AGENDA

WEST KENT CCG HEALTH AND WELLBEING BOARD MEETING

Date: Tuesday 21 January 2014
Time: 5.30 pm
Venue: Rooms 1B & 1C - Maidstone House, King Street, Maidstone

Membership:

Dr Bob Bowes (Chairman),Councillor Steve Beerling, Lesley Bowles, Alison Broom, Councillor John Cunningham, Councillor Richard Davison, Councillor Roger Gough, Jane Heeley, Dr Caroline Jessel, Dr Tony Jones, Veronika Segall Jones, James Lampert, Mark Lemon, Councillor Brian Luker, Mairead MacNeil, Reg Middleton, Dr Sanjay Singh, Malti Varshney, Evelyn White and Dr Meriel Wynter

---

Continued Over/:

Issued on 14 January 2014

The reports included in Part I of this agenda can be made available in **alternative formats**. For further information about this service, or to arrange for special facilities to be provided at the meeting, **please contact MARK LEMON** on 01622 696252

Kent County Council, Policy and Strategic Relationships, Room 2.65, Sessions House, Maistone, ME14 1XQ

discussion.

6. **Young People's Substance Misuse Service** 18 - 24
   Report of Angela Slaven

7. **Kent Alcohol Strategy** 25 - 27
   Report of Meradin Peachey

8. **Dual Diagnosis Provision in Kent** 28 - 32
   Report of Amanda Honey

9. **Community Safety (barriers and perspectives)** 33 - 40
   Report of Colin Thompson (Kent County Council, Public Health)

10. **Current Barriers and Ways Forward** 41 - 45
    Report of Colin Thompson (Kent County Council, Public Health)

11. **Better Care Fund** Verbal Report
    Oral Update by Mark Lemon

12. **CCG Commissioning Plans** Verbal Report

13. **Any Other Business**

14. **Date of Next Meeting**
    The next meeting of the Board is scheduled for 18 February 2014 at Maidstone Borough Council offices.

WEST KENT CCG HEALTH AND WELLBEING BOARD (EXTERNAL MEETING)

Tuesday, 17 December 2013

Present: Councillor Roger Gough (Chairman), Tony Jones, Malti Varshney, Mark Lemon, Jane Heeley, Councillor Cunningham, Councillor Davison, Councillor Luker, James Lampert, Tracey Beattie, Caroline Jessel, Mairead Macneil.

Others in Attendance: Jo Tonkin, Katie Latchford, Bruno Capone, Martine McCahon, Steve Inett, John Littlemore, Ivan Rudd.

APOLOGIES FOR ABSENCE

WKHWB50 Apologies for absence had been received from Dr Bob Bowes, Councillor Beerling, William Benson (Tracey Beattie in attendance) and Dr Sanjay Singh.

DECLARATION OF DISCLOSABLE PECUNIARY INTERESTS

WKHWB51 There were none.

MINUTES OF THE PREVIOUS MEETING

WKHWB52 Councillor Davison reiterated that the terms of reference with regard to voting rights had still not been clarified. The agenda front sheet stated that the quorum would be a third of voting members, but that the minutes of the last meeting said that the Boards would have no voting members at all, since resolutions would be made by consensus. Mark Lemon explained that the Kent Health and Wellbeing Board had not agreed the proposed terms of reference for the CCG area Boards and that as such, the West Kent Health and Wellbeing Board had no agreed terms of reference. Mr Lemon would be producing an options paper for the Kent Health and Wellbeing Board. Councillor Cunningham suggested simply removing the word *voting*, so that the quorum would be one third of members of the Board.

It was noted that Councillor Gough's name needed to be corrected and that Reg Middleton had been incorrectly listed as attending the meeting.

With the permission of the Chairman, Caroline Jessel asked the Board whether it would nominate volunteers to participate in a forthcoming project called "Call to Action" about how the NHS would change to deal with future challenges. The Board endorsed Tony Jones and Malti Varshney as representatives of the Board on the project.

RESOLVED: That, subject to the above, the minutes of the meeting of 19 November be agreed.

UPDATE ON PROGRESS IN WEST KENT AGAINST THE DEMENTIA ACTION PLAN

WKHWB53 Martine McCahon introduced the report on progress in developing dementia care in West Kent. It was known that the number of people living with dementia was set to increase as the population lives longer. Diagnosis rates in West Kent (currently 42%), in common with other CCGs in Kent, are below the national average (48%). A number of projects are aimed at

increasing awareness (for both staff and patients / carers) of the benefits of the support available, reducing stigma attached with dementia and making it easier to obtain a diagnosis, with the expectation that over time this will increase diagnosis rates. It remains the ambition of WK CCG to achieve the national target of 66% diagnosis rate by March 2015.

Ms McCahon felt that it was a good example of integrated commissioning but that it remained a challenge to understand the breadth of the contribution made by the voluntary sector to dementia care. The diagnosis rate appeared low at 42% and had gone down from the level reported previously. Ms McCahon introduced Bruno Capone who explained to the Board that:

- Dementia was difficult to diagnose in a timely way
- A diagnosis of dementia must be correct, and not be masked by other conditions
- GPs had reported that the 10 minute screening questionnaire was time consuming since 50 or 100 screenings would only potentially lead to one diagnosis
- Self screening tests would be a good future collaboration opportunity with KCC
- Healthcare professionals and the independent care sector needed training on how to deal with dementia
- Crisis support plans were increasingly important, especially with regard to latter stages sufferers
- The range of projects available needed to be linked together with a clear outcome to enable patients to maintain their independence

The Board commented as follows:

- Gail Arnold queried whether the increase in dementia sufferers was related to the ageing of the population
- Tony Jones emphasised the need for the private sector providers of care to be engaged with future plans
- The Chairman said that the Kent HWB would be looking at dementia in May 2014
- Steve Inett felt that the patient voice and feedback on admissions should be included
- Malti Varshney stated that integrated care must be aligned with integrated commissioning

Tony Jones explained that a hospital admission for a dementia sufferer would be likely to increase cognitive decline. It was vital that there were mechanisms to keep dementia sufferers out of hospital. For example, the unintended consequences of concern at a care home about a dementia sufferer could lead to an hospital admission which in turn would impact negatively on the health of the sufferer. Care should take place in a community setting, with the safety of the patient foremost.

Tracey Beattie enquired about whether the prescribing rate was higher or lower than average. Bruno Capone said that it seemed high, and felt that there was little or no reason to put people with dementia on anti-psychotic drugs. Dr Capone emphasised that the impact of recent projects would be that the level of correct and timely diagnoses of dementia would increase.

Caroline Jessel had read that type 2 diabetes was thought to be a cause of

Alzheimer's, and asked whether projects could focus on the prevention of diabetes. Secondly she recalled that the previous dementia strategy had three categories of dementia, with the most severe requiring palliative care, and queried whether that was still the case. Mr Capone responded by saying that the care plan approach was needed for all patients at an individual rather than generalised level. Caroline Jessel re-emphasised that the emphasis needed to be on prevention. Martine McCahon surmised that confidence about how to deal with dementia sufferers was key to avoid poor decisions being taken.

ACTION:

- Need to explore how can we focus on prevention of dementia
- There needs to be links with housing and the KCC's accommodation strategy for people with Dementia.
- Patient and carer experience should be prioritised regarding service planning for dementia
- There should be case note audits undertaken for people admitted to care homes/the acute trust considering if these were inappropriate why is this – identifying gaps across the system including support to ensure safe risks can be taken to support people in the community
- Are prescribing rates in WK higher/lower/same as the national average for dementia drugs?
- A report regarding dementia friendly communities should be tabled at the WK HWBB
- Are projections regarding increasing numbers of people with dementia based just on age? If so should this be reviewed? This needs to be looked into.
- Need to consider how will WK address people not wanting a diagnosis of dementia?

CHILDHOOD OBESITY TASK AND FINISH GROUP

WKHWB54 Katie Latchford introduced the report and asked the Board to note that Gravesham and Dartford had incorrectly been included on the attendees list on page 33.

The group had identified six key priorities:

- Work on childhood obesity needs to focus on early intervention and prevention with families and children aged 0-5.
- Support should be given in pregnancy to those women identified as having a high BMI. There is currently a minimal service offered in West Kent and no consistency in referrals or support across the area.
- There needs to be more consistency and clarity on referrals following the 2 year check where children are identified as overweight or obese. Currently referred back to GP, onward referral and support not monitored or reported – pathway needs to be clearer.
- There are currently no comprehensive 0-5 preventative services

and thought needs to be given to how we deliver this in partnership, including weight management for under 2s and services for under 5s.

- Work needs to be undertaken to support professionals across the sector in challenging where obesity is present in a child or family, and giving consistent messages and advice.
- Current child weight management pathway is not working for under 5s and further work needs to be undertaken to identify the barriers for older children and adolescents.

Malti Varshney commended the report and felt that the work of the group could be shared across Kent. It was important that GPs made an input to the work. Tony Jones commented that he had no examples where a child had been referred to him and he felt that behaviour change had to be promoted through parents.

Councillor Cunningham felt that the final report would be improved if it could show the impact of the work in a chart format.

ACTION:

1) That the group invite with Tony Jones to participate as appropriate in the work of the group; and
2) Subject to the group noting the comments made by the Board, the approach identified in the report, be endorsed.

PROGRESS MADE BY CHILDREN AND YOUNG PEOPLE TASK AND FINISH GROUP

WKHWB55 Jo Tonkin introduced the report. The current governance framework for achieving children and young people's outcomes in West Kent was described as fragmented and immature. Links to Kent Children's Safeguarding Board and opportunities for learning about safeguarding issues for the West Kent population needed to be considered. There were opportunities to better assist in integrated commissioning, provision or person centred approaches. There were changes being made to the overall governance structure in Kent which had the potential to accelerate the priorities for children and young people that West Kent Health and Wellbeing Board had identified. Progress was being made against the priorities but clarity of leadership, purpose and expectation was required. Schools were a key partner in progressing improvements for health and wellbeing but were largely absent from Health and Wellbeing Board discussions.

