AGENDA

CABINET

Monday, 12th July, 2010, at 10.00 am	Ask for:	**Karen Mannering / Geoff Mills**
Darent Room, Sessions House, County Hall, Maidstone	Telephone:	**(01622) 694367/ 694289**

Tea/Coffee will be available 15 minutes before the meeting.

UNRESTRICTED ITEMS

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

1. Declaration of Interests by Member in Items on the Agenda for this meeting
2. Minutes of the Meeting held on 14 June 2010 (Pages 1 - 8)
3. Revenue & Capital Budget Monitoring Exception Report (Pages 9 - 24)
4. Children and Young People of Kent Survey 2009 (NFER) (Pages 25 - 42)
5. KCC Strategy for the Employment of Socially Excluded Adults (PSA 16) (Pages 43 - 72)
6. A Hidden Harm Strategy for Kent (Pages 73 - 88)
7. "Towards a Smokefree Generation" Kent Tobacco Control Strategy 2010-2014 (Pages 89 - 134)
8. Operation Find and Fix - Weather Damage Repairs to Roads (Pages 135 - 138)
9. Decisions from Cabinet Scrutiny Committee - 23 June 2010 (To follow)
10. Other items which the Chairman decides are relevant or urgent

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Katherine Kerswell
Group Managing Director
Friday, 2 July 2010

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

KENT COUNTY COUNCIL

CABINET

MINUTES of a meeting of the Cabinet held in the Darent Room, Sessions House, County Hall, Maidstone on Monday, 14 June 2010.

PRESENT: Mr P B Carter (Chairman), Mr N J D Chard, Mr G K Gibbens, Mr R W Gough, Mr P M Hill, OBE, Mrs S V Hohler, Mr A J King, MBE, Mr K G Lynes, Mr R A Marsh and Mr J D Simmonds

IN ATTENDANCE: Mr D Cockburn (Executive Director, Strategy, Economic Development & ICT), Mr M Austerberry (Executive Director, Environment, Highways and Waste), Ms A Honey (Managing Director Communities), Ms L McMullan (Director of Finance), Mr O Mills (Managing Director - Adult Social Services), Ms R Turner (Managing Director Children, Families and Education) and Ms M Peachey (Kent Director Of Public Health)

UNRESTRICTED ITEMS

1. Minutes of the Meeting held on 17 May 2010
(Item 2)

(1) The Minutes of the meeting held on 17 May 2010 were agreed and signed as a true record.

2. Revenue & Capital Budget Outturn 2009-10, Roll Forward and Key Activity Indicators
(Item 3 - Report by Mr John Simmonds, Cabinet Member for Finance and Lynda McMullan, Director of Finance)

(1) Mr Simmonds briefed the meeting on the main points arising from this report and highlighted in particular some of the areas of potential pressure in Directorate budgets.

(2) The provisional outturn on the revenue budget showed an under spend of £8.826m (excluding schools) which was some £0.959m higher than the projected under spend reported to Cabinet at its meeting in May. Mr Simmonds also referred to the Capital Budget Outcomes and achievements as detailed in paragraph 7 of the report.

(3) Mr Simmonds said the overall budget situation was therefore balanced with sensible levels of reserves. This was the tenth year in succession the County Council had maintained its budget in limits and he placed on record his thanks to officers for the part they had played in that achievement. Mr Carter also placed on record his thanks to both members and officers in bringing in a balanced budget with an under spend of some £8.8m on the revenue side.

(3) **Resolved:**

(a) That the provisional outturn position for 2009-10. be noted

(b) Agreement be given to the £1.453m requests for roll forward of the 2009-10 revenue under spending to fund existing commitments, as detailed in Appendix 2.of the Cabinet report

(c) Agreement be given to the revenue under spending within the Finance portfolio being held in a new Corporate Restructuring Reserve (as detailed in section 3.4.1 of the Cabinet report).

(d) Agreement be given to the remaining £5.373m of the 2009-10 revenue under spending being set aside in the Economic Downturn reserve.

(e) it be noted that that £2.415m of capital re-phasing from 2009-10 will be added into 2010-11 and later years, as detailed in Appendix 3 of the Cabinet report and the 2010-11 Capital Programme would also be adjusted to reflect other 2009-10 variances as reported in the outturn.

(f) the final monitoring of the key activity indicators for 2009-10 as detailed in Appendix 4.of the Cabinet report be noted; and,

(g) the final financial health indicators for 2009-10 be noted as detailed in Appendix 5.of the Cabinet report, and,

(h) Cabinet place on record it's thanks to Officers for the part they had played in bringing in a balanced budget.

3. Response to Government Savings Announcement

(Item 4 – Report by Mr John Simmonds, Cabinet Member for Finance and Lynda McMullan, Director of Finance) (The Chairman declared consideration of a supplementary report circulated at the meeting to be urgent on the grounds that it contained for members consideration the most up to date information from government since the publication of the original Cabinet report.)

(1) This report updated Cabinet on the recent announcement of in-year reductions in Government grants. Cabinet also received a supplementary report which provided new and additional information and confirmed that the impact on the County Council was a loss in revenue grants of £10.865m and a loss of capital grants of £4.653m, leading to a total loss of £15.518m.

(2) Mr Simmonds briefed Cabinet on the main points arising from these losses and said the Council would need to quickly determine what budgets would be affected. None of the losses were to be ring fenced other than the £0.441m saving on Kick-start, although it was pointed out there would be a disproportionate effect on the CFE budget, a view which was endorsed by Mrs Hohler. The Council therefore had almost total flexibility on how it would wish to allocate the required savings.

(3) During the course of discussion cabinet members highlighted some areas of key concern and projects which could be affected as result of these reductions. Mr Carter said that now the general level of savings was known more detailed work

would need to follow and there would be a further report to the meeting of Cabinet at its meeting in July.

(4) **Resolved** that: the reductions in revenue and capital grants be noted and that and that there would be a further report to Cabinet at its meeting in July.

4. Treasury Management

(Item 5 - Report by Mr John Simmonds, Cabinet Member for Finance and Lynda McMullan, Director of Finance)

(1) Treasury Management is reported on a quarterly basis to the Governance and Audit Committee with regular reports now being made to Cabinet to help increase the level of communication on these issues.

(2) Mr Simmonds briefed the meeting on the latest position regarding the Council's approach to its strategy regarding deposits which had been helpfully informed by having the opportunity to discuss these matters first through the cross-party Treasury Advisory Group. One of the main points to arise from this was the recommendation that the maximum duration of deposits be extended from 6 to 12 months. Mr Simmonds also briefed Cabinet on why it was now thought right to take within strict and controlled circumstances long term borrowing opportunities.

(3) The report also provided an update on the latest position regarding the recovery of monies which the County Council had invested in Icelandic Banks. The position was the Heritable recovery process was proceeding as the administrator had initially set out and to date the Council had received payments totalling £6.4m from a total exposure of £18m. Ernst and Young had increased its base case recovery to 79-85% and further payments on a quarterly basis were expected through 2010/11. The claims against Glitnir and Landsbanki are subject to ongoing litigation and the details of this were set out in the report.

(4) **Resolved**

(a**)** The recommendation of the Treasury Advisory Group to extend the maximum duration of deposits from 6 to 12 months be accepted; and

(2) the long term borrowing opportunities which have been taken be noted together with the action being taken in connection with the litigation in Iceland on the Glitnir and Landsbanki claims.

5. An Alcohol Strategy for Kent

(Item 6 - Report by Mr Mike Hill, Cabinet Member for Community Services and Amanda Honey, Managing Director Communities)

(1) Mr Hill said The Alcohol Strategy for Kent set out the way forward for agencies across the county to work in partnership to prevent the harm caused by alcohol misuse. The issues around alcohol misuse raised important issues for KCC which needed to have in place an effective and responsive system. Mr Hill also spoke of the good work undertaken by the County Council Select Committee which had reviewed

the health implications and the costs associated with alcohol misuse. The report of the Select Committee had also been built upon by the work being undertaken by the Kent Action on Alcohol Steering Group.

(2) During the course of discussion members spoke in support of the Strategy and its objectives. The Strategy spanned across the services of KCC and linked into community safety issues, work with young people as well as health and mental health issues.

(3) **Resolved** that the Kent Alcohol Strategy 2010/2013 be approved

6. The BSF and Academies Programme - An Update Following Recent Government Announcements (To follow)
(Item 7– Report by Sarah Hohler, Cabinet Member for Children, Families & Education Directorate and Rosalind Turner Managing Director – Children, Families & Education Directorate) (Grahame Ward Director – Capital Programme & Infrastructure and Rebecca Spore – BSF Team were present for this item)

(1) Following the creation of the new coalition Government and the creation of the new Department for Education (replacement to the previous DCSF) there had been a number of announcements by the DfE and actions by Partnership for Schools (PfS) that had a direct bearing on the Council's current BSF and Academies Programmes, and these were detailed in the report.

(2) In presenting the report Mr Ward and Ms Spore detailed progress on each Wave in the BSF programme and provided an update on both Batch 1 and Batch 2 of the Academies Programme. Wave 3 was already well underway and would be unaffected by any funding announcements. As to the other Waves, there may be a degree of uncertainty in the way forward until the governments funding intentions became clearer but in the meantime work would be progressing on each Wave and Batch on the basis detailed in the report.

(3) **Resolved** that the current position be noted,

The following are unrestricted minutes of matters which were discussed at the meeting as being exempt under Section 100A of the Local Government Act 1972, on the grounds that they involved the likely disclosure of exempt information as defined in paragraphs 3 and 4 of Part 1 of Schedule 12A of the Act.

7. The BSF and Academies Programme - An Update Following Recent Government Announcements (To follow)
(Item 9 - Report by Mrs Sarah Hohler, Cabinet Member for Children, Families & Education Directorate and Rosalind Turner Managing Director – Children, Families & Education Directorate) (Mr Grahame Ward - Director – Capital Programme & Infrastructure and Rebecca Spore – BSF Team were present for this item)

(1) This report outlined the potential financial implications and existing contractual commitments in relation to the Building Schools for the Future Programme and Batch 1 and Batch 2 of the Academies Programme. The report outlined the work

undertaken to date in respect of both the programmes and indicated the possible costs and contractual implications should it not prove possible to progress them any further in the light of financial restrictions.

(2) During the course of discussion Mr Carter spoke about the need for the Council to look carefully at all options and to proceed with this work as far as was possible before there was a need to take final decisions which could only be taken against a background of legal and financial certainty as to the Council's position on the way forward. He said, and it was agreed that a letter be sent to the Minister setting out Kent's position in respect of BSF and Academies and the current position of each Wave. The letter would particularly bring to the Ministers attention the County Council's concerns regarding the contractual implications for Kent should Wave 4 be halted.

(3) **Resolved.**

(a) Wave 4, work should continue until the June budget and the position should then be re-assessed in consultation with the Local Education Partnership;

(b) in respect to Waves 5 and 6, that the work being undertaken so far be completed and at that stage put on hold until a clear way forward for BSF is announced;

(c) a letter be sent to the Minister setting out the County nt position in respect of BSF and Academies and the position of each Wave. The letter would also highlight the concerns which the County Council has in terms of the contractual implications should Wave 4 be halted; and

(d) reports be submitted to future Cabinet meetings as appropriate until the situation is resolved.

8. The Future of Older Persons' Provision in Kent County Council

(Item 10 - Report by Mr Graham Gibbens, Cabinet Member for Adult Social Services and Oliver Mills, Managing Director, Kent Adult Social Services (Mrs T Dean and Mr L Christie were present for this item as was Ms C Highwood, Director of Strategic Business Support, KASS)

(1) Kent Adult Social Services (KASS) was reviewing its capital provision, and specifically the in-house provision of residential services for older people. The drivers for this included the need to modernise services and to respond to changing demands, both as a result of predicted needs, and also the style of support that people were beginning to demand. At the same time the costs of the current service, together with the costs of any capital required for upkeep, and more critically for modernisation, would also have to be taken into account. The report therefore considered the potential options and opportunities and detailed the consultations to be undertaken to enable future decisions to be taken on modernising the service.

(2) Mr Gibbens gave a detailed explanation as to the reasons a review of these services was being undertaken. He spoke about the need to look carefully at the current levels of provision and how that could be better matched to meet future needs

and demand. Whilst there would always be a need to provide residential care, Mr Gibbens said current evidence suggested that in future more people would, with appropriate support, wish to stay in their own homes.

(3) Mr Gibbens said looking at some of the facilities currently in use it was obvious there were buildings and facilities that were in great need of modernisation and costly to run. The report therefore detailed a number of options for the future of 12 of the 16 care homes in Kent which because they were older buildings and did not have the facilities to meet modern expected standards, needed to be part of an assessment as to their long term suitability as care homes. Therefore said Mr Gibbens whilst moving forward in looking at the options would inevitably create anxiety and concerns for residents, their families and staff, the opportunity had to be taken now to look at ways to modernise services and to provide the quality of care expected in a modern environment

(4) During the course of discussion Mr Christie asked questions relating to the number of beds and staff likely to be affected. Officers advised that some 282 people were served by the existing homes of which 105 had permanent residency. The remainder were either respite or short term clients. The 6 homes mentioned for possible closure had between them a total of some 378 staff which equated to 184 FTE,

(5) Mrs Dean asked questions around how members would continue to be involved as the consultation process progressed. She also asked about the involvement of local members and how would the decisions be taken; individually or as package. Mrs Dean also asked whether KCC withdrawing from this sector in the way proposed would have an effect on future prices paid in the private sector. Mrs Dean also asked what checks would be made on those companies or organisations KCC may consider going into partnership with at some future date. She also said she felt the helpline designed to keep people informed needed to be open 24/7 and that the Council should be seen to be doing all it could to keep people informed as to how they are going to be helped and supported through this process.

(6) Mr Gibbens said that when the time came he expected all decisions would be taken at the same time but on an individual basis. He would be writing to all members of the Council inviting them to a briefing and this matter would also be discussed at the next meeting of the Adult Social Services Policy Overview and Scrutiny Committee. There would also be measures in place to ensure local members as well as Mrs Dean, Mr Christie and the other members of the Council were kept informed as the consultation process progressed. Mr Mills said that he and his officer team were very much aware of the concerns which Mrs Dean and Mr Christie had raised and they would be doing everything they could to ensure that the consultation process was undertaken with care, sensitivity and transparency. Mr Mills also said he would keep a close eye on the price issue raised by Mrs Dean but he did not expect that would in the event be an issue. He also said that any potential partners would be appropriately vetted as to their suitability and ability to give a long term commitment. There would also be one to one help and support to residents and their families and all this would be started immediately.

(7) In concluding the discussion Mr Carter thanked Mrs Dean and Mr Christie for attending the meeting and said whilst some tough decisions needed to be taken. This was only the launch of the consultation process. He therefore agreed that the

consultation process should now commence on the basis set out in the report and described during the course of the discussion. He also said consideration would be given at the end of the consultation as to whether the decisions would be taken by Cabinet or by the Portfolio Holder.

(8) Resolved

(a) the consultation process into options by which it was intended to modernise the facilities available to older people as described in the Cabinet report be endorsed and

(b) future decisions on the transfer to an independent sector provider or on closure should be entered on the Forward Plan, and only be taken after discussion in the Adult Social Services Policy Overview and Cabinet Scrutiny Committee, at the appropriate time

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To: CABINET – 12 July 2010

By: John Simmonds, Cabinet Member – Finance
Lynda McMullan, Director of Finance

REVENUE & CAPITAL BUDGET MONITORING EXCEPTION REPORT

1. Introduction

1.1 This is the first exception report for 2010-11. It reflects our response to the recent in year revenue Government grant reductions in section 2 and section 3 identifies a number of significant pressures that will need to be managed during the year if we are to have a balanced revenue position by year end.

1.2 Our response to the in year capital grant reductions is detailed in section 4 and details of issues faced within the capital programme are provided in section 5.

2. IN YEAR REVENUE GRANT REDUCTIONS

2.1 The Government recently announced the following 2010-11 revenue grant reductions for Kent:

Table 1: Government Revenue Grant reductions

	£000s
REVENUE BASE	
• Area Based Grant for CFE	6,873
• Area Based Grant for Supporting People	736
• Area Based Grant for Road Safety	608
• DoT Kickstart 2009 Specific Grant	441
• Area Based Grant for Stronger Safer Communities	132
	8,790
REVENUE ONE-OFFS	
• Performance Reward Grant (PRG)	1,326
• LABGI	750
	2,076
TOTAL 2010-11 REVENUE GRANT REDUCTIONS	**10,866**

2.2 As we have been prudent in our assumptions regarding our success in achieving PRG, we hadn't allocated the full expected PRG into cash limits and therefore the loss of £1,326k does not impact on our budget, it does though remove our anticipated flexibility to allocate this funding in due course. That therefore leaves a £9,540k in-year revenue grant reduction for us to address. Our response to this in-year is detailed in the table below; and was approved by the Leader in a Key Decision signed on 18 June and considered by Cabinet Scrutiny Committee on 23 June:

Table 2: KCC proposals to address revenue grant reductions

Proposal	£000s	Comments/Action	Impact on cash limit
CFE portfolio:			
1. Drawdown Asylum Reserve	-800	This is considered possible following successful negotiations with Government during 2009-10 over future funding levels. This will leave £890k in the reserve	A reduction in the Asylum gross cash limit on page 19 of the budget book from £16,670k to £15,870k

Proposal	£000s	Comments/Action	Impact on cash limit
2. Drawdown the Contact Point Reserve	-500	The DfE have very recently announced that this project is being disbanded, therefore the reserve is no longer required, although there will be some residual costs and therefore a balance of £84k will remain in the reserve.	A reduction in the grant & contingency gross cash limit on page 23 of the budget book from £18,153k to £17,653k
3. Reduce the bad debt provision	-500	The bad debt provision was increased at the end of 2009-10 by £500k due to one outstanding debt of £1m. The debtor is withholding the funds until the transfer of land is resolved. Following discussions with Legal and Property Services it is now clear that this will be resolved and the debt will be paid during 2010-11; therefore the bad debt provision can be reduced.	A reduction in the grant & contingency gross cash limit on page 23 of the budget book from £17,653k (see item 2 above) to £17,153k
4. Re-badge ABG expenditure against DSG	-2,000	Although the Government has reduced CFE's element of the Area Based Grant (ABG), a saving against the Connexions Service, which is fully funded from this grant, cannot be made in 2010-11 as the contract was signed last year. We are therefore looking to re-badge some of this expenditure against the Dedicated Schools Grant (DSG) in order to meet the ABG reduction. This will result in a reduction in the Directorate's element of the DSG reserve balance of £2m. This will not impact upon schools.	A reduction in the grant & contingency gross cash limit on page 23 of the budget book from £17,153k (see items 2 & 3 above) to £15,153k
5. Underspend against the Early Years entitlement extension funded by Standards Fund	-1,500	Based on previous experience, it is considered likely that we will underspend against this grant by £1.5m during 2010-11. This is because the take-up of places in early years provision by families has always fallen short of the full entitlement made available through the grant funding.	A reduction in the grant & contingency gross cash limit on page 23 of the budget book from £15,153k (see items 2, 3 & 4 above) to £13,653k
6. Review of expenditure against Specific Grants	-800	We have analysed the grants and focussed the savings on those areas that will have the least impact upon staffing (because in-year savings would be difficult to achieve) and that minimise the impact on schools and front-line services. The result is planned savings in the following areas: • £555k from Extended Services – Start Up grants where money has not been committed • £139k on Targeted Support for Primary schools in respect of early years foundation stage curriculum where funding has not been committed • The balance of £106k is coming from savings across six other grants, namely Choice Advisers, Care Matters, Play, Designated Teachers, Music and Health Needs.	A reduction in the grant & contingency gross cash limit on page 23 of the budget book from £13,653k (see items 2, 3, 4 & 5 above) to £12,853k
	-6,100		

Proposal	£000s	Comments/Action	Impact on cash limit
EHW portfolio:			
7. Road Safety ABG	-608	(i) Reduce contribution to the Kent & Medway Safety Camera Partnership by £440k (ii) £168k of other road safety reductions, including not going ahead with the speed limit review.	A reduction in the KHS gross cash limit on page 49 of the budget book from £61,136k to £60,528k
	-608		
Communities portfolio:			
8. Drawdown Supporting People Reserve	-736	The intended purpose of the Supporting People reserve is to manage the impact of anticipated reductions in the main Supporting People grant over the next few years. In the short term the elimination of the Supporting People Admin grant will be mitigated by a drawdown from the reserve. Whilst we endeavour to make efficiencies over the medium term, it is inevitable that front line service will be affected in the future in order to manage the anticipated reductions in the main grant now that the reserve balance will be depleted. This approach will be confirmed with the Commissioning Body at their next meeting, which is due later this month.	A reduction in the Supporting People gross cash limit on page 57 of the budget book from £32,830k to £32,094k
9. Stronger, Safer Communities ABG	-132	This reduction in funding will be communicated to the CDRPs (District Councils), with the view that they will be required to amend their in-year expenditure accordingly.	A reduction in the ABG Safer, Stronger Communities & other centrally held allocations gross cash limit on page 99 of the budget book from £1,510k to £1,378k. (Although shown within the Finance portfolio in the Budget Book, £1,385k of this budget is to be transferred to the Community Safety budget within the Communities portfolio)
	-868		
Finance portfolio:			
10. Drawdown from Economic Downturn Reserve	-1,964	Following the Government grant reductions, it is now appropriate to draw down some of this reserve.	A reduction in the Contribution to/(from) Reserves gross cash limit on page 99 of the budget book from -£3,461k to -£5,425k
	-1,964		
TOTAL	**-9,540**		

2.3 It should be noted that although a number of our proposals in dealing with these grant reductions are to drawdown reserves, this is only a short term solution in order to give us time to address these reductions with longer term solutions. These draw-downs from reserves have also been possible due to either a recent change in circumstances, such as projects being disbanded eg Contact Point, or because resources were specifically set aside for circumstances such as these eg Economic Downturn reserve.

2.4 As two of the Government grant reductions shown in table 1 totalling £1,191k, are specific grants (LABGI and Kickstart), these reductions will have a net nil impact on our cash limit as, for LABGI, both our expenditure and income cash limits will be reduced, and, for Kickstart, neither the expenditure nor the income were included in our original budget figures. The remaining £8,349k grant reduction all relates to Area Based Grant (ABG) and will result in a reduction to portfolio cash limits, as ABG is treated as a funding source of our budget requirement in a similar way to formula grant and council tax income. Our overall budget requirement will reduce as a result of these reductions. The impact of these proposals on our portfolio revenue cash limits is shown in table 3 below:

Table 3: Portfolio revenue cash limit adjustments required as a result of the grant reductions and our proposed treatment

Portfolio	£000s	Comments
CFE	-6,100	
KASS	0	
EHW	-167	The portfolio is having its Kickstart grant income cut but the related expenditure will remain and therefore an increase to the net cash limit of the portfolio is required of £441k. This is in addition to the reduction in Road Safety ABG of -£608k.
Communities	-736	
Localism & Partnerships	0	
Corporate Support & Performance Management	0	
Finance	-2,096	As the CFE ABG reduction is £6,873k but the portfolio savings proposals total £6,100k, the balance of £773k together with the impact of the LABGI grant cut of £750k and the Kickstart grant cut of £441k will be met by drawing down the Economic Downturn reserve. In addition the £132k reduction in the Stronger Safer Communities ABG will affect the Finance portfolio cash limit as explained in item 10 in the above table.
Public Health & Innovation	0	
Regeneration & Economic Development	+750	The portfolio is having its LABGI grant income cut but the related expenditure will remain and therefore an increase to the net cash limit of the portfolio is required.
	-8,349	

2.5 It is also likely that there will be a further impact on our funding levels as a result of the new Government's aim to reduce public spending, as external partners seek to pass on their Government grant reductions. Two confirmed examples are provided in section 3.5.2 below, where the Sports Development Unit have recently been informed of reductions to their funding from the Department of Health and Youth Sports Trust.

3. 2010-11 REVENUE MONITORING POSITION BY PORTFOLIO

A summary of the forecast revenue pressures, excluding schools, is shown in table 4 below:

Table 4: 2010-11 Revenue pressures:

Portfolio	£m	Pressure/Saving
Children, Families & Education	+0.435	Ongoing impact of pressures experienced in 09-10 on Fostering, 16+ Service & Legal Services together with pressures on residential care, adoption services and delays in the restructure savings. These pressures are largely offset by a continuation of the savings in 09-10 on social worker vacancies and Home to School Transport.
Kent Adult Social Services	+3.032	Continuation of the trends in 09-10 relating to demographic pressures and more complex needs, particularly within Residential Care for Learning Disability, Physical Disability and Mental Health clients, partially offset by the release of unallocated contingency budgets and savings from vacancy management.
Environment, Highways & Waste	+0.290	Pressure on Waste contract prices offset by reduction in Waste tonnage. Increased costs due to greater take up of Freedom Pass partially offset by staff vacancy savings.
Communities	+0.842	Reduction in funding within the Community Learning Service since the budget was set Reduction in Sports Development Unit External funding as partners seek to pass on their reductions in Government grants
Localism & Partnerships	+0.254	Restructure of staff officer/Member support areas & shortfalls in pay and supplies budgets within Democratic Services
Corporate Support Services & Performance Management	-0.450	Increased income within Legal Services
Finance	0	-£1.016m relating to 2010-11 write down of discount saving from 2008-09 debt restructuring but as planned this will be transferred to the Economic Downturn reserve.
Public Health & Innovation	0	
Regeneration & Economic Development	0	
Total	**+4.403**	

3.1 The £4.403m pressure shown in table 4 above is before the implementation of management action. Directorates are currently working to identify options to reduce these pressures with the intention of delivering a balanced budget position by 31 March 2010. Details of management action plans will be reported in the first full monitoring report to Cabinet in September.

3.2 Children, Families & Education portfolio:

A net pressure of £0.435m is forecast due to:

3.2.1 **+£0.125m Residential Care** - a gross pressure of £0.625m is forecast, partly offset by additional income of £0.500m. Despite the underspend experienced in the previous year, and subsequent saving offered up, the service has recently experienced an increase in the number of children placed in independent sector residential placements resulting in an estimated gross pressure of £0.900m. This budget is particularly volatile due to the high cost of placing a single child in residential care. This pressure is partially offset by contributions from health and other education services of £0.500m. There is currently a high level of activity in independent sector residential care for disabled children, which could lead to further pressures on this service. The figures are currently under investigation and a further update will be given in future monitoring reports.
The pressure on independent sector placements is expected to be partially offset by an underspend on secure accommodation of around £0.275m.

3.2.2 **+£1.350m Fostering** – this service overspent by £1.7m in 2009-10 partly due to the very high levels of Independent Fostering Allowances (IFAs) and in-house fostering placements. The pressure on these services is expected to continue in 2010-11 due to the full year effect of children placed in 2009-10 and additional placements expected in 2010-11. Although significant funding was made available as part of the MTP, this has been insufficient to cover the demands for these services resulting in a forecast pressure of £1.2m for IFAs and £0.3m for in-house fostering placements. These pressures are offset to some degree by a forecast underspend in the County Fostering Team of £0.150m partly due staffing vacancies (£0.050m) and delays in the commissioning of the county wide therapeutic service which is expected to commence during the Summer (£0.1m). The Head of Service is looking at the forecast to see what options there are to reduce this pressure without impacting upon service delivery. Work is also continuing with the London Boroughs in respect of the issue of Looked After Children being placed in Kent by them. The Managing Director has met with a delegation of London Authorities in late May and discussed their placement polices and the pressure this puts on the schools and other local services in East Kent. There was general recognition that authorities should try and develop more local provision and if they had to place out of area they should try to avoid East Kent which already has a high number of vulnerable children and young people. A number of actions have been agreed and there is confidence that the London authorities recognise the issue and will work with Kent to ensure that there is more local provision for their looked after children.

3.2.3 **+£0.100m Adoption** – Adoption payments are linked to earnings and to the needs of the child. This year there is an estimated pressure of £0.2m following the payments review, which may be linked to the impact of the recession on adopters' incomes. This is partially offset by a £0.1m underspend on Special Guardianships Orders.

3.2.4 **+£1.000m 16+ Service** – in 2009-10 the 16+ service ended the financial year with a pressure of £0.835m. A provision was made in the MTP to fund this pressure however due to significant demands on this service resulting from a peak in the number of children turning 16, the service is continuing to forecast a significant pressure of around £1m. This has resulted from a high number of children transferring to this service in high cost placements (residential care and independent fostering allowances). This forecast assumes that a number of children will transfer to lower cost supported lodgings, however the authority has a legal obligation to maintain the existing placement if the child requests. Further updates will be given in future monitoring reports. The Head of Service is looking at the forecast to see what options there are to reduce this pressure without impacting upon service delivery.

3.2.5 **-£2.400m Assessment & Related** - a high level of staff vacancies resulted in an underspend of £3.658m in 2009-10. Recently there has been a number of successful recruitment drives, both nationally and internationally, and whilst we continue to advertise social work posts on a rolling basis, it is expected that the underspend on staffing for the current year will be in the region of £2.4m. However, £1m of this underspend will be required to fund the one-off costs incurred by delays to the directorate restructure (see 3.2.8 below).

3.2.6 **-£1.000m Home to School Transport (-£0.500m SEN & -£0.500m Mainstream)** – successful contract renegotiations in the previous financial year will be enjoyed this current year and we are currently projecting a £1m underspend, £0.5m for SEN and £0.5m for Mainstream. Given the

significant underspend realised last year, we think there may be further savings to be accessed and we are seeking a more detailed forecast from the Passenger Transport Unit. As in previous years, an accurate forecast will not be available until the September pupil numbers are known, and this will be included in the second quarter's monitoring, to be reported to Cabinet in November.

3.2.7 **+£0.260m Business Planning & Management Unit** – this reflects a continuation of the pressure on the Legal services budget following the introduction of the public law outline, a change in the way care proceedings are conducted.

3.2.8 **+£1.000m Restructure** – the CFE SMT have agreed that the costs of delays in the restructure will be funded from the one-off use of £1m of staffing underspend from the Specialist Children's Services budget (see 3.2.5 Assessment & Related above). A more detailed forecast of this potential pressure will be conducted later in the year when budgets have been re-issued to reflect the new structure.

3.2.9 **Asylum** - The Asylum Service is undergoing a major review to bring the unit costs down to £150 per week, and is forecasting to come in on budget this year. However, the work that the UK Borders Agency are doing to speed up the ARE (All Rights of appeal Exhausted) process could have an adverse impact on the budget because the removal process has not been accelerated in tandem, as was promised. The UKBA will fund the costs of an individual for up to three months after the ARE process, but the LA remains responsible for costs up under the Leaving Care Act until the point of removal. As the gap between the date of ARE and the date of removal widens, then our ability to achieve a balanced position on Asylum becomes more difficult. It should be noted that since 1 April 2010 there have been 20 young people declared ARE but there have been only 4 removed from the UK. Whilst overall numbers have remained relatively stable, the last weekend in June saw the arrival of 17 new UASC at Dover. The Government are working with other European partners to set up a centre in Kabul to support returning asylum seekers which may improve the timescale for removal, but the completion date of the centre is not yet known. An update will be provided in the first quarter's monitoring report to Cabinet in September.

Risks not currently included in the forecast:

3.2.10 **LSC Transfer** - Prior to the transfer of post 16 funding responsibility on 1 April 2010, the LSC had met the costs of term time residential placements at Independent Specialist Providers (ISP) for post 18 learners. This was a unique situation for Kent learners. Whilst the current position was accepted by the LSC and they funded those placements, that was not the initial stance of the new Young People's Learner Agency (YPLA). Following intense discussion with them, the ISP placement funding has now been confirmed, but only for the current financial year. There is still a considerable amount of work to do with the YPLA in order to secure the future position and ensure there is no financial impact on KCC.

3.2.11 **Schools:**

There is a great deal of uncertainty around the impact of the government's proposals for academies, and how many of our schools may be fast-tracked to academy status this year. This could have a small impact on our budget this year, as schools take with them a proportion of centrally held funds, which would not necessarily generate a corresponding saving within the directorate. More information will become available as we move through the year and updates will be provided in future monitoring reports.

3.3 <u>Kent Adult Social Services portfolio:</u>

3.3.1 The initial forecast indicates a pressure of £3.032m. It should be noted that detailed forecasts are currently being worked on, in order that the report to be Cabinet in September is more firmly based. Over the forthcoming weeks, the KASS SMT will be working to ensure that appropriate Guidelines for Good Financial Practice are in place to reduce the pressure in order to achieve a balanced position by the end of the financial year. KASS are also in the process of reviewing all cash limits and affordable levels of activity in the light of the 2009-10 outturn and any changing trends in activity that have become apparent since the budget was set. Requests for virement or for realignment of gross and income cash limits will be submitted as part of the first full monitoring report to Cabinet in September.

This forecast pressure assumes that all savings identified within the Medium Term Plan will be achieved. Work is on-going with Areas to identify methods of accurately tracking progress against each saving on a monthly basis.

