service improvements for those with common mental health problems
- To deliver personalisation
- To address specific needs for groups such as offenders or those with dual diagnosis

The full strategy outlined the sources and influences on shaping the vision and commitments, notably the Joint Strategic Needs

Assessment, the NSF for Mental Health, the publication of *New Horizons: A shared vision for mental health*, the pledges made by South East Coastal Strategic Health Authority in *Healthier People, Excellent Care*, and results from our own local engagement work.

1.2 A summary version of the strategy was produced at the beginning of April 2010. Detailed planning with the communications departments of the five key agencies was undertaken to maximise circulation of the summary document, and to give opportunity for feedback by the widest group of stakeholders. The summary version had a paper insert with feedback questions (to return by post), and the same questions could be completed online using surveymonkey. Details of the communication strategy to achieve maximum coverage is explained in Appendix 2. Particular efforts were made to ensure that we secured responses from groups representing clients with different disabilities (sensory, physical, learning) and (through the Community Development Workers) to secure Black Minority and Ethnic perspectives.

The formal engagement ran from 2nd April 2010 to 7th May 2010. A week after launch of the engagement process the Department of Health General Election purdah guidance arrived. Subsequent advertising of the strategy was constrained in view of guidance to be 'careful not to promote a government policy during the election campaign'. The full strategy was removed from NHS Medway's website on 12th April 2010. No face-to-face events were planned for this period.

However, we are very confident that there has been widespread distribution of the strategy summary document at the outset and during this engagement period.

An Equality Impact Assessment has been part of this engagement process, as detailed below.

## 2. Equality Impact Assessment

An initial screening was undertaken to assess the impact of this strategy on a comprehensive list of equalities issues:

- Race
- Gender
- Gender identity
- Disability

- Religion or belief
- Sexual orientation
- Age (including younger and older patients)
- Human Rights
- Socio-economic

2.1 Strategy Purpose and Focus

The two broad aims of the strategy were made clear for this screening, one preventative and one to improve services for those in receipt of them, and both being underpinned by better partnership working across public, voluntary and independent sector agencies, including employers.

The prime focus of the strategy is on:

- The residents of Kent and Medway, of whom one in four will have a mental health problem at some time in life.

- The residents at higher risk, in known higher risk groups, as identified in the Joint Strategic Needs Assessment (JSNA).

- Those with common mental health problems, such as anxiety or depression (between 163,000-190,000 people, as estimated in the JSNA), and of whom a quarter need treatment.

- Those with severe mental illness (about 60,000 people).

- Those with severe and enduring mental illness (about 12,000 people).

- The carers of all these people.

The intended effects across all residents will be around awareness-raising, building wellbeing behaviours, and better signposting to sources of help.

Higher risk groups will receive more targeted support, such as resilience-building, access to activities that build social capital, and self-referral access to talking therapies.

Service users, and carers, should benefit from more urgent access in times of crisis or urgent need, more services at home or closer to

home or in a community place of their choice, and more individually-oriented and personalised services over which they can exert more control.

The strategic intent is to remove barriers to accessing the benefits of this strategy – and many of these are operationalised in contracts with providers. For example, in 2010-11, our major Mental Health provider Kent and Medway NHS and Social Care Partnership Trust (KMPT) is contracted to provide ethnicity data on all clients using all services and for all those subject to any action under the Mental Health Act.

Community Development Workers over the last year have been working with KMPT to ensure they provide more culturally sensitive services.

2.2 Joint Strategic Needs Assessment – significant needs identified for distinct groups.

The Joint Strategic Needs Assessment, completed in Spring 2009, identified some equality groups with significant needs, either from a prevention or support perspective, or for specific service improvements or interventions.

Demographic change (an increase of approximately 40% of those aged over 65) highlighted the need to recognise the significant impact on demand for services by older people, and for plans to promote their wellbeing and those who care for them.

It also advises that, although Kent and Medway's communities are less ethnically diverse than the rest of England, local programmes should be developed to deliver race equality in mental health.