The Chairman felt that the leadership should come from the Board, and that one of the findings of the group could recommend that. It would then complement the priorities of the Kent Health and Wellbeing Strategy. The development of the Children and Young People's subgroup was supported, and it was felt that the membership of that subgroup could be sourced from the Board.

ACTION:

1) The Chairman would meet with other Health and Wellbeing Board Chairmen where the Children's architecture issue will be addressed to seek agreement concerning the way forward.

2) The recommendations as set out in the report, be endorsed by the Board.

WEST KENT HEALTH AND WELLBEING BOARD MENTAL HEALTH TASK AND FINISH GROUP

WKHWB56 Ivan Rudd introduced the report. It was noted that the final sentence of item 3 on page 43 should have read ...'*campaign plan team to meet in January'.* Steve Inett queried the role of acute services which did not seem to be covered in the report. Malti Varshney responded by saying that the Board should not replicate the work of the CCG, but that a more holistic report could be prepared for a future update from the group, if required. A visiting member commended the inclusion of veterans in the report, and noted that more work could be done on housing veterans.

ACTION: That Ivan Rudd liaise with interested parties on veterans and that a future update from the group notes the comments made by the Board.

WEST KENT INTEGRATED COMMISSIONING GROUP UPDATE

WKHWB57 James Lampert introduced the report and the Board noted that the item was not a task and finish group, but a report to the Board from the West Kent Integrated Commissioning Group.

Endorsement from the Board was sought for the 4 priorities identified by the group:

- Falls prevention in older people
- Self-Care/Self-management
- Winter Warmth
- Integration of community equipment and assistive technologies

In response to a question from Tracey Beattie, James Lampert explained that the voluntary sector had not been involved in the work as the group was made up of commissioners only. Councillor Cunningham commended the ongoing work in Tunbridge Wells on falls prevention. Jane Heeley added that there would be a good opportunity to identify the return on investment in terms of quality of life improvement.

ACTION: That subject to the group considering the comments of the Board, the four priorities for the group be endorsed.

CHILD AND ADOLESCENT MENTAL HEALTH SERVICES - RESPONSE FROM THE WEST KENT CCG

WKHWB58 The Chairman requested that the Board note the report. Mairead Macneil understood the pressure that the provider was under, but felt that the impact of improvements had not yet been seen. The Chairman reported that the future of the service would be discussed at the Kent Health and Wellbeing Board and the current challenges would be suitable for review by the Kent Health Overview and Scrutiny Committee.

ANY OTHER BUSINESS

WKHWB59 The late item on Tobacco Control was taken after item 7. Jane Heeley outlined the progress of the task and finish group and explained that collaborative links with Kent Fire and Rescue Services and midwifery services were being pursued. There was also a natural synergy between the work of the tobacco group and the obesity task and finish group. Councillor Luker queried whether the spend per smoker of £1000 per annum was correct, and Jane Heeley confirmed that it was. Councillor Cunningham felt that the group should look more closely at schools, since young people tended to start smoking with their peer group. Jo Tonkin said that the Board could consider a future topic around the leadership given by schools to young people on health.

Turning to other business, the Chairman said that a conference call would take place to set the forward work programme of the Board and District Council colleagues were urged to involve themselves proactively in setting the work programme.

Due to resource changes at Tunbridge Wells, the Committee clerking role would need to be reviewed.

ACTION: That Mark Lemon resolve the future committee clerking role for the West Kent Health and Wellbeing Board, in liaison with District representatives.

DATE OF THE NEXT MEETING

WKHWB60 The date of the next meeting would be 21 January 2014, at Tonbridge and Malling Borough Council.

NOTE: The meeting concluded at 19:30.

Item ……..

Decision No……..

By: Colin Thompson

To: West Kent Health and Wellbeing Board, January 21st, 2014

Subject: Overview of substance misuse data in West Kent CCG district areas

Classification: Unrestricted

---

1. Purpose

1.1 To inform the Health and Wellbeing Board regarding the population health data of the four districts in the West Kent CCG area.

2. Alcohol data

2.1 Alcohol misuse is one of the major causes of liver disease. The figure below shows that since 1970, liver disease mortality has increased considerably, yet mortality from other diseases have reduced.

Figure 1

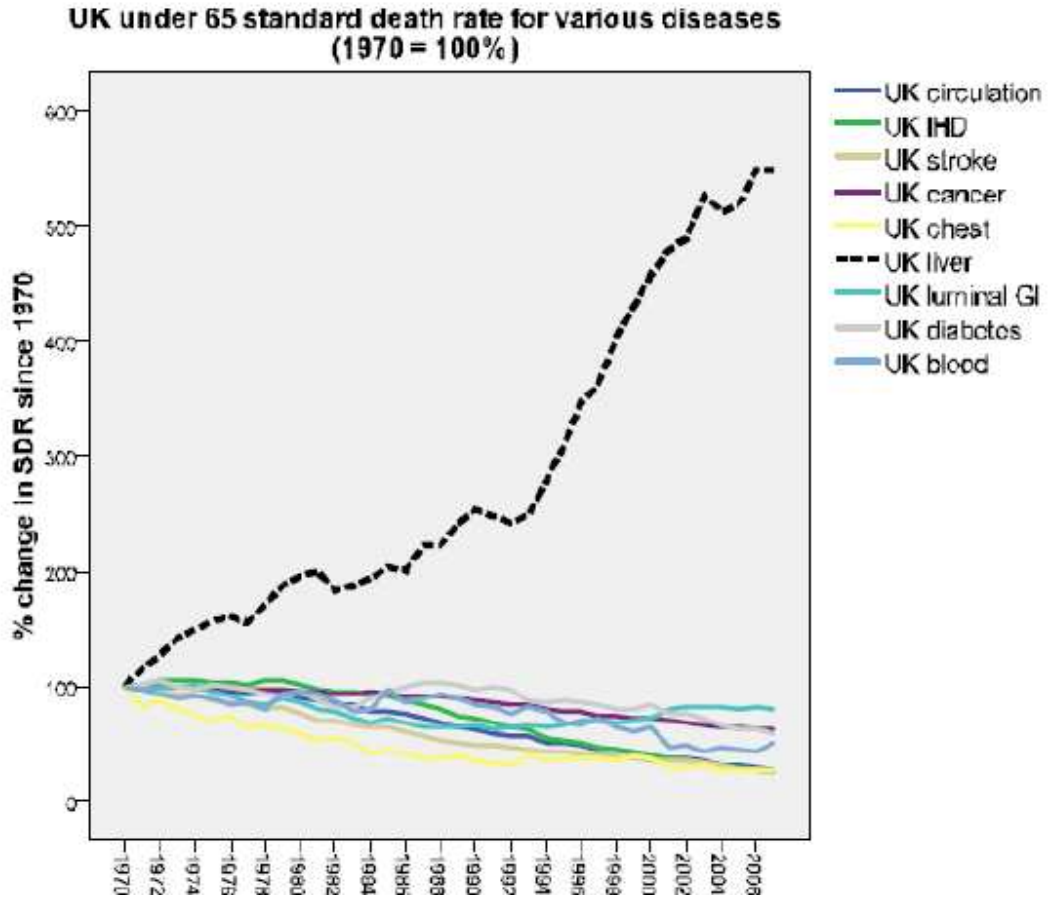

Table1: Hospital admissions for evidence of alcohol involvement by blood alcohol level/level of intoxication or toxic effects of alcohol

District Name	June 2011 - May 2012	June 2012 - May 2013	Number difference	% Diff
Maidstone	92	89	-3	-3.3%
Sevenoaks	55	80	25	45.5%
Tonbridge and Malling	80	97	17	21.3%
Tunbridge Wells	101	103	2	2.0%
KCC	930	1,006	76	8.2%

There was a reduction in the number of people admitted in Maidstone district, although there have been increases in the other districts. There was a considerable increase in Sevenoaks over the 12 month period, although it is still the lowest out of the four districts.

Table 2: Recorded crime attributable to alcohol: All ages

District Name	Number of all recorded crime attributable to alcohol (2010/11)	Crude rate per 1,000 population			
		2007/08	2008/09	2009/10	2010/11
Maidstone	828	7.65	6.96	6.12	5.70
Sevenoaks	398	4.30	4.20	4.22	3.61
Tonbridge and Malling	488	5.54	4.80	4.34	4.64
Tunbridge Wells	439	5.61	4.85	4.92	4.35
South East	51,683	8.49	7.79	7.34	6.89
England	366,791	9.14	8.54	8.01	7.58

Recorded crime attributable to alcohol has reduced in all districts since 2007. All districts are lower than the regional and national average. Sevenoaks is more than half the rate of the national mean.

Figure 2

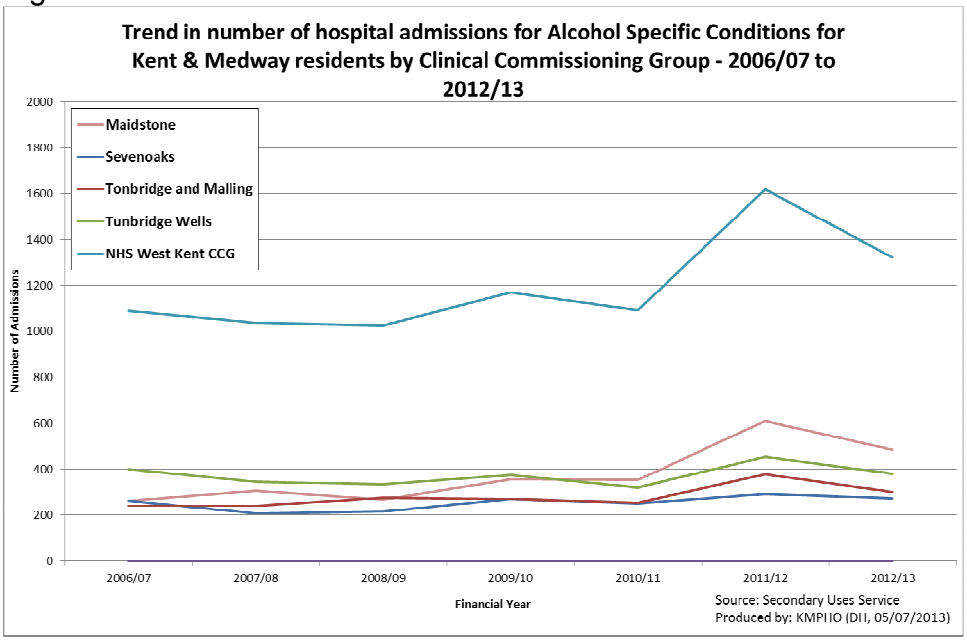

Figure 2 shows that there has been a slight overall increase in the number of alcohol specific admissions since 2006. There was a spike in the number of admissions in 2011/2012.