The main reasons for the £3.032m pressure are detailed below:

3.3.2 **-£0.571m Older People Other Services** – this follows the release of £0.519m of uncommitted contingency, which is used to reduce the overall portfolio pressure. There are also small variances, both over and under, against the remaining services, including payments to voluntary organisations, day-care, and meals.

3.3.3 **+£4.102m Learning Disability Residential** – this includes estimates of costs for clients known to be coming into residential placements during the year ahead. Alongside demographic growth within this client group, there is increasing pressure relating to new and existing clients whose needs are becoming more complex. This is particularly true for those clients coming through transition from childhood. The forecast assumes that a number of clients will be transferred into Supported Accommodation placements during the year and the success of this will have to be closely monitored. The number of clients has increased from 632 in March to 666 in April although 25 of these are S256 placements wholly funded by health. It should be noted that the cash limit was previously reduced to fund expected growth in other services including direct payments and supported accommodation. The Directorate is reviewing these assumptions for the first full monitoring report where requests for virement or realignment of gross and income cash limits may be submitted.

3.3.4 **-£0.900m Learning Disability Other Services** – following the release of £0.830m of Contingency held by the Managing Director to offset the overall pressure within the portfolio, together with other small variances from cash limit.

3.3.5 **+£0.717m Physical Disability Residential** – this pressure results from similar pressures seen within Learning Disability Residential. The number of clients has increased from 222 in March to 225 in April and this level remains significantly higher than the affordable level. It should be noted that as with Learning Disability Residential, the cash limit was previously reduced to fund expected growth in other services including direct payments and supported accommodation. Again the Directorate is reviewing these assumptions for the first full monitoring report where requests for virement or realignment of gross and income cash limits may be submitted.

3.3.6 **+£0.451m All Adults Assessment & Related** – it is expected that this pressure will be reduced through vacancy management.

3.3.7 **+£0.883m Mental Health Residential** – the number of clients expected to remain within a residential placement is above the level afforded in the budget. The affordable level was reduced as a result of the decision in 2008-09 and 2009-10 to transfer cash limit from this line to fund expected growth in other services including direct payments and supported accommodation, and to reflect the changed priorities in the Directorate and the desire for clients to remain within a community based setting.

3.3.8 **-£0.200m Mental Health Direct Payments** - as referred to above the affordable level was increased in both 2008-09 and 2009-10 to reflect the changed priorities in the Directorate to keep clients, wherever possible, within a community based setting such as supported accommodation or via direct payments, rather than residential care, however this change has not happened as quickly as anticipated.

3.3.9 **-£0.310m Mental Health Assessment & Related** – this in part results from vacancy management but also from difficulties in recruiting qualified social work staff. Savings also accrue from difficulties experienced in recruiting to senior positions for joint health/social care posts.

3.3.10 **-£0.181m Mental Health Other Services** – this results from small variances against a number of budget lines including payments to voluntary organisations, daycare, facilities and community services.

3.3.11 **-£0.577m Strategic Business Support** – this is spread across a number of teams both at Headquarters and in the two Areas and reflects vacancy management, as well as cases where posts have been funded through a grant. There are also cases where there has been backfilling of posts and this has either been done at a lower cost or the post has not been covered, both of which have added to the underspend. There have also been savings against non-pay costs.

3.3.12 In addition to these variances, there are a number of other smaller variances, each below £0.1m, across all other services which make up a further £0.382m underspend.

3.4 Environment, Highways & Waste portfolio:

A net pressure of £0.290m is forecast due to:

3.4.1 **Waste:**

3.4.1.1 **+£1.1m Price pressure:** The RPI index for April was much higher than budgeted, which has put significant price pressure on some of the Waste contracts. The Allington waste to energy price per tonne is £2.38 more than the budgeted figure, which increases costs by £0.773m (assuming minimum tonnage through Allington of 325,000 tonnes). Inflation on other disposal and household Waste Recycling Centre contracts is expected to increase the total price pressure on waste to £1.1m.

3.4.1.2 **-£1.1m Tonnage:** This price pressure is expected to be offset by overall tonnage being less than the budgeted 760,000 tonnes. It is very early in the year to predict outturn tonnage with any level of certainty but there is an expectation that tonnage will be at least 16,000 tonnes below budget which would give a saving of £1.1m at an average disposal cost per tonne of £68. Therefore at this stage it is expected that the waste budget will break even.

3.4.2 **+£0.390m Freedom Pass:** Initial estimates on the cost of the Freedom Pass show a pressure of £0.390m due to the popularity of the pass and the number of journeys now being undertaken. This may increase during the year depending on the take-up of passes in the new academic year and more will be known around October.

3.4.3 **-£0.100m Resources:** Vacancies are being held in Resources to offset these pressures.

3.4.4 The directorate is looking at ways to address this unresolved net pressure of £0.290m but there are no firm plans at present. The lack of room for manoeuvre in waste disposal and the constant pressures on highways maintenance mean that finding alternative savings is very difficult. However, the directorate will do everything it can to produce a balanced budget by year end and is confident of doing so.

3.5 Communities portfolio:

A net pressure of £0.842m is forecast which is due to:

3.5.1 **+£0.750m Community Learning Service (Adult Education & KEY Training)** – since the Budget Book was published, the service has been notified that funding has reduced by £0.750m. The service is currently devising management action to mitigate against this funding pressure.

3.5.2 **+£0.092m Sports Development:** we have recently received notification from external funding partners that we will not be receiving specific sources of funding this year as a direct result of the new Government's aim to reduce public spending for the following projects:

- -£60k from Department of Health towards physical activity work, which will reduce our ability to meet the LAA National Indicator 8 target).
- -£20k from Youth Sport Trust to run specific training for teachers

In addition, we have recently received notification from Sport England that the Recruit into Coaching project has been cut, for which we were expecting £12.5k.

It is currently expected that expenditure will be reduced accordingly to offset the impact on the outturn position.

3.5.3 **Coroners:** the service is not currently reporting an adverse variance, but the budget allocated to long inquests, which is demand led, remains exposed to an increase in the number of referrals of suspicious deaths. Already this financial year, an inquest has been conducted that is expected to cost in the region of £0.045m so a recurrence of such inquests would be a pressure on the service.

3.6 Localism & Partnerships portfolio:

A net pressure of £0.254m is forecast, which is due to:

- **+£0.254m Democratic Services** – Of this, £0.175m is due to the restructure of the Staff Officer/Member Support areas. The remaining £0.079m is due to shortfalls in pay and supply budgets within Democratic Services.

3.7 Corporate Support Services & Performance Management portfolio:

A net saving of £0.450m is forecast, which is due to:

- **-£0.450m Legal Services** – this is a projection based on the 2009-10 outturn position.

3.8 Finance portfolio:

Within this portfolio there is a saving of £1.016m which relates to the write down in 2010-11 of the £4.024m discount saving on the debt restructuring undertaken at the end of 2008-09. (£2.362m was written down in 2008-09 and 2009-10, therefore leaving a further £0.646m to be written down over the period 2011-12 to 2012-13). As planned, this saving will be transferred to the Economic Downturn Reserve; hence a balanced position is currently forecast for this portfolio.

4. IN YEAR CAPITAL GRANT REDUCTIONS

4.1 The Government recently announced the following 2010-11 capital grant reductions for Kent:

Table 5: Government Capital Grant Reductions

	£000s
• Integrated Transport Block	4,105
• Road Safety capital grant	508
• PRN Network funding	40
TOTAL 2010-11 CAPITAL GRANT REDUCTIONS	**4,653**

4.2 All of these grant reductions are from the Department of Transport. This reduction is all absorbed within the EH&W portfolio capital programme as follows; and as set out in the Key Decision signed by the Leader on 18 June:

Table 6: KCC proposals to address capital grant reductions

Proposal	£000s	Comments/Action	Impact on cash limit
1. Reduce Integrated Transport schemes	-4,105	Schemes to the value of £4,105k will no longer happen (see section 4.4 and Appendix 1)	A reduction in the 10-11 Integrated Transport schemes capital cash limit on page 55 of the budget book from £11,065k to £6,960k
2. Safety Camera Partnership	-508	New speed signs expected as a result of the Speed Limit Review will no longer be installed, as the review is not going ahead, (see revenue reduction item 7 in table 2), and no more speed cameras will be installed.	A reduction in the 10-11 Safety Camera Partnership capital cash limit on page 55 of the budget book from £632k to £124k
3. Highway Major Maintenance	-40	The major maintenance budget will be reduced	A reduction in the 10-11 Highway Major Maintenance/Other Capital Maintenance/ Bridge Assessment & Strengthening capital cash limit on page 55 of the budget book from £40,505k to £40,465k
	-4,653		

4.3 The impact of this is a reduction in the EHW portfolio capital cash limit for 2010-11, per page 56 of the Budget Book, from £153,024k to £148,371k.

4.4 Following the reduction of £4.105m Government Grant on the Integrated Transport Block (IT) this year, the County Council has to reduce the IT programme in line with this reduction.

In order to ensure best value for money, it is recommended that we award priority to those schemes which are already being constructed, those which contribute to road safety, those which tackle congestion and those which attract matched funding.

Schemes which are proposed as not being funded this year will receive further consideration if a Member wishes to contribute from their Member Highway Fund, and/or will receive further consideration next year once the national funding position is clearer. These schemes are listed in Appendix 1.

5. 2010-11 CAPITAL MONITORING POSITION BY DIRECTORATE

5.1 There have been a number of cash limit adjustments since the published 2010-11 budget book, some of which have already been reported, full details below:-

Table 7: Capital Cash Limit changes:

		£000s 2010-11	*£000s 2011-12*
1	As published in 2010-11 Budget Book exc PFI	460,330	*434,818*
2	Roll forwards agreed at Cabinet on 14th June		
	Children, Families & Education (CFE)	689	
	Children, Families & Education (CFE) - schools budget	14,107	
	Kent Adult Social Services	560	*-95*
	Environment, Highways & Waste	489	*32*
	Communities	226	*113*
	Regeneration & Economic Development	67	
	Corporate Support Services & Performance Management	452	
	Localism & Partnerships	3	
3	Highways major Maintenance - member highway fund reserve - EH&W portfolio	-2,100	
4	Modernisation of LD services - additional PEF2 and capital receipt - KASS portfolio	1,423	*68*
5	Multi Agency Specialist Hubs - alignment of grant - CFE portfolio	-501	*501*
6	A2 Linear project - additional external funding - EH&W portfolio	574	
7	Major schemes - premiminary design fees - additional grant funding - EH&W portfolio	389	
8	Ashford Futures - Drovers roundabout junction - additional grant funding - EH&W portfolio	405	
9	Dartford social and healthcare - reduction in external funding - KASS portfolio		*-640*
10	Learning Disability Dev Fund - additional external funding - KASS portfolio	70	
11	Mod of OP services - Broadmeadow - additional external funding - KASS portfolio	180	
12	Ashford Gateway Plus - additional grant funding - CMY portfolio	40	
13	Academies - grant funding banked - CFE portfolio	1,002	
14	Dartford Grammar School - additional developer contributions funding - CFE portfolio	155	

		£000s 2010-11	*£000s 2011-12*
15	Specialist Schools 2009-10 allocation - additional grant funding - CFE portfolio	125	
16	Previously reported cash limit changes:		
	Gateway - CSS&PM portfolio	-7	
	Multi Agency Specialist Hubs - CFE portfolio	10	
	Sustaining Kent - KPSN - CSS&PM portfolio	-7,314	*-7,314*
	Harnessing Technology - CFE portfolio	-2,050	*-4,721*
	Transformation in Adult Social Care - KASS portfolio	730	
	Re-phasing as agreed at Cabinet on 29th March	24,655	*-2,504*
	Re-phasing as agreed at Cabinet on 19th April	8,358	*-849*
	Re-phasing as agreed at Cabinet on 17th May	5,794	*69*
		508,861	***419,478***
17	PFI	45,101	*88,000*
		553,962	*507,478*

5.2 The current forecast capital position by portfolio, is shown in table below.

Table 8: 2010-11 Capital Variances:

	Variance
	This month
Portfolio	
	£m
Children, Families & Education (CFE)	-2.547
Kent Adult Social Services	0.000
Environment, Highways & Waste	-0.019
Communities	-1.680
Regeneration & Economic Development	0.000
Corporate Support Services & PM	0.000
Localism & Partnerships	0.000
Total (excl Schools)	-4.246
Schools	0
Total	-4.246

This month there is re-phasing of -£4.2m and a real variance of -£0.04m. The main movements this month are detailed below:

5.3 Children, Families & Education portfolio

The forecast for the portfolio has moved by -£2.547m. Projects subject to re-phasing and overall variances affecting 2010-11 are:

- Kingsmead (-£2.0m): the original intention for this element of the capital programme was for a site purchase for a new amalgamated School. The project is not now proceeding and we are examining other options.
- Multi Agency Specialist Hubs (-£0.705m): the re-phasing relates to all three centres (Swale -£0.453m, Maidstone -£0.153m & Thanet -£0.100m). There have been a number of delays in agreeing sites for the location of the MASH centres & agreeing final build specifications.
- Primary Improvement Programme (+0.120m): in seeking approval to spend cash limits were re-profiled to represent the latest phasing of a number of projects. The re-phasing predominantly relates to two projects (St Matthews +£178K and Newlands -£41K).

Overall this leaves a residual balance of +£0.038m on a number of more minor projects.

5.4 Communities portfolio

The forecast for the portfolio has moved by -£1.680m this is due to re-phasing detailed below:
Edenbridge Community Centre (-£1.68m): Since initially being included in the programme this project has been significantly re-scoped and will now cost £3.2m. The timeline for the project has now been fixed and agreed with the developer and partners, so the phasing needs to be revised.

5.5 Capital Project Re-phasing

Normally, cash limits are changed for projects that have re-phased by greater than £0.100m to reduce the reporting requirements during the year. Any subsequent re-phasing greater than £0.100m is reported and the full extent of the re-phasing will be shown. The table below summarises the proposed re-phasing this month of £4.2m.

Table 9 – re-phasing of projects >£0.100m

Portfolio	2010-11	2011-12	2012-13	Future Years	Total
	£k	£k	£k	£k	£k
CFE					
Amended total cash limits	222,297	233,962	248,101	154,816	859,176
Re-phasing	-2,569	2,787	-218	0	0
Revised cash limits	**219,728**	**236,749**	**247,883**	**154,816**	**859,176**
KASS					
Amended total cash limits	14,455	7,285	2,640	1,162	25,542
Re-phasing	0	0	0	0	0
Revised cash limits	**14,455**	**7,285**	**2,640**	**1,162**	**25,542**
E,H&W					
Amended total cash limits	167,010	119,582	83,605	224,661	594,858
Re-phasing	0	0	0	0	0
Revised cash limits	**167,010**	**119,582**	**83,605**	**224,661**	**594,858**
Communities					
Amended total cash limits	28,725	10,311	3,060	350	42,446
Re-phasing	-1,680	1,680	0	0	0
Revised cash limits	**27,045**	**11,991**	**3,060**	**350**	**42,446**
Regen & ED					
Amended total cash limits	11,996	4,230	3,242	2,980	22,448
Re-phasing	0	0	0	0	0
Revised cash limits	**11,996**	**4,230**	**3,242**	**2,980**	**22,448**
Corporate Support & PM					
Amended total cash limits	16,078	9,317	9,549	2,663	37,607
Re-phasing	0	0	0	0	0
Revised cash limits	**16,078**	**9,317**	**9,549**	**2,663**	**37,607**
Localism & Partnerships					
Amended total cash limits	503	500	500	0	1,503
Re-phasing	0	0	0	0	0
Revised cash limits	**503**	**500**	**500**	**0**	**1,503**
TOTAL RE-PHASING >£100k	**-4,249**	**4,467**	**-218**	**0**	**0**
Other re-phased Projects below £100k	+44	-44	0	0	0
TOTAL RE-PHASING	**-4,205**	**+4,423**	**-218**	**0**	**0**

6. RECOMMENDATIONS

Cabinet is asked to:

6.1 **Note** the initial forecast revenue and capital budget monitoring position for 2010-11.

6.2 **Note** our response to the in year revenue grant reductions and the consequent changes to revenue cash limits as detailed in section 2.

6.3.1 **Note** our response to the in year capital grant reductions and the consequent changes to capital cash limits as detailed in section 4, and

6.3.2 **Agree** the Integrated Transport schemes to be deferred, for reconsideration next year once the national funding position is clearer, as proposed in Appendix 1.

6.4 **Agree** that £4.249m of re-phasing on the capital programme is moved from 2010-11 capital cash limits to 2011-12 and future years.

APPENDIX 1

Proposed 2010-11 LTP Integrated Transport Schemes NOT funded this year

Description	Scheme Objective	Saving
QUALITY BUS PARTNERSHIPS		
Bus Stop infrastructure impts in Dover District **(Town & Pier, Dover)**	Tackling congestion	-50,000
Bus Stop Improvements - Route 12/711/712 (Folkestone to Dover) **(Shepway, Folkestone Harvey Central)**	Tackling congestion	-50,000
Thanet Quality Bus Partnership **(Thanet, Margate Central)**	Tackling congestion	-50,000
Bus Stop Infrastructure Improvements **(Ashford Town, Victoria)**	Tackling congestion	-100,000
Canterbury QBP **(Canterbury, Harbledown)**	Tackling congestion	-130,000
Thanet Quality Bus Partnership (**Thanet, Margate Central) Phase 2**	Tackling congestion	-50,000
Tunbridge Wells QBP [Tunbridge Wells]	Tackling congestion	-50,000
Bus Priority Measures, West Malling to Leybourne (Design Only) **(Tonbridge & Malling)**	Tackling congestion	-50,000
Canterbury Bus Strategy (Tourtel Road) **(Westgate, Canterbury)**	Tackling congestion	-95,000
Bus stop infrastructure improvements **(Maidstone)**	Tackling congestion	-113,000
Pembury bus route Improvements **(Tunbridge Wells)**	Tackling congestion	-331,000
QBP Scheme **(Sheway South, Maidstone)**	Tackling congestion	-75,000
		-1,144,000
CYCLE SCHEMES		
Christchurch School to Park Farm cycleway **(Stanhope, Ashford**)	Tackling congestion	-60,000
A264 Langton Road Cycleway **(Tunbridge Wells, Rusthall)**	Tackling congestion	-70,000
Phoenix Place cycle Route **(Dartford)**	Tackling congestion	-10,000
Cycle Infrastructure Improvements **(Gravesham, Pelham)**	Tackling congestion	-5,000
St John's Road cycle route (Campus Link) **(Tunbridge Wells)**	Tackling congestion	-115,000
Capital maintenance of cycle network **(T & M, Aylesford)**	Tackling congestion	-173,000
Beechwood Avenue **(Dover)**	Tackling congestion	-45,000
Hall Rd/Coldharbour Rd cycle link (Cygnet Leisure Centre) **(Gravesham)**	Improving Accessibility	-20,000
London Road Cycle Route (Phase 2 - Birchwood) **(Sevenoaks)**	Improving air quality	-40,000
Cycle Network Improvements (Sittingbourne) **(Swale)**	Tackling congestion	-60,000
Dane Valley Cycle Routes (Phase 5) **(Thanet, Westgate-on-Sea)**	Tackling congestion	-170,000
St John's Road Bus and Cycle Lanes **(Tunbridge Wells, Southborough and High Brooms)**	Tackling congestion	-85,000
Homewood Avenue **(Swale)**	Tackling congestion	-99,400
Henley Fields Cycle Track **(Ashford, Stanhope)**	Tackling congestion	-76,000
Old Thanet Way Cycle Route **(Canterbury, Westgate)**	Tackling congestion	-158,750
Connect 2 **(Canterbury)**	Tackling congestion	-30,000
Princes Road cycle Route (Crayford Boundary - Shepherds Lane) **(Dartford)**	Tackling congestion	-121,000
		-1,338,150
NETWORK BENEFIT SCHEMES		
Darent Valley Accessibility Improvements **(Sevenoaks, Swanley White Oak)**		-25,000
Winterfield La, East Malling - Speed Limit Reduction **(T & M)**	N/A	-5,000
Pembury Road Completion Dunorlan Park **Tunbridge Wells**	N/A	-55,000
Borden Traffic Management **(Swale)**	Safety measures	-60,000
Pysons Road, Broadstairs **(Thanet, ST Peters))**	Tackling congestion	-100,000
Littlebourne High Street (Preventing Property Damage) **(Canterbury)**	Remedial works	-50,000
A229 Gills Green, Hawkhurst **(Tunbridge Wells)**	Casualty reduction	-30,000
Nortfleet - Ebbsfleet station **(Gravesham, Woodlands)**	Improving Accessibility	-40,000
Coldharbour Road, Northfleet **(Gravesham)**	Improving Accessibility	-46,000

Description	Scheme Objective	Saving
Medway Valley Line Station accesses **(Maidstone)**	Improving Accessibility	-70,000
Lynsted Footway **(Swale)**	Improving accessibility	-85,000
Garlinge Primary School - Safe Routes to School **(Thanet)**	Casualty reduction	-111,000
B2079 Lady Oak Lane-Bedgebury Road **(Tunbridge Wells)**	Casualty reduction	-35,000
		-712,000
KENT WIDE SCHEMES		
Cycle Parking at Stations Countywide	Tackling congestion	-75,000
Off-highway works to support Exemplar STP's	Tackling congestion	-80,000
		-155,000
Reduction in staff costs required to deliver IT programme		**-400,000**
Variations to and re-scoping of a range of existing IT schemes		**-355,850**
TOTAL		**-4,105,000**

By:	Sarah Hohler, Cabinet Member for Children, Families and Education Rosalind Turner, Managing Director for Children, Families and Education
To:	Cabinet – 12 July 2010
Subject:	Children and Young People of Kent Survey 2009. (NFER)
Classification:	Unrestricted

Summary:	The purpose of this report is to inform Cabinet of the key findings from the 2009/10 Children and Young People of Kent Survey and to discuss the implications across the County Council as we develop the next 3 year Children and Young People Plan.

Introduction

1. (1) A third Children and Young People of Kent survey has been completed. NFER were commissioned (following a procurement process) to conduct the survey which took place in Kent schools and colleges between October and December 2009.

(2) Two questionnaires were administered, one for 7 to 11 year olds and one for 11 to 19 year olds. All Kent schools (excluding independent schools) and Colleges of Further Education were invited to take part in the survey. The primary questionnaire was completed at 339 schools and the 11-19 survey at 75 schools and colleges.

(3) A total of 39,733 children and young people completed the survey (28,417 children in the 7 to 11 age group and 11,316 in the 11 to 19 age group). The total number was down on the previous survey when 45,000 took part. This can be explained by schools being required to opt into the 2009 survey (rather than opt out) and parents being given the opportunity to withdraw their children from the survey.

(4) As in previous years the survey has produced a wealth of information on the views of children and young people in Kent in relation to:

- Being Healthy
- Staying Safe
- Enjoying and Achieving
- Positive contribution.
- Economic Well Being
- Living in Kent.

(5) Each participating school and college will receive its own report with the results of the survey. There are also reports by LCSP area (allowing comparisons with previous years) and a county wide report. NFER has also provided the raw data to allow the Local Authority to undertake further analysis at district level.

Summary reports are also available for the findings for the following groups:

- Children and young people eligible for free school meals
- Children and young people with English as an additional language
- Children and young people with special educational needs
- Children and young people who are Looked After.

(6) The CFE Participation Officer also conducted 16 focus groups in schools and other locations and this enabled disabled young people or those for whom English is an Additional Language to put their views across. (A separate report is available with the outcomes from these groups).

(7) The NFER report provides valuable information for CFE and other KCC Directorates. Key topics include healthy living, attitudes to drinking and smoking, accessing information, community safety, bullying, attitudes to school, taking part in positive activities, access to leisure activities, future aspirations and perceptions of life in Kent. Specific questions will be of interest to different services, for example the question on dealing with anti social behaviour and crime should be of particular interest to community safety. The questions on taking part in exercise and accessing sport are relevant for sports development. KDAAT should find the feedback on substance misuse of value. Also, the information on accessing activities outside school and the barriers to using these activities is of particular interest to Kent Youth Service. It is also of interest to see the impact of KCC policies – for example it is noticeable that there has been an increase in the proportion of young people age 11 to 16 travelling to school by bus and a decrease in the proportion travelling by car – probably due to the impact of the Freedom Pass.

KEY DETAILS – Outcomes of the NFER Survey 2009

2. (1) The report provides valuable information on the views of children and young people in Kent. The Executive Summary and a summary table showing the key changes in results between 2007 and 2009 are attached in Appendix 1. The full report is available at the following link.

http://www.kenttrustweb.org.uk/Children/kct_cyp_survey_2009.cfm

(2) Overall the report is very positive and, when comparing findings with previous years, there has been significant progress in many areas. Graphs outlining trends are attached as appendix 3.

Examples include:

- The proportion of young people drinking alcohol and getting drunk has reduced (though a minority continue to report that they regularly get drunk and smoke).
- There is a decrease in those reporting feeling sad or depressed at least once or twice a week.
- Higher proportions of children (7 to 11 years) feel safe at school and in their local area compared to 2008.
- There has been an increase in the proportion of young people who feel they have a say on issues affecting the area where they live.
- There has been an increase in the proportion of children (7 to 11 year) who said they enjoy going to school and think they are doing well in school.

- There was an increase in the proportion of young people who said they haven't been bullied in the past year. Of those that said they had been bullied there has been a decrease in the physical and verbal bullying.

(3) The survey findings indicate that there are issues that need to be addressed, for example:

- Vulnerable young people score below average on the "being healthy" measure.
- Approximately half of the 11 to 16 year group report finding it difficult to learn because their lessons are disrupted by other pupils.
- Most young people think they have enough information on: the effects of alcohol and drugs (74%), the effects of smoking (74%), internet safety (73%) and sexual health (63%). **But** only 39% say they get enough information about relationships.
- 48% of young people think they are getting good careers advice but 31% are not sure and 16 % disagree (5% didn't respond).
- Although taking part in positive activities compares well with the results of the Tell Us survey, young people in Kent indicated that cost and unavailability of activities are more significant barriers to taking part compared to the national picture.
- Only 41% of 11 to 16 year olds and 37% of post 16s said they never feel unsafe on a bus or train.

(4) In the 2009 survey, NFER used "multilevel modelling" which allows more detailed insights to highlight the responses of different groups. This assists in targeting the responses to the issues raised. For example there is a strong link between being female and experiencing bullying and not feeling safe in the local community.

Using the Survey Results

3. (1) The findings of the survey are used to inform commissioning, planning, and performance monitoring of services across agencies. The Kent Children's Trust is required to publish a new Children and Young People's Plan 2011-14 by 1 April 2011, the NFER survey, along with other feedback from children, young people, parents and carers, will form a key element in the development of the new plan.

(2) The findings are being made widely available across KCC and Kent Children's Trust partner agencies so that maximum use is made of the results. As it is the third annual survey, the results now include trend information and multi-variate analysis that enables greater targeting of services.

(3) As in previous years there has been considerable interest in the survey as it not only provides a comprehensive picture of children and young people's views but it also provides very detailed information for a range of organisations including Kent health services, Kent Youth Service, KDAAT, Sports Development, Kent Safeguarding Board, Safer Kent and Kent Police. The survey results provide evidence to benchmark against key performance indicators.

(4) The survey also provides valuable data for the 414 schools and colleges that took part. This includes information about children's views on being healthy, staying safe, bullying, attitudes to school and future aspirations. Schools use this information in planning and to meet the school self evaluation requirements.

(5) Information sheets have been produced for children and young people with feedback on the key findings from the survey.

Future Arrangements.

4. (1) The survey provides a wealth of information for schools, local partnerships, the Kent Children's Trust Partners and KCC. However, the survey can be seen as costly at £158,000 i.e. about £3.97 per child. Benefits from the survey are identified in Section 3.

(2) Having completed the survey for three years, it has been decided to review how to maintain and build on the valuable intelligence this brings to Kent, while ensuring best value in future surveys. It may be possible to enter into negotiation for a better deal for future surveys and consider other methodologies. This could include making the survey totally on-line (the previous surveys have been in paper format for 7 to 11 year olds) or undertaking it every two years

(3) CFE and the Kent Children's Trust will also continue to use innovative approaches to involve and seek the views of families and communities, including children and young people.

Recommendations

Cabinet are asked to:

1. Note the contents of this report and the Children and Young People of Kent (2009/10) report.

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Background Documents

Executive summary

Introduction

For the third consecutive year, the National Foundation for Educational Research (NFER) was commissioned by Kent County Council (KCC) to conduct an independent survey of children and young people, to gather their views and experiences across a range of issues relating to the five Every Child Matters (ECM) outcomes and life in Kent, and to inform planning, service development and review at strategic level, local level and in Kent schools.

The survey aimed to:

- provide information on children and young people's needs and priorities across the county, to inform future planning of services
- assist KCC in meeting their 2010 target to 'listen to young people's views and opinions and develop their ideas to improve education and life in Kent'
- enable comparisons to be made with the findings from the NFER 2006/07 and 2007/08 surveys in Kent and with the Tellus4 national survey.

Methodology

The survey methodology was similar to that used in the Kent NFER 2007/08 survey but also involved more sophisticated statistical data analyses. There were two surveys: one for primary pupils (aged 7-11) and one for secondary and college students (aged 11-19), including those participating in work-based learning (WBL). The content of the surveys was similar to the previous surveys to enable comparisons over time, but with some changes to reflect the latest requirements of KCC and its partner agencies.

Primary schools were offered the opportunity to take part in a paper survey. The survey for 7-11 year olds was administered by teachers in school, at class level. The aim was for one class to represent each year group (years 3 to 6 only), giving a total of four classes per school (and up to 120 pupils per school).

The survey for 11-19 year olds was provided online and administered by staff in schools and other educational establishments. In schools, up to 50 pupils per year group (years 7 to 11/13) were invited to participate, giving a total of up to 250 pupils (for schools without a sixth form) and 350 (for schools with a sixth form). Up to 100 students were invited to participate per college and up to 25 young people were invited to participate per WBL provider.

Overall, the primary survey period ran from 5 October to 27 November and the secondary survey period ran from 5 October to 4 December 2009.
A total of 28,417 children (aged 7-11 years from across 339 establishments) completed the survey on paper and 11,316 young people (aged 11-19 years from across 75 establishments) completed the online survey. Overall therefore, this report is based on the views and experiences of almost 40,000 children and young people in Kent.

The survey responses were analysed and reported as percentages. Factor analysis was used to create 'measures' of each ECM outcome and multilevel modelling was then used to explore the pupil- and school-level characteristics that were associated with these outcomes. The aim of this analysis was to provide KCC with more detailed insights into the five ECM outcomes and to provide evidence to support focused targeting of policies and practice (as well as planning and evaluation) towards appropriate groups of children and young people.

Key findings

Being healthy

Most children and young people in Kent knew how to be healthy and reported participating in a range of healthy behaviours, such as sleeping well, exercising and eating fruit and vegetables. However, over half of the children (aged 7-11) reported that they eat crisps, sweets or chocolate (despite a decrease from last year) and watch lots of television. The majority of young people (aged 11-19) also reported participating in a range of healthy behaviours, although the majority reported they regularly watch television or play computer games for two hours or more. About three quarters of the children (aged 7-11) reported they usually feel happy and about four fifths of the young people (aged 11-19) reported that they enjoy their life. There has been a decrease since last year in the percentage of 11-16 year olds who say they feel very sad or depressed regularly.

Overall, it was evident that there was an association between being less healthy (on the being healthy measure) and being in years 3 to 5 or year 9 and above, or having special educational needs (SEN). In addition, there was an association between a low score on the being healthy measure and higher levels of deprivation in the 7-11 age group and being female or being of Black British or Dual heritage/Mixed origin in the 11-19 year group.

Although the proportion of young people drinking and getting drunk has reduced, a minority of young people continue to report that they regularly drink alcohol, get drunk and smoke. Those (aged 11-19) showing a lower score on the measure of attitudes towards smoking and alcohol included those in year 8 and above, with SEN, eligible for free school meals (FSM) and attending a boys' school or special school/pupil referral unit (PRU).

Overall, the majority of young people feel they are getting enough information about healthy living such as about the effects of alcohol and drugs, smoking and internet safety. However, despite an increase in the post-16 group, the majority of young people did not feel they knew enough about where to get advice about relationships.

Staying safe

Most children and young people in Kent felt safe in school and in their local areas and, albeit to a slightly lesser extent, travelling to and from school. In addition, nine out of ten children (aged 7-11) knew how to stay safe and three quarters of young people (aged 11-19) felt that they made decisions to keep themselves safe. In one aspect of staying safe, sharing personal information over the internet, young people (aged 11-16) were less likely than post-16s in Kent to have done so. Nevertheless, most 11-19 year olds felt that they had received enough information on internet safety and, although a notable minority felt that they had not had sufficient information, the proportion had reduced since last year.

While most children and young people felt safe at school and in the local area, it emerged that children and young people who were eligible for free school meals or those with SEN were associated with a lower score on the measure of how safe they feel at school and in the local area.

From a pre-determined list, the most common safety-related worries for children (aged 7-11) were broken glass, people hanging around and busy roads and traffic. For young people (aged 11-19), knives, drugs and dark places were the most common worries. While around one third of 11-16 year olds and two fifths of post-16s felt that the police were good at addressing anti-social behaviour, there was a level of uncertainty about this among young people. Overall, it was evident that there was an association between feeling less safe (on the safe in the community measure) and being female.

