HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

Tuesday, 2nd July, 2024

2.00 pm

Kent County Council
kent.gov.uk

AGENDA

HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

Tuesday, 2 July 2024 at 2.00 pm

Ask for: **Emily Kennedy**
Telephone: **03000 412188**
dominic.westhoff@kent.gov.uk

Membership (16)

Conservative:	Mrs L Game (Chair), Mr P Cole (Vice-Chairman), Mr D Beaney, Mrs P T Cole, Ms S Hamilton, Mr A R Hills, Mr A Kennedy, Mr J Meade, Mrs L Parfitt-Reid, Mr D Ross and Ms L Wright
Labour:	Ms K Constantine and Ms K Grehan
Liberal Democrat:	Mr R G Streatfeild, MBE
Green and Independent :	Peter Harman and Jenni Hawkins

UNRESTRICTED ITEMS

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

1 Introduction/Webcast announcement

2 Apologies

3 Declarations of Interest

4 Minutes of the meeting held on 15 May 2024 (Pages 1 - 8)

5 24/00058 - Nurturing little hearts and minds: a perinatal mental health and parent-infant relationship strategy (Pages 9 - 134)

6 24/00057 - Nourishing our next generation: a 5-year infant feeding strategy (Pages 135 - 296)

7 24/00056 - Kent Young Persons Drug and Alcohol Contract Commissioning (Pages 297 - 320)

8 24/00055 - Kent Adult Drug and Alcohol Treatment Contracts - re-commissioning (Pages 321 - 350)

9 Public Health Performance Dashboard - Quarter 4 2023/24 (Pages 351 - 360)

10 Work Programme (Pages 361 - 364)

MOTION TO EXCLUDE THE PRESS AND PUBLIC FOR EXEMPT ITEM

That, under Section 100A of the Local Government Act 1972, the press and public be excluded from the meeting for the following business on the grounds that it involves the likely disclosure of exempt information as defined in paragraph --- of Part 1 of Schedule 12A of the Act.

EXEMPT ITEMS

(At the time of preparing the agenda, there were no exempt items)

Benjamin Watts
General Counsel
03000 416814

Monday, 24 June 2024

KENT COUNTY COUNCIL

HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE

MINUTES of a meeting of the Health Reform and Public Health Cabinet Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Tuesday, 14 May 2024.

PRESENT: Mr P Cole (Vice-Chairman), Mrs P T Cole, Ms K Grehan, Ms S Hamilton, Peter Harman, Ms J Hawkins, Mr A Kennedy, Mr J Meade, Mr R G Streatfeild, MBE and Ms L Wright

ALSO PRESENT: Mr D Watkins

IN ATTENDANCE: Dr A Ghosh (Director of Public Health) and Mr D Westhoff

UNRESTRICTED ITEMS

312. Introduction/Webcast announcement
(Item 1)

Tributes for James Williams, Director of Public Health Medway

1. Dr Ghosh led the tributes to the late Mr James Williams, the former Director of Public Health at Medway Authority. Tributes were also made by Mr Watkins and Mrs Cole.
2. The Chair asked for it to be recorded in the minutes that the Health Reform and Public Health Cabinet Committee offered their condolences on the sad passing of Mr Williams.

313. Declarations of Interest by Members in items on the agenda
(Item 3)

None were received.

314. Minutes of the meeting held on 5 March 2024
(Item 4)

RESOLVED that the minutes of the meeting held 5 March 2024 were a correct record and that a paper copy be signed by the Chair.

315. Verbal updates by Cabinet Member and Director
(Item 5)

1) Mr Watkins, Cabinet Member for Adult Social Care and Public Health, gave a verbal update on the following:

a) **Kent's Public Health Champions** – Mr Watkins said that 130 people working for Kent councils, schools and charities acted as public health champions who inspired others to look after their health and wellbeing and spread the word of local support available to residents. It was said that these champions organised community activities, attended local events to raise awareness and signpost people to specialist support. It was noted that all champions gain nationally recognised Royal Society of Public Health qualifications, with 40 qualifying every year. Mr Watkins congratulated 18 people who completed their qualifications recently.

b) **National Walking Month** – Mr Watkins noted that May marked National Walking Month and the public was being encouraged to join the national celebration to boost fitness and wellbeing. It was said that Active Kent and Medway had a Travel Your Way challenge to walk every day and One You Kent organised large group walks.

c) **Measles, Mumps and Rubella (MMR) Vaccinations** – Mr Wakins said that additional catch-up clinics had been announced where under-19s could catch up on their MMR vaccines. It was noted there had been a rise in cases of measles which could lead to serious illness but 99% preventable through two doses of the vaccine.