Figure 3

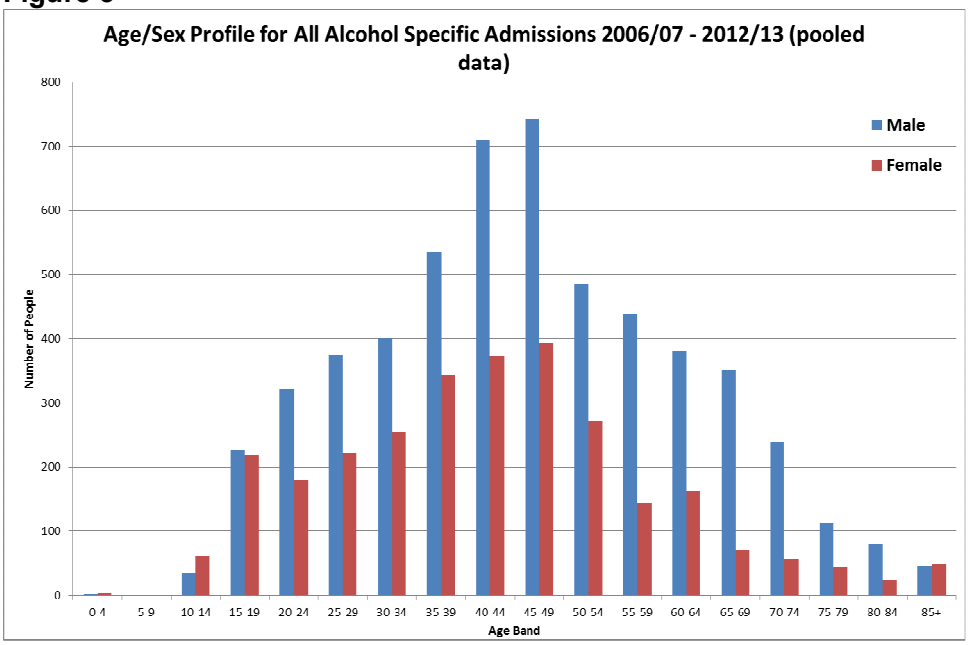

Figure 3 shows alcohol specific admissions and that males are admitted to hospital more than females (with the exception being for the 10-14 age group). Males aged between 40-44 and 45-49 are the most likely age group to be admitted.

Figure 4

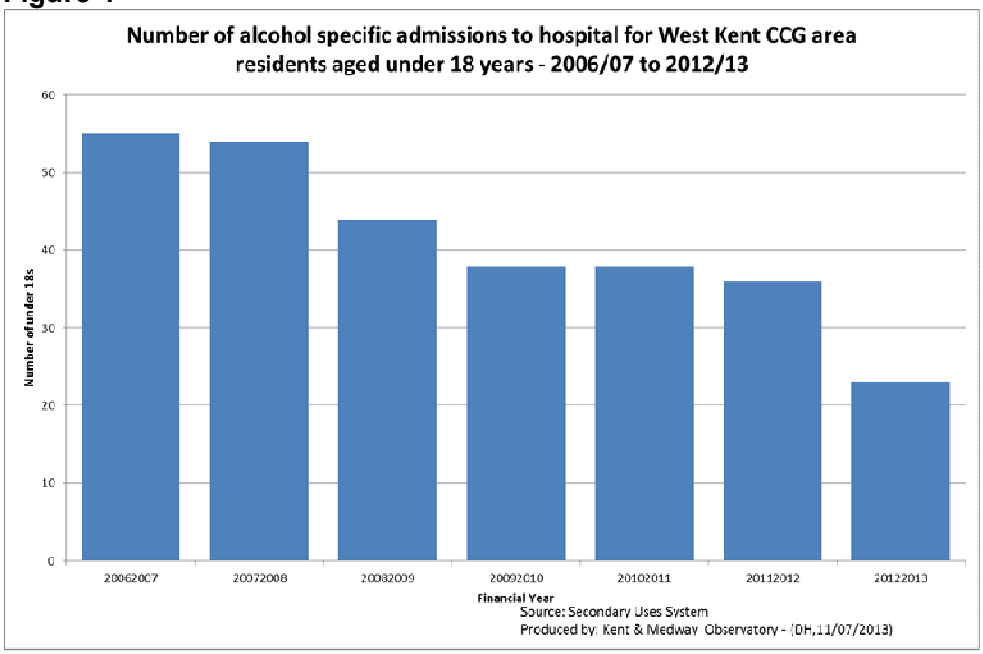

Figure 4 shows that alcohol specific admissions for under 18s have decreased considerably since 2006. This trend is similar in other parts of the county.

Table 3: Estimates of the number of abstainers, lower, increasing and higher risk drinkers by district.

District	Abstain	Lower	Increasing	Higher
Maidstone	13,219 (11.3%)	81,589 (69.9%)	15,793 (13.5%)	6,134 (5.3%)
Sevenoaks	10,887 (11.9%)	62,751 (68.3%)	13,302 (14.5%)	4,872 (5.3%)
Tonbridge and Malling	10,113 (11.0%)	64,278 (70.1%)	12,490 (13.6%)	4,872 (5.3%)
Tunbridge Wells	9,033 (10.8%)	57,505 (68.7%)	12,045 (14.4%)	5,154 (6.2%)

The estimates of the number of abstainers, lower, increasing and higher risk drinkers for each district shows similarities, across the four districts. Tunbridge has a higher proportion of higher risk drinkers and lowest proportion of abstainers.

3. Drug data

Table 4:

Table - Number of annual admissions to hospital for drug related conditions by Clinical Commissioning Group

CCG	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
NHS Ashford CCG	50	49	70	80	68	83	87
NHS Canterbury and Coastal CCG	99	200	189	224	254	265	299
NHS Dartford, Gravesham and Swanley CCG	135	184	161	178	214	265	302
NHS Medway CCG	290	299	282	309	359	374	355
NHS South Kent Coast CCG	132	162	198	212	219	247	318
NHS Swale CCG	108	103	87	123	109	151	153
NHS Thanet CCG	131	168	187	197	209	249	279
NHS West Kent CCG	328	328	306	364	357	477	528
Kent & Medway	1273	1493	1480	1687	1789	2111	2321
Source: Secondary Uses Service							

Table 4 shows the number of admissions to hospital for drug related conditions has increased in all CCG areas. In West Kent, the number has increased by 60%

Figure 5: Admissions for Mental and Behavioral Disorders due to Psychoactive Substance Use (2011/12)

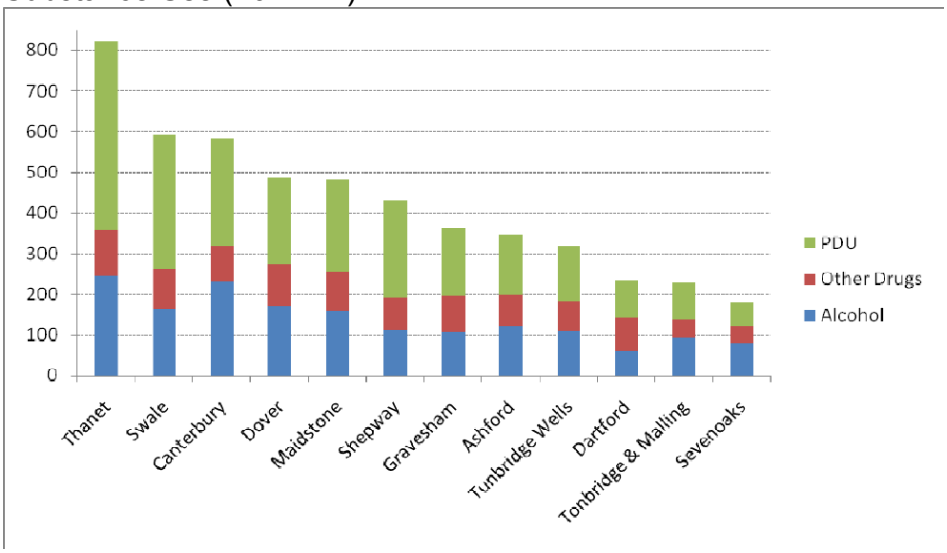

Figure 5 shows the breakdown of those admitted. Problem Drug Users (PDUs) were lowest in Sevenoaks. Maidstone had the highest number from local authorities in West Kent CCG.