All these points have been taken into account in the strategy, which puts a considerable focus on the mental health risks for those who are:-

- Deprived
- In poverty
- Unemployed or in debt
- On commissioning improved services for prisoners
- Those with dual diagnosis, and those with learning disability and mental health
- On prioritising specialist outpatient services for people with

eating disorder, borderline and antisocial personality disorder, and ante- and post-natal mental health care

Because of the strong correlation between mental ill health and deprivation, the strategy says that more services should be targeted at areas of higher deprivation, such as the seaside towns.

Ensuring those with serious mental illness have good physical health care is flagged as important, as is the need to clarify whether women with serious mental illness have equal access to services.

Resources to manage common mental health disorders are recommended to be targeted to addressing health inequalities and to meeting the needs of particular groups (recently unemployed, black and minority ethnic communities, women, pregnant women and new mothers, older adults in the community and in care homes, carers, and people with physical health conditions).

## 3. Report structure

3.1 This report now:

- Summarises the feedback received during the engagement period.
- Describes the substantive changes made to the strategy as a result of the engagement and as a result of undertaking an Equality Impact Assessment.
- Outlines the next steps to launch.

## 4. Summary of feedback received:

4.1 Quantitative Analysis

In response to the invitation to feed back comments on the strategy or summary version of strategy NHS Medway received 92 completed responses using surveymonkey, and 26 returned paper questionnaires. Several email responses were also received that commented on parts or all of the strategy, from both internal and external sources, but these did not respond to the structured feedback questions.

Fifty seven of 118 (48%) agreed that the vision said what it should say, without further qualification. Many of the other responses confirmed that it did but added their own emphasis, and a few pointed

out what they thought were gaps. Less than 10% of comments about the vision were negative.

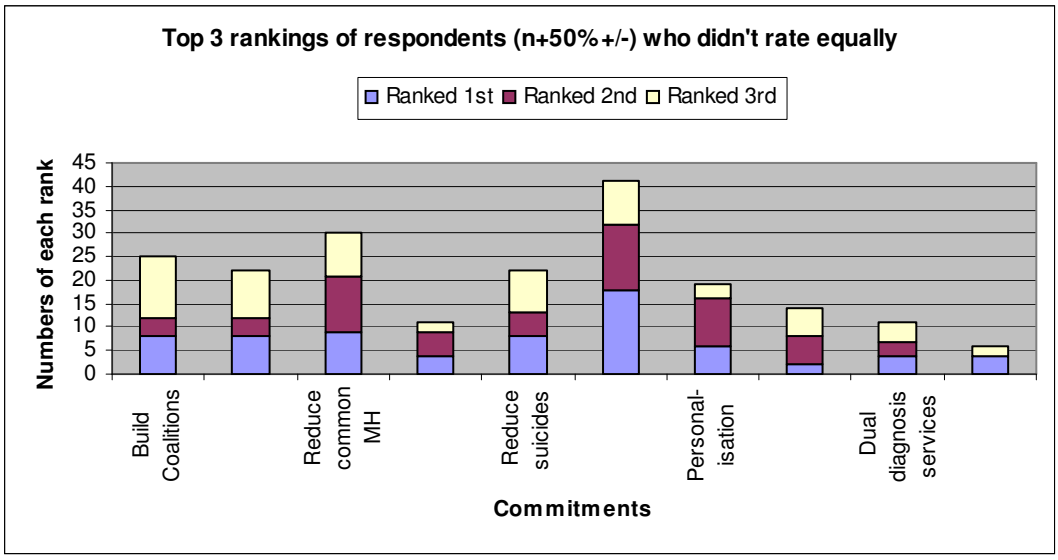
Forty six of 118 (39%) of the total respondents to the survey stated they saw the commitments as of equal importance, 64 (54%) said they didn't, and eight (7%) didn't comment. Some of those agreeing that the commitments were of equal importance then went on to give their top three priorities.

Most of the on-line responses gave postcodes and this demonstrated a good wide spread of responses across the county.