While around half of the children (aged 7-11) said that they had been bullied, there was some indication of an improvement in this as there was a decrease in the percentage of children who said that they had been called names. A slightly higher proportion of 11-16s had experienced bullying over the last year compared to post-16 young people. Of the 11-19s who had experienced bullying in the last year, it was more often verbal than physical. The percentage of young people reporting both verbal and physical bullying had decreased this year. Among children and young people, there was an association between being bullied and being female, being eligible for free school meals, having SEN and living in a deprived area.

Enjoying and achieving

The prevailing view among children and young people was that they liked being at school, though some did not feel this, and most felt that they were doing well at

school. They particularly liked the social aspect of being with their friends and going on trips, but many also valued the cognitive and skills-based elements and, although to a lesser extent, the majority enjoyed the academic aspects of school. Overall, children (aged 7-11) were positive about their teachers in relation to helping them understand but were more circumspect about how far their teachers listened to them or helped children who are good at something to improve, as a notable minority did not agree that this was the case.

While about a quarter of 11-16 year olds and two fifths of post-16s said that they experienced no barriers to learning, the most common barrier identified by those who did, related to other pupils disrupting their lessons. To a lesser extent other barriers related to their relationships with teachers and the amount of feedback and support received. Overall, the evidence suggests that among young people (aged 11-19) there was an association between feeling less positive on the enjoying and achieving in learning measure and being female, eligible for free school meals, or having SEN.

Making a positive contribution

About three in five young people (aged 11-19) had participated in a group activity led by an adult in the last four weeks. In addition to going to the park or a playground, which was most popular, the second most popular activity was attending sports clubs. A notable minority were attending youth clubs and participating in arts-based activities and volunteering, the latter more so for post-16s. The least common activity was participating in an after school club, as was the case last year. Cost and availability are the main barriers to participation but not having someone to attend with and lack of time and accessibility were also factors. Nevertheless, many young people (aged 11-19) say that nothing stops them from participating. The evidence suggests that young people who were female, eligible for free school meals or older young people (year 9 and above) were associated with a reduced tendency to participate in activities.

There was an increase in the percentage of children (aged 7-11) who helped people who were being bullied, put litter in the bin and recycled. Similarly, there was an increase in the proportion of 11-16 year olds who recycled, helped people who were being bullied and helped a neighbour, compared with last year.

Achieving economic well-being

Overall most young people (aged 11-19) thought that they would get the job they wanted in the future. Around half of 11-16 year olds were considering continuing in learning to higher education. The main barriers to their future plans were not having the necessary qualifications, however, a notable minority said that they did not have sufficient information. In the 7-11 age group, the analysis showed that girls and those with a statement of SEN were associated with a lower score on the economic wellbeing measure, while among young people (aged 11-19), those who were eligible

for FSM and those who were recognised for school action on the register of SEN were associated with a lower score on the economic wellbeing measure.

Key statistics

Being healthy

- 68 per cent of children (aged 7-11) and 43 per cent of young people (aged 11-16) reported eating five or more fruit and vegetables on most days.
- 77 per cent of children (aged 7-11) reported playing sports on most days and 56 per cent of young people (aged 11-16) reported exercising for an hour or more on most days.
- 6 per cent of young people (aged 11-16) reported getting drunk at least once or twice a week.

Staying safe

- 36 per cent of children (aged 7-11) reported being picked on or bullied at school and 28 per cent of young people (aged 11-16) reported being bullied in the last year.

Enjoying and achieving

- 85 per cent of children (aged 7-11) reported enjoying school at least sometimes and 55 per cent of young people (aged 11-16) reported that they liked being at school.
- 68 per cent of children (aged 7-11) felt they were doing well at school and 80 per cent of young people (aged 11-16) felt they were doing at least quite well at school.

Making a positive contribution

- 57 per cent of young people (aged 11-16) reported participating in a group activity led by an adult outside school lessons in the previous four weeks.
- 49 per cent of young people (aged 11-16) felt they had a chance to have a say on school issues, at least sometimes.

Achieving economic well-being

- 51 per cent of young people (aged 11-16) reported that they plan to go to university in the future.
- 63 per cent of young people (aged 11-16) felt they would be able to get the type of job they wanted in the future.

Living in Kent

- 83 per cent of children (aged 7-11) reported that they like living in the area in which they live and 84 per cent of young people (aged 11-16) reported that their area was a good place or an okay place to live.

9. Changes over time summary

This section highlights the main changes in children and young people's views and experiences over time (**over a two year period from 2007 to 2009**). The changes presented are statistically significant and only changes of more than four percentage points are given. Where the increase or decrease is a positive change, this is indicated with green and where it is in a negative direction, this is indicated with red.

Overall, nearly all of the changes are positive and show that a larger proportion of children and young people feel safe in the area where they live, enjoy school and recycle in 2009, compared to 2007.

Summary of changes in survey results over time (children aged 7-11 years)	
Being healthy	• There has been an increase (four percentage points) in the proportion of children who report that they **play outside**.
Staying safe	• There has been an increase in the proportion of children who **feel safe at school** (five percentage points) and **feel safe going to and from school** (four percentage points). • There has been a decrease in the proportion of children who **worry about people hanging around** (five percentage points) and who **worry about being on a bus or train** (four percentage points). • There has been an increase (five percentage points) in the proportion of children who report they would **talk to an adult at school when they need help**. • There has been a decrease (four percentage points) in the proportion of children who report that they have been **called names or talked about by other children**.
Enjoying and achieving	• There has been an increase in the proportion of children who report that they **enjoy going to school** (seven percentage points), **like lessons** (seven percentage points) and **like reading** (five percentage points). • There has been an increase (five percentage points) in the proportion of children who think they are **doing well at school**. • There has been an increase in the proportion of children who, **after school, play with their friends** (four percentage points), **do things with their family** (four percentage points), and **use the internet** (four percentage points).
Making a positive contribution	• There has been an increase in the proportion of children who report that they **recycle** (nine percentage points) and **help collect money for charity** (four percentage points). • There has been an increase in the proportion of children who report that **their ideas are as good as other children's** (four percentage points) and who feel **adults notice when they work hard** (four percentage points).
Achieving economic well-being	*There are no overall differences between responses from children in 2007 and 2009.*
Living in Kent	• There has been an increase (six percentage points) in the proportion of children who **like living in Kent**.

Summary of changes in survey results over time (young people aged 11-16 years)	
Being healthy	• There has been an increase in the proportion of young people **travelling to school by bus** (11 percentage points) and a decrease in the proportion **travelling to school by car** (five percentage points). • There has been an increase (five percentage points) in the proportion of young people **eating school meals**. • There has been a decrease (five percentage points) in the proportion of young people **eating five or more portions of fruit or vegetables on *most days***. • There has been an increase in the proportion of young people who report they ***never* drink alcohol** (15 percentage points), ***never* get drunk** (12 percentage points) and ***never* smoke** (four percentage points). • There has been an increase in the proportion of young people who report that they ***never* feel sad and depressed** (four percentage points). • There has been an increase in the proportion of young people who report they **receive enough information about how to access advice on relationships** (four percentage points).
Staying safe	• There has been an increase in the proportion of young people who report they **receive enough information about internet safety** (13 percentage points). • There has been an increase (five percentage points) in the proportion of young people who report they **feel safe in school**. • There has been an increase (five percentage points) in the proportion of young people who feel **there is an adult at school who can help them when they cannot deal with issues on their own**. • There has been an increase in the proportion of young people who report that the following concerns are not a problem in the area they live: **people on drugs** (seven percentage points), **people carrying knives** (six percentage points) and **travelling on a bus or train** (five percentage points).
Enjoying and achieving	• There has been a decrease in the proportion of young people who feel a **lack of feedback on their progress in school is a barrier to learning** (four percentage points), but an increase in the proportion who feel that **not having a computer at school is a barrier to learning** (four percentage points).
Making a positive contribution	• There has been a decrease in the proportion indicating that they **would like to recycle** (eight percentage points) and an increase in the proportion reporting that they **do already recycle** (11 percentage points). • There has been an increase in the proportion of young people who report that they **do already help people who are being bullied** (four percentage points) and **help a neighbour** (five percentage points). • There has been an increase (four percentage points) in the proportion of young people who report that they would **not consider raising money for charity**. • There has been an increase (five percentage points) in the proportion of young people who **feel they have a say on issues affecting the area where they live** either *sometimes* or *often.*
Achieving economic well-being	• There has been a decrease (five percentage points) in the proportion of young people who **think they will be able to get the sort of job they want**.
Living in Kent	• There has been an increase (four percentage points) in the proportion of young people who **like the area where they live**.

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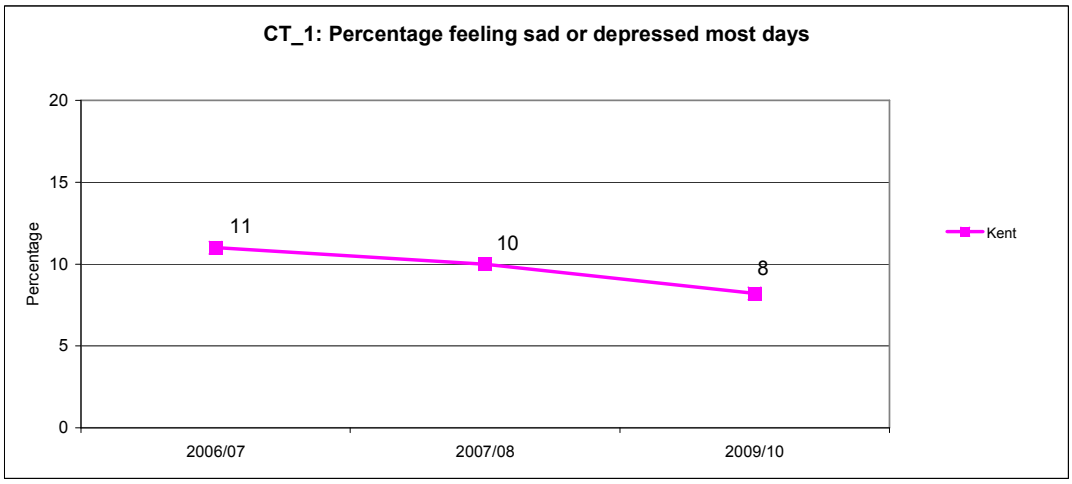
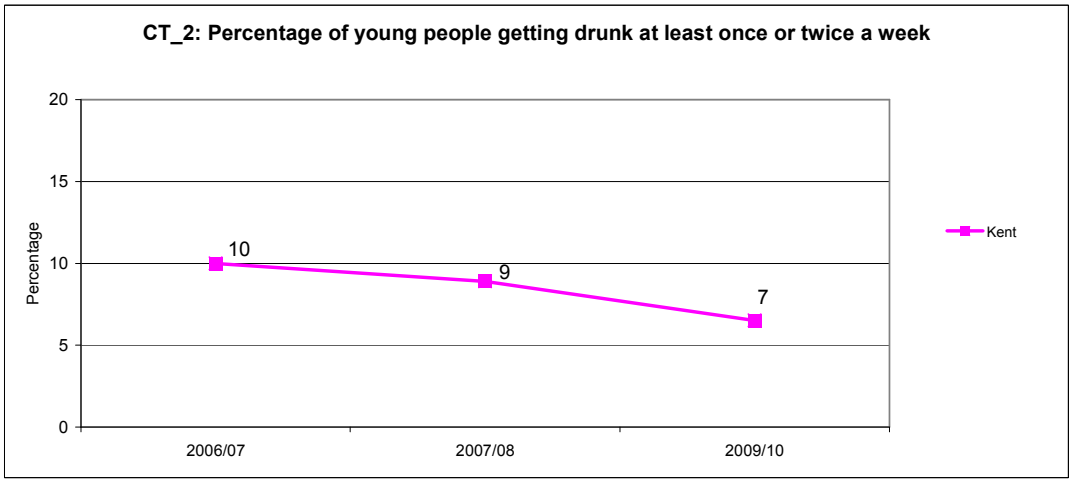


Source: Kent County Council, Children and Young People of Kent Survey, 11-19 year olds
Indicator Toolkit data provided through the KCT Multi-Agency Data Group



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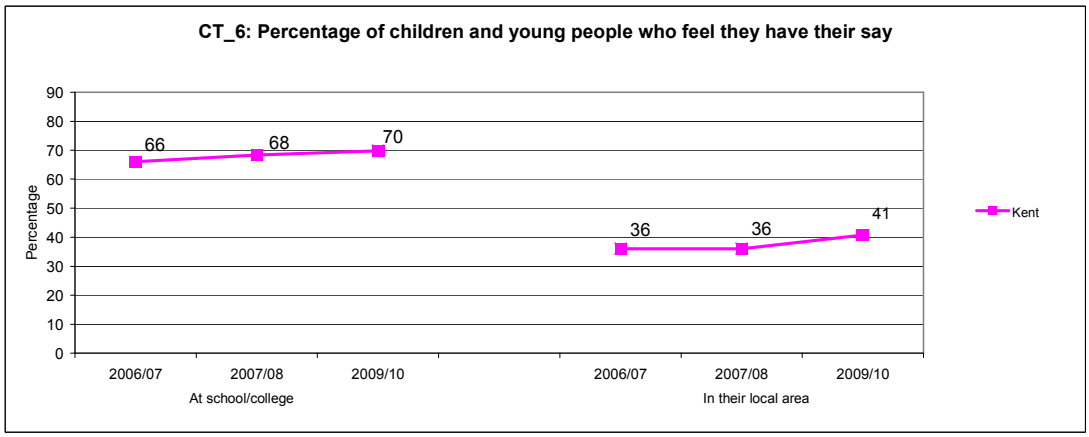
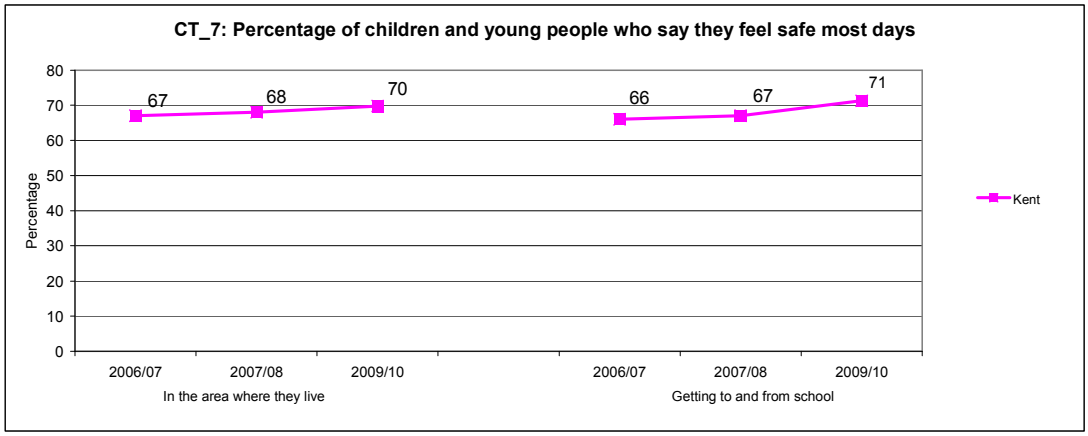


Source: Kent County Council, Children and Young People of Kent Survey, 11-19 year olds
Figures shown are for the percentage who feel that they have a chance to have their say 'often' or 'sometimes'
Indicator Toolkit data provided through the KCT Multi-Agency Data Group



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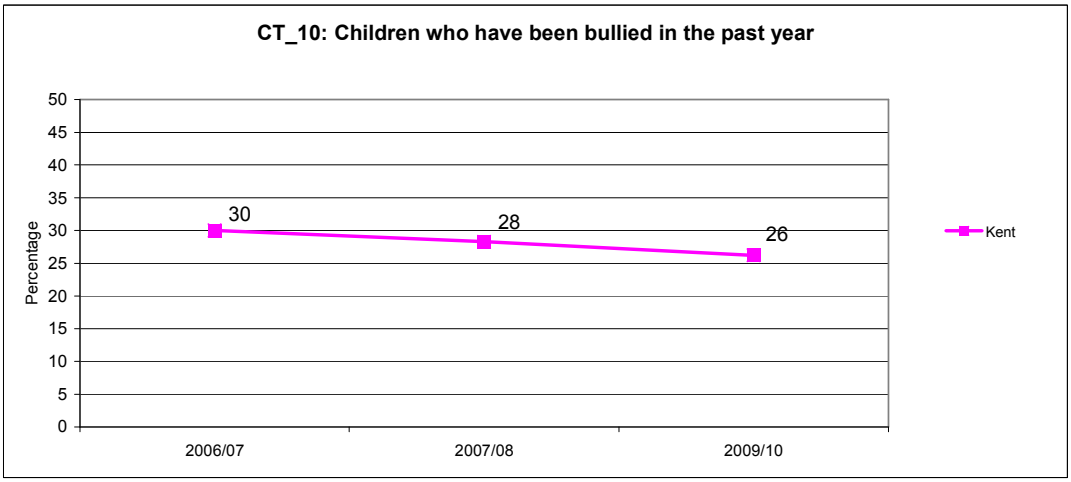

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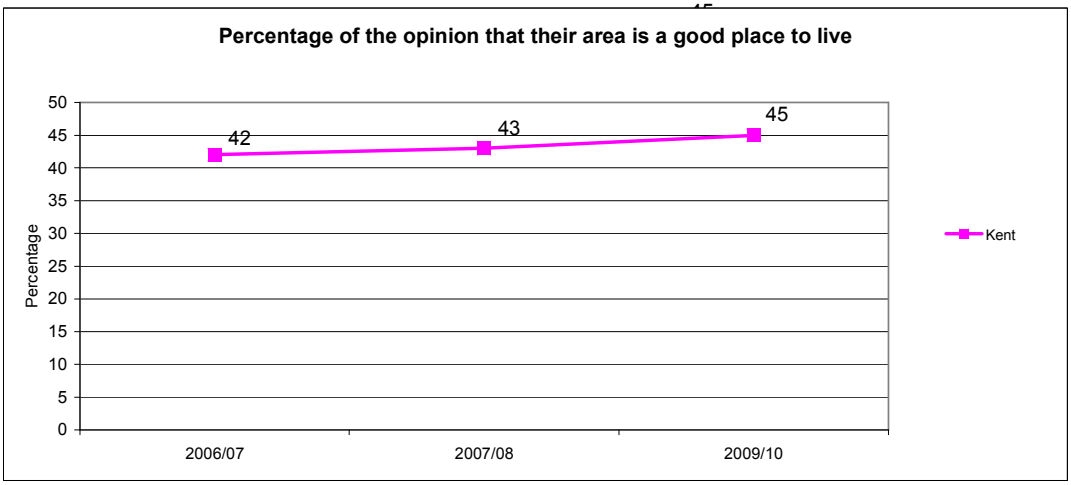
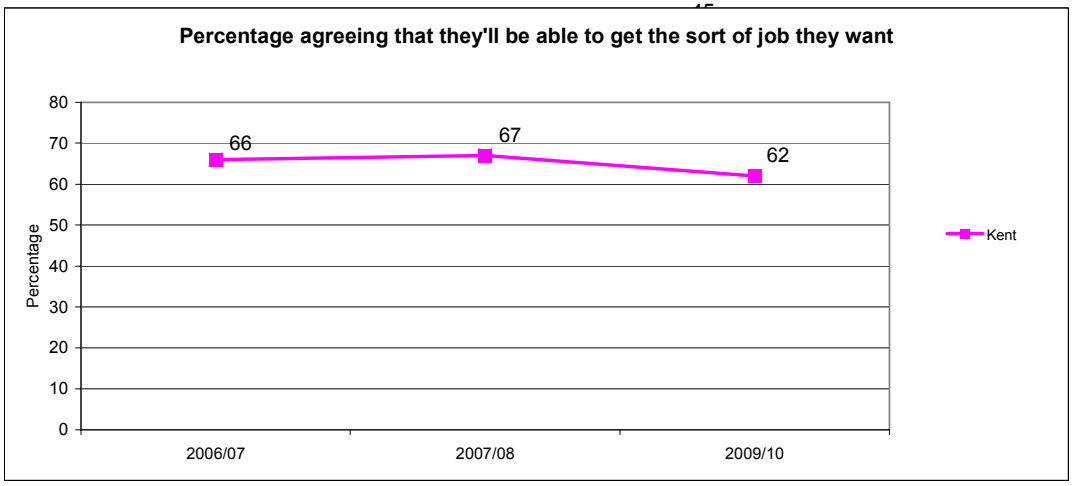


Source: Kent County Council, Children and Young People of Kent Survey, 11-19 year olds



Source: Kent County Council, Children and Young People of Kent Survey, 11-19 year olds

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By:	Graham Gibbens, Cabinet Member, Adult Social Services Oliver Mills, Managing Director, Kent Adult Social Services
To:	Cabinet – 12 July 2010
Subject:	**KCC STRATEGY FOR THE EMPLOYMENT OF SOCIALLY EXCLUDED ADULTS (PSA 16)**
Classification:	Unrestricted

Summary:	This paper sets out a cross-directorate strategy to enable a co-ordinated KCC response to tackling unemployment of 4 groups of disadvantaged adults at greatest risk of social exclusion - care leavers, adults with moderate to severe learning disabilities, adults in contact with secondary mental health services, and offenders under supervision.

Background

1. (1) The Employability Group established in 2008, was set up to ensure there was a co-ordinated KCC response to supporting those at greatest risk of social exclusion or those viewed as disadvantaged in employment. Kent Adult Social Services, Communities, and the Supporting Independence Programme were central to establishing this group. There has been strong Member support for the Employability Group and has been "championed" by Kevin Lynes, Roger Gough and Graham Gibbens. The Employability Group is currently chaired by Margaret Howard (KASS – Director Commissioning and Provision West Kent), and has representation at a senior level from all Directorates.

(2) The main objective of the Employability Group as set out in the terms of reference is to develop, implement and monitor an employment strategy for disadvantaged groups in Kent. It was decided by the group to focus the strategy on PSA 16, the groups at highest risk of social exclusion (care leavers, adults with moderate to severe learning disabilities, adults in contact with secondary mental health services, and offenders under supervision). This paper sets out the progress in developing the strategy, which can be read in draft in Appendix 1.

Policy Context

2. (1) PSA 16 relates to care leavers, adults with moderate to severe learning disabilities, adults in contact with secondary mental health services, and offenders under supervision in settled accommodation and employment (national indicators 143 – 150), which we report on but is not in the suite of indicators in our Local Area Agreement. We are accountable for PSA 16 performance through reporting mechanisms for these national indicators and the regional PSA 16 structures introduced to drive forward improvements, especially in relation to learning disability and mental health. Additionally, we have to report on how we perform as a local authority employing people with learning disabilities through the Kent Learning Disability Partnership Board. This may be expanded to include other groups as PSA 16 policy intent is keen to ensure that the public sector leads by example.

(2) The Government's report *State of the nation report: poverty, worklessness and welfare dependency in the UK* (May 2010), which will be used to inform forthcoming policy decision in improving life chances, again highlights these four particular groups. It states that people with learning disabilities have a significantly lower employment rate than other disabled groups. It also states that people with severe and enduring mental health conditions, people with learning disabilities, offenders and ex-offenders and care leavers are significantly more likely to experience multiple disadvantage and are particularly vulnerable.

(3) *Vision for Kent* clearly sets out to achieve:

- Economic Success – increasing employment rates amongst disadvantaged groups and areas, reducing poverty and encouraging social inclusion though innovative and flexible approaches
- Stronger and safer communities – working collaboratively at a local level
- Enjoying life, improved health, care and well-being, earning for everyone
- Improved health, care and well-being – provide health through large employers and use employment, commissioning and other practices to enhance healthy living and well-being.

(4) *Unlocking Kent's Potential*, KCC's Framework for Regeneration published in October 2009 sets out a vision in which local government, the wider public sector, business and the community work together to support the county's development. Within this, it makes a commitment to promoting independence and reducing welfare dependency, recognising the need to develop new routes to support socially excluded adults accessing work.

(5) Our performance against the national indicators for employment is as follows:[1]

- NI 144 – offenders under probation supervision in employment – increased performance from 76.6% to 79% from 2006 to 2009 (against a national average of 76.6% to 78.6%, and South East average of 74.8% to 77.3%)
- NI 146 – Adults with learning disabilities in employment – new indicator from 2008 with performance of 6% (against a national average of 7.8%)
- NI 148 – care leavers in employment, education or training – increased performance from 53.4% to 62.7% from 2006 to 2009 (against a national average of 63% across the years and South East average of 60.1% to 61.3%
- NI 150 – Adults in contact with secondary mental services in employment – new indicator from 2009 with unreported performance.

(6) We are unable to report on the numbers of people with learning disabilities employed in the public sector or by KCC in our yearly report submitted recently. We currently do not have a mechanism to determine the numbers of people we employ from the PSA 16 groups.

(7) Given the policy drivers and our performance, it is clear that we need a strategy to drive forward improvements in the numbers of people from the PSA 16 groups in employment. This includes us as one of the major employers in Kent as we are aspiring to be leaders in reducing welfare dependency through employment with those most disadvantaged and should be in a position to lead by example.

[1] See Appendix one - 7.1 PSA 16 data tables

Strategy outline

4. (1) The strategy seeks to improve the employment levels of the PSA 16 groups, and outlines how we can do this as an employer, a service provider, a procurer of goods and services and as a community leader. In terms of approach, the strategy recommends that KCC should seek to understand and develop best practice to inform its own recruitment practices and to establish leverage to influence third parties. The strategy sets out a plan for KCC to improve its own recruitment levels of the PSA 16 groups in year one, and to then influence third parties in year 2 and 3 (see appendix one). Whilst this strategy was written before the election, the overall context remains unchanged.

(2) This strategy intends to build on current successes in Kent in tackling worklessness, especially around young people not in education, employment or training, especially efforts around Apprenticeships. It must be recognised that those from the PSA 16 group are up to 50% more likely to be in the group who are not in education, employment or training.

(3) Positive interest and engagement of Apprenticeships is starting to gain real momentum across Kent. However, it still remains a significant challenge to facilitate and place young people who require additional support or have individual barriers that need to be supported to enable their participation in Apprenticeship programmes. Young people who tend to experience most difficulty include care leavers, young offenders, young parents, and young people with learning/physical barriers.

(4) In a focused attempt to address these challenges faced by many young people, KCC has identified £500k in 2010/11 to establish a focused "apprenticeship pilot" that will embrace and build on progress and success of the Kent Apprenticeships strategy, by providing targeted focus and support for vulnerable young people. The pilot will offer a tangible solution and effective delivery model that will support the wider PSA 16 targets highlighted within this strategy.

(5) This strategy will ensure that our current efforts meet the needs of the PSA 16 group, we identify gaps, and we provide appropriate support to increase their representation in employment. It will also ensure that we use our new responsibilities for funding through the YPLA (Young People's Learning Agency) to ensure better employment outcomes through transition.

Financial implications

5. (1) Knowing the pressures on public sector funding, finding efficiencies at present is critical. Having a cross-directorate approach to employment for the PSA 16 groups will support finding these efficiencies as this is a cross-cutting issue with all directorates having a part to play. A cross-directorate approach will only enhance our efforts and ensure value for money.

(2) KCC through KASS, supported by our Regional Improvement and Efficiency Partnership (IESE – Improvement and Efficiency South East) and the Department of Health has commissioned research on the cost benefit analysis of supporting people with disabilities into employment. Baseline data has focussed on people with a learning disability and has indicated that there is a savings of £1.6k per person per year to the local authority and £5.8k to the taxpayer for every person supported into employment. This

research will be broadened in the next year to include people with mental health difficulties. The researchers have indicated that they are encouraged by these initial findings and anticipate there will be increased savings in year 2 of the project. Based on these findings, addressing the employment needs of the PSA 16 groups, will find overall savings to KCC.

(3) The key impact and outcome of the "apprenticeship pilot" will be focused on increasing participation, retention and positive outcomes for young people and employers. Greater public sector savings are anticipated as the pilot is intended to provide and foster meaningful solutions to vulnerable young people helping them to tackle and face their personal challenges and move forward positively with their lives.

Personnel and training implications

6. (1) In addition to PSA 16 groups, KCC has a number of priority groups from which it strives to recruit in order to better reflect the communities we serve, tackle unemployment and influence demographics (as we have an ageing population). The priority groups are:

- Young people – in particular aggressive targets to employ more apprentices and graduates
- People from a black and minority ethnic groups
- People who are lesbian, gay, bisexual and transgender
- Disabled people

KCC will need to manage these priorities in the context of savings targets and the forecast reduction in posts. Therefore, a framework is being developed that will support managers when recruiting staff so that we can maximise opportunities to target people from these priority groups. The framework will be presented to COG and dovetail with vacancy management processes.

(2) We have not yet reported on those with mental health difficulties in employment, and it is recognised that the mechanisms in place for learning disability in employment do not adequately capture our performance. We do not have a mechanism in place to count those from the PSA 16 group that we employ, which will require a level of resource. It is recognised by the Employability Group that it will be problematic to gather data from our current workforce, and recommends that this is only done for new recruits.

(3) Anecdotally, the Employability Group understands that line managers lack confidence in managing people from the PSA 16 groups. Line managers will require training to develop this confidence and to understand the clear business case.

(4) There is a clear business case which sets out the value of employing a diverse workforce, supporting the delivery of more efficient and higher quality services (*Valued in Public, Employers Forum on Disability)*.

(5) Each Directorate will need to identify resource for their actions in the Action Plan. It is likely that these will already be in place as the strategy builds on our current response to worklessness. However, it must be recognised that this effort will need to be captured and built on through the ongoing work of the Employability Group.

Property implications

7. (1) There are currently no known property implications for this strategy. However, it must be noted the work of Total Place could have an effect in year 2 and 3, which may identify cost savings in relation to property.

Equality Impact Assessments

8. (1) An Equality Impact Assessment on this strategy has not been undertaken to date. The strategy does recommend positive action be used to drive up performance in the numbers of disabled people employed, in line with recommendations made following our assessment for the Equality Standard for Local Government. However, care will need to be taken not to discriminate on the basis of race, gender, disability, age, faith or sexuality.

Next steps

9. (1) A version of this paper was taken to each Directorate SMT where it received an overall positive response and support. Comments were taken on board and the paper amended accordingly as per comments. If the strategy is agreed, the Action Plan will need to be further developed with clear actions from each directorate, co-ordinated through the Employability Group. Governance arrangements will need to be considered, and this is currently being picked up through the review of cross-cutting boards being undertaken through COG.

(2) The reporting process will be through the Personnel Committee on a yearly basis as part of the monitoring and governance arrangements.

(3) An Equality Impact Assessment will need to be undertaken, and further work will need to be done on both public involvement and communication.

Recommendations

10. (1) Cabinet is asked:

a) To NOTE the development of the KCC Strategy for the Employment of Socially Excluded Adults
b) To APPROVE continued ongoing support for the adoption of the strategy
c) To CONSIDER / DISCUSS the implications for the governance of the Employability Group to ensure clear accountability in each Directorate, and strategically (Regeneration Board and Workforce Development).

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KCC Strategy for the Employment of Socially Excluded Adults (PSA 16)

March 2010
Emilene Gibson
(Kathryn Melling – KASS)

Contents

1.0 Executive Summary

1.1 Vision

'We will increase the number of Socially Excluded Adults who are in work, within KCC and the wider Kent community, focusing on people's abilities and potential rather than their circumstances, diagnosis or impairment'

KCC Employability Group is seeking to improve the employment levels of:

- **Care Leavers,**
- **Adults with Learning Disabilities,**
- **Adults in contact with secondary mental health services and**
- **Offenders under supervision in Kent.**

These cohorts have been targeted because they are the four client groups in PSA 16, those who are particularly vulnerable to multiple forms of disadvantage. PSA 16 will be part of our Comprehensive Area Assessment to determine how well we are working together with other public bodies to meet the needs of the people of Kent. A series of recent Government papers, reports and initiatives highlight the importance of supporting these groups into meaningful and sustained employment. All focus on the win-win outcome for individuals, communities and wider society in getting socially excluded adults back into work promoting social and economic inclusion, and bringing financial savings to public services.

Most significantly, the data and reports illustrate that if these groups of Socially Excluded Adults are left without the necessary support to get them in to work, there is every likelihood that they will become even further socially excluded as the economic recovery begins, the longer-term cost to society will increase and these people will find their return to social inclusion an even harder journey to make.

This strategy outlines how KCC can increase employment levels for Socially Excluded Adults through its role as an employer, a service provider, a procurer of goods and services and as a community leader. In terms of the approach, it is recommended that KCC should seek to understand and develop best practice to inform its own recruitment practices and to establish leverage to influence third parties. It is suggested that KCC looks to improve its own recruitment levels of Socially Excluded Adults in year one, in years two and three it should aim to influence third parties across Kent.

Currently, KCC does not record numbers of PSA16 cohorts in employment in the organisation. Tracking new employees in KCC from the PSA16 cohorts is required and therefore this strategy recommends that the Employability Group finds a practical and workable solution.