2) Dr Anjan Ghosh, Director for Public Health, provided a verbal update on the following:

a) **Measles Update** - measles infections continued to rise nationally with an increase of cases in the Southeast. There had been several probable cases in Kent but no confirmed cases.

b) **Pertussis / Whooping Cough** - there was an increase across England following a prolonged period of low cases. The trend was for a seasonal variation in cases every two-to-three years but the recent uptick was larger than usual, potentially due to a steady decline in the uptake of vaccinations for pregnant women and young children. The United Kingdom Health Security Agency (UKHSA) and KCC communications were distributing messages to urge parents and carers to check their children's vaccination status and to respond to invites from the NHS or book appointments with their GP practice.

c) **Kent and Medway Better Health and Wellbeing Community Fund** – 98 applications had been received for the £90,000 fund. A brochure on all grants awarded would be published in early June.

d) **Kent and Medway Suicide Prevention Programme** - a further award had been received at the National Positive Practice in Mental Health Awards Ceremony in the category of suicide prevention services. Dr Ghosh thanked all of those who worked and supported the programme.

e) **Family Hubs Update** – the programme was in its third year and plans for future sustainability were in development to embed and expand a new

model beyond year 3. Two public consultations on key strategies had been completed and were in the process of being finalised.

f) **Mental Health Awareness Week** – this year's theme was about raising awareness for how good physical activity was for the body and mind.

g) **Healthy Alliances** – progress was being made with district and borough partners on developing the alliances.

h) **Research and Innovation Hub** – it had recently been agreed with the Corporate Management Team to set up a governance structure to underpin all research in the Council. It was noted that much inward investment was being received for public health research.

i) **Gypsy, Roma Traveller (GRT) Community** – a learning network had been convened with 25 participants and a project plan was in place for the first step of engagement with communities.

j) **Collaboration with Adult Social Care** – progress was being made in changing the shape of demand and providing care to residents closer to their homes and in the community. Dr Ghosh noted that this would come to the committee at an appropriate time.

3) In response to comments and questions, it was said:

a) Dr Ghosh reassured a Member that the grants would be directed at the communities and areas that needed them most.

b) It was said there was a deep involvement with districts in countering anti-vax misinformation. There was ongoing targeting of the Primary Care Networks where vaccine uptake was below 85%.

c) Dr Ghosh said a dedicated team were working on engagement with the GRT community and information on how the 25 participants were identified could be shared after the meeting.

d) On how success could be measured for suicide prevention strategies, it was said that there had been success in attaining real-time information which could be shared, an approach pioneered by Kent. Progress was being made but there were many challenges ahead. More data could be shared outside the meeting.

RESOLVED that the updates be noted.

316. 24/00028 - Spending the Stop Smoking Services and Support Grant *(Item 6)*

Rutuja Kulkarni-Johnston, Consultant in Public Health, Luke Edwards, senior commissioner and Chris Beale, commissioner, and Debbie Smith, Public Health Specialist, were in attendance for this item.

1. Dr Ghosh introduced the report. Ms Kulkarni-Johnston provided an overview of the framework for spending the grant, with additional details provided by Mr Beale.

2. In response to comments and questions, it was said:

   a) Asked what support residents would receive to stop smoking it was said the funding would be used to increase and expand the support and services on offer. The behavioural support with nicotine replacement therapy was considered the best approach and consisted of a seven-week programme, which would see increased capacity.

   b) Work on engagement and motivation would be central to the approach to reach out to those unlikely to engage in the services available and motivate users throughout the process of stopping smoking.

   c) There would be active engagement with workplaces and employers to help distribute information about the support available and create smoke-free environments.

   d) A range of media options were available including graphic imagery. It was noted that the materials were not a mandatory part of the curriculum in schools but their use was encouraged. There was a need for some smokers to see hard-hitting images and messaging which would be included in an alternative programme.

   e) Dr Ghosh said they would be happy to provide annual updates on the programme and regular updates would come to the committee through the performance dashboard. Penalties for missing targets were not expected in year one but there was a process to notify the central government during year one if adequate progress was not being made.

   f) Mr Watkins praised the initiative introduced by the government and thanked the Committee for the points raised during the discussion.

3. RESOLVED the Health Reform and Public Health Cabinet Committee endorsed the proposed decision to:

   a) Approve the commissioning of Stop Smoking Services to deliver against the Support Grant and project requirements;

   b) Approve the framework arrangements set out in the report for ongoing management of the Stop Smoking Services and Support Grant 2024/2025 to 2028/2029;

   c) Delegate authority to the Director of Public Health, in consultation with the Cabinet Member for Adult Social Care and Public Health and Corporate Director for Finance, to revise and amend the arrangements set out in the framework details, subject to the scope and terms and conditions of the grant funding;

d) Delegate authority to the Director of Public Health, in consultation with the Cabinet Member for Adult Social Care and Public Health, to take relevant actions, including but not limited to, awarding, finalising the terms of and entering into the relevant contracts or other legal agreements, as necessary, to implement the decision; and

e) Delegate authority to the Director of Public Health, in consultation with the Cabinet Member for Adult Social Care and Public Health, to award extensions of contracts for commissioned services in accordance with future grant allocations.