4.2 Evident Priorities

Approximately 50% of respondents ranked their top three commitments. These results are shown in the chart and graph below.

| | Build Coalitions | Lessen stigma | Reduce common MH disorders | Improve Physical health | Reduce suicides | Care in a crisis | Personal-isation | Better recovery outcomes | Dual diagnosis services | Better care for offenders |
|---|---|---|---|---|---|---|---|---|---|---|
| Ranked 1st | 8 | 8 | 9 | 4 | 8 | 18 | 6 | 2 | 4 | 4 |
| Ranked 2nd | 4 | 4 | 12 | 5 | 5 | 14 | 10 | 6 | 3 | 0 |
| Ranked 3rd | 13 | 10 | 9 | 2 | 9 | 9 | 3 | 6 | 4 | 2 |




4.3 Positive / Negative Balance of Comments

Whilst it is interesting to see the spread and priority given to the

commitments the number of responses is very small, and do not persuade us to move from a position of seeing all commitments as of equal importance.

Many comments were made about the positive impact of the vision and the commitments. The vision was variously described as 'highly laudible', 'impressive', 'long overdue', 'ambitious', 'optimistic', 'positive', 'challenging' and 'fab'. A couple of helpful suggestions were made on rewording the vision.

The strategy was described as 'articulate', 'innovative in places', 'joined-up', as having 'a coherent continuum of interventions', and expressed in simple everyday language.

'The commitments are awe-inspiring.'

'The ten commitments are a great idea. It breaks the service commitments down into bite-size pieces so you can see what to expect from your NHS.'

One respondent implored – 'please don't just raise our hopes'.

There were few negative or sceptical comments about the vision or commitments. Some said the vision was vague; and the strategy overall was too ambitious for some and not ambitious enough for others. There were single comments such as 'lip service', 'motherhood and apple pie', 'a pipe dream', 'too long and bureaucratic', 'weak' and 'written in 'strategy-speak'. One said the money spent on publishing the document was wasted and should be spent on front-line services.

'You can tick all the boxes and fail to see the person.'

'This will all go quietly into the night and nothing will change and we will hear no more about these posturings.'

Some comments asked who and particularly how the strategy would all get delivered, and if there would be specific targets set within the strategy. One respondent suggested we should try to do less but do it more effectively.

One telling comment, from a friend of a service user, said that trying to find out about mental health services was:

'like navigating with a candle and a half drawn map'.

4.4 Comments by Commitment

i. *Build coalitions between all agencies*

This commitment wasn't greatly commented on, but the focus was on the importance of raising understanding across agencies. Several agencies were mentioned as important to involve – Connexions, unions, Department of Work and Pensions (DWP), Department of Health and Social Security (DHSS), housing authorities, educational institutions, colleges of Further Education (FE), police, libraries, the Samaritans, and the voluntary sector as a whole. Encouragingly some agencies put themselves forward as wanting to be involved.

One respondent stated that the 'multi-agency feel is not in evidence'.

Another that the predominantly blue colouring of the summary booklet gave it an (unintended) NHS feel.

'More emphasis on joint working across partners including those outside of the NHS to look at wider issues that also impact on mental health, like housing'.

One of the respondent's must-dos was:

'Agencies working together for the greater good without being petty or defensive'.

ii. *Lessen stigma, discrimination and unhelpful labelling*

At least 15 respondents mentioned concerns regarding stigma, and some identified the need for more public education about mental health as a means of reducing this.

'Too many people are ashamed to be mentally ill so pretend all is well'.

We should prioritise 'anti-stigma' campaigns to promote the mentally ill as real people who had a life before becoming ill and most of whom will be able to have a life again with the right help and support'

There were a few comments around the theme of workplace stress, realistic workloads, employer support, and the place of the unions.

'The PCT along with its partners should lead by example, i.e. tackle stigma, discrimination and mental health awareness within their own organisations and monitor the effectiveness of this'

There were a couple of comments from service users about feeling like they were not taken seriously by professionals, and also a coupe of comments about the fabric of NHS facilities making service users feel like they weren't valued.

iii. *Reduce the occurrence and severity of common mental health problems*

This commitment attracted many comments on the importance of prevention and need for more focus, on the value of public education, and on the need for resilience-building. Respondents particularly liked the 'five-a-day' principles. At least 12 mentions were specifically made of them, and some additional mentions of the value of activities:

'Putting things in place to help people achieve the wellbeing 5 a day, e.g. free / low cost accessible exercise activities, safe cycle paths, learning opportunities, support for community groups, promotion of volunteering, schemes to enable individuals to support others'.