Figure 6

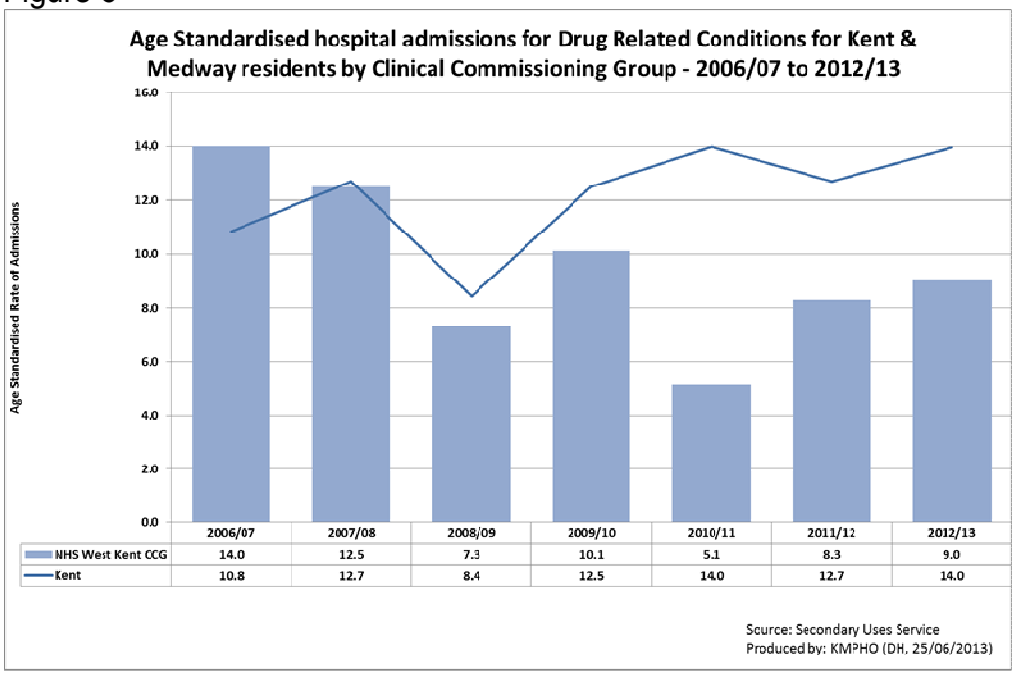

Figure 6 shows the age standardised admissions for drug related conditions and compares West Kent CCG with the Kent average. There has been an overall decrease since 2006/07. The rate for West Kent CCG is consistently lower than the Kent average.

4. Recommendations:

5.1 Members of the Health and Wellbeing Board are asked to note the Kent Alcohol Strategy.

6. Contact details

Report Author:
Colin Thompson, Public Health Specialist
Email: colin.thompson@kent.gov.uk

Item ……..

Decision No……..

By: Colin Thompson

To: West Kent Health and Wellbeing Board, January 21st, 2014

Subject: West Kent Adult Integrated Substance Misuse Service

Classification: Unrestricted

---

1. Purpose

1.1 To inform the Health and Wellbeing Board of an overview of the West Kent Adult Integrated Substance Misuse Service that has been commissioned by Kent County Council.

2. Overview

2.1 The Kent Drug and Alcohol Action Team (KDAAT) Partnership undertook a competitive tendering exercise in 2011 for a prime provider of substance misuse (drugs and alcohol) services in the districts of Dartford, Gravesham, Maidstone, Sevenoaks, Tonbridge and Malling and Tunbridge Wells (West Kent). The contract was awarded to CRI and following a 3 month transition period the service commenced on 1st April 2012.

2.2 CRI have been commissioned to deliver a range of interventions in order to prevent problematic substance misuse, reduce substance misuse related crime and enable the long-term recovery, rehabilitation and social re-integration of people in Kent affected by substance misuse including:

- Assertive outreach
- Brief Advice and Information
- Harm Minimisation Interventions (e.g. BBV testing and vaccinations)

- Needle and Syringe Programmes
- Pharmacological Interventions
- Structured Psycho-social Interventions
- Intensive Key working
- Structured Group Work Programmes
- Community Detoxification
- Access to in-patient stabilisation and detoxification
- Access to residential rehabilitation
- Criminal Justice Interventions (Arrest Referral Scheme, Alcohol Treatment Requirements, Drug Rehabilitation Requirements, Alcohol and Cannabis Diversion Scheme
- Tailored interventions to improved social functioning and enhance life skills
- Family focused interventions (including support to carers/significant others)
- Initiatives to promote general physical improvement

2.3 CRI have secured hubs in Maidstone, Gravesend and Tonbridge to deliver their services from.

3. CRI model of service delivery

3.1 CRI work in partnership with Sussex Partnership NHS Foundation Trust (SPFT) and the Royal Society for the encouragement of Arts, Manufactures and Commerce (RSA).

3.2 The programme is underpinned by a whole person recovery approach. This is one of the RSA's flagship programmes which was developed as a result of the 2009-11 project in West Sussex. The system is a high level commissioning framework for those seeking to move towards recovery focused services supported by vibrant recovery communities. It includes the provision of an everyday activities programme, public events programme, volunteer scheme, and small sparks scheme. Central to CRI's model is the support of a dedicated Recovery Worker, case managing the entire recovery journey. They will work as a multi-skilled member of a multi-disciplinary team, thereby eroding traditional role-silos to deliver a holistic, needs-led service in line with CRI's 'Foundations of Recovery Programme'.

3.3 CRI's Peer Mentoring programmes is an essential component of the model.

3.4 The duration of the contract is two years, with the option to extend for a further two years (subject to satisfactory performance).

4. Payment by results

4.1 The service is part of the National Payment by Results (PbR) Pilot. The model allows for independent assessment of need and assignment of a tariff which uses financial incentives to reward the prime provider for:

- improving outcomes for individuals and families with substance misuse problems especially those with most complex needs (in terms of freedom from dependency, offending, health and wellbeing), and
- reducing need and demand for public services amongst people who have had substance misuse problems.

The assessment and payment framework promotes a holistic approach to recovery in line with the aims of the National Drug Strategy. The provider will only receive PbR payments when they can demonstrate progress against on the full range of client needs that contribute to the wider impact of substance misuse.

4.2 The LASARS is a new service that was formed from the existing care management team and operates independently of the provider in West Kent. The LASAR service is responsible for the assessment of stock and flow clients and the assignment of a band in line with the Kent PbR tariff model. The LASARS conduct a comprehensive assessment of the individual's needs. Following the assessment, individuals are categorised into one of the following bands:

- Critical
- Substantial
- Moderate
- Low
- No need for structured treatment.

4.3 Service users are assigned an overall band according to the highest level of need identified in the two domains. This will ensure that the overall band is a holistic view of the client's need and complexity.

4.4 The Reduction in Offending Payments is based on "the Home Office Model" which calculates the average number of offences committed by a cohort of individuals recorded as being in structured treatment and provides an estimate of the cost to the community of those offences. From this information it will be possible to estimate the savings to the community ("Estimated Community Savings") as a result of successful treatment:

- 53% of the £200k offending pot will be paid if baseline performance is equalled
- The full £200k will be paid if a 4.3% reduction in offending is achieved
- The price per offence saved will be set at £3.9k ('economic' pricing)

4.5 The Kent PbR model incentivises the provider to help individuals achieve and sustain recovery in the long term. Tariffs reflect case complexity and level of need so that sustained recovery of clients with critical needs attract a higher payment for the provider than those with low or moderate needs. The model also allows the provider to have the freedom and flexibility to innovate, pioneer new interventions and do what is

needed to promote recovery and support people to sustain freedom from dependency on drugs or alcohol rather than delivering a standard service focused on clinical treatment.

4.6 An annual contract value of £4m has been made available for the West Kent substance misuse service. Payments are split between up-front funding (core activity) and PbR payments with PbR payments accounting for an increasing share of the total over the life of the contract.

5. Recommendations:

5.1 Members of the Health and Wellbeing Board are asked to note the report.

6. Contact details

Report Author:
Colin Thompson, Public Health Specialist
Email: colin.thompson@kent.gov.uk

THE REPORT

Item 0.0
Decision No

By:	Angela Slaven, Director of Service Improvement, Customer and Communities
To:	West Kent Health and Wellbeing Board, Tuesday 21st January 2014
Subject:	Young People Substance Misuse Service
Classification:	Unrestricted

Summary
The retendering of the young peoples' substance misuse services in Kent concluded with the contract being awarded to KCA. As KCA were the current provider there was no transition period required. The contract began on the 1st January 2013. Performance to date has been positive: young people accessing the service is 33% over target; 100 per cent of referrals receiving a care plan within two weeks; 96% of planned exits which is well above the national average; the number of Youth Offending Service clients accessing the service is 148% over target; and, the number of parents and carers support is also over target.

1 Introduction

1(1) In June 2011, the KDAAT Board agreed plans to competitively retender early intervention and specialist treatment services for young people in Kent. A Procurement Plan was developed and agreed in March 2012. The contract was awarded to KCA on the 1st October 2012.

1(2) The consultation period had substantial engagement from key stakeholders in Kent, in addition to the national providers of young peoples' substance misuse services. Over 100 young people took part in the process, with significant support provided by the Kent Integrated Youth Services.

1(3) This report presents a update on the progress of KCA's model of service delivery.

2 Service Outcomes

2(1) KCA have been commissioned to deliver a range of interventions in order to prevent problematic substance misuse, reduce substance misuse related crimes and enable the long-term recovery, rehabilitation and social re-integration of young people in Kent affected by substance misuse including:

- 2(1)(a) Improved emotional health and wellbeing, and quality of life for young people, their parents and carers and their families
- 2(1)(b) Well-informed and supported families and carers
- 2(1)(c) Improved relationships between the young person and their parents and carers

2(1)(d) Reduced substance misuse related crime, anti-social behaviour, entry into the criminal justice system as a result of substance misuse and re-offending
2(1)(e) Increased engagement in positive activities and engagement with social peers
2(1)(f) Increased engagement in education and training including but not limited to; a reduction in the number of young people who are excluded from school as a result of their misuse of substances
2(1)(g) Increased housing stability for young people
2(1)(h) Improved public health and reduced health inequalities in Kent, including but not limited to; prevention of substance misuse related deaths, in teenage pregnancy and blood borne viruses

3 KCA's Model of Service Delivery

3(1) Running throughout the model are three 'golden threads':

3(1)(a) Holding hope – all young people can, and deserve to, succeed. KCA hold hope for them even when they are not able to
3(1)(b) Doing with and not unto – we do it together with partners/carers, working to find solutions to difficulties
3(1)(c) Passion with purpose – KCA will champion young people and have an agreed plan and vision which will be driven with energy and vigour. Underpinning this is strong governance, rooted in shared values and agreed ways of working

3(2) The service model comprises an Access and Engagement Centre and two Operational Hubs:

3(2)(a) The Access and Engagement Centre is the 'front door' to KCA services across Kent (situated in Faversham) and the central point of access for the twelve districts. It operates an advice line, telephone consultations and a duty team who are the first point of contact for referral and immediate liaison with parents/carers, young people and professionals
3(2)(b) KCA have established two operation hubs across Kent that are responsible for providing both early intervention and specialist treatment in each of the twelve localities – Chatham (KCA West Kent and Medway) and, Canterbury (KCA East Kent). Services are delivered within local communities at times and places which suit young people and their families/carers; this includes home visits and outreach across Kent

3(3) The Centre is firmly focussed on actively engaging the parent/carer, young person and referrer from the outset. This ensures that those who need a service receive an appropriate intervention. If the young person dis-engages, the Centre takes an assertive approach to re-engagement. The Centre does lead a number of work streams to build capacity in key areas including:- Family Engagement, Workforce Development, Social Work Student Placements, and the training and recruitment of Volunteers.