In preparing this strategy paper, a number of people were consulted from a wide range of directorates, a list of the individuals that have contributed can be found in the appendices. Support for this initiative was extremely high, and it was notable how keen people were to make suggestions and find ways of making this work. Thank you to everyone who has contributed.

2.0 Introduction

The concept of worklessness – and the role that local authorities can play in tackling it - has become increasingly prominent. Despite years of low unemployment in the last decade, the number of people excluded from the jobs market through ill health, disability and personal circumstances has remained persistently high. With recession and a tighter labour market, the challenge of engaging Socially Excluded people in employment is becoming ever greater.

From a cost perspective it is well documented how lengthened periods of unemployment have a negative impact on both physical and mental well-being. Therefore, if left unaddressed 'worklessness' can increase the cost of public services over time.

KCC has a major role in tackling worklessness. We are already managing a Future Jobs Fund programme, enabling young people in long term unemployment to access work. Through our apprenticeships programme and a more diverse approach to educational provision, we are providing new opportunities for people to gain the right skills to enter fulfilling employment. And we also have a major role in providing and facilitating supported employment for people with learning disabilities, physical disabilities and mental health conditions.

However, there is more that we can do. This strategy is specifically concerned with KCC and how it can increase employment of Socially Excluded Adults through its role as an employer, a procurer of goods and services, a service provider and a community leader and exemplar.

- **Its primary aim is to drive an increase in the number of employed Socially Excluded Adults within KCC and in the wider Kent community.**

- **Its secondary aim is to increase the employability levels of Socially Excluded Adults, to raise their levels of competency and their transferable skills.**

The business case for change and taking action on worklessness and incapacity at a national level is highlighted in a recent review of the health of Britain's working-age population, carried out by Dame Carol Black. It assesses the financial cost to Britain of not facing up to these issues is an estimated cost to the economy of over £100bn through ill-health and associated sickness absence and unemployment. Mental ill health accounts for approximately £30 - £40bn of this[2].

The groups of Socially Excluded Adults we are looking to support in our delivery strategy are tracked and measured as part of KCC's Comprehensive Area Assessment, and specifically, they are the PSA16 cohorts of:

- **Care Leavers,**
- **Adults with Learning Disabilities,**
- **Adults in contact with secondary mental health services and**
- **Offenders under supervision.**

The PSA 16 cohorts are up to 50% more likely to be not in education, employment or training (NEET). This strategy will add weight to current efforts to support the NEET group, focusing on those who have been excluded from mainstream NEET programmes due to their circumstances, diagnosis or impairment.

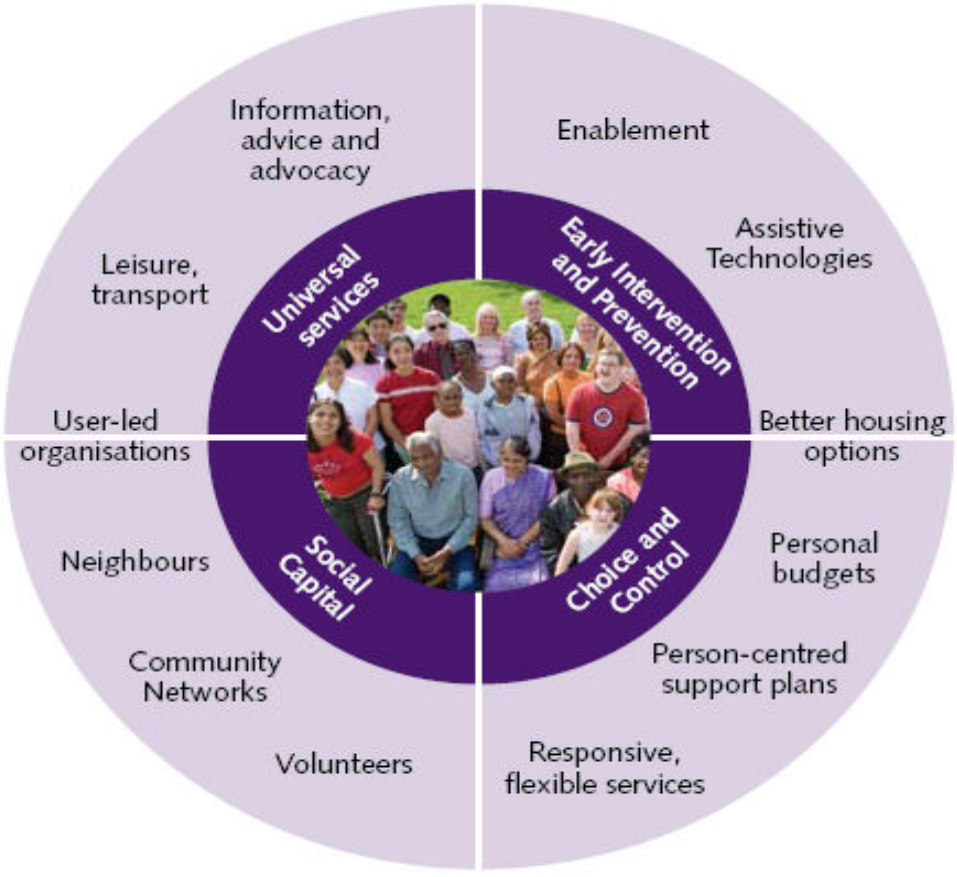
[2] Working our way to better mental health website http://www.workingforhealth.gov.uk/initiatives/Mental-health-and-employment-strategy/default.aspx

3.0 Strategic Context

3.1 The National Picture

The strategy draws on a raft of National Government initiatives to support Socially Excluded Adults – these groups have been identified because, notwithstanding the benefit of employment to individuals in terms of well-being, financial security and social inclusion, there is a significant financial and social cost to the nation if they are left unsupported and 'adrift'. They also represent a challenge to the Government's aspiration to achieve 80% employment and to reduce the overall dependency on the welfare state.

Moreover, this strategy is aligned with the national Total Transformation Agenda. The diagram below[3] summarises the structure of this approach. Simply put it's about people being in control of the support they need to live their life as they choose, not providing a life for them. Employment for Socially Excluded Adults is a key component as it will promote independence, ensuring early intervention and prevention, and will build social capital.



There have been a series of recent Government papers that outline the key issues for our respective groups. These papers explore entrenched behaviours and attitudes in society and look to understand how to improve the opportunities and employment paths for Socially Excluded Adults. Below is a summary of some of the key national papers that relate to this KCC Employment Strategy for Socially Excluded Adults:

[3] Self Directed Support: Active Lives for Adults. March 2010. Slide 11.

- The strategy addresses the findings of the recent Communities and Local Government paper ***'Tackling Worklessness'***. This review highlights the rise of 'worklessness' in British communities, with some wards experiencing exceptionally high levels of 'worklessness' running through generations. The Houghton report has identified that Socially Excluded Adults are at risk of being left even further behind when the economic recovery happens.

- The strategy directly supports and draws on the delivery plan set out in the cross-government strategy ***'Valuing Employment Now'*** (2009) that focuses on ensuring more people with a learning disability get and keep jobs, with public bodies leading the way.

- The strategy aligns with the cross-government strategy launched on 9th December 2009 ***'Working our way to better mental health: A framework for action'*** and ***'Work, Recovery and Inclusion*** to increase the numbers of people with mental health conditions in employment with support to employing managers and staff dealing with mental health issues.

- The strategy links with a series of papers relating to offenders – the Social Exclusion Unit report ***'Reducing Re-offending by ex-prisoners (2002), Delivering better housing and employment outcomes for offenders on probation (DWP 2009),*** and ***Improving Health, Supporting Justice – the national delivery plan of the Health and Criminal Justice Programme Board (DH 2009).*** These look at the cost to society and individuals when ex-offenders do not find meaningful and sustained employment.

- This strategy also aligns with the recent announcement from the Department of Schools Children and Families – stating that all care leavers would be given a guaranteed opportunity to get training, mentoring and access to jobs. The Children's Secretary is now asking all Local Authorities to support this positive scheme to ensure that 6,000 young people leaving the care system in the next year have an opportunity to succeed and thrive.

- This strategy supports the Department for Education initiative From Care 2 Work, which requires every local authority to provide young people leaving care with more opportunities to develop the employability skills needed to be successful in the employment market. Young people leaving care have significantly poorer outcomes than their peers in relation to education, training and employment. There is evidence that many care leavers enter and stay in low-skilled work or are dependent on benefits. From Care 2 Work aims to tackle this inequality by creating opportunities and raising aspirations.

3.2 National Agendas, Targets and Reporting

There are also a series of national government reporting requirements that align with this employment strategy:

PSA 16 is a cross government initiative that is jointly owned by the seven government departments with an interest in this area of work:

- Department for Work and Pensions (DWP)
- Ministry of Justice (MoJ)
- Department for Communities and Local Government (CLG)
- Department of Health (DH)
- Department for Children Schools and Families (DCSF)
- Cabinet Office (CO)
- Department for Business, Innovation and Skills (BIS)

National and regional targets are being set for PSA16 cohorts; [4]According to National PSA 16 data for 2008/09 only 3.4% of Adults in contact with Secondary Mental Health Services were in employment, for Adults with Learning Difficulties it was only 7.5%. For Offenders under Supervision, the figure is higher at 46.5%, and for Care Leavers it is 63% (however the Care Leaver figure aggregates those in employment, education and training). PSA16 trend data for Adults in contact with secondary Mental Health Services and Adults with Learning Difficulties is not available, however, for the remaining two cohorts, there has been little movement and the figures have stagnated since 05/06 having stayed within a +/-range of 2%. Targets will ensure equal life chances for everyone by 2025, and locally we will be expected to demonstrate progress at increasing the numbers of Socially Excluded adults in employment year on year.

National PSA16 targets also require that Socially Excluded Adults are supported into suitable accommodation – because accommodation is vital as a foundation to stable employment[5]. For the purposes of this strategy KCC should look to understand how to support staff from PSA16 categories into stable and suitable accommodation together with employment and see this aspect as an important and central element to the success of its strategy.

There are currently a range of National Indicators (NI143 – NI150) which measure the proportion of Socially Excluded Adults in suitable accommodation and in employment that we are required to report on regularly (see 4.1) as part of our Key Performance Indicators. In addition, for individuals with Learning Disabilities, there is an additional requirement for the Kent Learning Disability Partnership Board to provide detailed reporting to GOSE and the SHA on the number of people in paid employment in the public sector and the number of people who are working less than 16 hours per week, who would like to work more.

3.3 Understanding the challenge and the opportunity

Discrimination and a lack of enlightenment generally about the employment of Socially Excluded Adults can be found in recent research into people's perceptions and attitudes.

For individuals with Learning Disabilities, there is a need for a dedicated employment strategy because they have not benefited from the progress made for disabled people generally. While the employment rate of disabled people in Britain overall has risen steadily, that of people with learning disabilities is much lower – just 10% for people receiving adult social services[6]. This represents a waste of talent and opportunity for people with learning disabilities, employers and our wider economy and society.

- 62% of respondents to a Mencap survey in 2008 assumed that people with learning disabilities are unable to work.
- The Government is committed to achieving equality for all disabled people by 2025, as set out in ***Improving the Life Chances of Disabled People***[7]. This includes the chance for all disabled people to get a job. We know that 65% of people with learning disabilities would like a paid job.[8]

[4] PSA16 data for Kent, SE England and England is available in the appendices of this report.
[5] PSA16 data on accommodation is available in the appendices of this report
[6] *The state of social care in England 2006-07*, Commission for social Care Inspection (2006); *Valuing People Now: a new three-year strategy for people with learning disabilities*. Department of Health (2009)

[7] *Improving the Life Chances of Disabled People*, Prime Minister's strategy unit (2005)
[8] *Adults with Learning Difficulties in England 2003/4*, Eric Emerson (2005)

Research available on the ***Working Our Way to Better Mental Health*** website shows that:

- More than 25% of the population think that people who have mental health conditions should not have the same rights to a job as anyone else.
- Many employers do not believe that they employ anyone who has a mental health condition.
- Fewer than four in ten employers have said that they would recruit someone who had a mental health condition.

Amongst offenders and ex-offenders there are far reaching implications in terms of how tackling worklessness in this cohort can reduce the cost to society and the tax-payer as well as provide the opportunity of a new start (and all that implies – in relation to self-esteem, quality of life, long-term social improvement etc.) for the people concerned.

A Ministry of Justice report showed that having a paid job to go to on release from prison led to a reconviction rate within 12 months of 45%, compared to 62% of those looking for work and 72% for those not seeking work (May et al., 2008). In addition, approximately 100,000 people leave prison each year in the UK. At least 90% of those leaving prison enter unemployment and they comprise between 2% and 3% of the average monthly in-flow to the unemployment pool.

3.4 The Kent Picture

In August 2009, 94,380 people in Kent of working age were not in work – the equivalent of over 11% of the working age population. Over half of Kent's workless population (48,580 people) are in receipt of Employment and Support Allowance, Severe Disablement Allowance and various forms of incapacity benefit.

Work carried out by 'Total Place' has found the cost of social benefits for working age people in Cliftonville West and Margate Central is £48m per year. The total benefits spend in Thanet for working age people is £180m, so therefore around 10% of the people in Thanet get 26% of the social benefits spend in Thanet. If the spend in these two wards on social benefits was at the Kent average, it would be £11m per year, a reduction of £37m per year.

Numbers claiming incapacity benefits have been persistently high for many years; even at times when unemployment has been low and labour demand high, incapacity benefit claimant numbers have not moved.

This suggests that the barriers to work experienced by incapacity benefit claimants are high. The most common medical reason for incapacity is mental and behavioural disorders, which account for 42% of claimants in Kent. Applying the social model of disability this includes Mental Health, Learning Disabilities as well as drug and alcohol dependency[9] . National survey work undertaken with a number of local authority areas also highlights a number of additional barriers[10] . Most significantly:

- **Very long term detachment from the labour market is common: nearly 60% of incapacity benefit claimants in Kent have been claiming for over five years.**
- **Qualifications levels among claimants are generally very low: 60% in a recent national survey had no formal qualifications (with higher proportions in deprived areas). This compares with less than 12% in Kent without formal qualifications.**
- **Only 27% stated that they wanted a job, now or in the future.**

[9] CLG (October 2009), Understanding and Tackling Worklessness Vol 1, p.50
[10] Sheffield Hallam University (2008), Women on Incapacity Benefits: New Survey Evidence

Reports have shown that Kent has a higher than average size care industry – this has boosted the number (and therefore the population levels) of individuals from 3 out of the 4 cohorts we are concerned with. This has been driven by a higher than average number of private care providers including private fostering and adoption agencies – attracted to the Kent coast due to its accommodation suitability/type and geography.
Data relating to the incidence rates of PSA16 categories in the Kent community is outlined below[11] (a proxy figure of the national rate has been shown for those with Learning Disabilities). These cohorts are not mutually exclusive – so an individual can fall into more than one category.

Learning disability:
Incidence levels are estimated as being between 2-2.5%. However moderate to profound disability is known from those who receive services and is 0.35%. Unless someone is a service user then it may be hard to get them to provide information on disability. Hence a range of 0.5% to 1.5% is sensible.

Mental Health:
In Kent there are 7,780 people on the mental health register with GPs – equates this to 1% of the population and is on a par with figures from Kent and Medway Joint Strategic Needs Assessment – Mental Health for incidence of those with a severe mental illness. The Sainsbury Centre for Mental Health uses a broad definition and finds a wider prevalence of 3% for any type of severe mental illness. Therefore the range of individuals with Mental Health Conditions is between 7,000 and 20,000[12].

Offenders:
These figures are more difficult to estimate – however the probation team in Kent are working with 3,669 offenders with community orders or suspended sentence order at any given time - this implies an incidence level of 0.5%. However this is likely to under-estimate the full number passing through the system in a year.

Care Leavers:
KCC has a statutory duty to support Care Leavers in to employment, training or education and bears the costs of doing this. Kent experiences significantly higher costs than other areas due to the higher incidence of Asylum seeker children who are care leavers and who go through further education. A fair estimate is that 420 children leave care a year aged 16 or more providing a pool of about 3750 care leavers aged 16 to 24 or 2% of this age range – this would translate to KCC ensuring that 2.4% of all apprentices being care leavers.

3.5 Linking with Regional Agendas & Priorities

Developing KCC's role in supporting Socially Excluded Adults directly links to our broader regeneration strategy. *Unlocking Kent's Potential*, KCC's Framework for Regeneration published in October 2009, sets out a vision in which local government, the wider public sector, business and the community work together to support the county's development. Within this, it makes a commitment to promoting independence and reducing welfare dependency, recognising the need to develop new routes to support Socially Excluded people in accessing work.

Kent County Council is actively supporting this through our work in promoting apprenticeships, providing new opportunities for young people through Future Jobs Fund and developing KCC's Workforce and Equalities Strategies that encourages recruitment from younger age groups.

[11] KCC Performance Team/various regional reports
[12] Kent and Medway Joint Strategic Needs Assessment – Mental Health, p. 12

This strategy therefore supports our overall regeneration objectives for the county as well as our commitments as an employer and purchaser of services. This is consistent with the key themes set out in ***Vision for Kent***, the County's Sustainable Community Strategy, specifically these are:

Economic Success – increasing employment rates amongst disadvantaged groups and areas, reducing poverty and encouraging social inclusion through innovative and flexible approaches.

Stronger and safer communities – working collaboratively at a local level

Enjoying life, improved health, care and well-being, earning for everyone – promoting independence through employment for those who are able to work

Improved health, care and well-being – promote health through large employers and use employment, commissioning and other working practices to enhance healthy living and well-being.

3.6 Challenges for people out of work for long periods

With long periods out of work (and the negative spiral this can create by impacting on physical and mental health and on self-confidence and aspiration), low qualification levels and limited reported desire to work, the challenge of bringing incapacity benefit claimants back into the labour market is high.

At the same time however, employer discrimination (or perceptions that employers may be discriminatory) towards those with physical or mental disabilities may also hamper the ability of some to access employment. The recent review by Dame Carol Black of the health of the working population noted the need to provide better information and advice to employers on support for staff with poor health, despite some evidence of an improvement in employer approaches[13].

[13] SWP/Department of Health (2008), Working for a Healthier Tomorrow: Dame Carol Black's review of the health of Britain's working age population.

4.0 Measurement

4.1 National Indicators

There are currently a range of National Indicators (NI143 – NI150) which measure the proportion of Socially Excluded Adults in suitable accommodation and in employment. In an ideal scenario KCC would track its performance in employing Socially Excluded Adults against all these indicators. To date these are not measured against the KCC workforce owing to difficulty in capturing this type of data from existing employees.

Ref NI	PSA 16 Indicator
143	Offenders under probation supervision living in settled and suitable accommodation
144	Offenders under probation supervision in employment
145	Adults with learning disabilities in settled accommodation
146	Adults with learning disabilities in employment
147	Care leavers in suitable accommodation
148	Care leavers in employment, education or training
149	Adults in contact with secondary mental health services in settled accommodation
150	Adults in contact with secondary mental health services in employment

4.2 Measurement across KCC Employees and Kent

Performance and measurement discussions with Personnel and Development have flagged that there is currently no single solution to understanding flows of Socially Excluded Adults into and out of KCC.

The Employability Group recommendation is that the data recorded on employment of Socially Excluded Adults in KCC will be for all new employees and will not be a review or census of existing staff.

Tracking new employees in KCC from the PSA16 cohorts is required and therefore this strategy recommends that a practical and workable solution is found.

KCC Directorates will need to recognise and support implementation of new policies related to the employment of Socially Excluded Adults put in place by Personnel and Development. A staff recruitment communications platform will need to be built to promote the significance of social inclusion and openness to recruiting Socially Excluded Adults to KCC.

4.3 KCC Engagement and Understanding

In order to engage and secure buy-in to this strategy it will be important to consult with Union (UNISON) representatives at an early stage.

In terms of staff and management's engagement and understanding a separate approach is required. In order to assess the success of implementation of the KCC Employment Strategy, it will be important to have an understanding of employing managers' awareness, knowledge and understanding around employing Socially Excluded Adults. It would be helpful for employing managers to be provided with a tool to self-assess their awareness, knowledge and understanding.

Possible areas to assess include:

- Have you been on training relating to this strategy?
- Do you know where to go to get support if you need it?
- Have you worked with Personnel and Development to consider how job roles can be shaped to suit the needs of Socially Excluded Adults?
- Do you have an understanding of the untapped pool of talent available to KCC in these groups?
- Do you have an understanding of the benefits to us as an organisation?

4.4 Targets

The Employability Group has agreed:

- By the end of year one KCC should be able to show an increased number of newly employed individuals from these 4 groups.
- At the end of year one a review of progress will be carried out and a decision will be made around whether targets should and can be set for future years - what metrics should be included in the targets and how they will be collated.

National policy intent is to close the gap between the overall rate of employment for those with disabilities and those with mental health and learning disabilities.

5.0 Next Steps & Implementation

This strategy [to be] was agreed by the Employability Group on 19 March 2010. It will then be taken to the following Groups for ratification and sign off:

- KCC Chief Officers' Group
- Directorate Senior Management Teams
- KCC Strategic Equalities Group
- Equality Lead Officer Group
- Headquarters Corporate Consultative Forum
- Workforce Strategy Board

This strategy provides an overarching outline of the issues and ways to address them; however the Employability Group now requires a sequential detailed action plan, containing specific actions for service Directorates – timescales for producing this action plan should be agreed at the Employability Group meeting on Friday 19th March 2010.

6.0 Delivery Strategy

The key outcome for this strategy is to increase employment levels of Socially Excluded Adults in KCC and the wider Kent economy.

Implementing a successful long-term strategy for raising the employment levels of Socially Excluded Adults requires a structured approach:

- Year one will focus on KCC as an employer of Socially Excluded Adults and laying down solid foundations for success.

- Years two and three will focus on how KCC can influence third parties in Kent and use its own experience to leverage increased employment of Socially Excluded Adults across Kent.

- A review of progress, current knowledge and achievements at the end of year one is recommended in order to refine targets and goals for the organisation for years two and three.

6.1 Governance

The Employability Group (EG) chaired by Margaret Howard and with representatives from each Directorate, holds responsibility for actions that drive implementation of this strategy.

6.2 Strategy Implementation

The key actions outlined below provide the Employability Group with a focus for its agenda in the near term.

1) Maintain an awareness of policy in this area – to guide the strategy through the policy process.
2) Measurement – agree headline measurements and criteria for success.
3) Determine a series of practical pilot interventions that will enable the Employability Group to monitor and evaluate for success over a 3-6 month period.
4) Engage with partner agencies in the third sector to understand the extent to which interactions with people in those groups and how they are supported.

Immediate actions to move toward implementation of this strategy are:

- To undertake some form of analysis on cost-benefit
    i. **Criteria for the success of this strategy to be agreed**
    ii. **KCC builds appropriate understanding of key drivers of success**
    iii. **Appropriate funding is re-allocated and sourced**

- Set up a process for communicating the strategy
    i. **Evaluation and feedback process is set up and supports continuous improvement for KCC.**
    ii. **Staff engagement with the strategy is delivered**
    iii. **Third parties are influenced to take on Socially Excluded Adults in Kent.**

7.0 Appendices

Significant Contributions to this paper have come from:

- **Alison St Clair Baker**
- **Dee Watson**
- **Jacqui Ward**
- **Ross Gill**

Stakeholders Consulted	**Role**
Alison St Clair Baker	Service Development and Improvement Manager
Amanda Beer	Director of Personnel and Development
Barbara Cooper	Director of Economic Development
Chris Luke	Interim Director of Strategic Procurement
Debra Exall	Head of Strategic Policy
Dee Watson	Valuing People Now – Development Manager
Des Crilley	Director of Community Cultural Services
Jacqui Ward	Partnerships and Community Planning Officer
Julie Cudmore	Personnel Manager
Kathryn Melling	Employability Development Manager
Marissa White	Head of Extended Services
Nicola Lodemore	Personnel Policy Manager
Nigel Fairburn	Workforce Development Manager
Pauline Smith	County Manager – Supporting Independence Programme
Richard Fitzgerald	Performance Monitoring Officer
Robert Hardy	Director of Improvement and Engagement
Ross Gill	Economic Policy and Strategy Manager

Apologies	
David Cockburn	Executive Director Strategy, Economic Development and ICT
Elaine Mason	Organisation and Employment Wellbeing and Performance Manager
Paul Brightwell	Policy and Performance Manager Looked after Children

7.1 PSA 16 Data Tables

NI 143 Offenders under probation supervision living in settled and suitable accommodation

Area	2006/07	2007/08	2008/09
Kent	76.6%	76.8%	79.0%
South East	74.8%	75.8%	77.3%
England	76.6%	77.4%	78.6%
Essex	78.3%	79.9%	81.7%
Hampshire	76.9%	74.3%	78.5%
Lancashire	74.0%	77.1%	81.2%
Worcestershire	81.2%	81.8%	79.8%
West Sussex	74.6%	77.9%	81.1%

The percentage of offenders under probation supervision living in settled and suitable accommodation at the end of their order or licence. Under probation supervision: Serving a community order, or on licence. Settled accommodation is defined as: Permanent, independent housing, Bail/probation hostel, Supported housing. The indicator covers all individuals who had a probation assessment completed at 'termination of community supervision' or 'end of licence'

NI 144 Offenders under probation supervision in employment

Area	2006/07	2007/08	2008/09
Kent	52.5%	50.0%	51.4%
South East	52.4%	53.3%	52.6%
England	48.5%	48.7%	46.5%
Essex	53.4%	55.0%	56.3%
Hampshire	50.9%	56.3%	55.0%
Lancashire	48.8%	49.8%	47.3%
Worcestershire	46.6%	53.7%	50.4%
West Sussex	49.7%	54.0%	60.1%

The percentage of offenders under probation supervision in employment at the end of their order or licence

NI 145 Adults with learning disabilities in settled accommodation

Area	2006/07	2007/08	2008/09	Cohort size 2008/09
Kent	New Indicator	New Indicator	36.8%	3,820
South east			58.7%	
England			65.2%	
Essex			61.7%	3,435
Hampshire			61.0%	2,975
Lancashire			47.0%	3,195
Worcestershire			39.3%	1,460
West Sussex			67.8%	1,565

The percentage of adults with learning disabilities known to Councils with Adult Social Services Responsibilities (CASSRs) in settled accommodation at the time of their assessment or latest review. Includes those who are assessed or reviewed in the financial year and who have received a service, as well as who have not received a service. Settled accommodation: accommodation arrangements where the occupier has security of tenure/residence in their usual accommodation in the medium- to long-term, or is part of a household whose head holds such security of tenure/residence.

NI 146 Adults with learning disabilities in employment

Area	**2006/07**	**2007/08**	**2008/09**	**Cohort size 2008/09**
Kent	New Indicator	New Indicator	9.5%	3,820
South east			10.2%	
England			7.5%	
Essex			7.9%	3,435
Hampshire			11.0%	2,975
Lancashire			2.0%	3,195
Worcestershire			1.6%	1,460
West Sussex			16.3%	1,565

The percentage of adults with learning disabilities known to Councils with Social Services Responsibilities (CSSRs) in paid employment at the time of their assessment or latest review. Paid employment is measured using the following categories: Working as a paid employee or self-employed (30 or more hours per week), Working as a paid employee or self-employed (16 to less than 30 hours per week), Working as a paid employee or self-employed (more than 4 to less than 16 hours per week), Working as a paid employee or self employed (more than 0 to 4 hours per week), Working regularly as a paid employee or self-employed but less than weekly (e.g., fortnightly, monthly or on some other regular basis). The unpaid voluntary work categories are not to be included in the count of those who are in paid employment.

NI 147 Care leavers in suitable accommodation

Area	2006/07	2007/08	2008/09	Cohort size 2007/08
Kent	79.4%	85.8%	82.9%	190
South east	84.0%	85.1%	87.4%	
England	87.3%	88.4%	89.6%	
Essex	81.3%	95.9%	95.7%	100
Hampshire	81.8%	84.8%	90.2%	100
Lancashire	85.2%	82.7%	84.0%	100
Worcestershire	82.4%	92.3%	84.2%	40
West Sussex	82.4%	78.3%	80.0%	90

The percentage of former care leavers aged 19 who were looked after under any legal status (other than V3 or V41) on 1 April in their 17th year, who were in suitable accommodation. A review of their accommodation arrangements should take place within 3 months before or one month after the care leaver's 19th birthday. Suitable accommodation': Accommodation is to be regarded as suitable if it provides safe, secure and affordable provision for young people. It would generally include short-term accommodation designed to move young people on to stable long-term accommodation, but would exclude emergency accommodation used in a crisis.

NI 148 Care leavers in employment, education or training

Area	2006/07	2007/08	2008/09	Cohort size 2007/08
Kent	53.4%	54.7%	62.7%	190
South east	60.1%	61.3%	61.1%	
England	63.0%	64.9%	63.0%	
Essex	68.1%	74.5%	72.8%	100
Hampshire	62.3%	58.6%	64.1%	100
Lancashire	50.0%	42.9%	52.0%	100
Worcestershire	58.8%	64.1%	44.7%	40
West Sussex	68.2%	65.2%	58.9%	90

The percentage of former care leavers aged 19 who were looked after under any legal status (other than V3 or V41) on 1 April in their 17th year, who were in education, employment or training. A review of their education, employment or training status should take place within 3 months before or one month after the care leaver's 19th birthday. In education, employment or training': Engaged either full (at least 16 hrs per week) or part-time (less than 16 hrs per week). 'Employment' includes paid employment, self-employment, and voluntary unpaid work.

Children in legal status V3 or V4 are subject to short-term break agreements.

NI 149 Adults in contact with secondary mental health services in settled accommodation

Area	2006/07	2007/08	2008/09	Cohort size 2008/09
Kent	New Indicator	New Indicator	6.5%	435
South east			21.2%	
England			21.5%	
Essex			17.8%	3,490
Hampshire			4.7%	280
Lancashire			0.7%	2,300
Worcestershire			40.2%	370
West Sussex			14.5%	1,855

The percentage of adults receiving secondary mental health services in settled accommodation at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting. Adults receiving secondary mental health services: Those aged 18 to 69 who are receiving secondary mental health services and who are on the Care Programme Approach. Settled accommodation: Refers to accommodation arrangements where the occupier has security of tenure or appropriate stability of residence in their usual accommodation in the medium- to long-term, or is part of a household whose head holds such security of tenure/residence.

NI 150 Adults in contact with secondary mental health services in employment

Area	2006/07	2007/08	2008/09	Cohort size 2008/09
Kent	New Indicator	New Indicator	N/a	435
South east			3.2%	
England			3.4%	
Essex			6.3%	3,490
Hampshire			2.5%	280
Lancashire			8.0%	2,300
Worcestershire			4.3%	370
West Sussex			1.8%	1,855

The percentage of adults receiving secondary mental health services in paid employment at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting. Employed: Those who are employed by a company and have their National Insurance paid for directly from their wages. It also includes those who are self employed (i.e., those who work for themselves and generally pay their National Insurance themselves); those who are in supported employment; and those who are in permitted work (i.e., those who are in paid work and who are also receiving Incapacity Benefit).

7.2 Characteristics of Incapacity Benefit/Severe Disablement Allowance Claimants

May 2009	Kent (5)	Great Britain (%)
Gender		
Male	57	57
Female	42	43
Age		
16-24	6	5
25-49	48	47
50-59	32	34
60 and over	14	14
Duration		
Up to 6 months	0	1
6 months to 1 year	6	6
1 to 2 years	11	10
2 to 5 years	21	21
5 years and over	59	62
Disease		
Mental and behavioural disorders	42	43
Injury/Poisoning	5	5
Musculoskeletal	17	18
Respiratory/Circulatory	6	7
Nervous System	8	7
Other	21	21

8.0 References and Background Reading

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- An evaluation of the costs and financial benefits of supported employment in North Lanarkshire (2007). Dr Stephen Beyer, Welsh Centre for Learning Disabilities, Cardiff University. June 2008.
- Employment and Training for Ex-Offenders. June 1998.
- Department for innovation, universities and skills, Offenders are your Business: Delivering Next Steps in Skills and Employment for Offenders 2009.
- Department for Work and Pensions, Research Report No 610, Delivering better housing and employment outcomes for offenders on probation, Nicholas Pleace and Jon Minton. 2009.
- Securing employment for offenders with mental health problems. Towards a better way. Chiara Samele, Jo Keil and Stuart Thomas. 2009.

9.0 Detailed Action Planning for Outcomes

This table summarises some of the conversations with stakeholders – and includes thoughts and ideas on how to best approach and tackle delivery of the 10 key outcomes.