'I sing in one of the singing for mental health groups that have been set up in East Kent and I think these groups are making a substantial contribution to supporting people with long-term mental health issues. The project deserves to be supported and expanded across the whole of Kent and Medway'.

Two comments mentioned developing more non-medical / alternative to drugs interventions.

'I would like to see a lot of effort being put on the tremendous value of Art and Creativity.'

Some respondents raised early recognition and early intervention as issues. One respondent highlighted the importance of availability of debt-counselling. There were some related comments that waiting times for services such as counselling should be shortened, that eligibility requirements were too high and should be reviewed, that signposting to support or services should be improved, and that self-referral should be more publicised.

iv. *Improve life expectancy and physical health*

This commitment attracted few comments. One respondent stated they felt fobbed off if they went to their GP with a physical problem, as usually told it was linked to their mental health problem. Another respondent urged monitoring of the side-effects of long-term medications (obesity, diabetes).

Several comments came from learning disabilities groups or their representatives indicating that GPs will need extra training in understanding the mental health needs of people with learning disabilities.

v. *Reduce the number of suicides*

Again this commitment attracted very few comments - three comments about self-harm, one about risks to those being bullied, and one pointing to risks of other specific groups, i.e. those with personality disorders and those with eating disorders. One indicated the link between self-harm and suicide, and the concern that they were mostly referred back to primary care because they didn't meet eligibility criteria.

'Need to commission a specialist service for people who self-harm'

vi. *Access a crisis response service at any time*

This commitment area attracted the most comments by respondents of all the commitments. Fifteen percent of respondents made comments to the effect that access to a crisis response was difficult or took too long, of which some were specific about weekends or out-of-hours services. Some comments were that crisis responses were inappropriate, or they had a sense of a lack of urgency from services.

'The crisis team needs to be a lot more accessible and the staff need to be better trained'.

There were a couple of comments about websites not being helpful at an urgent time.

There were also a few related comments about waiting times for less urgent services, like talking therapy and counselling, and half a dozen comments referring to distance from acute beds and the difficulties that posed to patients and carers.

The need for psychiatric liaison services in all acute general hospitals was pointed out by a couple of respondents.

vii. *Offer a personalised service*

This commitment was not commented on a great deal. Three respondents referred to the need for more information to be able to make choices, one of which was specific to medications and one on choice of psychiatrist you see. This would relate also to lack of continuity of contact with the same staff, a concern raised by three respondents.

However, a couple of respondents were not sure if they'd be in 'a fit state' to make choices and wanted to emphasise widespread service quality.

viii. *Deliver better recovery outcomes, with care at home as the norm*

Many respondents commented on issues to do with recovery, but across several themes. To the fore were issues relating to support for carers (and friends and relatives). There were concerns expressed about carer's own mental health issues, some were 'long-suffering', they needed to be listened to, they needed assessments, they needed better advice.

The importance of secure accommodation and work was mentioned by five respondents, as well as the benefit of volunteering opportunities:

'Not everyone is able to work at a given time when experiencing mental health problems and may be able to volunteer instead (without the same amount of pressure as paid work). Volunteering is a significant contributor to wellbeing (not mentioned in the strategy either).'

A couple of respondents raised prescribing practices and lack of medication review as unhelpful to recovery:

'Hospital doctors MUST stop prescribing large doses of drugs within hours of first meeting non-violent depressed patients!! MONTHS could be knocked off recovery times by gentler prescribing.'

As with commitment 3 there were some comments about the value of different activities, exercise. Three respondents supported the development of peer support schemes and one of user self-help forums.

Time to access psychotherapy was mentioned by five respondents.