3(4) Each hub has a service manager overseeing a team of substance misuse workers who have lead roles in relation to early intervention, specialist treatment, Youth Offending Services (YOS), Child and Adolescent Mental Health Services (CAMHS), Looked After Children (LAC) and prescribing. These workers, for some of their time, are co-located with within these teams to strengthen joint working.

4. Key Elements of the Service

4(1) Enabling parents/carers to make referrals – KCA communicate and market the service widely using leaflets, websites and Facebook and alongside Adfam have hosted two focus groups with parents/carers during 2013. This has ensured their views are incorporated into service development.

4(2) Differentiating between needs and intervening early – KCA have bridged the link between universal and specialist services by defining the referral and care pathways to the service. The DUST screening tool (please see Appendix 1) has been adapted to reflect identification of need for an early intervention service for young people who are at risk of developing problematic substance misuse. These services are available to all young people in need; targeted groups include:

4(2)(a) Young people at risk of exclusion
4(2)(b) YOS clients
4(2)(c) Looked after Children
4(2)(d) Those with mental health problems

4(3) Experimenting 'at risk' stage – KCA deliver RisKit, an evidenced based multi-component programme, to address risk taking behaviours among vulnerable young people. The Programme was developed in partnership with the University of Kent.

4(4) Recreational/Regular substance use stage – KCA deliver brief interventions in 1-to-1 and group settings. The style and principles of Motivational Interviewing (MI) have been applied and the outcomes measured through the Teen Star Outcomes Tool.

4(5) Harmful/Dependant use – KCA have applied recognised models and approaches providing high quality specialist treatment to those young people who need it. This includes Cognitive Behavioural Therapy (CBT) and MI. These approaches offer the young person the opportunity to explore issues such as:

4(5)(a) family relationships
4(5)(b) self esteem
4(5)(c) confidence building
4(5)(d) anger management
4(5)(e) coping with anxiety

4(6) Each young person referred to specialist treatment has received a comprehensive assessment, risk assessment/risk management plan and a care plan with goals that the young person has agreed with their worker. Practitioners work with young people (weekly) to address needs and review progress.

4(7) Access to needle exchange services – this intervention has reduced current harm associated with injecting practices and more young people have engaged into specialist treatment where they receive pharmacological and psychological interventions.

4(8) Pharmacological interventions – KCA work with the appropriate substance misuse doctors in relation to substitute prescribing. Young People have benefited from a Mental State Assessment as they are often the most complex young people known to the service. In partnership with the CAMHS service KCA have assisted in the development of the Kent protocols in relation to psychiatry input for these young people as part of their intervention.

4(9) Addressing challenges of particular age groups – **Under 14's**, KCA continue to work with children services to provide a team around the child; **17-18 year olds**, KCA support young people to overcome the associated challenges i.e. transition to adulthood, by working with adult services. For those clients in this age group who are NEET KCA work with CXK and colleges supporting young people to access education and training.

4(10) Clients with poor written/spoken English – KCA have overcome these issues in a number of ways such as promoting the service in different languages and using interpreters when necessary which has ensured that a lack of English is not a barrier to accessing the service. Through the diversity training programme KCA staff are culturally competent with the evolving needs of service users and the communities they come from.

4(11) Effective links and DUST training – KCA have delivered DUST training to the children's workforce and in 2013 over 740 practitioners attended the training including social workers, A&E staff, and CAMHS. Eighty per cent of attendees felt they had a good knowledge of the range of specialist drug services for young people compared to sixty-four per cent before training.

4(12) Effectiveness of interventions – KCA measure the effectiveness of their interventions through a number of outcomes measures such as Teen Star, TOP'S and the use of service user satisfaction surveys. During 2012/13 the service achieved eight-two per cent planned discharges and ninety-four per cent said they would recommend the service to another young person.

4(13) Sub-contracting/supply chain – KCA have entered into a partnership agreement with Adfam for a one year fixed term contract.

5. Service User Involvement

5(1) KCA have a very strong track record of service user involvement and young people's participation. They have been successful in involving young people at every level of their services: from getting their advice on the design of a leaflet about cannabis to having young people sitting on interview panels. Young people's views were incorporated into the design for the new service model. During the implementation, young people were consulted on the changes KCA needed to make and how this affected them.

5(2) Significant achievements:

- 5(2)(a) RisKit evaluation: a qualitative evaluation of the RisKit tool in partnership with the University of Kent and current service users provided valuable information from young people about the effectiveness of that programme
- 5(2)(b) Focus group: eight young people attend the group whose purpose is to get feedback about services and their future and to give young people the opportunity to join a steering group with KCA and be part of the commissioning process
- 5(2)(c) Involving young people in setting up the service: service users are invited to send in their ideas which are shared with commissioners, KCA staff, and the Independent Monitoring Board (IMB)
- 5(2)(d) Developing and shaping the service: young people have been involved from the outset in shaping this service starting with the branding of the service. Young people also worked on the development of a micro-site of the KCA website, particularly the social media areas. This has resulted in a brand that is meaningful for them and has been effective in attracting young people who need the service

5(2)(e) Training: all young people are offered the opportunity to attend training on equal opportunities, diversity and confidentiality. This has resulted the majority of service users being involved in recruitment

6. Conclusion

6(1) The conclusion of the retendering process for the Kent Young People Substance Misuse Service and the selection of KCA as the provider has placed Kent in a strong position to progress over the next three years.

6(2) Now fully operational, the new Young People Substance Misuse service model in Kent offers a comprehensive treatment, recovery and support system for young people in Kent affected by drug and alcohol misuse as evidenced in the Case Study (Appendix 2) of a Young Persons journey through the service.

7. Recommendations

7(1) The Board are recommended to note the progress of the Young People Substance Misuse service.

Author Contact details:
Robin Cahill
Commissioning Officer
Tel: 01622 694511
Email: robin.cahill@kent.gov.uk

Appendix 1

DUST SCREENING TOOL

2011-09-19
Amended DUST.pdf

Appendix 2

CASE STUDY

KCA YP Case Study Nov 13.docx

Item ……..

Decision No……..

By: Meradin Peachey

To: West Kent Health and Wellbeing Board, January 21st, 2014

Subject: Kent Alcohol Strategy 2014-2016

Classification: Unrestricted

---

1. Purpose

1.1 To inform the Health and Wellbeing Board regarding the Kent Alcohol Strategy 2014-2016.

2. Background

2.1 The strategy builds from the previous Kent Alcohol Strategy 2010-2013. This draft strategy will go for public consultation via the Kent County Council website. It will take account of appropriate amendments from the consultation and a final version will be taken to the Kent Health and Wellbeing Board for final approval.

2.2 It has been developed via input from a range of partners including Public Health, Commissioned Services, Kent Police, Trading Standards and Community Safety.

2.3 The majority of people in Kent and the UK consume alcohol responsibly. In moderation, alcohol consumption can have a positive impact on adults' wellbeing especially where this encourages sociability. Well-run community pubs and other businesses form a key part of the fabric of neighborhoods, providing employment and social venues in local communities.

2.4 Excessive consumption of alcohol is a growing problem in Kent and across the country. Liver disease is the fifth largest cause of death in England. The average age of death from liver disease is 59 years, compared to 82-84 years for heart and lung disease or stroke, with a five-fold increase in the development of cirrhosis in 35-55 year olds over the last 10 years.

3. Kent Alcohol Strategy 2014-2016

3.1 The strategy sets the context in which agencies across Kent will work to address the problems associated with alcohol use across the county. It encourages partnership and joint working to create a healthier and safer population by reducing the level of individual and community harm related to alcohol misuse.

3.2 There are six key areas underpin the strategic framework:

- Prevention and identification
- Enforcement and responsibility
- Treatment
- Local Action
- Vulnerable groups and inequalities
- Children and young people

3.3 A section has been developed for each key area that explores current action, the planned activity for the future and how we will know it has been successful.

4. Implementation

4.1 A strategy implementation group will monitor progress on the strategy. This group will meet on a quarterly basis to monitor progress and will review the strategy on an annual basis.
The implementation group will include a range of partners from:

- Kent County Council Public Health Department
- Kent County Council – Kent Drug and Alcohol Action Team (KDAAT)
- Kent Police
- Kent County Council Trading Standards
- A representative from one of the district councils
- A representative from primary care

4.2 The group will develop an action plan with a timeline and agreed responsibilities to ensure that actions developed will be focussed on achieving the outcomes within the strategy. They will have the role of ensuring delivery plans and individual actions are robust and enacted (refreshing them on a periodic basis), and that partners undertake their assigned responsibilities.

The strategy implementation will have the role of making sure that delivery plans and individual actions are robust and acted upon (refreshing them on a periodic basis), and that partners undertake their assigned responsibilities. They will provide the reports to the KDAAT Board, and other relevant committees, and make the case for commissioning services as appropriate.