Outcomes	Activity
1 Overall employment levels of Socially Excluded Adults in KCC increase.	➢ The primary objective is to drive an increase in the number of employed Socially Excluded Adults within KCC and in the wider Kent community. ➢ The secondary objective is to increase the employability levels of Socially Excluded Adults, to raise their levels of competency and their transferable skills.
2 A comprehensive internal and external communications programme is set up to support the strategy.	Discussions with stakeholders have flagged the following activity as worthy of further exploration: ➢ Conduct some research to understand the KCC 'brand' as an employer with these groups – what is the gap in terms of how we need to be seen and how we are seen and structure communications accordingly. ➢ Influence national, regional and local level communications to maximise efficiencies and structure a 'joined up' key message system. Work should be closely aligned to the South East PSA16 communications programme. ➢ Raise the profile of KCC as an exemplar employer for Socially Excluded Adults. ➢ Illustrate in our communications the impact that the discarded many is having on our communities ➢ Provide clear figures and trend data including some illustration of how a change in approach may help improvements (draw on cost benefit work where necessary). ➢ Build a case study library to support both internal and external events and communications.
3 A cost-benefit analysis for supporting Socially Excluded Adults in to work is completed	There are several on-going pieces of work that a cost benefit analysis into supporting Socially Excluded Adults into Employment can draw on, these are: ➢ Work carried out by the Improvement and Efficiency South East (IESE) and DH – will provide a short, medium and long-term framework and structure that can be a sensible structure for this work. The respective dates for these outputs are; March 2010, December 2010 and June 2011. ➢ This work has research peer review by analysts from the Department of Work and Pensions, and takes a holistic approach to assessing costs and income to the state. It will review financial costs and flow-backs to the Local Authority in the short, medium and long-term. ➢ Work has also been done through the 'Total Place' project – any work on cost-benefit should also seek to draw on this. ➢ Outputs from this work should aim to include a 'funding' budget that should come as support money for Socially Excluded Adults.
4 KCC builds appropriate understanding of key drivers of success.	➢ Gain a detailed understanding of the full range of skills and talents of people from the 4 groups of socially excluded adults and how they can bring benefit to KCC and the wider Kent business community. ➢ KCC should establish a full understanding of how the private and third sector and its existing partners already employ Socially Excluded Adults and the benefits to their businesses, and how it can encourage more widespread engagement.

	➢ Establish knowledge and best practice around supporting Socially Excluded Adults into and in work.
5 Criteria for the success of this strategy agreed	➢ Both qualitative and quantitative measures are used ➢ A practical and workable solution to tracking and measuring the levels of KCC employees from PSA16 cohorts needs to be found and implemented.
6 Staff engagement with the strategy is delivered.	➢ Line managers in KCC will need to have the confidence and knowledge to support and employ Socially Excluded Adults. ➢ Training modules for managers in this area will need to be organised and run. ➢ All paths for applying for work in KCC should be reviewed to ensure that Socially Excluded Adults have a fair chance of securing work. ➢ Re-working the recruitment process to ensure that 'working' interviews are offered. ➢ Review job design to ensure that vacancies are accessible to PSA16 groups. ➢ A team of expert Mentors and Employment champions to support and facilitate key activity should be put together. ➢ KCC should aim to access the appropriate high-quality expertise, whether in-house or externally in supporting individuals into work and in work.
7 Evaluation and feedback process is set up and supports continuous improvement for KCC.	➢ Clear aims should be set out at the beginning of any new role that identifies objectives for the employee and the employer (manager and employee to agree these). Feedback to Personnel and Development, the manager and the employee should be discussed regularly to identify iterative improvements.
8 Appropriate funding is re-allocated and sourced.	***Funding is found through the –re-allocation of existing monies as well as seeking new and additional funding*** ➢ Bids should be made to the following funds o The Regeneration Fund o The Challenge Fund o The Innovation Fund should be re-contacted at the end of March to see if there is any further opportunity to win funding ➢ Outputs from the cost-benefit analysis should be used to support applications for funding and to help KCC to re-allocate resources over the long-term to support Socially Excluded Adults back into work both within KCC and in the wider Kent Community.
9 Third parties are influenced to take on Socially Excluded Adults in Kent.	Suggestions on this area have focused on mapping out key aspects around how best to influence and how to ensure that best practice is used and shared: ➢ Map out how to leverage KCC's position and influence the district towards the increased employment of Socially Excluded Adults. ➢ Work with the Office of Government Commerce to understand how contractual arrangements can be shaped to support increased 'scores' for supplier bids to KCC. ➢ Develop a clear understanding of whether existing initiatives are being used to support Socially Excluded Adults and how we could use positive action to encourage better take up. ➢ Gauge how well the services we commission are performing in increasing

	the employment rates of the four groups. ➢ Ensure that the services we commission are using best practice guidance – how can we ensure that they are? ➢ Illustrate how we can better use existing funding to provide better support to the Socially Excluded Adults' employment outcomes. ➢ Find ways for KCC to tap into the Kent Partnership and leverage its position to encourage increased employment amongst Socially Excluded Adults.
10 Employment levels for Socially Excluded adults are increased through KCC and the wider Kent economy.	➢ A year one review should be carried out to inform and scope strategy plans and work for years two and three. This review should include an assessment of whether targets are appropriate and at what level they should be set.

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To Cabinet – 12 July 2010

By: Mr Hill, Cabinet Member for Community Services
Amanda Honey, Managing Director Communities

Subject: A Hidden Harm Strategy for Kent

Classification: Unrestricted

Summary: This paper presents a Hidden Harm Strategy with a focus on delivering improvements in outcomes for children and young people who are affected by their parent or carers drug and alcohol misuse. The Strategy has been developed by the multi agency Hidden Harm Working Group and has been subject to extensive consultation. The Hidden Harm Strategy will impact positively on outcomes for children and families through coordinated interagency partnerships and joined up front line delivery as required by the National Drugs Strategy and Think Family approach. The full Strategy is provided in Appendix 1 of this document.

1.0 Introduction

1.1 Improving the outcomes for children and young people affected by drug and alcohol use requires a strategic response that translates into coordinated interagency partnerships and effective, joined up frontline service delivery.

1.2 The Strategy has been developed and driven through a multi agency Hidden Harm Working Group which feeds into the Kent Safeguarding Board through its Chair Angela Slaven.

1.3 The draft strategy has been presented to CFE SMT (January 2009) Communities SMT (Jan 2009), Kent Safeguarding Children's Board (February 2009), has been noted by the Kent Children's Trust and has been out for consultation to a wide range of professionals in children/, young people and adult services as well as service users. The Final Strategy will be presented at Kent Children's Trust Board and Cabinet in July.

2.0 Implementation:

2.1 **Launch:**

Once agreement from Cabinet has been achieved, the Strategy will be launched. Three launches are planned which will mirror the structure of Local Safeguarding Boards in Kent and will bring together practitioners and managers from adult treatment services, children young people's and family

services , service users and academics to build their knowledge and identify how their practice can improved.

2.2 **Action Plan:**

An action plan has been developed and progress has already been achieved through the Hidden Harm Working Group and the Family Services Development Officer in KDAAT.

2.3 **Needs Assessment:**

A needs assessment has been undertaken and demonstrates the poor quality of recording around this issue. Improvements are being made. The needs assessment will be fed to Safeguarding Board and into the Children and Young People's Needs Assessment process.

2.4 **Information Sharing Protocol:**

Information sharing agreements already exist between children and adult mental health services. We aim to build on this protocol to ensure a universal response to ensuring joined up services for children and young people's and adult services.

3.0 Resource Implications

3.1 Services relating to Young People's Drug and Alcohol commissioning will be subject to review within the emerging financial frameworks and options are being considered with a planning process for implementation to manage and mitigate the impact on service delivery should there be a reduction in funding levels.

4.0 Recommendations

4.1 Cabinet Members are asked to approve the attached Kent Hidden Harm Strategy

Background Documents:

Hidden Harm Strategy

Name of Officer: *Jo Tonkin*
Title of Officer: *KDAAT Young Persons Manager*
Date of Report: *04.06.10*

KENT HIDDEN HARM STRATEGY

2010 - 2013

Contents

Executive Summary

This strategy **commits** Kent County Council and its partners in the Children's Trust to improving outcomes for children and young people who are affected by a parent's or carers drug or alcohol use. It aims to achieve significant service improvement through the collection and collation of intelligence relating to substance misuse and its impact on families, on practice and on improvement in outcomes by 2013.

The recognition that the harms to children of drugs and alcohol misusing parents are significant and enduring is central to this strategy. These children and young people come into contact with services but often only when their need is significant and they require specialist interventions, either as children or adults.

Current reporting indicates significant gaps in practice. This failure means that we are not clear about the positive outcomes that are being achieved, the risks that are being managed and the good practice that is emerging. Little systematic recording reflects a lack of understanding of this issue and how it impacts on children and young people's lives.

In the past work that has developed has been, on an adhoc basis dependent on the success of lottery funding or willingness and interest of individual managers. This is not withstanding significant policy developments in the form of **Think Family**, the development of Joint Information Sharing Guidance between adult treatment and children and family services', and the updated 'Working Together to Safeguard Children' document.

This strategy does not expect to orientate additional resources to this issue, but rather its overarching principle is that of improved and integrated practice to achieve the improved outcomes for children, young people and their families.

Introduction

In 2003, the Advisory Council on the Misuse of Drugs (ACMD) produced a report[1] on the negative consequences of parental substance misuse on children and young people. Since this report was published, agencies across Kent have become more aware of this *Hidden Harm.* Whilst improvements have been made in the past few years, it has become clear that a more integrated approach is necessary to improve the outcomes for these families.

There are still many children and young people whose experiences are not being systematically heard, recorded or reported upon. The result is that their needs are not being met. At the same time it is clear that these children and young people are accessing our specialist services and appear in the case load of Child Protection teams, of the Youth Offending Service and as adults in specialist treatment services.

Recognising and reporting on the children, young people, and families who engage in services together with the outcomes achieved will enable the demonstration of what works, how to prioritise and re-orientate resources and see how investment in earlier identification will reap benefits.

Progress has been slow but significant. Work to develop greater multi agency accountability in Kent started in 2007. This strategy and its action plan has been developed and widely consulted upon with real enthusiasm being shown by adult drug and alcohol service users, and provider services in the voluntary sector.

The national context has also moved on and is changing constantly. Significant changes include:

- The development of the Think Family approach.
- The provision of Guidance for Information Sharing between adult treatment providers and children and families

The revised 'Working Together to Safeguard Children' brings together these approaches with a clear aim to ensure that the needs of children of substance misusing parents are included in Safeguarding Board's annual assessment of need and is reflected in the annual action plan.

Regionally within Kent, some specialist practice has developed and is progressing well, the Sunlight Project and the Substance Misusing Parents project have all contributed to the development of good practice.

Together this strategy, local practice and the National Policy Framework presents an opportunity to embed accountability, improve practice and ensure the best possible outcomes for children, young people and their families.

Aim

The aim of the strategy is to improve the lives and futures of all children affected by drug and alcohol misuse in their families through accessing services within integrated and multi disciplinary settings in a way that is timely and relevant.

In doing this, children in Kent whose parents, carers or siblings misuse substances can expect to be:

- Seen and heard
- Safe and secure at home
- Cared for and encouraged
- Supported to be healthy and do well
- Provided with extra help when needed

Children affected by parental substance misuse may experience their lives being compromised in all five areas. However it can be most noticeable within:

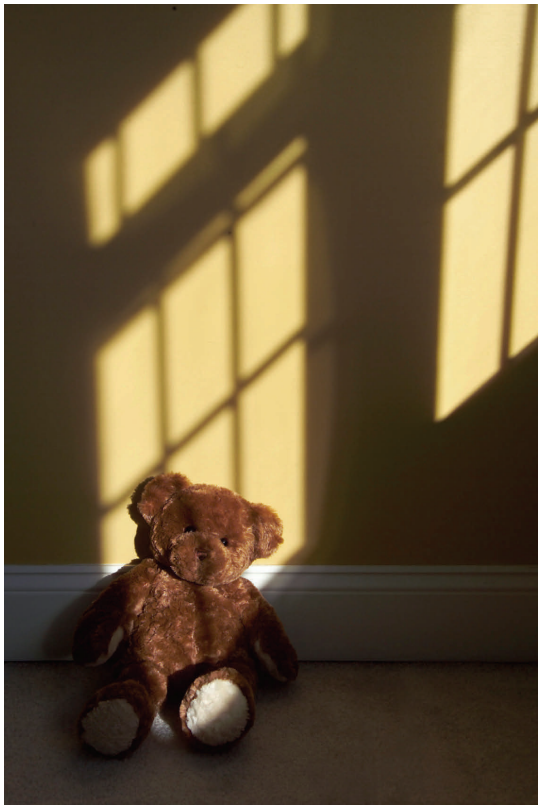
Be Healthy includes; physical, mental and emotional health, sexual health, healthy lifestyles, and choosing not to take illegal drugs. Their parents, carers and families should promote healthy choices.

Stay Safe includes; being safe from neglect, violence and sexual exploitation, accidental injury and death, bullying and discrimination, crime and anti-social behaviour. Parents, carers and families should provide safe and stable homes.

Parents and carers can expect to:

- Be able to take care of self and others in positive and healthy ways
- Be able to recognise and meet their children's developmental needs
- Be able to respond to children/young people's needs as a priority
- Be able to access universal and addition support services for self and children across lifespan
- To value, promote and seek education, training and employment for self and children

The Impact of Substance Misuse in Families on Children



"Hidden Harm" vividly describes the situation of many children and young people living in substance misusing households. Often suffering in silence, they are not known to services and either do not know who to turn to for help or fear telling anyone about what goes on at home.

Substance misuse in families is characterised by the use of illicit drugs and/or alcohol to a degree where the physical, emotional, psychological, behavioural well-being and care-taking capacity of the parent is compromised. It is associated with socio-economic deprivation and other environmental factors such as domestic violence. These may affect parenting capacity, which can be characterised as unpredictable and chaotic.

The substance misuse of a sibling can also affect the child and family in a negative way affecting both the parent's parenting capacity and the non using child's physical, emotional, psychological, behaviour and well-being. For the purpose of this strategy sibling substance misuse is recognised as a significant Hidden Harm.

The adverse consequences for children will vary according to age, stage of development and protective factors in the wider environment. These are likely to be multiple and cumulative in nature.

It is only through listening closely to the children involved that we can fully comprehend the impact that substance misuse in the family has on their emotional and physical welfare. Children and young people tell us[2]:

"I feel angry because my mum chooses drugs over me"

"I am scared because strange scary men come to the house to get money from mum's boyfriend"

"When she buys drugs she goes to some scary places that scare me"

"I feel left out and on my own"

"Dad doesn't want to be with us, I don't think he likes us"

"I don't want anyone to know, I feel embarrassed"

Key Strategic Links

Key National Strategies:

- Every Child Matters: Change for Children, 2003 initiated a change agenda throughout children and young people services with a focus on 5 key outcomes.

- Children's Plan: Building Brighter Futures, 2007 set out what needs to be done to secure the health and well-being of children and young people, safeguard the young and vulnerable, and achieve world-class standards.

- The National Service Framework for children, young people and Maternity services, 2004 has eleven clear standards for promoting the health and well-being of children, young people and mothers; and for providing high quality services which meet their needs. It includes a commitment to supporting parenting.

- Think Family: Improving the Life Chance of Families at Risk – Cabinet Office, 2008 recognises the role of parents, carers and the wider family in ensuring the best possible outcomes for their children and indicates government support for practice that supports the development of parenting support and family focussed interventions.

Key National Guidance:

Working Together to Safeguard Children 2010[3] replaces the document of the same name in 2006 and notes the that it is the responsibility of the Local Safeguarding Children Board (LSCB) to take full account of the particular challenges and complexities of work around these children and families by ensuring LSCB policies, procedures and information sharing protocols are in place as well as ensuring close collaboration between DAAT's, CDRPs, health, social care, courts prisons and probation.

Joint Guidance on Development of Local Protocols between Drug and Alcohol Treatment Services and Local Safeguarding and Family Services, 2009 which guides adult treatment to develop information sharing protocols with children and families services and links to family focussed and parenting services.

Key Local Strategies:

- Kent Strategy for Supporting Parents: identifies the need to support families affected by parental substance misuse by developing co-ordinated services that meet the whole family's needs, enhancing physical, social, educational and emotional well-being and improving outcomes for all family members.

- Kent Alcohol Strategy 2010-13: makes reference to the Hidden Harm Strategy and its outcomes.

Hidden Harm in Kent:

There is no reliable current, collated data that can evidence the number of children affected by substance misuse. This poses a challenge for the development of an improved response.

Nationally, it is understood:

- Around 3% of all children under 16 are affected by parental drug misuse[4].
- 10% of all children are affected by parental alcohol misuse[5].

In Kent:

- 56.1% of children subject to a child protection plan are estimated to be affected by their parents' substance misuse[6].

Children of substance misusing parents interact with many services and present at targeted and specialist service levels, the extent to which the needs are being met is unclear both because of a failure of early identification and poor data collection. This reflects the lack of a shared understanding and a potentially a lack commitment to addressing these young people's needs outside of specialist treatment services.

What is Currently Happening?

Services for children of substance misusing parents are inequitable across Kent and have not been developed with a countywide and integrated approach. Gaps exist in services according to age group, district and the level of need. The Sunlight Project currently funded through the National Lottery is valued but is only funded until December 2011.

The challenges are:

- ensuring that early intervention services work more effectively with children of substance misusing parents and carers to improve access to specialist services improving access for all children of substance misusing parents across Kent.
- The Substance Misusing Parent's Service is a joint initiative between Thanet, Dover, and Canterbury Children and Families Teams, and Kent Drug and Alcohol Action Team.

The project targets the following groups:

- Parents with a child or children on the CP register where parental substance misuse is a factor.
- Parents with a child at risk of becoming looked after, where substance misuse is a characteristic.

- Parents who are using drugs or alcohol in a way that is affecting their ability to parent adequately.

- Women who are pregnant and whose substance misuse may be harmful to the unborn child.

The aim of this project is to support parents so that risk can be minimised and families can be kept together. This has the benefit of reducing the number of Looked After Children and the number of children on Child Protection Plans. Longer term benefits for children include improved developmental progress for pre-school children and improved educational outcomes through attendance, behaviour and achievement for older children.

The Sunlight Project works across the districts of Swale, Dover and Canterbury and is funded by the Big Lottery until December 2011. The project works with children 7-13yrs to provide support via group work delivered locally in schools or community spaces. The aim is to help improve the emotional and psychological well-being of children.

Young Carers projects exist across Kent and work with young people who provide care to parents, siblings who have a disability, and those with mental health and substance misuse problems. The aim is to provide support and access to leisure opportunities and advocacy services.

KDAAT Adult Treatment Systems Change Pilot: Drug treatment pilots have been developed in Swale and Gravesham, and seek to implement a more family focussed and integrated approach with a commitment to supporting recovery and transition to integrated community services.

Priorities for Action:

Achieving the aim of the strategy and delivering improved outcomes for all children affected by drug and alcohol misuse in their families will require action by a wide range of agencies across Kent. These actions have been grouped into seven priority areas. Detailed actions to deliver each of the objectives and priorities are included in the Hidden Harm Strategy Delivery Plan.

1. **A joint-strategic lead to ensure that all relevant agencies are enabled and encouraged to share responsibility for furthering the Hidden Harm agenda, in a co-ordinated and integrated way.**

    - Ensure a co-ordinated response to Hidden Harm across the county
    - Develop a framework for assessing the effectiveness of service responses to the Hidden Harm agenda
    - Establish and strengthen strategic partnership working

2. **An accurate up-to-date demography of children in Kent affected by parental substance misuse to ensure that their needs can be accurately assessed and services developed/re-configured in line with specific identified need.**

    - Identify gaps within current service provision
    - Strengthen the intelligence products to better establish the scale of the 'Hidden Harm' problem in Kent in order to estimate the number of children affected by parental substance misuse.

3. **Increased awareness of Hidden Harm issues across local children's partnerships and adult treatment systems leading to an improvement in the outcomes for children and young people.**

    - Embed in the adult treatment assessment form, the CAF and Pre CAF, a robust system to identify and safeguard children of substance misusing parents
    - Improve treatment agencies capacity to respond to parental substance misuse
    - Equip all practitioners with the skills to identify and react to potential cases of Hidden Harm aligned with the2020 Children and Young People's Workforce Strategy
    - Families with Hidden Harm issues are identified and the opportunity to expedite access to services is made available ensuring swift access to mainstream services
    - All partners to work together to identify potential new funding streams

4. **Increased range and effectiveness of multi-agency partnership working arrangements sustained by shared language, common practices and shared processes/ protocols, and jointly-commissioned holistic services to ensure an effective joined-up response.**

   - Improve interagency collaboration, building on models of best practice
   - Identify the children of substance misusers at the earliest possible opportunity
   - Develop a common approach to priority pathways

5. **Ensuring that safeguarding and child protection processes are actively prioritising the needs of children of substance misusers, and developing effective approaches to meet their needs in timely, appropriate and family-focused ways.**

   - Improved integrated care pathways

6. **Service user involvement in the implementation of the Hidden Harm strategy and to involvement of children, parents and families in the commissioning system.**

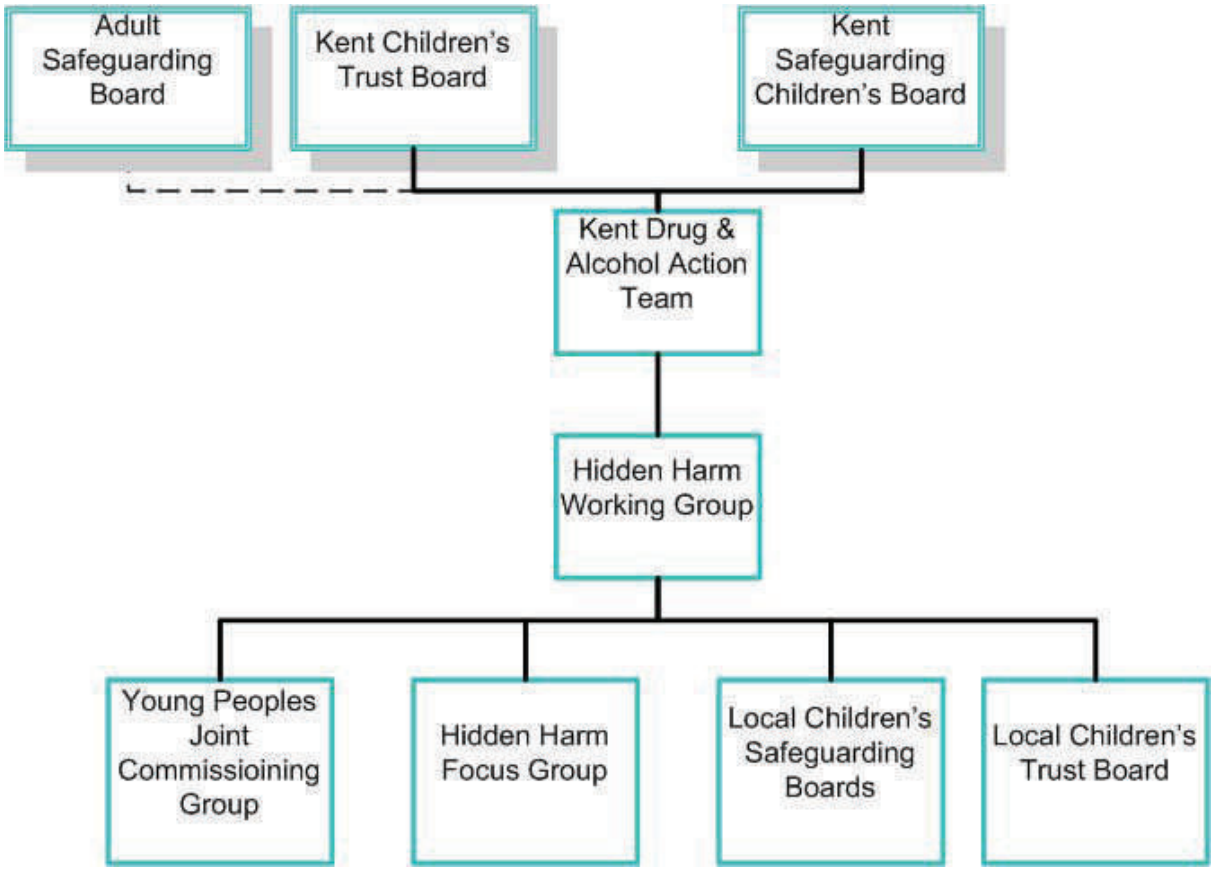
   - Ensure that Parents, children and families views are incorporated in the future planning and commissioning of services
   - Raise awareness about the harm caused to children as a result of parental substance misuse and increase knowledge about services available to address the problem

7. **Well-equipped practitioners who have the necessary skills for early identification, assessment and intervention and that the workforce is competent in safeguarding.**

   - Ensure all treatment service staff and practitioners are competent and confident in Safeguarding Procedures and practices
   - Ensure all family service staff are competent and confident at early screening and assessment for parental substance misuse

Governance

This Strategy is supported by a delivery plan, which will be progressed by the Hidden Harm Working Group:



Monitoring and Evaluation

Improving outcomes for children and young people for whom the impact of substance misuse is often "hidden" is not easily defined. This strategy will be assessed against the progress of the delivery plan and the actions in the Children and Young People's Plan. It will be monitored through the KDAAT Board and Think Family Overview Group.

Resources

This Strategy is predicated on the principle that better outcomes for children and young people can be achieved through improvements in integrated practice and family focussed working. This will require workforce development that addresses the key skills and competencies to deliver effective interventions that improve outcomes for children and young people.

References:

1. Hidden Harm - Responding to the needs of children of problem drug users, Advisory Council on the misuse of drugs, 2003

2. Quotes from children attending the KCA Sunlight Project

3. Amendments to this document are currently being consulted upon and makes specific reference to 'Joint Guidance on Development of Local Protocols between Drug and Alcohol Treatment Services and Local Safeguarding and Family Services, 2009

4. Hidden Harm - Responding to the needs of children of problem drug users, Advisory Council on the misuse of drugs, 2003

5. Prime Ministers Strategy Unit (2003) Alcohol Harm Reduction Strategy for England' http://www.newcastle-staffs.gov.uk/documents/community%20and%20living/community%20safety/caboffce%20alcoholhar%20pdf.pdf

6. This is based on a local file audit of children on the Child Protection Register. Data is not currently recorded in way that can be reported on in a robust and timely way.

All images within this document are used for illustrative purposes only and any person depicted in the image is a model.

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To: **Cabinet – 12 July 2010**

By **Alan Marsh, Cabinet Member for Public Health**
Meradin Peachey, Kent Director of Public Health
Allan Gregory, Tobacco Control Manager

Subject: **"Towards A Smokefree Generation"**
Kent Tobacco Control Strategy 2010-2014

For decision

Summary:

This strategy enables Kent partners to acknowledge the importance of supporting a comprehensive approach to tobacco control; for their own organisation and the communities that they serve, by incorporating tobacco control measures into their strategic plans and commissioning intentions.

1. Introduction and Background

i. Tobacco Control incorporates a range of activity to reduce the effects of smoking, preventing young people starting to smoke, NHS smoking cessation services, reducing exposure to secondhand smoke and reducing availability of tobacco products.

2. Why do we need a Tobacco Control Strategy?

i. Tobacco use cannot be viewed as just a health issue – it is everyone's priority because of the toll of death and disease that smoking causes. For tobacco use to be effectively tackled, a range of people need to take action and work together. Tobacco control that is a focused, sustained and coordinated action on a number of fronts by a wide range of agencies, organisations and individuals is vital if the significant achievements of recent years in the fight against tobacco are to be built on.

ii. Successful tobacco control interventions will not be achieved without high-level support and leadership. To achieve success the infrastructure and resources necessary to implement a comprehensive tobacco control programme must be made available. The strategic and operational aspects of tobacco control go hand in hand, but one working without the other is unlikely to see the results that a joint effort could produce.

iii. The clear message of a comprehensive approach to tobacco control is aimed at influential local leaders such as Local Authority Leaders, Directors of Public Health, Commissioning leads and local politicians. They, and indeed anyone who has a leadership role within local communities, can play a crucial role in ensuring that this strategic approach to tobacco control is achieved.

3. The challenge to Kent Partners

i. The actions recommended within this strategy have the potential to reduce the harmful effects of smoking and reduce prevalence within local communities, but only if they are implemented with the energy, vitality and backing of senior level personnel who have the ability to:

- put in place a sound local infrastructure and dedicated resources;
- drive capacity building where required;
- identify the overlap between national targets and local aspirations, translating tobacco control evidence into prioritized local action;
- ensuring that tobacco control aspirations are embedded within Local Area Agreements;
- promote inter-agency collaboration by sponsoring activity at organisational level;
- provide the political will, strategic thinking and high-level recognition that tackling smoking is a priority;
- show a willingness to help overcome issues that arise as part of local tobacco control work;
- demonstrate unquestionable commitment to a comprehensive tobacco control programme.

4. The potential benefits

i. We can reduce the massive burdens that tobacco use inflicts on our communities. Comprehensive tobacco control efforts can impact on health inequalities, reduce the economic burden on society and reduce the death, disease and disability that people throughout the country suffer because of smoking. Prioritising tobacco control will create many benefits.

ii. The recommendations in this strategy:

- are based on evidence of effectiveness and represent the actions that will have the most impact on reducing smoking prevalence, improving health and wellbeing and reducing health inequalities;
- will support the achievement of other PSA, LAA and local targets;
- can help Local Authorities to promote the economic, social and environmental wellbeing of communities.

5. The Burden of Tobacco in Kent

- Smoking is the most significant cause of preventable ill-health in Kent.

- Damage to health caused by smoking does not discriminate between class or wealth. When it comes to the county, smoking is the leading cause of inequalities in Kent.

- Over 2,000 Kent residents die prematurely each year due to smoking and the average smoker loses more than seven years of healthy life. More men than women die of smoking-attributable illness – smoking is a big contributor to the gap in life expectancy between men and women, and between the poorest in society and the better off.

- There are over 10,000 admissions to our hospitals each year which are due to smoking. This is estimated to cost NHS Eastern and Coastal Kent £12m and NHS West Kent £10m each year. The annual outpatient activity costs associated with smoking in East and West Kent are estimated to be £1.3m and £860,000 respectively.

- The wider economic impact of smoking is substantial. Each year in Kent, cigarette breaks and smokers' sick days cost employers around £215million. The average smoker spends £1000 a year on tobacco, regardless of their socio-economic status. Fires due to smoking cost £3.3million each year in consequential and response costs.

- In addition to the direct health benefits, strong action in tobacco control and in supporting smokers in stopping is likely to be highly cost effective across the Kent economy. These benefits will not be fully realised in the short term, but will be significant in the medium to long-term.

- Despite sustained education about the health effects of smoking, adolescents continue to smoke, suggesting that traditional approaches may educate, but they do not influence. Young people tend to respond to social trends. Evidence from youth advocacy forums show they want 'just the facts' to allow them to make up their own mind about tobacco, rather than being told the 'rights and wrongs' of tobacco use. Social influence is probably therefore the best intervention.

6. Kent Alliance on Smoking & Health (KASH) continues to drive action

- The role of the Kent Alliance on Smoking & Health (KASH) is to engage all partners in making an active contribution to reducing the impact of smoking on health and health inequalities. The Kent Tobacco Control Strategy finished in 2008. It was highlighted by the DH Tobacco Control National Support Team as good practice.
- The Tobacco Control Steering Group was re-established in January 2009, with a renewed and heightened level of partner engagement
- KASH reports to the Kent Public Health Board to increase the breadth of influence of the Alliance, raise its profile, endorse senior level engagement from the Kent Partnership and to contribute its activity to the Local Area Agreement
- The Kent Director of Public Health as the chair of the Public Health Board reports to the PCTs
- The Alliance continues to report on project work undertaken, directly to the DH

7. Strategy Development

i. In 2009/2010, KASH has been focusing on:
   - Continuing to develop effective partnerships and to tackling the public health issue of tobacco as a shared priority.
   - Developing a comprehensive Kent Tobacco Control Strategy

- Implementing a strategic tobacco control programme with a specific focus on Young People
- Wider support for improving smoking cessation targets for the PCTs.

ii. As a result of this exercise, a Kent Tobacco Control Strategy has emerged as follows:

Aim
• Tackle the Health Inequalities caused by tobacco. • Reduce the harm caused by tobacco • Reduce the prevalence of smoking in Kent
Vision
• It is hard for anyone to start using tobacco • It is easy for anyone to stop using tobacco • There is no exposure to second hand smoke • Action is based on evidence and best practice • Partners are exemplars in tobacco control • This vision is communicated effectively

8. Impact on the Kent Partner organisations

i. The main impact of this strategy is the promotion of commissioning decisions to support tobacco control programmes as well as stop smoking services.

ii. If there is a failure to support, then the infrastructure required to deliver the tobacco control programmes that will deliver the potential savings identified, will be lost.

iii. The commitment to the partnership approach, and leadership through the alliance, enables Kent partners to acknowledge the importance of supporting a comprehensive approach to tobacco control; for their own organisation and the communities that they serve, by incorporating tobacco control measures into their strategic plans and commissioning intentions.