One respondent specifically mentioned more support for those who had come into care under a Section 136 to ensure they were able to cope after discharge.

ix. *Ensure more people with dual diagnosis receive an effective service*

This commitment attracted few comments. The Medway Drug and Alcohol Partnership pointed out this group of people is 'invariably highly complex with very specific vulnerabilities and all too few protective factors'. There were single comments about poor services and support, about focusing on drug pushers and pubs that tolerated it, on more effective treatment for alcohol abuse, and on ensuring those with dual diagnosis could access talking therapies. There were two comments about improving services for the homeless and rough sleepers.

x. *Deliver effective mental health services for offenders*

This commitment attracted the least commentary of all. One comment was about improved support for offenders in the community, as there were large numbers; one referred to the value of court diversion; one to the high level of self–harm in prisons.

4.5 Other themes that emerged

*Finance and funding*

At least 15 comments referred in some way to how the strategy would be paid for, and some that services were already underfunded or funding would be cut in future. One said the strategy was unachievable 'due to costs, lack of resources, lack of motivated staff, lack of professionalism and driven commitment.' One put the question –

'How do you make any organisations commit to it without any financial incentives?'

*Communication, communication, communication*

Some respondents referred to two-way better communication between GPs and consultants, or that communication was necessary to make the system 'joined-up', and some referred to communication

between services and patients:

'How about some clarity for service users and families about what they should expect, what questions they should be asking (and not just another leaflet left on the bed of an already frightened and confused person).'

*Young people, Child and Adolescent Mental Health Services and transition*

There were four specific comments urging better Child and Adolescent Mental Health Services (CAMHS) transition services, together with a range of wider comments regarding support for vulnerable young people, such as Looked After Children and young offenders. A comment from Connexions suggested a Families Intervention Project approach as part of the vision.

*Quality and Standards*

There were five or six specific comments that raised a variety of service quality issues – such as lack of facilities in hospital (exercise facilities, internet access, a ban on mobile phones, suggestions for a 'survival pack' for emergency admissions, etc.), and failure to use care plans. A couple of comments drew attention to the poor fabric of some patient accommodation, and there were several references to service access and waiting time issues. There were just a few comments about poor interactions with professionals.

A more general comment:

'the emphasis appears to be on diversification and quantity. What happened to quality?'

*Workforce and training*

Six comments referred to the need to improve GP training on mental health issues, and a couple of these were specific to people with a learning disability. There were three comments about better training for all health professionals, a couple directed at Accident and Emergency staff, and a specific comment about health professionals going to see what goes on in some voluntary schemes.

There were two comments about the need for specialist mental health teams (crisis) and psychiatrists being better trained to deliver

recovery, and a couple of comments suggesting the need for workforce changes, e.g. such as the appointment of nurse consultants.

4.5 Equality Impact comments

The largest number of comments about a group whose needs the strategy should address better were those with learning difficulties, followed by 16-18 year olds and students, and for homeless people. Those with learning disabilities were explicit on needing more time and easier read information to respond to consultations such as this one. The national picture of over-representation of 'Black' and 'Black British' ethnic groups among inpatients and among those compulsorily detained is reflected locally.

No other specific 'needs' groups were mentioned more than once.

There were two comments requesting more support for people having marital difficulties or relationship breakdown, and also for new mothers. There were single comments for those with physical disabilities, those with autism, those with Aspergers, commuters, those in the armed services and ex-servicemen, the recently bereaved, refugees and asylum-seekers, and those in rural areas.

In the light of responses from those with and representing those learning difficulties we did consider adding a further commitment relating to the client group with learning difficulties but, on balance, given the commitment to access to mainstream services we opted not to.

5. Substantive changes / additions made to strategy

5.1 **Amendments to the vision and commitments**

To make it more accessible the summary version of the strategy offered a slightly different version of the vision than the full document that was available. In the light of feedback the wording of the vision has been amended as follows:

There is no health without mental health.
With our partners, we will make mental health everybody's business, addressing the diverse needs of people living in Kent and Medway.
We will promote good mental health and wellbeing in the community, reduce the number of people who get common mental health problems, and lessen the stigma and discrimination associated with

NHS Medway

mental ill-health.
We will ensure that prevention is targeted at those at higher risk but also that the right services are there when people need them.
Services will be personalised, will involve service users and their families in equal partnership, will aid recovery and will help people reintegrate into their communities. They will promote the best care and promote accessible, supportive and empowering relationships.
Wherever possible, services will be community-based and close to where people live.