The KDAAT Board will be the accountable body for the strategy and therefore take overall responsibility for the targets and performance measures. They will scrutinise reports, periodically provide progress updates, highlight successes and good practice as well as request remedial action when necessary.

5. Recommendations:

5.1 Members of the Health and Wellbeing Board are asked to note the Kent Alcohol Strategy.

6. Background Documents

Appendix 1 – Draft Kent Alcohol Strategy (2013-2016) (please note that draft was released in 2013, but final version will be 2014-2016)

Adobe Acrobat Document

Figure 1 Kent Alcohol Strategy draft

7. Contact details

Report Author:
Colin Thompson, Public Health Specialist
Email: colin.thompson@kent.gov.uk

THE REPORT

From:	Amanda Honey - Corporate Director, Customer & Communities
To:	West Kent Health and Wellbeing Board, January 21st, 2014
Decision No:	
Subject:	Dual Diagnosis Provision in Kent
Classification:	Restricted

Summary

There has been substantial development in identifying the issues that affect service delivery and outcomes of substance misusers with co-existing mental health problems in Kent. The development and implementation of the Kent and Medway Joint Working Protocol for co-existing mental health and substance misuse disorders (dual diagnosis) aims to address barriers to treatment as well as improving outcomes for this client group as outlined in the Kent Joint Health and Wellbeing Strategy.

Recommendation(s):

Note the contents of this paper and endorse the set-up of the Kent and Medway Dual Diagnosis Steering Group

1. Introduction

1(1) Individuals with co-existing mental health and substance misuse (drugs and/or alcohol) problems (dual diagnosis) often have multiple and complex long term needs, which require a coordinated and seamless, multi-agency response. Due to a variety of factors; such as a shortage of resources, lack of clarity around local service responses and a lack of workforce skills, this client group often fails to receive good quality and consistent care and often falls through gaps between the services.

1(2) The formation of the Kent and Medway Dual Diagnosis Working Group and the Development of the Kent and Medway Joint Working Protocol for co-existing mental health and substance misuse disorders (dual diagnosis) in 2011 aimed to address these concerns and barriers that had been identified in relation to services for dual diagnosis clients locally.

2. Context

2(1) The term 'dual diagnosis' covers a broad spectrum of mental health and substance misuse problems that an individual might experience concurrently. The nature of the relationship between these two conditions is complex and varies from individual to individual.

2(2) Dual diagnosis affect a third of mental health service users, half of substance misuse service users and 70 per cent of prisoners. Service users with a dual diagnosis typically use NHS services more and cost more.[1]

.2(3) A recent analysis of National Drug Treatment Monitoring Data (July 2013) has revealed that:

- There has been an increase in the proportion of dual diagnosis clients in structured treatment in Kent over the past three years from 11.1% as of July 2011 to 13.7% as of July 2013.
- The proportion of dual diagnosis clients differs across districts with the highest rates of dual diagnosis recorded in Tunbridge Wells (21%), Tonbridge and Malling (20%) and Sevenoaks (20%) and the lowest rates in Ashford (10%) and Dartford (11%).
- Significantly fewer dual diagnosis clients are in regular employment (10%) in Kent compared to non-dual diagnosis substance misuse clients (17%).
- Alcohol is the primary substance of misuse for 39.7% of dual diagnosis clients. This is comparatively high with only 27.3 of non-dual diagnosis clients with alcohol as their primary substance.
- Unsuccessful exits have fallen over the past three years for non-dual diagnosis substance misuse clients but have risen slightly for dual diagnosis clients.
- Referral sources have remained stable over the past three years with 42.8% of dual diagnosis clients referring themselves into structured treatment in Kent as of July 2013. GP and psychiatry services however only account for 8.4% of all client referrals.

3. Current Provision

[1] National Mental Health Development Unit and The NHS Confederation, 2009, p1

3(1) Treatment for dual diagnosis clients in Kent is provided within a 'serial' or 'parallel' model. Within the serial model treatment is consecutively provided by mental health (Kent and Medway NHS & Social Care Partnership Trust (KMPT) and substance misuse services (CRI in West Kent and Turning Point in East Kent), depending on the presenting problem, implying treatment of one condition before the other. Within the parallel model, treatment is provided concurrently by both mental health and substance misuse services (but not necessarily in harmony).

3(2) Without integrated treatment systems (treatment provision by one practitioner/service in a single setting), dual diagnosis clients move frequently between services, often not being adequately provided for in either Substance Misuse Services or Mental Health Services.

4. Progress

4(1) In 2010 KMPT facilitated a number of stakeholder events for Kent and Medway with a view to developing localised dual diagnosis integrated care pathways. A number of themes emerged from these events:

- No locally agreed definition of dual diagnosis
- The need for better communication between the services (including GPs) was highlighted repeatedly
- Lack of knowledge and understanding about the 'other' services in relation to accessibility, referral criteria, range of services offered and responsibilities
- Lack of joint working
- Dual diagnosis clients were felt to be 'bouncing' between services
- Knowledge gaps, with both substance misuse and mental health service providers lacking awareness of the skills in each other's' specialities
- Lack of protocols/agreed screening tools
- Incoherent or different approaches to treatment (e.g. abstinence approach versus a harm reduction approach; compulsory treatment versus non-compulsory treatment.

4(2) Subsequently KMPT produced ,as part of their CQIN, the Kent and Medway Joint Working Protocol for co-existing mental health and substance misuse disorders (dual diagnosis) – See Appendix 1.

4(3) KCC identified non-recurring funds to support the implementation of the protocol and appointed an independent facilitator to run a number of dual diagnosis workshops in Kent during June and July 2013.

4(4) The delivery of these workshops was well received by substance misuse and mental health staff and created the opportunity to deal more effectively with dual diagnosis.

5. Next Steps

5(1) The Kent and Medway dual diagnosis working group that was originally set up to draft the Kent and Medway Joint Working Protocol for co-existing mental health and substance misuse disorders recommends that its membership is being reviewed and replaced by a Kent and Medway Dual Diagnosis Steering Group. This is to reflect the changes in governance arrangements that took place in April 13 in accordance with the Health and Social Care Act 2012.

5(2) The Kent and Medway Dual Diagnosis Steering Group will have strategic oversight to ensure that the outcomes for people with both mental health needs and substance misuse problems as outlined in the Kent Joint Health and Wellbeing Strategy are being met and monitored against. (See Appendix 2 for Draft Terms of Reference)

5(2) It is also envisaged that the Kent and Medway Dual Diagnosis Steering Group has strategic oversight over a number of Task and Finish Groups that will be developed to implement the actions that have been identified following the dual diagnosis workshops. These include:

- the development of a comprehensive Dual Diagnosis Training Programme,
- development of a network of dual diagnosis champions across mental health and substance misuse services
- Improved partnership working between substance misuse services and mental health services
- Meeting the needs of elders with co-existing mental health and alcohol problems
- Meeting the needs of people with co-existing substance misuse problems and personality disorders
- Meeting the needs of people with co-existing substance misuse problems and psychosis

6. Financial Implications

6(1) KCC have identified £40,000 non-recurring funds to enhance dual diagnosis provision in Kent over the next year.

8. Conclusion

8(1) Significant progress has been made over the past three years in identifying the issues that affect the service delivery and outcomes of substance misusers with co-existing mental health problems.

8(2) The progress of this work has resulted in the development of the Kent and Medway Joint Working Protocol for co-existing mental health and substance misuse disorders.

8(3) To sustain this progress and to improve outcomes a new governance framework is required to ensure Kent is meeting the needs of people affected by dual diagnosis.

9. Recommendation(s)

The West Kent Health and Wellbeing Board is asked to:

i) Note the contents of this paper and endorse the set-up of the Kent and Medway Dual Diagnosis Steering Group

10. Background Documents

Appendix 1 - Kent and Medway Joint Working Protocol for co-existing mental health and substance misuse disorders (dual diagnosis)

2013V1.0DualDiagnosisProtocol.pdf

Appendix 2 – Draft Terms of Reference – Kent and Medway Dual Diagnosis Steering Group

2013-12-06 Kent and Medway Dual Dia

11. Contact details

Report Author:
Gaby Price, Commissioning Officer
Email: gaby.price@kent.gov.uk

Director Lead:
Amanda Honey, Corporate Director, Customer & Communities
Email: amanda.honey@kent.gov.uk

Item ……..

Decision No……..

By: Compiled by Colin Thompson following submission from the four district councils

To: West Kent Health and Wellbeing Board, January 21st, 2014

Subject: Barriers from the perspective of community safety partnerships

Classification: Unrestricted

---

1. Purpose

1.1 To inform the Health and Wellbeing Board regarding community safety partnerships of the four districts in the West Kent CCG area and their activity relating to substance misuse.

2. Background

2.1 Each local authority (unitary and districts) have community safety partnerships (CSPs). They are made up of representatives from the 'responsible authorities', which are the: police, local authorities, fire and rescue authorities, probation service and health (clinical commissioning groups).

2.2 The responsible authorities work together to protect their local communities from crime and to help people feel safer. They work out how to deal with local issues like antisocial behaviour, drug or alcohol misuse and reoffending. They annually assess local crime priorities and consult partners and the local community about how to deal with them.

2.3 Substance and alcohol misuse is associated with a wide range of criminal and anti-social behaviour, particularly public drunkenness and street drinking, violence, domestic violence, injury and deaths and casualties due to road traffic accidents.

3. Maidstone

3.1 Alcohol is a significant factor for much of the crime and disorder in Maidstone town centre, particularly in the night time economy. Alcohol and Substance Misuse are highlighted as a key priority through Maidstone's Strategic Assessment.