9. Implementation Framework

i. It is proposed that the Kent Tobacco Control Strategy is clearly formatted to ensure that partner organisations are clear about their role in tobacco control. This will serve as a way of monitoring the delivery of the Kent Tobacco Control Strategy.

ii. Smoking creates major health, economic and social burdens within our communities, which is why tobacco control needs to be elevated to a high level within organisations that can play a role in reducing smoking rates. A proposed Kent Tobacco Control Framework will:
- provide everyone involved with local tobacco control with new ideas for making a difference in their areas – showing what can be achieved, and how to do it;
- help organisations work towards their next priorities. (Tobacco control has not ended with the Smokefree legislation of July 2007 and while more than one in five adults are smokers in England, there is much more to be done);

- brings together in one place both the evidence and relevant practical experience on local comprehensive tobacco control, providing ideas and robust evidence to justify the case for focusing on comprehensive tobacco control action;
- will be structured around the 'vision' workstreams;
- will promote the focus on protecting young people in Kent as a priority.

iii. This approach is supported by the Kent Partnership. KASH will formally support and drive this process by providing workshops, seminars and events as appropriate.

10. Conclusions

i. This strategy addresses the proportions of our population that remain exposed to the significant health risks from smoking, and are concentrated in our more deprived communities. Beyond the well-recognised effects on health, tobacco also plays a role in perpetuating poverty, deprivation and health inequality.

ii. Tobacco control – not just Stop Smoking Services or media campaigns in isolation, but an integrated package of interventions – has enormous potential to tackle health inequalities and the ongoing burden of disease caused by smoking. The driving ethical principle of tobacco control is that of fairness:
- A fair chance for children and young people to grow up in an environment where smoking is not seen as the norm;
- for smokers to get help to quit (as the majority wish to do); and
- for people to live and work without being exposed to the hazards of secondhand smoke.

iii. This strategy advocates how smoking prevalence can effectively be further driven down in our communities. The practical recommendations in this document, particularly those aimed at protecting young people from the dangers of tobacco; set out a systematic approach to delivering an effective and comprehensive tobacco control programme for Kent.

iv. This strategy enables Kent partners to acknowledge the importance of supporting a comprehensive approach to tobacco control; for their own organisation and the communities that they serve, by incorporating tobacco control measures into their strategic plans and commissioning intentions.

v. Tobacco use cannot be viewed as just a health issue – it is everyone's priority because of the toll of death and disease that smoking causes. For tobacco use to be effectively tackled, a range of people need to take action and work together. Tobacco control that is a focused, sustained and coordinated action on a number of fronts by a wide range of agencies, organisations and individuals is vital if the significant achievements of recent years in the fight against tobacco are to be built on.

11. Recommendation:

i. Cabinet is asked to give its support and approval to this strategy.

Background documents: ‘A Smoked Free Future’ - report by the Department of Health February 2010 and ‘Smoking in Kent – Death, Disease and Economic Impact Attributable to Smoking – May 2009 – published by the Kent and Medway Public Observatory.

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Equality Impact Assessment

Towards a Smokefree Generation

Kent Tobacco Control Strategy 2010-2014

Name of Policy or Service	"Towards a Smokefree Generation" Kent Tobacco Control Strategy 2010-2014
Responsible Manager	Allan Gregory Tobacco Control Manager Kent Public Health Department
Date EIA Completed	May 2010
Review Date	May 2011

Contents

Equality Impact Assessment

Why this is important?

1. All individuals and population groups should have equal opportunity to benefit from Department of Health policy. But inequalities in health between different ethnic groups and between men and women are well documented and long-standing. We cannot simply assume that health policy will be equally beneficial for everyone. A professional approach to policy-making means testing our assumptions. By assessing potential effects of a policy on particular populations in a rigorous way, we can increase the probability that a policy will promote equity of outcomes.

2. Equality impact assessment is also a legal requirement. Public bodies have for many years been required not to discriminate in the delivery of their services or in employment on grounds of gender and race. Since 2002, public authorities have been required to assess and monitor the impact of all relevant policies on race equality. A similar duty came into force in December 2006 to assess the impact of policies on disabled people under The Disability Discrimination Act 2005. The Equality Act 2006 imposed a duty to promote equality between women and men from April 2007. Another part of the Equality Act will prohibit discrimination in service delivery on the basis of religion or belief and sexual orientation. We must also pay due regard to underpinning human rights issues.

3. If policies are assessed for their impact on different sections of the population from the outset, we are better placed to meet our legal obligations. More importantly, we are more likely to produce better policy that will benefit everyone in the population.

Introduction

4. Smoking is by far the biggest cause of preventable death and the significant contributor to the gap in health and life expectancy between the richest and the poorest. Smoking kills one-in-two of all lifelong users. There is a strong social gradient to smoking, with lower socio-economic classes being much more likely to smoke at higher rates within their community and being much more likely to smoke more individually, start smoking at an earlier age and smoke for longer. Smokers are also likely to be over-represented within certain vulnerable and minority groups. Health inequalities and differences in life expectancy between one community and another are central issues for comprehensive tobacco control.

5. *Towards A Smokefree Generation*, a new comprehensive tobacco control strategic framework for Kent, describes a raft of measures, which if implemented by local partners can deliver a vision of a smokefree future, free from the harms of tobacco use.

6. The measures and aspirations described in the strategy will have particular significance and impact on certain communities and disadvantaged, vulnerable and minority groups. This Equality Impact Assessment (EIA) examines the impact of this tobacco control strategy on particular groups who may be subject to discrimination on the grounds of race, age, gender, religion, sexual orientation or disability. This assessment also presents the possible impacts of proposed policies and ways to mitigate inequalities for particular groups. Wherever possible, the assessment is supported by evidence. This EIA also highlights areas where there continues to be gaps in the evidence base and where further research might usefully be commissioned. *This EIA will therefore serve as a reference point for Kent partners, for when they take forward their own plans for developing local tobacco control action.*

7. Narrowing health inequalities is a top priority for Kent partners. This strategy aims to narrow the gap in health outcomes across geographical areas, across socio-economic groups, between males and females, across different minority ethnic groups and age groups. Reducing smoking rates in disadvantaged groups and areas is a key factor in reducing the health inequalities gap.

Background to Strategy

8. Tobacco use cannot be viewed as just a health issue – it is everyone's priority because of the toll of death and disease that smoking causes. For tobacco use to be effectively tackled, a range of people need to take action and work together. Tobacco control that is a focused, sustained and coordinated action on a number of fronts by a wide range of agencies, organisations and individuals is vital if the significant achievements of recent years in the fight against tobacco are to be built on.

9. This strategy enables Kent partners to acknowledge the importance of supporting a comprehensive approach to tobacco control; for their own organisation and the communities that they serve, by incorporating tobacco control measures into their strategic plans and commissioning intentions.

Summary of Research and Issues

Health Inequalities & Social Economic Disadvantage

Issues

10. Tobacco use exhibits a strong social gradient. Historically higher socio-economic groups have reacted to the evidence on the harms from tobacco use by quitting smoking in ever greater numbers. However, the decline in smoking rates has been much slower for lower socio-economic classes.

11. Arguably, any tobacco control strategy is likely to result in a bigger decline for higher socioeconomic classes than for lower socio-economic classes, unless specific measures are taken to guard against this widening of the health inequalities gap by specifically targeting and influencing disadvantaged, vulnerable and minority groups with high rates of smoking.

12. Even with appropriate policies developed to guard against increasing health inequalities, it is likely that the effect of any tobacco control measures on higher socio-economic classes will be just as great as increasingly smoking is not seen as an acceptable habit

13. Other lifestyle diseases and unhealthy behaviours, such as alcohol abuse and drug misuse, very often accompany high rates of smoking within disadvantaged areas. It is clear that we cannot tackle the problem of health inequalities caused by smoking in isolation.

14. Some disadvantaged groups, such as prisoners, smoke at very high rates (70%+). Currently smokefree legislation describes exemptions for prisons, meaning prison wardens and other non-smoking prisoners are exposed to dangerous secondhand smoke.

Policies and impacts

15. The focus on reducing health inequalities in Spearhead areas has, to date, ignored pockets of deprivation and high smoking rates in otherwise wealthy (non-Spearhead) areas. The 2010 Public Sector Agreements for smoking targeted smoking rates within the general adult population and within routine and manual workers. The use of 'routine and manual workers' as a proxy for disadvantage in order to target health inequalities is not perfect – there are considerable differences in income within the routine and manual group. However, it does target high rates of smoking as despite routine and manual workers representing just one third of the adult population, they represent over half of all smokers. Also, by targeting routine and manual smokers, we are able to pick up on high smoking rates within non-spearhead areas. (N.B. There are no Spearhead areas within Kent).

16. To implement the Kent tobacco control strategy and most accurately target health inequalities attributable to smoking, we propose to combine an occupational measure (routine and manual) of smoking with a geographical measure. The details of this have yet to be finalised and its construction will be reliant on the accuracy and availability of ward-level data. One of the proposals in the strategy is to work with local delivery colleagues and the Kent and Medway Public Health Observatory to develop an adequate and robust geographical indicator to target health inequalities attributable to smoking.

17. This strategy, does not commit partners to a specific quantifiable aspiration for reducing smoking rates within disadvantaged local areas, as this will largely depend on the future national and local health inequalities strategy post the 2010 PSAs.

18. The Government will also be taking specific action to make available appropriate and accessible support to particular disadvantaged communities and groups, such as prisoners. We will also be working with local community leaders and local authorities to promote smokefree environments.

Race

Issues

19. Smoking rates vary considerably between ethnic groups and also between men and women within those groups.

20. There is evidence to show that some communities have higher smoking rates compared with the general population. For example, some black and minority ethnic (BME) groups have higher smoking rates than the general population. The national statistics reveal high prevalence rates among Bangladeshi men at 40%, Irish men at 30%, Black Caribbean men at 35% and Pakistani men at 29%. Among women, around 5% of Bangladeshi women smoke, compared with 25% of Irish women[1].

21. The evidence behind why some ethnicities have higher smoking prevalence than others is wide ranging and can be due to any number of social or cultural factors.

[1] NHS Information Centre. *Health Survey for England 2004*: Health of Ethnic Minorities. Available from: www.ic.nhs.uk

22. For example, there is some evidence around tobacco use amongst Bangladeshi and Pakistani men and this seems to be heavily linked to gender, age, religion, and tradition. Smoking is a widely accepted practice in Pakistan and in Bangladesh smoking for men is associated with socialising, sharing, and male identity. Smoking prevalence is lower for Pakistani and Bangladeshi women as it seems to be associated with stigma and shame[2].

23. Smoking rates are higher amongst lower socio-economic groups. Some BME groups experience higher levels of deprivation and their smoking rates may therefore be linked to disadvantage rather than, or in addition to, race and culture. Tobacco control policies will be developed and implemented in a way that addresses the inter-relationship between race, smoking and disadvantage[3].

24. There is some evidence to suggest religion can influence smoking behaviour. For example, smoking prevalence is high among Muslim communities globally[4]. However, a number of other factors including culture, traditions, attitude, family environment and socio economic status are likely to be more important.

25. Smokeless tobacco comes in many different forms around the world. We know that the use of such products is inconsistent across communities and age groups but emerging evidence is highlighting products are mainly imported from South Asia, and in England pockets of high prevalence have been identified amongst Bangladeshi, Indian and Pakistani populations. In contrast to the gender divide for smoking, a high prevalence of use has been observed among Bangladeshi women[5].

26. Smokeless tobacco of the types used by South Asian groups in the UK have been shown to cause oral cancers. Anecdotal evidence suggests that it is the older generation who are much more likely to use smokeless tobacco such as paan and zarda (chaat). Smokeless tobacco is largely unregulated and is sold in many different types of shops. It does not carry the same health warnings as smoked tobacco.

<u>Policies and impacts</u>

27. The Government currently funds pilots in two regions to evaluate smoking cessation interventions for BME communities, looking at shisha smoking and smokeless tobacco.

28. The deliver the strategic aim of reducing health inequalities within the strategy, it is assumed that local partner action will target specific action in minority and disadvantaged communities to tackle high smoking rates:

    a) improving the accuracy of local smoking prevalence data to identify those groups with high smoking rates, and work with Local Stop Smoking Services to develop best practice in reaching out to and supporting quit attempts within minority and ethnic groups with high smoking rates;

[2]Bush J et al. Understand influences on smoking in Bangladeshi and Pakistani adults: community based, qualitative study. *British Medical Journal*. [Online]. 2003;326(7396):962. Available from: doi: 10.1136/bmj.326.7396.962

[3] Erens B (eds.) et al. Department of Health. *The Health of Minority Ethnic Groups, Health Survey for England 1999*. The Stationary Office Ltd. London. 2001

[4]Ghouri N et al. Influence of Islam on Smoking among Muslims. *British Medical Journal.* [Online]. 2006; 332: pp.291-294. Available from: doi:10.1136/bmj.332.7536.291

[5] McNeill A. Smokeless tobacco in the UK: products, populations and policy, Results of a Cancer Research UK funded project. *Conference presentation*. ASH Wales, Cardiff, October 2009

b) creating integrated public health care packages, tailored to the individual and supporting a wide range of health improvement interventions to improve general health and well being and to empower communities to take action against tobacco related harm to their communities;

c) recruiting well-known and trusted community leaders to help promote NHS Stop Smoking Services in minority and disadvantaged communities;

d) developing a communication strategy and cessation interventions for smokeless tobacco users where required.

Age

Issues

29. Smoking affects people of all ages, both directly and indirectly, through passive smoking. As such, the policies to address the issues here are wide ranging. Prevalence of smoking is strongly related to age.

30. Adult smoking rates have declined from 28% in 1998 to 21% in 2007 yet evidence shows that over a fifth of the adult population or 8.5 million people in England smoke today[6] and, in 2007, over 80,000 people died from a smoking related disease[7], the majority in middle age[8].

31. The highest rates of smoking are in the 20-24 age-group (32%) and the 25-34 age group (26%). The prevalence of smoking then declines with those over the age of 60 reporting the lowest prevalence[9].

32. Life-long smokers lose on average 10 years of life; whatever age a smoker quits they will see some benefit in terms of life years saved, though this benefit diminishes with age. However, pre-operative smoking cessation can bring about great benefits at any age in terms of reduced recovery time and bed-days. Within 8 hours of quitting, the chance of having a heart attack greatly diminishes and progressive conditions such a chronic obstructive pulmonary disease can be better controlled. This all supports the use of policies aimed at driving down prevalence of smoking among the older population.

33. Smoking in adults also perpetuates smoking uptake in youth as studies have shown that 16-17 year olds have a perception that 50% of adults smoke when this is far from the truth[10].

34. Quit attempts are relatively consistent across age groups but with younger people making more quit attempts. Though older people make fewer attempts they have a higher rate of success in stopping smoking[11]. Smokers over the age of 60 who set a quit date with the NHS Stop Smoking Services are more likely to be successful than any other age groups in quitting successfully with the support of these cessation services. In particular, the over-60 population are the most successful at

[6] Office for National Statistics. *General Household Survey 2007, Smoking and drinking among adults 2007*. Newport. 2007

[7] The NHS Information Centre. *Statistics on Smoking, England, 2009*. Health and Social Care Information Centre, United Kingdom. 2009

[8] Peto R. The hazards of smoking and the benefits of stopping: Cancer Mortality and overall mortality. *International Agency for Research on Cancer Handbooks on Cancer Prevention*. 2007;11:pp. 15-27

[9] The Information Centre for health and social care. *Statistics on Smoking, England, 2009*. United Kingdom. 2009

[10] West R. Smoking in England. The Smoking Toolkit Study. [Online]. Available from: http://www.smokinginengland.info/. Accessed 28 October 2009

[11] West R. Smoking in England. The Smoking Toolkit Study. [Online]. Available from: http://www.smokinginengland.info/. Accessed 28 October 2009

going smokefree[12]. Smokers on average have to make multiple quit attempts before they can remain quit.

35. Nationally, smoking prevalence among 11-15 year olds is down from 13% in 1996 to 6% in 2007. However, every year 250,000 people take-up smoking and of these 200,000 are below the age of 19. Approximately 100,000 16 year olds smoke or 17% of the total number of 16 years olds[13]. Children below the age of 14 are usually anti-smoking – the challenge for tobacco control policies is not behavioural change but behavioural maintenance.

36. A range of inter-related factors operating at the individual, family, social, community and societal levels influence whether a young person starts and continues to smoke. These include: growing up in an environment where smoking is the norm among family and friends, having positive beliefs about the benefits of smoking for example in terms of their image and mood control, having access to cigarettes, discounting health risks, and having disadvantaged social, educational and economic circumstances.

37. People who start smoking at an early age are more likely than other smokers to smoke for a long period of time and more likely to die prematurely from a smoking-related disease.

38. To prevent take-up of smoking previous government measures focused on reducing the appeal and supply of tobacco to young people through a combination of mass media and legislation such as raising the age of sale of cigarettes to 18, banning tobacco advertising and including picture warnings on tobacco packs.

39. Young people are more likely than adults to buy tobacco from vending machines and from friends. Under current rules, a retailer can be fined and prevented from selling tobacco if they are caught selling it to under-18s on three separate occasions.

Policies and impacts

40. Renewed focus by the NHS on smoking cessation in Secondary Care will bring about a reduction in bed-days and is likely to benefit older people more.

41. Increasing referrals through the health and social service should benefit all age groups. However, specific local prioritisation of resources can be used to target particular age groups as characterised by the service user. Prioritisation of smoking cessation resource will be informed by local commissioning plans.

42. Primary Care Health Professionals will be encouraged to promote smoking cessation interventions for all age groups, and outline the benefits of quitting at any age.

43. In 2010, the Department of Health will develop a new national marketing strategy for the period 2011-15. This will include a focus on young people to prevent uptake.

[12] The Information Centre for health and social care. *Statistics on NHS Stop Smoking Services in England, April to December 2007*. London. 2008

[13] West R, Smoking Prevalence Pipe Model, The Smoking Toolkit Study. [Online]. Available from: http://www.smokinginengland.info/. Accessed 28 October 2009

44. Young people are particularly price sensitive[14]: to reduce the affordability of tobacco, the Government will seek to maintain downward pressure on the illicit market and consider real increases in duty on a Budget-by-Budget basis.

45. To take action on the attractiveness of tobacco products, the Government will also consider the evidence for introducing plain packaging. To reduce exposure to tobacco the government has introduced a ban (from 2013) on the display of all tobacco products.

46. To restrict the availability of tobacco to young people, the government has introduced measures to ban the sale of tobacco from vending machines.

47. Promoting the voluntary adoption of smokefree environments in the home and in the private car, can have the potential benefit of protecting millions of children from the harms of secondhand smoke (SHS) and averting thousands of related hospital admissions. Cotinine testing in children in the Health Survey for England shows a constant decline in exposure to SHS over the past decade.

48. The national aspiration to reduce smoking rates in 11-15 year olds to 1% by 2020, is ambitious but achievable if adult smoking rates also fall significantly. However, it is likely that when we reach very low rates of smoking (1-2%), we will encounter other issues and lifestyle diseases one can expect to find clustered in disadvantaged areas. Therefore in order to achieve this aspiration, we will need to take a holistic approach to tackling health inequalities.

49. Smoking has a high impact on the mortality and morbidity of older people, but they are more likely to be successful in stopping smoking than are younger people. The evidence that much of the harm from smoking can be halted or even reversed challenges the view that is commonly held by older smokers that the damage has been done and is irreparable. Referrals of older people through NHS Stop Smoking Services will be encouraged.

Gender

Issues

50. In 1980, men were reported to smoke at a higher percentage at 42% than women at 36%. Today the statistics are still showing men at a higher rate though it has decreased considerably. Men are still more likely to smoke at 22% than women at 19%[15]. This disparity in attitudes to smoking and quitting between men and women is due to a number of factors, with women being more likely to access specialist support to quit.

51. Pregnant women from lower socio-economic groups are nearly twice as likely as pregnant women from higher socio-economic groups to smoke throughout pregnancy.

52. Among children aged 11-15 years, girls are two and a half times more likely to be regular smokers[16] but boys catch up with girls around ages 16-19[17].

53. There is limited understanding as to why there are gender differences in youth smoking. There are a wide range of factors that influence smoking uptake in youth

[14] Hopkins D et al. Reviews of evidence regarding interventions to reduce tobacco use and exposure to environmental tobacco smoke. American Journal of Preventive Medicine. 2001;20: (2S): pp. 16-66

[15] The Information Centre for health and social care. *Statistics on Smoking, England, 2009.* United Kingdom. 2009

[16] The Information Centre for health and social care. *Statistics on Smoking, England, 2009.* United Kingdom. 2009

[17] Office for National Statistics. *General Household Survey 2007, Smoking and drinking among adults 2007*. Newport. 2007

such as: their attitudes, beliefs, self-esteem, risk taking age, educational attainment, personal environment e.g. family and friends, school, and the wider social cultural environment such as social norms and access to cigarettes. However, for the most part research on gender differences presents an unclear picture[18].

54. To date there has not been a huge amount of focus looking at gender in regards to smoking although mass media campaigns have used gender characteristics in marketing to help reduce smoking. An example of this is in anti-smoking advertising to show smoking as a habit that makes you unattractive, stains teeth and makes you smell unpleasant.

Sexual Orientation

55. There is some evidence showing minority groups such as lesbians, gays, bisexuals and transsexuals (LGBT) smoke at higher rates than the general population. The reasons behind this are not well known yet but there are suggestions that gay and lesbian social spaces (such as bars), violence, stress, and discrimination, as well as barriers to healthcare access and treatment services, contribute to the higher rates of smoking[19].

56. Related studies have shown also that smoking prevalence is also uncommonly high among gay men and women who are HIV positive and that quitting can help control their condition.

Policies and impacts

57. This strategy aims for all policies to have an overall positive effect in reducing gender differences in smoking. It is not anticipated that any of the policies will increase gender differences in smoking, as there is a strong evidence base for most policies promoted in this strategy.

58. A significant element of this strategy to protect young people, families and communities involves smoking cessation interventions aimed at pregnant women and young families, to protect both the woman and child from the harms of tobacco and secondhand smoke.

Disability

Issues

59. Whilst smoking rates amongst adults with disabilities varies, smoking rates are higher amongst those with mental health problems than the general population[20]. Sufferers of psychiatric disorders have a deep dependence on tobacco[21] and they are likely to be heavier, more dependent smokers and have smoked longer than smokers in general population[22].

[18] Amos A et al. Young people, smoking and gender – a qualitative exploration. *Oxford Journals*. [Online]. 2006;22(6): pp.770-781. Available from: doi: 10.1093/her/cy1075

[19] Lee J G et al. Tobacco use among sexual minorities in the USA, 1987 to May 2007: a systematic review. *Tobacco Control*. [Online]. 2009;18: pp. 275-282. Available from: doi:10.1136/tc.2008.028241

[20] Lasser K et al. Smoking and mental illness: A population-based prevalence study. *JAMA*. [Online]. 2000;284(20): pp.2606-2610. Available from: http://jama.ama-assn.org/cgi/content/abstract/284/20/2606

[21] Farrell M et al. Nicotine, alcohol and drug dependence and psychiatric comorbidity, Results of a national household survey. *British Journal of Psychiatry*. [Online]. 2001; 179: pp.432-437. Available from: http://bjp.rcpsych.org/cgi/content/full/179/5/432

[22] Office for National Statistics. *General Household Survey 2007, Smoking and drinking among adults 2007*. Newport. 2007

60. Although from 2008, all mental health units were required by law to be smokefree, psychiatric in-patient settings seem to have the highest level of smoking, with up to 70% of patients being smokers, of which 50% are heavy smokers[23]. The extremity of these statistics has led to higher mortality rates for those with mental illness for example those with schizophrenia have a higher death rate from respiratory disease then the average person[24].

61. Successful quit rates for people with mental health problems are low. This is due to the level of dependence, but also cultural factors such as staff and patients believing nicotine helps patients to cope with the symptoms of their illness or with the side effects of medication[25].

62. There is a lack of treatment and support for smokers to manage their nicotine dependence in mental health settings[26]. Studies have also shown that staff working in mental health institutions lack knowledge about tobacco dependence and its treatment[27].

Policies and impacts

63. The evidence base on mental disabilities and smoking is strong and for some time, there have been policies in place, which have tried to address the considerable issues here. Although there has been difficulty assessing what the best type of intervention is for people with mental health problems, there has been a realisation that interventions for the general population can also work for those with mental illness. For example, pharmacotherapy and other support like counselling seem to increase abstinence rates of smoking in those with mental health problems similar to the general population[28].

64. As such, this strategy aims to go a step further and provide guidance to help cessation services embed their services and tailor plans to achieve long-term cessation, in high prevalence health and social care settings such as prisons and mental health services.

Human Rights

65. This strategy does not breach any human rights as set out in the Human Rights Act 1998.

66. Many of the current and proposed national tobacco control measures involve legislation and work at European Union level to prove the greater public health good versus intellectual property and competition rights of private business. This is the case for the ban on the advertising and sponsorship of tobacco and a similar legal case must be made if the Government were to pursue plain packaging and put public health benefits before the intellectual property rights of the tobacco industry.

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[23] Jochelson J, Majrowski B. *Clearing the air: Debating smoke-free policies in psychiatric units.* United Kingdom. Kings Fund; 2006

[24] Joukamaa M et al. Mental disorders and cause-specific mortality. *British Journal of Psychiatry*. [Online]. 2001;179: pp.498-502. Available from: http://bjp.rcpsych.org/cgi/content/abstract/179/6/498

[25] Jochelson J, Majrowski B. *Clearing the air: Debating smoke-free policies in psychiatric units.* United Kingdom. Kings Fund; 2006

[26] Ratschen E, Britton J, Doody GA, McNeill A. Smoke free policy in acute mental health wards: managing the pitfalls. General Hospital Psychiatry 2009a; 131-

[27] Ratschen E, Britton J, Doody GA, Leonardi-Bee J, McNeill A. Tobacco dependence, treatment and smoke-free policies: a survey of mental health professionals' knowledge and attitudes. General Hospital Psychiatry 2009b; 31(6):576-82

[28] Department of Health. *NHS Stop Smoking Services, Service and monitoring guidance 2009/10*. London. 2009

67. When the Government reviews the current retailer scheme for tobacco, there will also be an opportunity to examine the existing powers of the police for confiscation of tobacco from minors (under the 1933 Children and Young People Act) and current sanctions on the supply of tobacco to young people. If required, we will seek to bolster these powers to protect the rights of children to the right to survival; to develop to the fullest; to protection from harmful influences, abuse and exploitation; and to participate fully in family, cultural and social life.

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Towards a Smokefree Generation

Kent Tobacco Control Strategy 2010-2014

Tobacco use cannot be viewed as just a health issue – it is everyone's priority because of the toll of death and disease that smoking causes. For tobacco use to be effectively tackled, a range of people need to take action and work together. Tobacco control that is a focused, sustained and coordinated action on a number of fronts by a wide range of agencies, organisations and individuals is vital if the significant achievements of recent years in the fight against tobacco are to be built on.

May 2010

SMOKEFREE
Kent Alliance on Smoking and Health

A future free from tobacco use will mean our children will not die early and unnecessarily from smoking-related illnesses.

"A Smokefree Future", Department of Health, 2010

Contents

Section ..... Page

Setting the scene

- Smoking is the most significant cause of preventable ill-health in Kent.

- Damage to health caused by smoking does not discriminate between class or wealth. When it comes to the county, smoking is the leading cause of inequalities in Kent.

- Over 2,000 Kent residents die prematurely each year due to smoking and the average smoker loses more than seven years of healthy life. More men than women die of smoking-attributable illness – smoking is a big contributor to the gap in life expectancy between men and women, and between the poorest in society and the better off.

- There are over 10,000 admissions to our hospitals each year which are due to smoking. This is estimated to cost NHS Eastern and Coastal Kent £12m and NHS West Kent £10m each year. The annual outpatient activity costs associated with smoking in East and West Kent are estimated to be £1.3m and £860,000 respectively.

- The wider economic impact of smoking is substantial. Each year in Kent, cigarette breaks and smokers' sick days cost employers around £215million. The average smoker spends £1000 a year on tobacco, regardless of their socio-economic status. Fires due to smoking cost £3.3million each year in consequential and response costs.

- In addition to the direct health benefits, strong action in tobacco control and in supporting smokers in stopping is likely to be highly cost effective across the Kent economy. These benefits will not be fully realised in the short term, but will be significant in the medium to long-term.

- Despite sustained education about the health effects of smoking, adolescents continue to smoke, suggesting that traditional approaches may educate, but they do not influence. Young people tend to respond to social trends. Evidence from youth advocacy forums show they want 'just the facts' to allow them to make up their own mind about tobacco, rather than being told the 'rights and wrongs' of tobacco use. Social influence is probably therefore the best intervention.

1.0 INTRODUCTION

Tobacco Control incorporates a range of activity to reduce the effects of smoking, preventing young people starting to smoke, NHS smoking cessation services, reducing exposure to secondhand smoke and reducing availability of tobacco products.

1.1 Why do we need a Tobacco Control Strategy?

Tobacco use cannot be viewed as just a health issue – it is everyone's priority because of the toll of death and disease that smoking causes. For tobacco use to be effectively tackled, a range of people need to take action and work together. Tobacco control that is a focused, sustained and coordinated action on a number of fronts by a wide range of agencies, organisations and individuals is vital if the significant achievements of recent years in the fight against tobacco are to be built on.

Successful tobacco control interventions will not be achieved without high-level support and leadership. To achieve success the infrastructure and resources necessary to implement a comprehensive tobacco control programme must be made available. The strategic and operational aspects of tobacco control go hand in hand, but one working without the other is unlikely to see the results that a joint effort could produce.

The clear message of a comprehensive approach to tobacco control is aimed at influential local leaders such as Local Authority Leaders, Directors of Public Health, Commissioning leads and local politicians. They, and indeed anyone who has a leadership role within local communities, can play a crucial role in ensuring that this strategic approach to tobacco control is achieved.

1.2 The challenge to Kent Partners

The actions recommended within this strategy have the potential to reduce the harmful effects of smoking and reduce prevalence within local communities, but only if they are implemented with the energy, vitality and backing of senior level personnel who have the ability to:

- put in place a sound local infrastructure and dedicated resources;
- drive capacity building where required;
- identify the overlap between national targets and local aspirations, translating tobacco control evidence into prioritized local action;
- ensuring that tobacco control aspirations are embedded within Local Area Agreements;
- promote inter-agency collaboration by sponsoring activity at organisational level;
- provide the political will, strategic thinking and high-level recognition that tackling smoking is a priority;
- show a willingness to help overcome issues that arise as part of local tobacco control work;
- demonstrate unquestionable commitment to a comprehensive tobacco control programme.

1.3 The potential benefits

We can reduce the massive burdens that tobacco use inflicts on our communities. Comprehensive tobacco control efforts can impact on health inequalities, reduce the economic burden on society and reduce the death, disease and disability that people throughout the country suffer because of smoking. Prioritising tobacco control will create many benefits.

The recommendations in this strategy:

- are based on evidence of effectiveness and represent the actions that will have the most impact on reducing smoking prevalence, improving health and wellbeing and reducing health inequalities;
- will support the achievement of other PSA, LAA and local targets;
- can help Local Authorities to promote the economic, social and environmental wellbeing of communities.

1.4 A New National Tobacco Control Strategy

On 1st February 2010, the government set out it's priorities for a smokefree future.

- Stopping young people being recruited as smokers by cracking down on cheap illicit cigarettes.
- Ensuring every smoker will be able to get help from the NHS to suit them if they want to give up.
- Consideration for the case for plain packaging of cigarettes.
- Stopping the sale of tobacco through vending machines
- Protecting everyone, especially children, from the harms of second hand smoke.

Three objectives have been set:

- *Stopping the inflow of young people recruited as smokers*: aspiring to reduce the 11-15 year old smoking rate to 1% or less, and the rate among 16 and 17 year olds to 8% by 2020.
- *Motivating and assisting every smoker to quit*: aspiring to reduce adult smoking rates to 10% or less, and halve smoking rates for routine and manual workers, among pregnant women and within the most disadvantaged areas by 2020.
- *Protecting our families and communities from tobacco-related harm*: aspiring to increase to two-thirds the proportion of homes where parents smoke but that are entirely smokefree indoors by 2020.

1.5 The Challenge for "Kent"

Smoking is the greatest cause of premature death in Kent, making it a public health area of priority. If the principles of tobacco control are applied comprehensively then the potential is enormous. Smoking as a normal activity will be challenged and tobacco use denormalised. The UK has been rated as the top country in Europe for tobacco control. This reflects significant progress made in the past decade but there is still more to be done. This strategy provides a range of proposed workstreams to make tobacco control most effective in local communities. What is required is a strategic commitment.

> "The year 2010 will be a landmark one for tobacco control in England. All partners will be focusing on delivering the current 2010 Public Service Agreement, but will also be laying the groundwork for delivering this strategy in earnest from 2011 onwards. PCTs in particular will be expected to continue to prioritise tobacco control and to set their own local goals that meet local needs."
>
> "A Smokefree Future", Department of Health, 2010

2.0 THE BURDEN OF TOBACCO IN KENT

Damage to health caused by smoking does not discriminate between class or wealth. When it comes to the health of county, smoking is the leading cause of inequalities in Kent; accounting for half of the difference in life expectancy between the most and least affluent groups.