The wording of commitment iv. has been amended as follows:

*Demonstrably improved the life expectancy and the physical health of those with severe mental illness, and demonstrably improved the recognition of mental health needs in the treatment of all those with physical conditions and disabilities*

5.2 Additions to actions under each commitment:

The following additional actions are proposed under each commitment in the strategy, with a priority indication:

| Commitment | Action | Priority |
|---|---|---|
| i. | | |
| ii. | | |
| iii. | ▪ .....including development of non-medical / alternative to drugs interventions<br>▪ Develop wider use of cCBT | Added to a commitment for 2010/11<br>Over 5 years |
| iv. | | |
| v. | | |
| vi. | ▪ We will develop liaison psychiatry services at all acute general hospitals in Kent and Medway<br>▪ Develop improved CAMHS transition services | Over 5 years<br>Over 5 years |
| vii. | ▪ We will commission providers to continue to make reasonable adjustments for people with any type of disability to access mental health services. | Over 5 years |

| | | |
|---|---|---|
| | ▪ We will stimulate peer support initiatives as a means to enabling more service users to getting a more personalised service. | Over 5 years |
| viii. | • Keep under review the training needs and workforce competences of key professional groups to deliver key elements of the strategy, such as supporting recovery, particularly for those at higher risk. | Over 5 years |
| ix. | | |
| x. | ▪ Minimise the number of transfers from prison to secure placements due to poor mental health support in prison | In 2010-11 |

5.3 Equality Impact specific recommendations

Under the Disability Discrimination Act we will commission providers to continue to make reasonable adjustments for people with any type of disability to access mental health services.

We will ensure that mental health promotion messages and materials are made more accessible to people with learning disabilities.

We will clarify whether women with serious mental illness have equal access to services.

More frequent monitoring of inpatient populations and those compulsorily detained (under Section 136) by ethnicity groups, together with action plans to address over-representation will be necessary.

More generally, supporting and encouraging stakeholder organisations to develop their Race Equality Cultural Capability (RECC) will be required.

## 6. Next Steps

A schedule of presentations to the West Kent PCT Board, the Medway PCT Board and the Eastern and Coastal Kent Commissioning Strategy Committee, and also the Councils, for formal sign-off has been agreed. This should be completed by August.

The Mental Health Directorate business objectives for 2010-11, agreed by the Kent and Medway Strategic Commissioning Board in May, already reflect the core of this year's priorities, and these have been captured in all three PCT's strategic commissioning refreshes earlier this year.

Should there be any amendments to make to the priorities as a result of this process they will be reflected in business objectives and prioritised appropriately. Progress against business objectives will be monitored quarterly as part of the directorate's governance process.

The specific set of strategy Key Performance Indicators – with explicit Key Performance Indicators for each commitment – is being finalised. Each KPI will have a 2008/09 or 2009/10 baseline and a proposed trajectory over the five years. Progress will be reviewed every quarter at the Kent and Medway Strategic Commissioning Board for Mental Health.

A review of equality impact will be undertaken at midpoint during the strategy period.

**Phil McSweeney**
**Project Co-ordinator**
**9th June 2010**

NHS
Medway

**Appendix 1**

**Vision statement**

"With our partners we will co-create a mental health system that makes mental health everybody's business. The system will address the varied needs of the people living in Kent and Medway. It will deliver a range of activities to promote positive mental health and wellbeing in the community, it will lessen the prevalence of common mental health problems, and it will lessen stigma and discrimination. We will ensure that prevention is targeted at those at higher risk. Service responses will intervene early when people develop problems, and will enhance the inclusion, physical health and optimal functioning of people who have severe mental health problems. Service providers will deliver a personalised service for all service users. Wherever possible, services will be community-based and close to where people live. They will work in equal partnership with service users and their families, and will aid recovery and reintegration through the provision not only of best practice care but of accessible, supportive and empowering relationships."