3.2 A Substance Misuse Group helps support or deliver a number of successful initiatives in the borough including;

- Maidstone Families Matter (Troubled Families): whole-family approach and support, Directed operations and supervision (to be undertaken by police and MBC Licensing Officers) to ensure that premises are well run;
- Worked with licence holders through the Night-time Economy Forum and other direct liaison;
- Promoted Maidstone as a safe place to visit for leisure and entertainment;
- Worked with local schools and hospitals to develop initiatives – such as Theatre ADAD's 'Wasted' - aimed at raising young people's awareness of the dangers of drugs and alcohol through the SMP Substance Misuse Sub-Group;
- Overseen the delivery of the Don't Abuse The Booze project, a two year project with a 'whole borough' integrated approach to firmly tackle problem drinking head-on by:
- Developing a comprehensive programme of alcohol education in our schools, Pupil Referral Units (PRUs) and colleges;
- Proactively reducing 'pre-fuelling' and binge-drinking;
- Challenging alcohol fuelled anti-social behaviour in identified 'hot-spots' in town centre and rural locations;
- Urban Blue Community Bus
- Reduce excess emergency ambulance call-outs and A&E admissions. A dedicated Street Population Officer on secondment from Porchlight, who works with CRI and the Maidstone Community Safety Unit
- SNAP (Say No and Phone Disco) under 18's disco

3.3 The Safer Maidstone Partnership has been successful in funding these initiatives through external funding streams including; £90,000 (Baroness Newlove's community safety fund) £45,000 (Police and Crime Commissioner and £157,000 (Kent Public Health).

3.4 The integrated approach will have a direct impact on reducing the four key harms arising from alcohol abuse: harms to health, harms to public order, harms to productivity and harms to families and society.

3.5 Initiatives that the SMP would like to present to and work with the Kent Health and Wellbeing Board to deliver are;

- Licensing: the issue of young people having access to alcohol - more work needed around education and prevention.

- Strengthening partnership working and appropriate information sharing to establish the scale of the problem of parental substance misuse and develop approaches to identify and work with families to improve outcomes (e.g. working with Maidstone Families Matter – the borough's Troubled Families programme).
- Support for older people who are at risk of alcohol misuse.
- Considering ways of providing access to alcohol screening and brief interventions in A&E and other acute settings.
- Pilot a GP Trainee street outreach programme with a drug treatment aspect, training and education services and skills development. By working with Maidstone Borough Council's Street Population Outreach Worker, CRI and Urban Blue Bus, the GP Trainee outreach programme would provide street based support for people who are or have been rough sleeping to provide support around mental health and drug use, homelessness and link to accommodation and other service providers.
- Establishing a single point of access for management of referrals and assessment of clients for substance misuse treatment services.
- Ensuring recovery support services (education, housing, benefits, employment) are available and fully integrated within the system for treatment of substance misuse.
- Understanding links between substance misuse and mental health and developing support systems
- Addressing legal highs, particularly young people thinking that these are 'safe'
- Trial Drug Tests on Arrest scheme to reduce the impact of alcohol and illegal drugs on levels of offending.
- Increase number of drug user offenders in treatment.

3.6 Such actions should be designed in partnership to achieve the following outcomes:

- More people who are at risk of or are engaging in substance misuse access and benefit from prevention and early intervention services.
- More people successfully recover from drug and alcohol problems, are engaged in education and employment and are not offending.
- Fewer people admitted to hospital with alcohol and drug related conditions.
- More children and young people are protected from the harm related to parental substance misuse.
- Fewer children and young people are drinking alcohol in a harmful way including binge drinking.
- Fewer young people report using illicit drugs.
- Fewer people engage in alcohol and drug related antisocial behaviour and Crime.

4. Sevenoaks

4.1 Between April 2012 – March 2013, there were 143 recorded drug offences in Sevenoaks District. This represents an increase from the previous year of 10%. This increase is compared with a county-wide increase of 1.3%. Despite this, Sevenoaks District remains the lowest in Kent for recorded drug offences. It ranks 1st lowest in its MSG.

4.2 Kent has seen a steady increase of alcohol related hospital admissions over the past ten years and alcohol remains the most common substance for those seeking treatment. According to the Kent Drug and Alcohol Action Team (KDAAT) there are an estimated 30,432 dependent drinkers and 17,410 binge drinkers in the County.

4.3 The trend for alcohol admissions in Sevenoaks has risen at a similar rate to those in Kent but overall levels have remained lower than the average admission rate and this year has the lowest overall number of admissions in Kent.

4.4 Sevenoaks Community Safety Partnership receives some funding from the Police & Crime Commissioner and part of this is used to fund a Substance Misuse Detached Youth Worker. The detached youth worker works with young people aged under 18 years old and visits schools and youth clubs. They are tasked to areas via the Community Safety Unit. Other drug and alcohol services are provided via CRI and KDASH.

4.5 The Community Safety Partnership work closely with the licensing team who are part of the Community Safety Unit (CSU). The Police Licensing Officer also sits within the CSU and there are good relationships and pro-active working together.

4.6 Barriers include not having representation from CRG's & Health Services on the Partnership, dealing with Substance Misuse and Mental Health Issues and a lack of local resources.

4.7 It would also be beneficial to have more information from the County Commissioned Services and Public Health team.

4.8 More communication would be a recommendation, working more closely with CSP's with someone sitting on the Partnership to make more links with Substance Misuse and Domestic Abuse and Crime.

4.9 Below are the actions that the CSP are taking forward for substance misuse in the 2013-14 action plan:

Priority Action	**Lead Agency**	**Other Partners**	**By When**	Funding
Structured early intervention projects identified for local needs to improve	CRI Substance Misuse TG	Kenward Trust KDAAT KCC Youth Services Domestic Abuse Group	On going	Existing Budgets

uptake of Recovery Board interventions				
Preventative and early intervention youth work to address identified local needs and improve well-being of young people	KCA Substance Misuse TG Kenward Trust	KDAAT KCC Youth Services Early Intervention Team	On going	Choosing Health CSP Alternative funding
Use a partnership approach to address underage drinking where it is reported by communities as a problem	Trading Standards	Landlords/Off License Substance Misuse Task Group KDAAT	June 2013	Existing budgets
Access to an identified substance misuse worker for the CSU to facilitate individual needs and training	CRI KCA CSU	Kenward Trust KDAAT Early Intervention Team Domestic Abuse TG	June 2013	Existing budgets

5. Tonbridge and Malling

5.1 Although some measures relating to alcohol and drug misuse give a positive picture of Tonbridge & Malling, important concerns remain. The related health, social and economic costs to individuals, families and communities are substantial. These include;

- Between October 2012 and September 2013 there were 273 recorded drug offences in Tonbridge and Malling, an increase of 19%.
- During June 2012 and May 2013 Tonbridge and Malling had 97 hospital admissions due to toxic effects of alcohol, or where there was evidence of alcohol involvement. This is a substantial increase from 53 the year before.
- Levels of dependent use of alcohol and drugs in Tonbridge & Malling are lower than the national average. However numbers of dependent users remain substantial and many of these individuals are very vulnerable.

- Children and young people affected by parental substance misuse are more likely to experience behavioural problems, poor educational attainment and to engage in substance misuse themselves.
- A substantial proportion of crime and antisocial behaviour is attributable to alcohol and drug misuse.

5.2 Tonbridge & Malling Borough Council supports a partnership approach towards setting out objectives and actions for alcohol and substance misuse that include:

- Ensuring effective provision of alcohol screening and brief interventions in general practice, and other primary care and criminal justice settings.
- Working with providers to introduce payment by results for adult substance misuse services that focus on recovery outcomes.
- Working with the Tonbridge & Malling Community Safety Partnership and Police interventions to reduce alcohol related violence against the person and antisocial behaviour.
- Commissioning the Kenward Trust through the Community Safety Partnership to engage with young people in the community to reduce their alcohol and drug consumption
- Supporting enforcement of licensing powers, including working with Trading Standards and Kent Community Action Partnership (KCAP) to tackling sales to underage drinkers.

5.3 Such actions should be designed in partnership to achieve the following outcomes:

- More people who are at risk of or are engaging in substance misuse access and benefit from prevention and early intervention services.
- More people successfully recover from drug and alcohol problems, are engaged in education and employment and are not offending.
- Fewer people admitted to hospital with alcohol and drug related conditions.
- More children and young people are protected from the harm related to parental substance misuse.
- Fewer children and young people are drinking alcohol in a harmful way including binge drinking.
- Fewer young people report using illicit drugs.
- Fewer people engage in alcohol and drug related antisocial behaviour and Crime.

5.4 The harm caused by misuse of alcohol and drugs to individuals, families and communities is substantial and is a concern in Tonbridge & Malling. Therefore, it is essential for any future commissioning of drug and alcohol support and services to support local programmes and interventions, which support;

- Prevention and early intervention of alcohol and drug related problems.
- Recovery orientated drug and alcohol specialist treatment.
- Families, children and young people.
- Tackling crime and anti-social behaviour relating to substance misuse.
- Focusing on outcomes and accountability.

5.5 Barriers to achieving the outcomes above could include:

- Lack of co-ordination between agencies working together to reduce alcohol and substance misuse. We need to ensure that we are working together so that we are not all trying to achieve the same outcomes but that different services are tackling different issues.
- Lack of funding to ensure the continuation of the services and to ensure that there are enough staff to support those who do require help.
- Concern about information sharing could mean that details about vulnerable people are not shared. This could then lead to people missing out on the treatment or support that they need.

6. Tunbridge Wells

6.1 Tunbridge Wells Borough Council commission partners such as Kenward Trust and the Space Cruiser to engage with and educate young people in various areas.

6.2 For 2013, the council are addressing problems at Paddock Wood, Rusthall and Sherwood on a regular basis. Careful commissioning is necessary due to a considerable reduction in budgets and staffing.

6.3 The council aim to inform young people of the dangers of drug use by engaging with them through various activities and in public areas. Once a relationship has been established, and drug use confirmed, we hope to refer them to KCA and other specialists for 1:1 remedial action.