Among the most deprived groups, three out of four families smoke and spend a seventh of their disposable income on cigarettes (Marsh A and McKay S, *Poor Smokers*, Policy Studies Institute, 1994). 'Smoking poverty' of this nature can see children in smoking households more likely to be lacking basic amenities such as food and clothing. In addition to the financial impact, smoking is the greatest single factor in the different life expectancy between social classes. Indeed, premature death is the most extreme form of social exclusion and without shared enthusiasm for explicit action, inequalities are likely to get even worse over the next few decades. Addressing the inequalities in health brought about by the use of tobacco remains a huge challenge

2.1 Prevalence of Smoking in Kent

In half of the local authority areas of Kent, smoking prevalence rates are higher than the national average.

Smoking rates in district authority areas have been estimated from results of the Health Surveys for England using know information on the local population, such as socio-economic status and ethnicity. Figure 1 shows expected prevalence of smoking in adults given local population characteristics, ranked from lowest to highest.

Where local population prevalence figures are lower than the Kent and/or National average, consideration should also be given to the prevalence at ward level. Figure 2 shows Tonbridge and Malling as an example of the how smoking prevalence is an indicator of health inequalities.

Figure 1: Estimated Smoking Prevalence of Kent by Local Authority

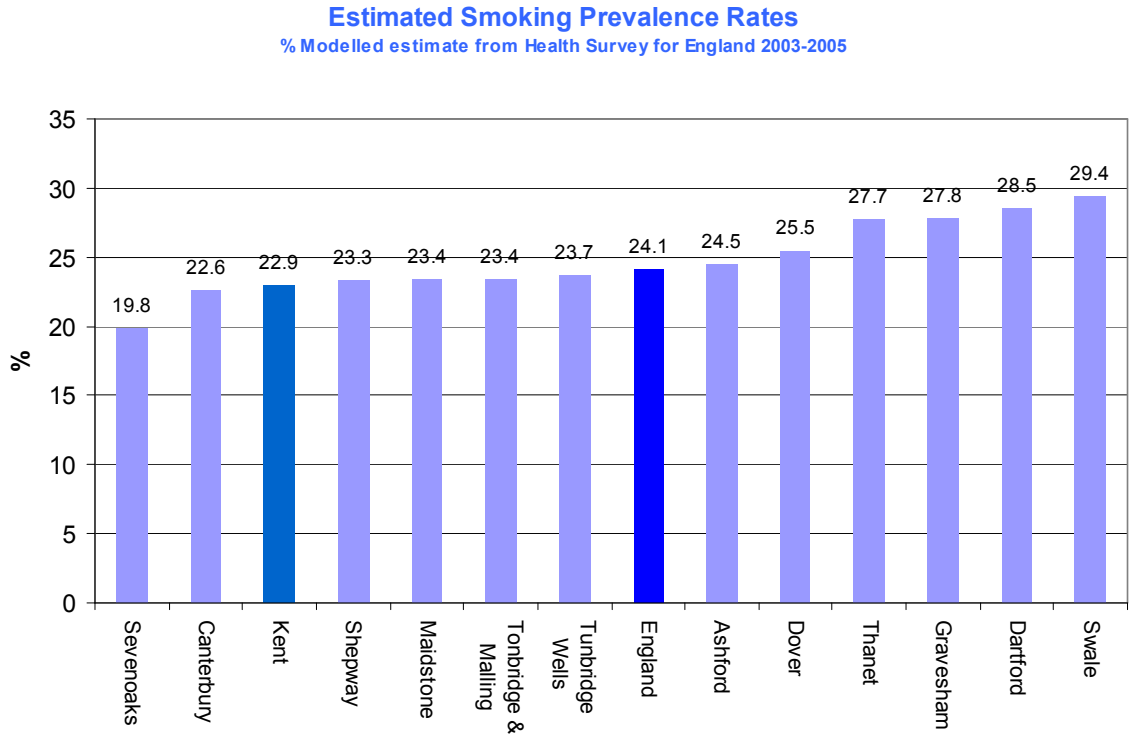
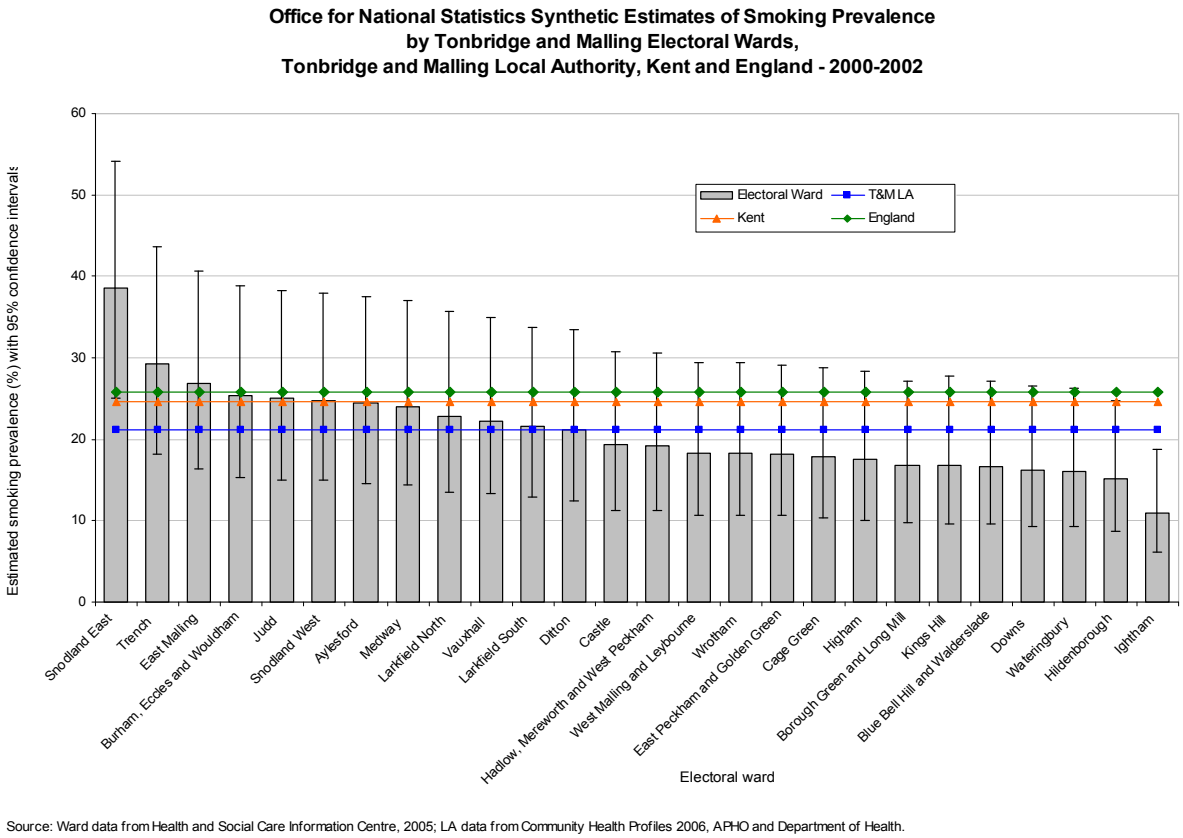
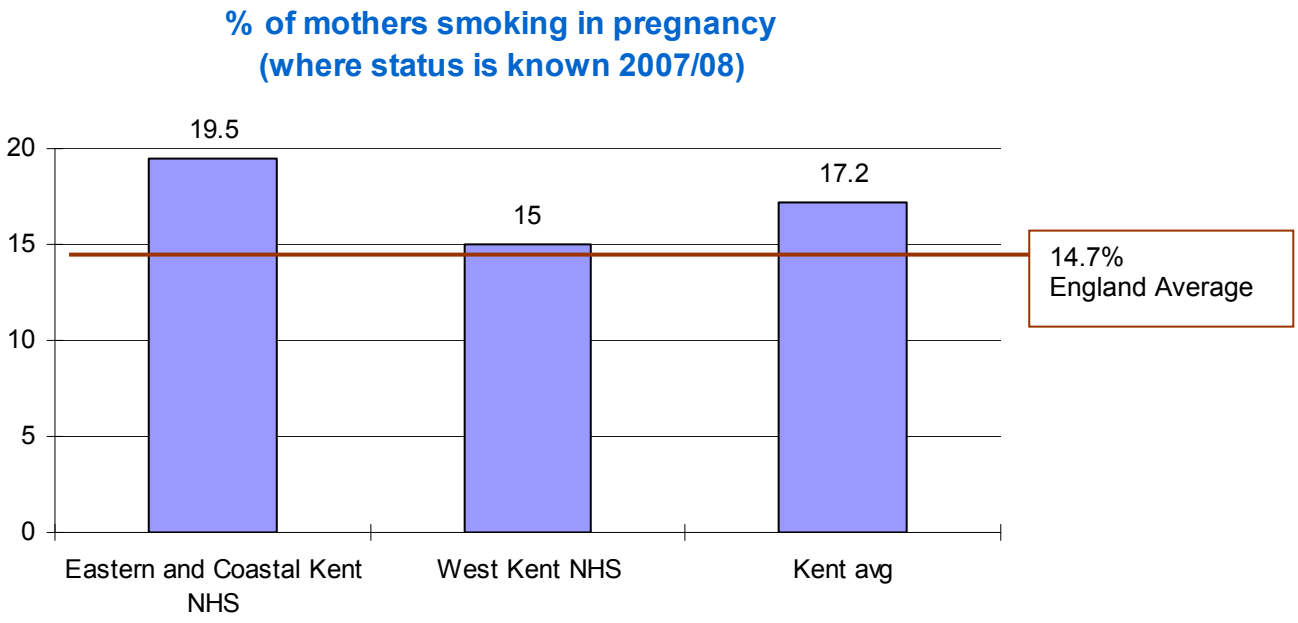


Figure 2: Smoking Prevalence in Tonbridge & Malling by Electoral Ward



Source: Ward data from Health and Social Care Information Centre, 2005; LA data from Community Health Profiles 2006, APHO and Department of Health.

Figure 3: Smoking Prevalence in pregnancy



2.2 Deaths attributable to Smoking in Kent

There are 2,250 deaths in Kent each year due to smoking – 17% of all deaths. Obviously, it is impossible to avert death altogether and these people would eventually have died of other causes; however, it is possible to describe these as premature, avoidable deaths.

More men than women die from smoking (and a greater percentage: 22% vs. 13%), and there are more deaths in the East of Kent than the West. Many of these deaths are due to cancers, particularly lung cancer.

2.3 Years of healthy life lost

Smokers in Kent stand to lose over two million years of healthy life by continuing to smoke.

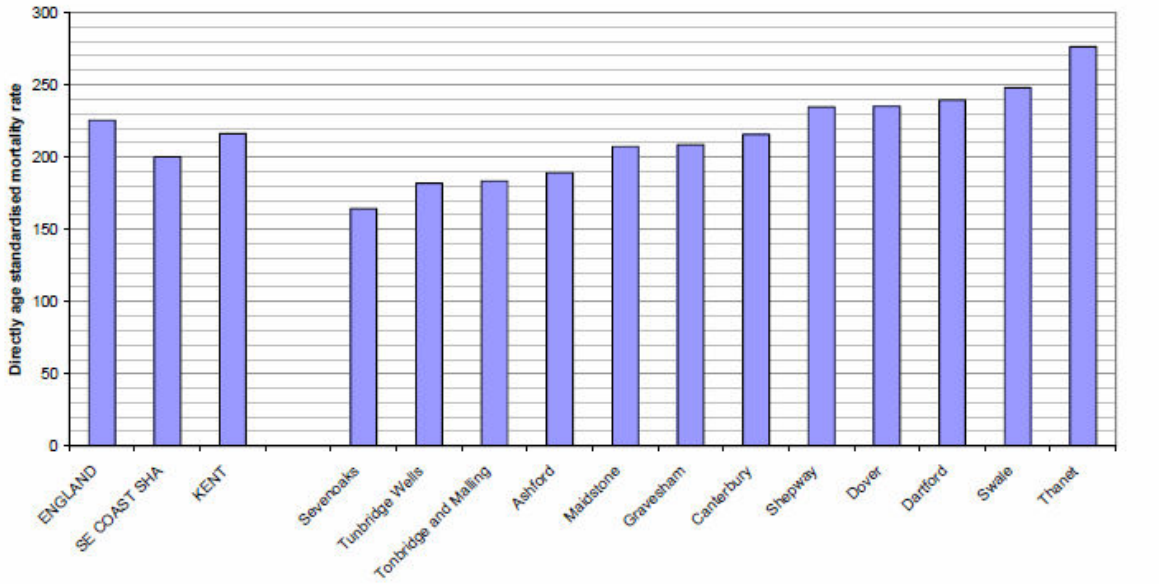
It is estimated that half of all smokers will die of smoking related disease and of these, half will die in middle age losing 20 to 25 years of life, and half will die in later life, eight years prematurely. The average number of years of life lost therefore equals 15.25 for those that die of smoking, or 7.625 years per smoker. There are 276,300 smokers in Kent (APHO modeled prevalence rates applied to ONS district populations 16+, 2007). That is a total of 2,100,000 years lost. It should be noted that not all of these lost years can be saved by simply getting smokers to quit, as smoking will have already caused harm to existing smokers – it is equally important to reduce the uptake of smoking amongst children and young adults.

Smoking not only shortens life, it reduces the quality of life at the end of life, such as mobility and independence - simply because smokers die earlier, this does not mean that they avoid ill health prior to death. This is supported by local statistics on healthy life expectancy at 65 years, which show there is no difference in years of poor health between populations with long life expectancy and those with short life expectancy.

2.4 Smoking Mortality Rates in Kent

Figure 4 shows that the Kent mortality rate due to smoking is higher than the South East Coast Strategic Health Authority rate but lower than the England rate. This is line with the known rates of smoking in these different areas, and reflects a national north-south deprivation gradient. The trend within Kent is also towards a higher mortality rate in the more deprived districts.

Figure 4: Directly age standardised mortality rates of deaths attributable to smoking in Kent Districts (source: APHO, 2008)



2.5 Impact of Hospital Admissions and Outpatient Attendances Attributable to Smoking

There are over 10,000 admissions to our hospitals each year which are due to smoking. This is estimated to cost NHS Eastern and Coastal Kent £12m and NHS West Kent £10m each year. The annual outpatient activity costs associated with smoking in East and West Kent are estimated to be £1.3m and £860,000 respectively.

[Note: Use of primary care services due to smoking (e.g. GPs, prescriptions, district nursing) has not been estimated or costed.]

For both East and West Kent, smoking admissions make up five percent of all admissions. Respiratory admissions are the most strongly attributable to smoking (20-21% of all respiratory admissions), while cardiovascular admissions are the biggest area of smoking attributable expenditure at £4.6m and £4.0m in East and West Kent respectively.

2.6 Workplace Productivity

The potential benefits for employing organisations – regardless of sector or industry – of supporting Smokefree legislation are significant. The total cost of smoking to Kent employers is estimated to be around £215 million; based on the cost of increased sickness leave and cigarette breaks taken by smoking employees. Employers should encourage and support staff with addiction to tobacco to contact NHS Stop Smoking services.

2.7 Smoking and Fires

A 2003 report for the Office of the Deputy Prime Minister found that smokers' households were 50% more likely to have experienced a fire in the previous year than tobacco-free households. While there may be other social or environmental factors to this statistic, local data shows that cigarette fires are more dangerous than other fires. The relative risk of dying in a fire caused by smoking is five times that of dying in a fire caused by another source. Known risk factors include smoking in bed and smoking whilst drinking alcohol – a cigarette contains chemicals designed to keep it burning, even after the smoker falls asleep. These deaths are avoidable tragedies.

Two to three people die every year in Kent in fires caused by smoking; accounting for 23% of all fire-related deaths in Kent.

The cost of smoking related fires can be divided into the response costs to the fire service in dealing with an incident, and the consequential costs, such as cost to insurers and property owners, and the physical, employment and emotional costs of injuries and death.

The total annual cost in Kent of smoking related fires is estimated to be £3.3million.

3.0 TOBACCO CONTROL IN KENT

The Department of Health currently provides funds to each Regional Public Health Group for work on the broad tobacco control agenda, supporting the national strategy for reducing smoking prevalence and tackling the death, disease and ill health caused by tobacco use. In the South East, part of this money has historically been passed on to Tobacco Control Alliances as a *contribution* to the work they are carrying out at a local level.

The Government published a new Tobacco Control Strategy, in February 2010. This promotes a renewed vision, ambition and commitment to the tobacco control agenda and provides a further opportunity to build on the achievements of the past 10 years, since the publication of the *'Smoking Kills'* White Paper (1998). The Health Bill (2009) introduces measures to prohibit the point of sale display of cigarettes and tobacco products, the banning of vending machines as a source of purchasing tobacco and considering the introduction of plain packaging.

It is therefore vital that we ensure comprehensive plans are in place at national, regional and local level to drive this work forward and address the wide range of issue that will impact on smoking behaviour.

It is well recognised that smoking is a major cause of health inequalities and that multi-agency partnership working is vital in addressing this issue. The health service cannot tackle this alone and tobacco control needs to be seen as *everybody's business* if we are to be successful.

Tobacco Control Alliances have an important role to play in bringing together key partners from across the locality, sharing information and experiences as well as pooling knowledge and resources to galvanise action that will really make a difference. Local action on tobacco control will also need leadership and support from within both PCT's and Local Authorities.

Tobacco control activities – and local Alliances – should form an integrated part of local planning and commissioning in order to secure continued action and commitment to this important issue.

The Department of Health's *High Impact Changes for Tobacco Control* document provides a more detailed background to the importance of local tobacco control activity, emphasising the reasons why high level support and commitment is so vital. It is also a useful resource for developing local plans and benchmarking activities.

Only by working together can we make a real and sustained difference to health and inequalities in Kent.

3.1 Kent Alliance on Smoking & Health (KASH) continues to drive action

- The role of the Kent Alliance on Smoking & Health (KASH) is to engage all partners in making an active contribution to reducing the impact of smoking on health and health inequalities. The Kent Tobacco Control Strategy finished in 2008. It was highlighted by the DH Tobacco Control National Support Team as good practice.
- The Tobacco Control Steering Group was re-established in January 2009, with a renewed and heightened level of partner engagement
- KASH reports to the Kent Public Health Board to increase the breadth of influence of the Alliance, raise its profile, endorse senior level engagement from the Kent Partnership and to contribute its activity to the Local Area Agreement
- The Kent Director of Public Health as the chair of the Public Health Board reports to the PCTs
- The Alliance continues to report on project work undertaken, directly to the DH

Terms of Reference: the role and function of a KASH

- Enhancing the **local infrastructure**
- Provide **leadership** and strengthen coordination
- Promote the **sharing of good practice** from within and beyond Kent
- In consultation, **develop action plans** on specific areas of work
- **Build capacity** for tobacco control activities across Kent, and provide strategic guidance and support for effective local activities
- Support **joint planning** between agencies around key issues – such as enforcement and tackling illicit trade
- Steer **research, evidence and quality** agendas to ensure that they complement Kent's strategic priorities
- **Represent** Kent at regional and national levels

Additionally, KASH considers…

- Ensuring that all PCTs, NHS Trusts, local authorities and key agencies and partners are engaged in the tobacco control with clear lines of accountability
- Strategic support and guidance for the work of the Alliance.
- The new Local Area Agreements reflect the impact of tobacco upon local communities and identify tobacco as a priority for improvement of health inequalities, life expectancy, and infant mortality.
- Ensuring that smoking related indicators are adopted, with subsequent tobacco programmes implemented through the LAA/CAA and its partnership.

3.2 The KASH Tobacco Control Steering Group

The role and membership of the Steering Group has been revised to ensure it is fit for the purpose of delivering the broad aims of the Kent Tobacco Control Strategy.

There have been major developments in tobacco control legislation over the last few years, with a national ban on smoking in enclosed public places introduced on July 1st 2007. KASH has been instrumental in supporting the implementation of smokefree legislation across Kent. Local Authority Environmental Health representatives have attended steering group meetings to feed back on smokefree compliance in their locality and share issues and good practice. It is proposed that less emphasis be placed upon these operational issues at steering group meetings, with updates on compliance instead given by a representative of the Public Health Technical Group, where these operational issues are discussed in more detail.

The steering group has been instrumental in driving organisations to contribute to the NHS smoking cessation services and increase referrals. This will continue.

It is no longer appropriate that the steering group *delivers* project work. Instead, the steering group *oversees* and directs tobacco control project work across Kent, in line with the aims of this Kent Tobacco Control Strategy.

The group also agrees the allocation of DH funding to specific project work.

3.3 KASH Project-based Sub-groups

It is proposed that delivery of the aims of the Kent Tobacco Control Strategy be managed by project work undertaken by specific sub-groups.

The formation of sub-groups is not a new idea. Sub-groups have previously met on an ad hoc basis to address specific issues such as 'age of sales' legislation. The key difference with this proposal is that the sub-groups will now be the main groups responsible for the implementation and delivery of project work, instead of the Tobacco Control Steering Group.

Sub-groups will consist of members from partner organisations with a defined project lead for each, who attends the KASH Tobacco Control Steering Group to represent each project. An example might be a project to develop a Smokefree Homes Award Scheme. A sub-group would meet to take forward the work and might include representatives from: Kent Fire & Rescue; Local Authority Environmental Health/Housing; Community Health Trainers; community nursing and community development workers. It is hoped that the formation of sub-groups to carry out distinct project work will facilitate engagement of a wider range of partner organisations, where it is currently not practical to invite them all to the steering group that we currently have.

The areas of work on which sub-groups focus will be determined by the key aims of the Tobacco Control Strategy and through the strategic direction of the Tobacco Control Steering Group. These groups will continue to meet for as long as their particular project is running and be responsible for implementation of project work. The frequency of their meetings will be decided by members.

3.4 Resources

The Kent Alliance is led by a Tobacco Control Manager, employed within the Kent Public Health Department. This post is funded by West Kent PCT, Eastern and Coastal Kent PCT and is hosted by Kent County Council.

The Alliance receives tobacco control project funding annually from the Department of Health. Whilst funding is available in 2009/10, we cannot depend on this being the case in future years. It is recommend that tobacco control activities – and Alliances – are mainstreamed into local planning and commissioning cycles to ensure future commitment and security to this important work.

This is not to say that funds will not be available for local tobacco control projects in future years. However, please be aware that DH allocations should only be seen as a *contribution* to local activity and that the current system may have to change. This contribution comes from Programme Funds that are usually short term.

Consideration should therefore be given as to how best to ensure Alliance structures and work-plans are locally sustainable.

3.5 Strategy Development

In 2009/2010, KASH has been focusing on:

- Continuing to develop effective partnerships and to tackling the public health issue of tobacco as a shared priority.
- Developing a comprehensive Kent Tobacco Control Strategy
- Implementing a strategic tobacco control programme with a specific focus on Young People
- Wider support for improving smoking cessation targets for the PCTs.

As a result of this exercise, a Kent Tobacco Control Strategy has emerged as follows:

Aim
• Tackle the Health Inequalities caused by tobacco. • Reduce the harm caused by tobacco • Reduce the prevalence of smoking in Kent
Vision
• It is hard for anyone to start using tobacco • It is easy for anyone to stop using tobacco • There is no exposure to second hand smoke • Action is based on evidence and best practice • Partners are exemplars in tobacco control • This vision is communicated effectively
Outputs / Delivery Plan
• A Tobacco Control Strategy for Young People in Kent

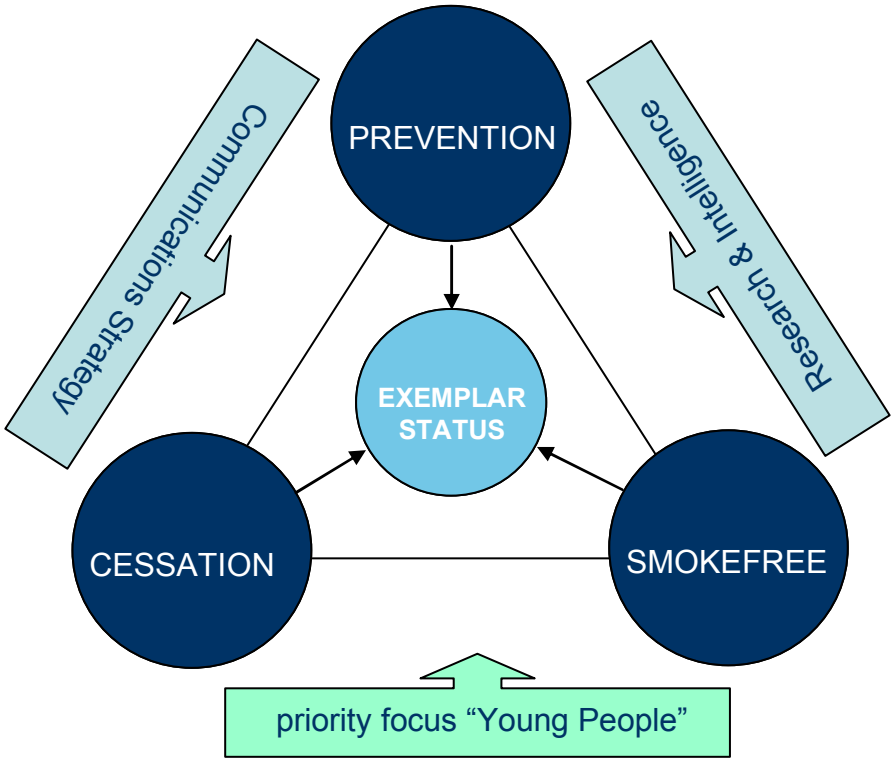
The following sections of this paper will detail further the Vision for Kent and focus on how this strategic vision can be delivered.

4.0 THE VISION FOR KENT

The Kent Tobacco Control Strategy fundamentally consists of six workstreams aimed at delivering the 'vision' for Kent, that:

- It is hard for anyone to start using tobacco
- It is easy for anyone to stop using tobacco
- There is no exposure to second hand smoke
- Action is based on evidence and best practice
- Partners are exemplars in tobacco control
- This vision is communicated effectively

In delivering this vision, KASH activities will focus on i) enabling partners to be clear about their contribution to a comprehensive tobacco control agenda and, ii) the cross-cutting issue of protecting young people from the harmful effects of tobacco.



4.1 Vision Workstreams

It is envisaged that each workstream will be operate as a sub-group of the Tobacco Control Steering Group. The priority actions for each of these workstreams will be to support of the focused strategy on protecting Young People.

4.1.1 A Tobacco Control Strategy for Young People in Kent

The government launched a consultation on the future of tobacco control in May 2008. The consultation received the largest ever response to a consultation of this kind – an overwhelming 96,000 responses.

One of the key drivers of the consultation was: Protecting children and young people from smoking: reducing young people's access to tobacco, reducing exposure to tobacco promotion, and protecting children from secondhand smoke to prevent future generations suffering poor health caused by tobacco.

There is a need to realise that traditional educational approaches have had limited impact and that success is likely to be achieved by implementing comprehensive tobacco control measures, and fully including young people in the process. Some 80% of people start smoking as teenagers and while smoking prevalence has declined in the last few decades, with around 9% of 11–15 year olds regularly smoking; those young people who do experiment run the real risk of addiction and of becoming long-term smokers. Also, prevalence appears to have stalled in recent years and there is a dramatic increase in prevalence over the age range – 16% of boys and 24% of girls being regular smokers at age 15. The traditional approach to the adolescent smoking problem has been to try to prevent uptake. However, despite sustained education about the health effects of smoking, adolescents continue to smoke, suggesting that traditional approaches may educate, but they do not influence.

KASH commissioned the Tobacco Control Collaborating Centre to deliver a comprehensive programme of work to focus on protecting the young people of Kent from tobacco. This will establish agreement on where joint work between Kent agencies impact on the smoking rates of young people in the county. This comprised of a number of interviews with personnel from a partner agencies across Kent and a stakeholder event held in October 2009.

Tackling youth smoking as a standalone intervention will probably have little impact. This specific focus is linked to the "Vision" workstreams, as youth prevention has to be part of a comprehensive tobacco control programme based on denormalising smoking as a habit. Thus, efforts to enforce smokefree regulations have a bearing, as do action on the illicit trade and enforcing the age of sale of tobacco.

Stand alone interventions unrelated to an overall coherent strategy are vulnerable to "short-termism" and individual enthusiasm. The county therefore proposes six key and mutually supported elements on which the partners in the county can focus:

ACCESS Challenged by Trading Standards.	**CURRICULUM** Tobacco education as part of PHSE Education.	**REFRAME THE DEBATE** Focus on "The Truth Materials" instead of the individual harm done by tobacco.
CAMPAIGN Recognise and publicise risks of second hand smoke to Young People. (Smokefree homes / cars; Smokefree pregnancies)	**CESSATION SUPPORT** … for vulnerable and excluded young people.	**CALL FOR ACTION** Produce an "Impact Statement on Young People and Smoking".

1. The access to tobacco goods by young people will be challenged through measures led by Trading Standards to enforce restrictions on underage sales.

2. Schools and education settings will be encouraged to work with partners to provide high quality Drug, Alcohol and Tobacco education and positively enable all children and young people to resist, or give up smoking.

3. The approach to discouraging tobacco use amongst young people will be re-framed and instead of focusing on the individual harm done by tobacco we will develop "The Truth" information pack for young people of school age and those attending college in a way that stresses the wider socio-economic and international implications of tobacco production and marketing.

4. We will build upon the public support for reducing the risks to vulnerable people of secondhand smoke by recognising and publicising the fact that exposure to tobacco smoke is damaging to young people's well-being. This will be done both in the Children's Trust Strategy "Positive About our Future" [See Smokefree Homes and Cars] and through information provided in SureStart and Children's Centres.

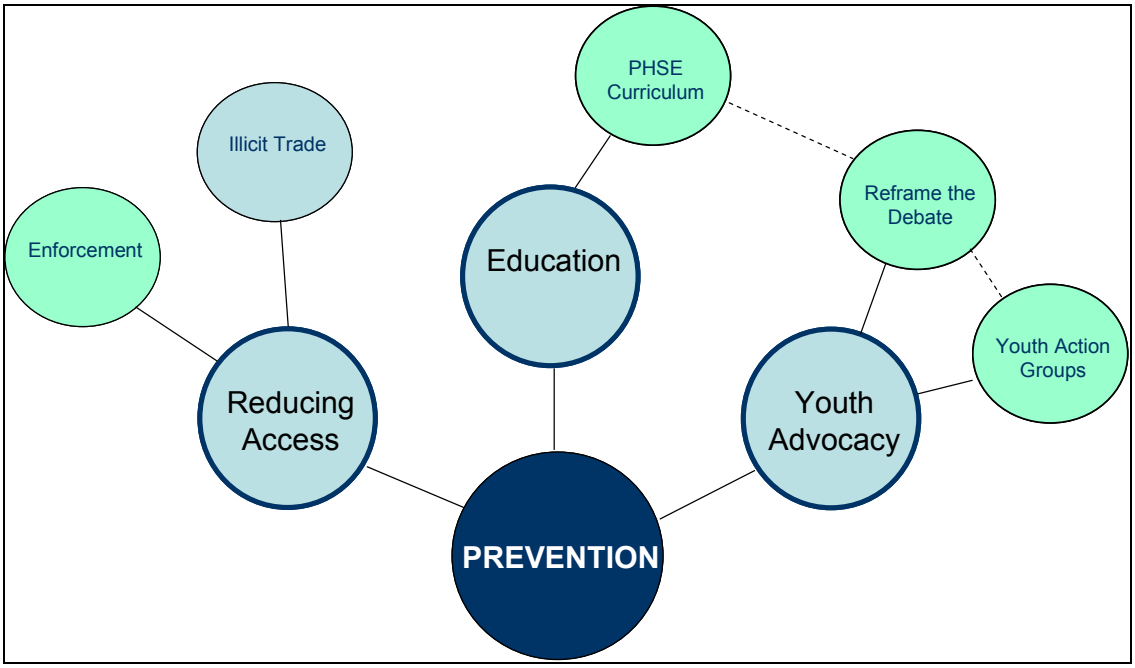
5. Vulnerable and excluded young people demonstrate a similar smoking profile to that of people in mental health institutions and custodial settings. Through the work of the Youth Offenders Team and the Youth Service and specifically in Pupil Referral Units we will ensure active cessation support measures for both service users and providers are readily available and service users and providers encouraged to take advantage of them.

6. We will produce an "Impact Statement on Young People and Smoking" which will provide the basis for all staff inductions programmes in Education, Children's Services, Leisure Services, Trading Standards, Community Services, PCT Provider Services, Youth Offending Teams and Police recruitment.

These six initiatives are intended to be supported by the normal Stop Smoking Service measures available to the population at large, though a special cessation service will be developed for those young people demonstrating higher prevalence levels together with parents seeking to quit. Their needs may be targeted through SureStart and Children's Centres.

4.1.2 PREVENTION: Making it hard for anyone in Kent to start smoking

Kent Trading Standards enforce legislation in the district relating to underage sales, sales of counterfeit goods and also play a part in the control of illegal supplies of tobacco. Her Majesty's Revenue and Customs (HMRC) and the UK Boarder Agency (UKBA) are the principal bodies for controlling illegal supplies of tobacco in the county.