**By 2015 we will have:**

***i. Built coalitions between all elements of public services, the voluntary sector, and the independent sector that focus on collaborative endeavour and shared enterprise to improve mental health and wellbeing***

***ii. Lessened the stigma, discrimination and unhelpful labelling attached to mental ill health and those using mental health services***

***iii. Reduced the occurrence and severity of common mental health problems, particularly by targeted actions to improve wellbeing for more of those people at higher risk***

***iv. Demonstrably improved the life expectancy and the physical health of those with severe mental illness, and demonstrably improved the recognition of mental health needs in the treatment of all those with physical conditions***

***v. Reduced the number of suicides***

***vi. Ensured that all people with a significant mental health concern,***

***or their carers, can access a crisis response service at any time and an urgent response within 24 hrs - and that service contact points are more local***

***vii. Ensured that all people using services are offered a personalised service, giving them more choice and control over the shape of support they receive wherever the care setting is***

***viii. Delivered better recovery outcomes for more people using services, with care at home as the norm***

***ix. Ensured that more people with both mental health needs and drug and/or alcohol dependency (dual diagnosis) are receiving an effective service***

***x. Delivered effective mental health services for offenders and those anywhere in the criminal justice system***

NHS Medway

**Appendix 2**

**Communication Strategy**

*Communication strategy to achieve maximum coverage*

The communication plan at the outset included notification of the opportunity to comment on the full strategy and summary version to all households in KCC and Medway Council via the residents' magazines (Around Kent and Medway Matters), and notification also to the following organisations:

- the media – all local radio, newspapers, websites and TV stations
- the communications leads at all of the following organisations:
  - NHS Eastern and Coastal
  - NHS West Kent
  - Kent County Council
  - Medway Council
  - Acute Hospital Trusts
    - Dartford and Gravesham NHS Trust
    - East Kent Hospitals University NHS Foundation Trust
    - Maidstone and Tunbridge Wells NHS Trust
    - Medway NHS Foundation Trust
  - South East Coast Ambulance Service
  - Kent and Medway NHS and Social Care Partnership Trust
  - KCA
  - Kent police
  - Kent fire and rescue
  - all the district councils
  - all the universities
    - Canterbury Christchurch
    - University for the Creative Arts
    - University of Greenwich
    - University of Kent
  - further education colleges

    - Mid Kent College
    - North West Kent college
    - South Kent College
    - West Kent College
  - Kent Probation
  - Utility companies
  - Connnexions
  - Kent and Medway Local Involvement Network
  - Businesslink
  - the Chambers of Commerce in Kent and Medway
  - the Association of Small Businesses
  - all the co-ordinating voluntary organisations (eg Councils for Voluntary Services)
  - and the carers' centres in Kent and Medway
  - Rethink
  - Sevenoaks Mind
- The Chairs, Chief Executives and senior teams of the three PCTs, and the Directors of Adult Social Services and relevant members of the two Local Authorities
- all GP practices in Kent and Medway, via the Kent Primary Care Agency
- Local Medical Committees
- all those who attended or were invited to the Joint Strategic Needs Assessment and vision-development workshops in June 2009
- Rethink
- Community Development Workers located with Rethink
- Kent and Medway DAAT teams
- a day centre for elderly Asian people in Gravesend
- Prison Governors
- Websites – liveitwell.org.uk
- Websites - signpostkent

Many of the agencies we contacted also committed to sending information about the Live It Well strategy on to their staff, adding it to staff briefings, adding to their intranet, and sending it to the agencies and individuals on their engagement databases.

Wherever possible the organisations listed above were supplied with paper copies of the strategy summary for their use and for distribution to service users, other agencies, or members of the public. We distributed to all public libraries, community centres, all general practices, community development workers, and to public events on request. We produced 5000 paper copies of the strategy summary for distribution.

We also produced an 'easyread' version. These were circulated to the Kent County Council Challenging behaviour Network, and the Valuing People Medway Partnership Board.

In addition, further opportunities were taken during the engagement period to raise awareness with:

The Public Health 'health and wellbeing event' in Medway

Several organisations contacted us during the period to ask for additional copies of the summary strategy, for example:

- Medway Cyrenians
- Canterbury and Coastal Rethink
- a parish council in Dartford