6.4 Drugs and alcohol can have a huge impact on antisocial behaviour and crime. However, it is very difficult to measure the impact we are having by addressing the root causes. The council aim to engage with young people at risk before they get involved in ASB or criminal activity. This is essential because an ASB incident costs £44 whereas a young person receiving a custodial sentence for the first time costs £52,825. If we can intervene early enough we can have a healthy impact on the individual and the taxpayer.

6.5 The Council hope to introduce a project into every one of their 34 junior schools in 2014, called Passport To Safety. Although. This is initially aimed at road safety we hope to cover issues such as eSafety, Stranger Danger, Bullying, Substance Misuse, First Aid, Healthy Eating, etc. within the PSHE's (Personal, Safety, Heath, Community) curriculum.

6.6 The Council are working with KIASS (Kent Integrated Adolescent Service) to put a multi-agency programme in place to engage this age group through: school, home and on an individual basis. Current thinking is through sports/art/drama/music combining with education on drugs and responsible living.

6.7 The council plan to work with the police and Pubwatch in 2014 to encourage safer socialising within the borough, relating to the Night Time Economy. Much of this will focus on early detection of substance misuse and providing immediate assistance and brief interventions where possible. The Council have carried out

several operations where we have commissioned the police drugs dogs around the town centre.

6.8 The council have an extremely good relationship with all our licensing authorities working closely to ensure objectives are achieved. Recently Operation Cleansweep enlisted all major partners, sweeping through Southborough, ensuring compliance with regulations.

6.9 The council recognise that it can sometimes be difficult to have new ways of working supported by other local authority officers/departments. The CSU & Police dynamic is changing and to remain effective the CSU needs to change and adopt new routes to market. Some local authorities have actually commissioned out their entire Community Safety Unit in order to implement cost effective strategies.

6.10 Whilst new ideas seem to be fully supported by borough and parish councillors, there seems to be a reluctance to change from some officers/departments. Without these changes CSU's are unlikely to survive in their current form amid continuing austerity cuts. There is a danger of complacency if the 'improvement' ethic isn't adopted by LA's. Also some of the partners in the CSP need to be reminded of their function and accountability and possibly a recommitment needs to take place.

6.11 The council have a number of recommendations for the future. These include;

- More flexibility and a more robust model/template which could be standardised across the county.
- Closer communication between agencies. Less individuality and more cohesive working practices.
- We also need to promote the services and function of the CSU to residents. This is very difficult to do within current limitations.

7. Recommendations:

7.1 Members of the Health and Wellbeing Board are asked to note the briefing.

8. Contact details

Report Author:
Colin Thompson, Public Health Specialist
Email: colin.thompson@kent.gov.uk

Item ……..

Decision No……..

By: Colin Thompson

To: West Kent Health and Wellbeing Board, January 21st, 2014

Subject: Substance misuse: ways forward

Classification: Unrestricted

---

1. Purpose

1.1 To inform the Health and Wellbeing Board of potential ways forward regarding the substance misuse agenda.

2. Licensing

2.1 Licensing authorities are responsible for administering the 2003 Licensing Act in their areas. This includes issuing licences and enforcing the conditions of the licence, often working with the police. Licensing authorities are part of the local council.

2.2 The Licensing Act 2003 requires each licensing authority to carry out its duties with a view to promoting four licensing objectives. These are:

- the prevention of crime and disorder
- public safety
- the prevention of public nuisance
- the protection of children from harm

2.3 These objectives comprise the basis on which the licensing authority determines what is in the overall public interest when carrying out its functions. A licensing authority may only restrict licensable activities where it

is necessary for the promotion of these licensing objectives. Each objective is of equal importance.

2.4 Agencies that are responsible authorities can make an objection to a license application so long as it is on the basis of one of the four licensing objectives highlighted in 2.2. Public Health Departments in England were included as a responsible authority from April 2013, but due to health not being included as one of the licensing objectives, it has not been possible in any area of England to make an objection utilising health data.

2.5 Public Health Departments can work with licensing departments on other aspects. One example is to establish a Cumulative Impact Policy (CIP). This is the promotion of the licensing objectives of a significant number of licensed premises concentrated in one area, where the number, type or density of premises selling alcohol is high or exceptional, serious problems of nuisance and disorder may be arising, or have begun to arise, outside or some distance from those premises. A CIP is being considered in Medway, but none of the districts in the West Kent CCG area have alcohol related crime rates that are significantly higher than the England average, so this is not likely to be a viable option.

2.6 Removing cheap, high strength alcohol from the shelves of off licences restricts its availability to street drinkers, dependent drinkers, and under age children, who may be attracted by its ability to cause drunkenness quickly and at little cost. If imposed as a licence condition, the requirement is usually that the shop may not sell beers and ciders above 6.5% ABV. In voluntary schemes, Police and Council officers generally identify the products they want removed from the shelves, and work is done in the area to assist and support problem drinkers. Participating retailers are awarded a plaque to place in their window and are mentioned in local publicity.

2.7 Dover District Council have implemented such a scheme and Thanet District are planning to introduce one from April 2014. It has involved establishing voluntary scheme with off-licenses not selling cheap super-strength beer and cider to street drinkers in a designated area of Dover town centre. The campaign was set up by the Community Safety Team at Dover District Council in partnership that includes Kent Police, Probation, Turning Point, Dover Town Councillors. The campaign is still in operation so there are no formal outcomes as yet, although initial data has shown that there has been a reduction in the number of calls made to the Dover Community Safety team in relation to concern over street drinkers in the specified area. The majority of off licenses in the specified area have supported the campaign. Outreach is a key component in offering support to street drinkers with the aim of engaging them with the treatment service.

3. Kent Community Alcohol Partnerships

3.1 Community Alcohol Partnerships form a key strategy of both the police and trading standards which aim to change attitudes to drinking by:

- Informing and advising young people on sensible drinking
- Supporting retailers to reduce sales of alcohol to underage drinkers
- Promoting responsible socialising
- Empowering local communities to tackle alcohol related issues.

3.2 A number of Community Alcohol Partnerships have been established successfully across the county. A Kent Community Alcohol Partnerships "Toolkit" has been launched. This is a web based product which provides local communities with the opportunity to establish Community Alcohol Partnerships in their own localities. Trading Standards will support the developments of these partnerships

3.3 Agencies should work together to consider increasing the number of Community Alcohol Partnership in appropriate areas to expand their positive impact.

4. Identifying more people who need support

4.1 Given the increasing number of chronic liver disease deaths and the considerable proportion of increasing and higher risk drinkers, it is imperative to identify people at risk and offer appropriate support.

4.2 Opportunistic screening and brief interventions is likely to contribute to the primary outcome of reducing alcohol-related harm and alcohol-related hospital admissions by targeting the delivery of screening and brief interventions to selected populations at an appropriate time and in an appropriate setting reducing alcohol consumption in those drinking at increasing and higher risk levels. Healthcare settings provide excellent opportunities for identifying alcohol misuse.

4.3 Research has shown that;

- up to 20% of patients presenting to general practice settings will be consuming alcohol at higher risk or increasing risk levels
- one in six people attending accident and emergency departments for treatment have alcohol -related injuries or problems, rising to 8 out of 10 at peak times (HEA, 1998)
- 1 in 16 hospital admissions are alcohol related
- 9% of 999 calls are related to alcohol misuse
- 7% of ambulance journeys are as a result of alcohol misuse

4.4 Hospitals are an effective setting to identify and offer support around substance misuse . Emergency departments are often the first point of contact patients have with a hospital. This makes them a good location in which to identify patients misusing alcohol or drugs early in their admission or to provide some form of brief intervention to those who leave. A programme of intensive care management and discharge planning delivered by an Alcohol Liaison Nurse in the Royal Liverpool Hospital was shown to prevent 258 admissions or re-admissions resulting in about 15 admissions per month saved. Economic analysis of such an appointment in a general hospital suggested that it was highly cost effective with the potential of saving ten times more in reducing repeat admission than the cost of the programme.

4.5 There are plans in place to commission a hospital and drug liaison nurse service at Maidstone Hospital this coming spring.

4.6 There is potential to develop pathways around

4.7 Training will offered to staff across a number of agencies to carry out IBA. The training will help professionals in identifying individuals whose drinking might be impacting on their health by delivering simple, structured advice.

4.8 KDAAT and Kent Public Health need to create better linkages between Criminal Justice System alcohol interventions, the alcohol treatment system, and anti-social behaviour interventions, in order to reduce alcohol related harm and offences.

5. Raising awareness

5.1 Raising awareness through campaigns in the press, radio and through partner newsletters including workforce initiatives about the risks of substance misuse (particularly around the use of legal highs) is a priority.

5.2 Campaigns will be evidence-led social marketing campaigns to foster a responsible drinking culture.

5.3 RisKit is a specialist programme targets young people who are identified as vulnerable or are involved in risk taking behaviour, such as drug and alcohol use, or unprotected sex. It is delivered by KCA in schools. Young people are screened with those who are identified as most likely to be involved in risk taking behaviour offered intense support around. RisKit aims to help young people to build their skills and resilience, explore the reasons why they might take risks in order to help them make safer choices for them. It has been evaluated it was shown that it is effective at reducing risk taking behaviour including alcohol misuse. Additional capacity has been

commissioned by Kent County Council to ensure the programme will be offered in more schools across the county.

6. Identifying CCG support

6.1 From April 2013, CCGs are required to be a 'responsible authority' and a member of local community safety partnerships.
6.2 A clinical champion should be identified in order to work with other partners to progress any work around pathways (ie Identification and Brief Advice)
6.3 It is important to ensure that there are strong links between Clinical Commissioning Group's (CCG's) and agencies that commission and provide support or treatment for substance misuse. This will allow for enhanced understanding of treatment needs, screening, referral and advice services and passing relevant information.

7. Recommendations:

5.1 Members of the Health and Wellbeing Board are asked to note the briefing.

6. Contact details

Report Author:
Colin Thompson, Public Health Specialist
Email: colin.thompson@kent.gov.uk