Example action:

i.) Focus on Illicit tobacco

Addressing the problem of illicit tobacco is a national priority and cross-government plans are currently being put into place. A national Marketing and Communications Strategy has also been developed (awaiting sign-off) and there will soon be resources and collateral developed for wider use with key partners to increase awareness of this issue.

A Regional Forum has been established to facilitate this process across the South East, with representatives from HMRC, Trading Standards, LACORS, Police and Public Health. An action plan is currently being developed that will be shared with Alliances in due course – key items within this are likely to relate to obtaining a better understanding of attitudes towards illicit tobacco and purchasing patterns, enforcement and communication messages. The Kent Tobacco Control Manager is a member of this forum.

The county of Kent is referred to frequently in Illicit Tobacco strategies as a major 'gateway' for illicit tobacco products entering the country as a whole. As a result, Kent welcomes the South East Regional approach and will actively support and participate in actions to address the illicit tobacco trade.

Kent will require the engagement of a full range of tobacco control stakeholders working together effectively to improve the intelligence base. Not only do Local Strategic Partnerships and local health strategies need to factor in smuggling as a priority issue but also look to Trading Standards, HM Revenue and Customs and Crime and Disorder Reduction Partnerships to support local efforts. There is also a potential role here for youth advocacy.

It should be noted that all stakeholders in the Kent understand that illicit tobacco sales risk undermining all other local tobacco control efforts. All partners should give this message when making public statements.

ii) Enforcement of under age sales legislation

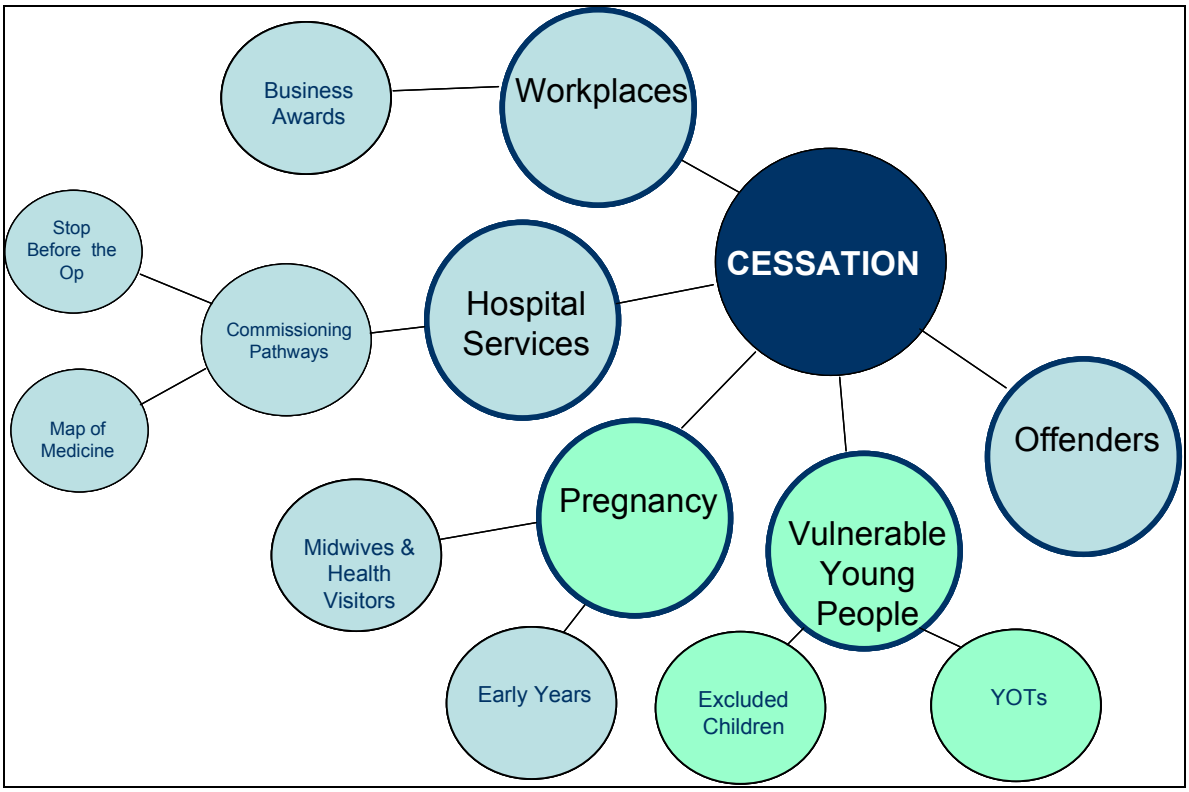
Kent Trading Standards have an opportunity to increase the profile of enforcing underage sales legislation; specifically focusing on tobacco. Trading Standards will be responsible for actions resulting from The Health Bill (2009) legislation currently going through parliament; with the banning of cigarette vending machines and the removal of Point of Sale merchandising materials.

iii) Development of Youth Advocacy

In support of the strategic focus on Young People, KASH will develop the role of youth advocacy and try to get youth leaders and young people to join the Alliance. Young people can make good advocates because smoking generally begins at school age. In addition to seeking out youth representation, KASH will work with youth forums and parliaments to gain an understanding of how children and young people feel about tobacco. Exploring ethical arguments such as tobacco farmers and the tobacco industry plus wider debates on the environmental impact of smoking could be a start point. The aim is to empower young people with a wider knowledge base about all tobacco control issues and capitalise on their energy and enthusiasm.

4.1.3 CESSATION: Making it easy for anyone in Kent to stop using tobacco

When talking about an integrated stop smoking approach we are highlighting the importance of embedding the idea that quitting smoking is not only achievable and desirable, but an outcome that should be encouraged and supported by all organisations. If we are to achieve the tobacco control aim of denormalising smoking as a desirable, everyday activity, then it is also important to ensure that supporting smokers to stop is the business of every organisation. As the most evidence-based support system available, local NHS Stop Smoking Services are one vital part of this equation, as are the other support options available from the NHS. Indeed, no other country in the world has an integrated Stop Smoking Service available to all and free at the point of delivery.



However, all too often the Stop Smoking Services are seen as the sole agency that can deliver tobacco control at a local level. It is a mistake to believe that Stop Smoking Services equate to tobacco control or that they can in isolation provide prevalence reduction on the scale that is required. Instead, they should be viewed as one vital element of an overall strategic and comprehensive tobacco control programme. They should be fully involved in tobacco control and seen as a resource for information on quitting support, providing expert advice to organisations that want to integrate a stop smoking approach for their workforce. This is also vitally important for the focus on routine and manual smokers.

To ensure continuing improvement of Stop Smoking Services, the Department of Health has issued updated *Service and Monitoring Guidance* to ensure adherence to the quality principles and consistency in data quality and data recording. KASH will also support the two Stop Smoking Services in Kent to deliver the DH Integrated Service Framework; ensuring that KASH partners have the capacity to signpost quitters into the stop smoking services (*see section 4.1.5: "Exemplars"* and section 4.3: "Young People's Strategy" – specifically concerning vulnerable young people and focus on Pregnancy/Early Years)

Example action:

i) Smokefree Kent Business Award

KASH will work with the Stop Smoking Services on the development of a Smokefree Kent Business Award. This will provide organisations with an economic assessment of the cost of smoking to their organisation, and will support the development of comprehensive smokefree policies (promoting wellbeing for staff and adherence to smokefree legislation). The scheme will reward organisations and ensure relationships are forged with the Stop Smoking Services.

The scheme will be targeted towards i) routine and manual employers, ii) areas of high smoking prevalence and iii) organisations that work with young people and families.

ii) Integrating Smoking cessation into hospital based services

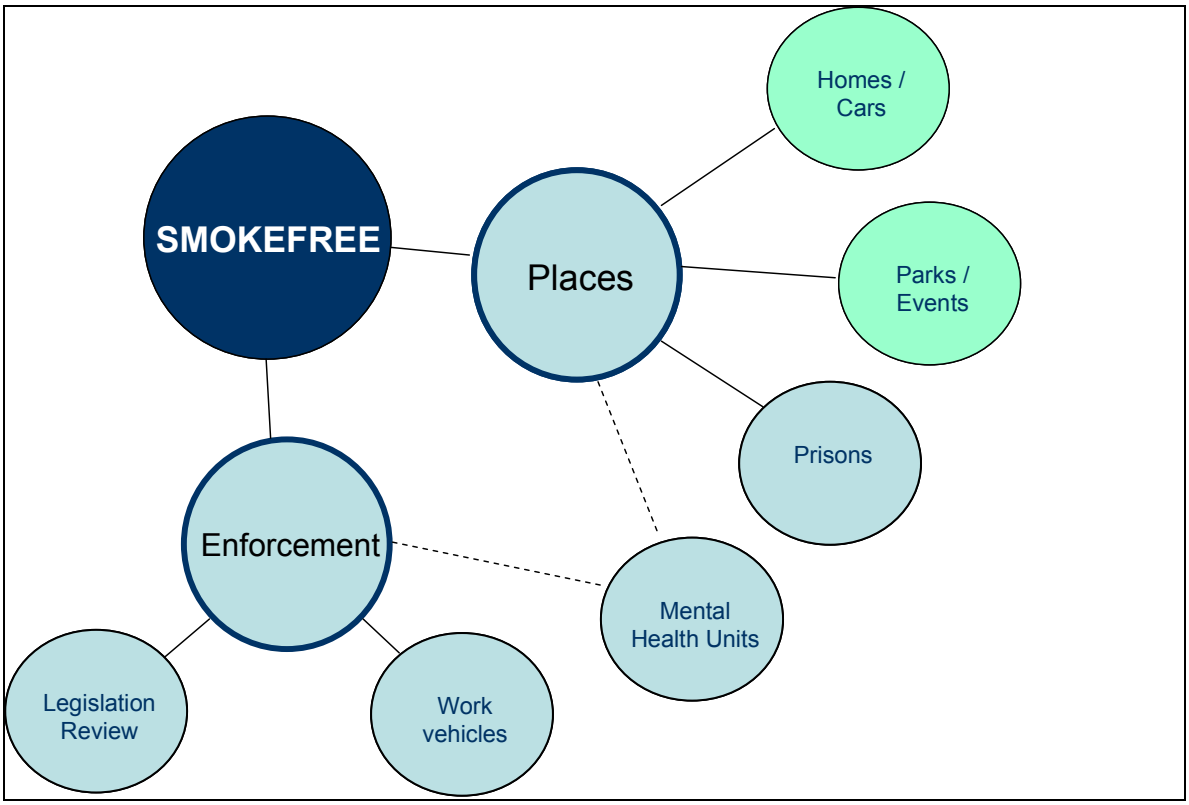
With particular reference to the economic burden of smoking on the NHS (referenced in section 2.5), there is a need to ensure that smoking cessation is integrated into clinical pathways. A high level commitment is required within acute and mental health trusts around the tobacco cessation agenda and therefore realise the potential of 'Stop before the Op' programmes and reduced bed days and post-operative complications.

4.1.4 SMOKEFREE: Ensuring that no one in Kent is harmed by secondhand smoke

The banning of smoking in enclosed public places in July of 2007 has had real impact and has underlined much of the work undertaken to promote healthy working environments. There is evidence already in Scotland of a 17% reduction in the number of heart attack admissions through 9 hospitals since smokefree policies came into force in 2006 and data from England suggests a correlation with significantly increased numbers presenting for cessation assistance.

There have been high levels of public support and compliance for the legislation. It is important though to continue to ensure that compliance monitoring is not allowed to lag. KASH works closely with environmental health colleagues at the Kent CIEH Public Health Technical Working Group where compliance is monitored and compliance issues are addressed.

Expected in the summer of 2010, the government will formally review the smokefree legislation. It is expected that this will advocate further measures to protect children and address further compliance issues around smoking in vehicles and 'smoking drift'. This should also provide an opportunity to focus on the compliance of smokefree legislation in mental health hospitals and the promotion of smokefree prisons.



Example action:

i) Smokefree Homes and Cars (protecting children)

There is an opportunity to learn from, and expand upon, the successful initiative undertaken in Tonbridge and Malling. The development of a Kent-wide Smokefree Homes initiative, delivered in partnership between Local Authorities, Kent Fire & Rescue Service and Stop Smoking Services is proposed.

ii) Smokefree Parks / Events / Sports grounds / Arenas

There is an opportunity for Kent partners, especially local authorities and the county council, to demonstrate a commitment to protecting children from tobacco by supporting the call for smokefree conditions (mandatory or voluntary) to be applied to events and/or facilities that are aimed at children and/or families.

4.1.5 EVIDENCED AND RESEARCHED: Ensuring that action is based on evidence and best practice

The value of organised, accurate and up-to-date information cannot be overstated. By collecting and making active use of reliable local data, the local needs, gaps, strengths and weaknesses of current and future tobacco control programmes can be assessed. Without such information it will be very hard to make good decisions about how to continue to tackle smoking locally or know where best to direct energy and resources. Nor will it be possible to demonstrate effectiveness, and without reliable information to back up arguments it will be hard to even get over the threshold of the high-level decision makers who need to be influenced.

There is a requirement to develop a systematic approach to identify exactly what data is needed to allow Kent partners to carry out the priority activities identified in this strategy. This should be the first task of the sub-groups that will take forward each 'vision' workstream. Sources might include Health Equity Audits (HEAs) or Joint Strategic Needs Assessments (JSNAs) of the health and wellbeing of a local community. The Kent Tobacco Control Framework (section 4.2) will require information sets for each workstream to ensure that activities are evidence based and include robust evaluation criteria.

The key element of this vision though, is about more than just data – it's about gathering intelligence and using innovative approaches to translate the available knowledge into informed planning and commissioning and tailored messages for the local population. This activity is intimately linked to the need for effective partnership working. Making the fullest use of the KASH partnerships to get the best data and information from all concerned is key. This will make it clear what has to be done, and why – in short helping to map and tailor services to a specific local authority area and support evaluation of the impact of KASH's work on reducing smoking prevalence.

i) Audit of tobacco control related data in Kent

The Kent and Medway Public Health Observatory continue to be a valuable resource in the collation, dissemination and analysis of tobacco control data. A specific 'tobacco control' depository will be created to ensure that all partners have access to national and Kent data sets and will promote an information exchange between Kent partners.

4.1.6 COMMUNICATIONS: Making sure that this vision is communicated effectively

Establishing a communications strand as part of a strategic approach to tobacco control is vital and needs to take account of internal and external communications: internal to ensure that all partners are on message, external to ensure that clear and consistent messages around tobacco control are being relayed to the general public. It is very important not only that communication reflects central messages and uses the NHS Smokefree national branding and imagery (where the focus is on activity encouraging smokers to stop), but also that, at a local level, all KASH members and champions are on message. This can be encapsulated in the phrase 'One message, many voices'.

The national Smokefree communications and marketing strategy focuses on routine and manual smokers and its overarching objectives are to trigger quit attempts, increase the effectiveness of quit attempts and reinforce motivation to quit. This important strategy represents a new way of working and has also included a move towards a model of community activation. This should facilitate three-way communication between local areas, the regions and national policy and thus ensure a co-ordinated and comprehensive approach to marketing.

i) Coordinated approach to marketing and communications – support to 'comms leads'

There is a need to provide brief training and education to ensure that planners, commissioners and service providers have a working understanding of the national strategy. A media/communications sub-group will created to co-ordinate local-level marketing messages to supplement and complement the marketing campaigns produced at a national and regional level. Communications leads from KASH partners and key stakeholders should contribute to this group.

- This should include a focus on the 'Many voices' aspect of communications. For example, teachers, council departments and business leaders could issue health messages. This could add credibility to a local campaign because it would not just be a public health body communicating about tobacco control.

- All media opportunities should publicise local NHS Stop Smoking Services and the package of national support available for smokers wishing to quit (including the NHS Smoking Helpline and website - www.nhs.uk/gosmokefree).

- Local messaging should be kept simple and consistent with national messaging, focusing on the unique selling points of the Services – they are free, smokers are up to four times more likely to quit if they use the Services, they have experienced staff, and have helped thousands of local people give up for good.

- Producing relevant resources for supporters to use – websites, policy papers, draft letters and press releases – so that partners can advocate Kent and national initiatives.

ii) Social Marketing Insights

With this new infrastructure in place, achieving a truly comprehensive approach to communications should be within reach, with all key partners giving key messages consistent with national campaigns and themes. And with a new focus on consumer insight, Kent will be better able to understand audience differences – for example, why routine and manual smokers find it harder to quit, how audiences differ in their smoking rates and why, and whether policy interventions are having an impact.

Particular focus should be given to understanding why young people take up smoking; and given information on tobacco control initiatives, which of these 'resonate' with young people so that they will in turn advocate the tobacco control message.

iii) promote use of Smokefree branding

Use the NHS Smokefree branding on all materials produced, while using existing DH marketing materials whenever possible for consistent messaging, to save money and to capitalise on the messages local people will be receiving from nationally funded marketing campaigns.

Consideration should therefore be given as to whether commissioned services should be required to use the 'Smokefree' brand. Proposals could include re-branding "KASH" as the "Smokefree Kent Alliance".

Communications Strategy	Research & Intelligence
• Coordinated approach to Marketing and Communications	• Develop a systematic approach to data needs
• Ensure National Smokefree campaigns are localised	• Translate available knowledge into informed planning and commissioning
• Utilise "Many Voices, One Message" concept	• Utilise social marketing approaches

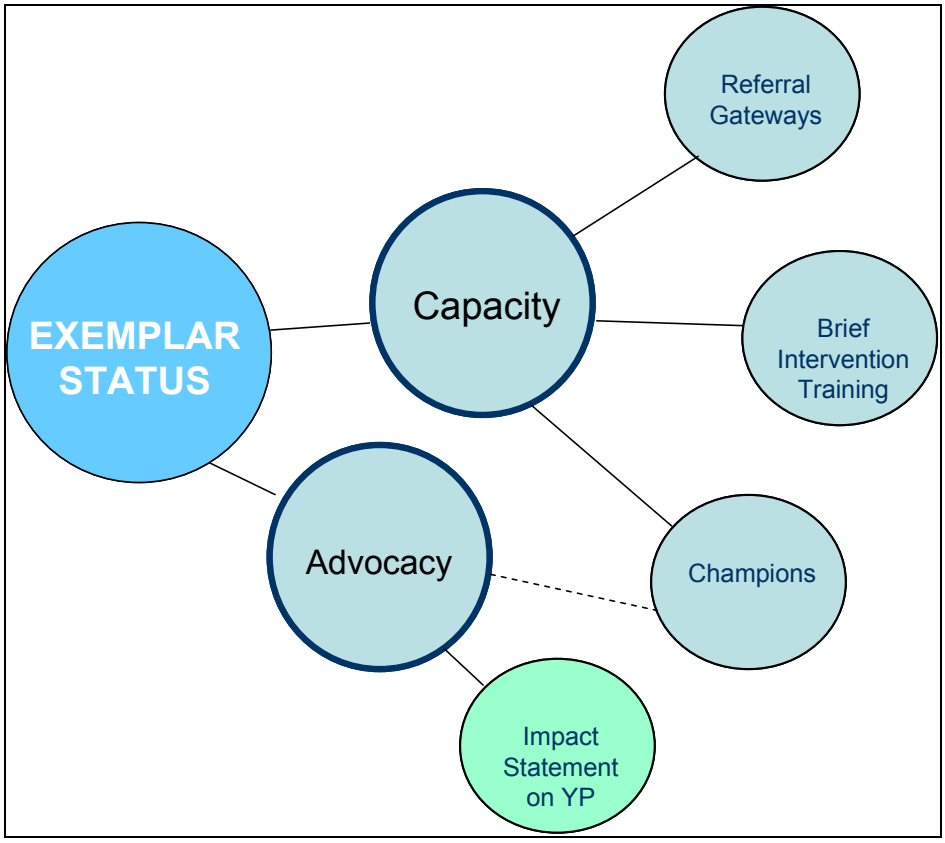
4.1.7 EXEMPLARS: Ensuring that Kent partners are exemplars in tobacco control

As advocates for tobacco control, it is imperative that Kent partners can be seen to be exemplars in their tobacco control practice.

KASH partners should strive to change the political, economic and social conditions that encourage tobacco use and gaining public and media support for tobacco-related issues with the ultimate aim of denormalising tobacco use – changing social norms. Although there have been many successes in recent years, the focus on ending the tobacco epidemic for the benefit of future generations needs to be maintained.

This vision needs to be linked to the overall communications strategy to ensure consistency and integration. Advocacy efforts ought to be evaluated as carefully as any other communication campaign.

This will also require the building of 'capacity' in tobacco control; developing people's skills and tools, building networks and training leaders, collaboration, and collecting local data and knowledge to provide an understanding of the local community. If the necessary consensus and political commitment for tobacco control in the area can be successfully developed, then delivering the recommendations ('visions') of this strategy will be that much easier. The key aim is to keep as many relevant people as possible interested in the tobacco control agenda, providing them with new angles as to why they should engage with the programme at every opportunity. There is a risk that if this momentum diminishes, previous achievements will be diluted and smoking prevalence will stabilise and then rise rather than fall.



Example action:

i) Identify tobacco control 'champions' / leads in each partner organisation

It will be necessary to target key decision makers in Kent partner organisations to fulfil the role of trained and educated ambassadors and champions who can sell the whole tobacco control message from executive level to grassroots level. These designated leads should have some element of tobacco control built into their role, and be supported by an overall lead with senior-level buy-in.

ii) Increasing Partner's Capacity in Tobacco Control

KASH will aim to ensure that all Kent partners have the knowledge and skills to become tobacco control advocates, understanding that tobacco control is core to their own organisation's concerns. For example, fire services and reducing fires, police and reducing crime through less illegal sales and activity on the streets, workplaces and reduced sick time/ smoking breaks and the benefits of stop smoking approaches to this, NHS and 'Stop before the Op' programmes.

This will be achieved through a programmed approach to encourage all partner organisations to develop organisational objectives around tobacco control with support from the Kent Tobacco Control Manager; and can include working, training and education programmes that promote tobacco control with proposals for joint action.

A minimum requirement should be an acknowledgement of the impact of smoking on young people (as detailed in section 4.3)

iii) Provision of brief intervention training to Kent partners

In liaison with the Stop Smoking Services and the public health training providers, KASH will support staff who could be trained to increase tobacco control capacity in brief interventions for stopping smoking. This might include community workers, community pharmacists, school nurses, occupational health nurses in the workplace, teachers, youth workers, trading standards officer; police personnel, fire service personnel, environmental health officers, frontline health and social care professionals, and voluntary and community organisation workers.

Organisations and individuals can then explain and signpost interventions which are not just around Stop Smoking Services but also include tobacco control in the widest sense.

4.2 Kent Tobacco Control Framework

It is proposed that the Kent Tobacco Control Strategy is clearly formatted to ensure that partner organisations are clear about their role in tobacco control. This will serve as a way of monitoring the delivery of the Kent Tobacco Control Strategy.

Smoking creates major health, economic and social burdens within our communities, which is why tobacco control needs to be elevated to a high level within organisations that can play a role in reducing smoking rates. A proposed Kent Tobacco Control *Framework* will:

- provide everyone involved with local tobacco control with new ideas for making a difference in their areas – showing what can be achieved, and how to do it;
- help organisations work towards their next priorities. (Tobacco control has not ended with the Smokefree legislation of July 2007 and while more than one in five adults are smokers in England, there is much more to be done);

- brings together in one place both the evidence and relevant practical experience on local comprehensive tobacco control, providing ideas and robust evidence to justify the case for focusing on comprehensive tobacco control action;
- will be structured around the 'vision' workstreams;
- will promote the focus on protecting young people in Kent as a priority.

This approach is supported by the Kent Partnership. KASH will formally support and drive this process by providing workshops, seminars and events as appropriate.

5.0 NEXT STEPS

This strategy addresses the proportions of our population that remain exposed to the significant health risks from smoking, and are concentrated in our more deprived communities. Beyond the well-recognised effects on health, tobacco also plays a role in perpetuating poverty, deprivation and health inequality.

Tobacco control – not just Stop Smoking Services or media campaigns in isolation, but an integrated package of interventions – has enormous potential to tackle health inequalities and the ongoing burden of disease caused by smoking. The driving ethical principle of tobacco control is that of fairness:

- A fair chance for children and young people to grow up in an environment where smoking is not seen as the norm;
- for smokers to get help to quit (as the majority wish to do); and
- for people to live and work without being exposed to the hazards of secondhand smoke.

This strategy advocates how smoking prevalence can effectively be further driven down in our communities. The practical recommendations in this document, particularly those aimed at protecting young people from the dangers of tobacco; set out a systematic approach to delivering an effective and comprehensive tobacco control programme for Kent.

This strategy enables Kent partners to acknowledge the importance of supporting a comprehensive approach to tobacco control; for their own organisation and the communities that they serve, by incorporating tobacco control measures into their strategic plans and commissioning intentions.

Strategy Delivery

- KASH will provide a framework for delivery of this strategy.
- Performance reports to the Kent Public Health Board

Mar-Jun 2010	Kent partners to sign off Strategy
1st July 2010	Launch Strategy (anniversary of Smokefree)
Sept 2010	Impact assessment of strategy to be completed by Kent partners
Dec 2010	Forward delivery plans to be confirmed by partner organisations
Feb 2011	Review of progress to the Kent Partnership

Supporting key resources for this strategy document:

- "A Smokefree Future: A Comprehensive Tobacco Control Strategy for England", Department of Health (February 2010) http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_111789.pdf

- "Smoking in Kent: Deaths, disease and economic loss attributable to tobacco smoking", Kent & Medway Public Health Observatory (May 2009) http://www.kmpho.nhs.uk/lifestyle-and-behaviour/smoking/

- "Excellence in Tobacco Control: 10 high impact changes to achieve tobacco control", Department of Health (May 2008) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084847

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By:	Nick Chard- Cabinet Member for Environment, Highways and Waste Mike Austerberry- Executive Director Environment, Highways and Waste John Burr, Director- Kent Highway Services
To:	Cabinet – 12th July 2010
Subject:	OPERATION FIND AND FIX- WEATHER DAMAGE REPAIRS TO ROADS
Classification:	Unrestricted

Summary:	Operation Find and Fix- Update to Cabinet on the progress with delivering repairs to roads, both with externally tendered contractors and the County's Maintenance Contractor.

Executive Summary – External find and fix (Non classified roads)

Completed (up to 22nd June) = 57,000m2
Cost (up to 22nd June) = £2.3m
Estimated total required = 170,000m2
Estimated completion date = early autumn 2010
Total estimated budget required = £6.5m
Total estimated costs of arranging, managing and supervising = £320k (5%)

Background

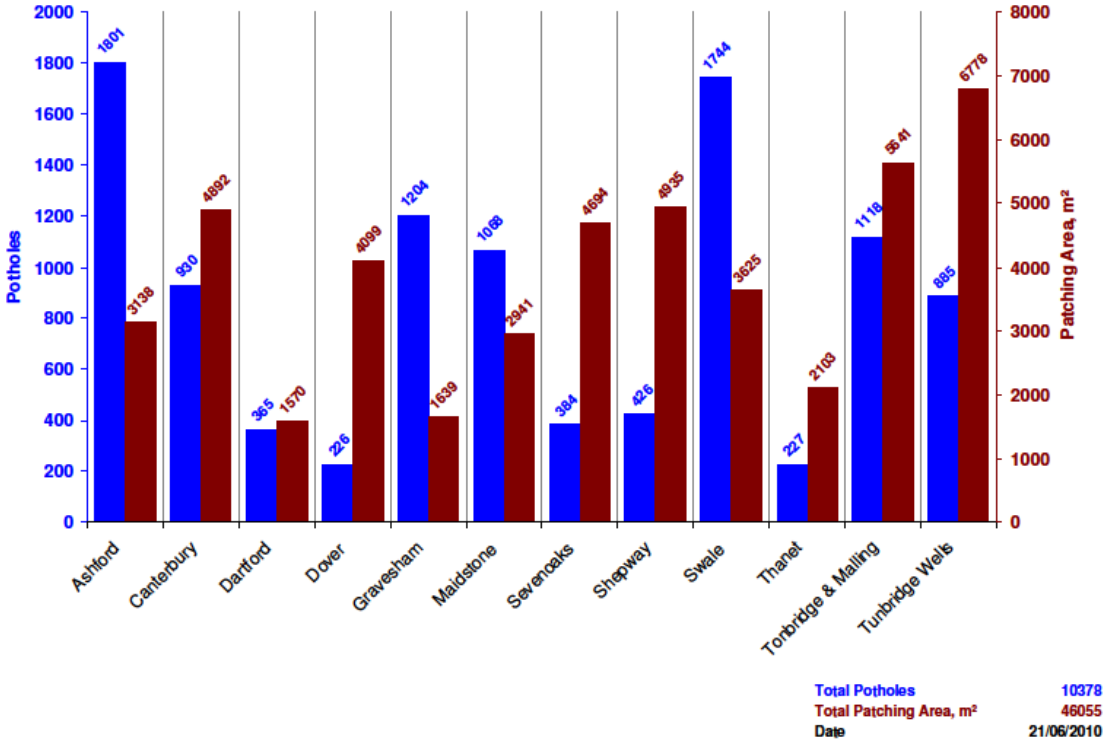
As part of the response to the unprecedented damage to the roads in Kent following the severe winter, KHS has been working to make all the roads in the county safe (in particular with repairs to potholes) and improve the condition of the carriageway surface. Previous cabinet papers have given updates on the delivery of repairs by the seven companies who were awarded contracts on 12th April to repair all the potholes, and carry out larger patching maintenance work, in the non-principal road network throughout each district with a first time permanent repair. This report (as requested at the 17th May 2010 Cabinet) gives an update on these contracts and also details how other roads are being repaired in relation to the weather damage.

External Find and Fix Progress (Non classified roads)

The contractors work on a "find and fix" basis using up to 5 separate gangs (and more in extreme cases) in each district, according to the size of the district. The contractors are able to work up to 7 days a week between 7am and 7pm. Kent Highway Services officers deploy the contractors, giving instructions to ensure the highest priority areas in each district are targeted first, and moving progressively to roads with a lesser volume of repair need**.** The programme of works is available to all members and members of the public via the KCC website.

The focus is on the county's non-principal roads, particularly the rural and estate roads which make up 71% of the total of the network. Other work is continuing in parallel, as appropriate and in particular critical safety defects, through the term maintenance contractor, Ringway.

After 10 weeks of the programme (up to 22nd June) some 57,000m2 of repairs (equivalent to almost 46 Olympic size swimming pools) have been completed.



Due to the approach of repairing **all** defects in a road, rather than simply those that are considered most critical to the safe passage of road users, the amount of patching in each road is almost 6 times greater that we would anticipate undertaking against normal "intervention" criteria. This inevitably means that each road takes longer to repair, however from the positive feedback received, this is clearly an approach that people favour.

At the current rate of repair, it is envisaged that the programme will be completed in early autumn.

Building on investment

KHS is planning to increase its programme for surface dressing rural roads over the coming 2 – 3 years, to be financed through re-prioritisation of existing capital maintenance spend. This will ensure that the significant investment made through the find and fix programme is protected over the coming years.

A and B Roads

The A and B roads across the county have continued to be repaired based on safety defects found by inspectors and reported by the public. However, to ensure that we are certain that all potholes are repaired, Ringway embarked in mid-June on a countywide programme to fix all defects on the A and B road network. Additional gangs are taking the same approach to the non-classified roads; that is, to repair all pothole defects in a road from start to finish. The roads have been programmed, and one to two days prior to the works starting an assessment of the road is made. This allows the correct method and machinery to be deployed to ensure efficiency and reduced disruption to the public (bearing in mind that these roads are more heavily trafficked). This process has been planned, with the programme of works available to all Members and members of the public via the KCC website. The works will take approximately 3 months (to early autumn) to complete.

Next Steps

The Cabinet report in May recommended that the budget for the external find and fix, non classified roads should be increased to £3.4m.

The find and fix approach is clearly showing favour with many people, however with the rate of repair significantly higher than normal (due to the high level of winter damage, and increased intervention levels as explained), the cost is greater.

We have continued to repair many of the county's worst roads and although there is still more to do, progress is good. On a find and fix approach it is inherently difficult to estimate the additional sums needed to complete the task. It is expected that the spend per road will start reducing as the project moves away from the worst roads to those with fewer defects. In the smaller sized districts there is already evidence of this. An overall assessment of the remaining work load suggests that we would require £6.5m to complete the programme (£3.1m additional to the already approved £3.4m).

KHS has been able to find approximately £1.5m towards this through efficiencies it has achieved in the market testing of machine surfacing works, and it is

proposed that Cabinet consider making an additional £1.5m available to complete the find and fix task across the county's network.

Beyond the completion of this task, any new safety critical potholes, or further deterioration of the road network not evident when the find and fix teams visited, will still be funded from within the KHS core budget and repaired using the permanent repair crews.

Recommendations

1. Cabinet note the progress on the external find and fix programme (non-classified roads).
2. Cabinet agree to allocate an additional £1.5m to this programme at this stage.
3. Cabinet note and support the approach to A and B road repairs.

Lead Officer: John Burr ext- 4192