317. 24/00036 - KCHFT (Kent Community Health NHS Foundation Trust) (twelve-month) Partnership Extension
(Item 7)

Chloe Nelson, Senior Commissioner, was in attendance for this item.

The discussion for items 7 and 8 were held at the same time.

1. Dr Ghosh introduced the report and noted the two extensions being discussed (24/00036 and 24/00037) were part of the wider Public Health Transformation programme.

2. Ms Nelson provided an overview of the two key decisions. The extensions would enable further data collection and prevent destabilising the workforce.

3. In response to comments and questions, it was said:

   a) A Member asked that progress be made quickly due to the pressures public health was facing. Dr Ghosh said there were 21 points of transformation and a decision had been made not to use external consultants, due to the complexity of the changes they would need to be phased in. Transformation work would still progress during and after the extensions. It was noted that the decision on the extensions had not been taken lightly but was necessary due to the Provider Selection Regime (PSR) which was a new regulation and previously untested. Legal advice had been sought on PSR.

   b) Mr Watkins said that the decisions were based on best practice and in the best interests of the people of Kent. A further overview of the decision-making process was provided. The transformation programme would be carried out in a timely manner.

4. RESOLVED the Health Reform and Public Health Cabinet Committee endorsed the proposed decision to

   a) Extend the Kent Community Health NHS Foundation Trust (KCHFT) partnership for 12 months, from 1st April 2025 to 31st March 2026, to support the Public Health Service Transformation programme; and

b) Delegate authority to the Director of Public Health to take other relevant actions, including but not limited to finalising the terms of and entering into required contracts or other legal agreements, as necessary to implement the decision to extend.

5. In accordance with paragraph 16.31 of the Constitution, Ms Grehan, Ms Hawkins and Mr Streatfeild wished for it to be recorded in the minutes that they voted to abstain on the proposed decision 24/00036 - KCHFT (Kent Community Health NHS Foundation Trust) (twelve-month) Partnership Extension.

318. 24/00037 - MTW (Maidstone and Tunbridge Wells NHS Trust) - 12-month Partnership Extension
(Item 8)

Chloe Nelson, Senior Commissioner, was in attendance for this item.

The discussion for items 7 and 8 were held at the same time.

1. RESOLVED the Health Reform and Public Health Cabinet Committee endorsed the proposed decision to

   a) Extend the Maidstone and Tunbridge Wells NHS Trust partnership for 12 months, from 1st April 2025 to 31st March 2026, to support the Public Health Service Transformation programme; and

   b) Delegate authority to the Director of Public Health to take other relevant actions, including but not limited to finalising the terms of and entering into required contracts or other legal agreements, as necessary to implement the decision to extend.

2. In accordance with paragraph 16.31 of the Constitution, Ms Grehan, Ms Hawkins and Mr Streatfeild wished for it to be recorded in the minutes that they voted to abstain on the proposed decision 24/00037 - MTW (Maidstone and Tunbridge Wells NHS Trust) - 12-month Partnership Extension.

319. Performance Management Overview: Public Health Commissioned Services
(Item 9)

Yozanne Parrett and Darren Jones were in attendance for this item.

1. Dr Ghosh introduced the report. He explained the current set of Key Performance Indicators (KPIs) were being reviewed to ensure they were still fit for purpose. In future, there would be two dashboards presented to the Committee – the KPI indicators and also a set of strategic indicators that would be linked to the Integrated Care Strategy.

2. Ms Parrett provided an overview of the report.

3. In response to comments and questions, it was said:

   a) the breakdown of health visiting carried out online or in person could be provided after the meeting.

   b) Monitoring the effectiveness could be helped by benchmarking the Council's data with that of comparable local authorities. This was to be made available in future.

   c) It was asked if the KPIs could be further integrated with the Integrated Care Strategy and other Council strategies. Dr Ghosh said that a link could be made between the KPIs and each of the 6 shared outcomes in the Integrated Care Strategy. It was noted that the indicators were not exhaustive but the KPIs chosen would provide an overview of the progress being made across Public Health and the Council.

4. RESOLVED the Health Reform and Public Health Cabinet Committee noted the approach being taken to Key Performance Indicator selection and target setting.

320. Draft Kent and Medway Integrated Care Strategy/Joint Local Health and Wellbeing Strategy Delivery Plan
(Item 10)

Mike Gogarty was in attendance for this item.

1. Dr Ghosh introduced and provided an overview of the report, setting out the development of the Shared Delivery Plan. The plan would be signed-off in June at the Integrated Care Partnership (ICP).

2. Mr Gogarty said that the document needed to be the catalyst by which to move the dial for people in Kent to change their lifestyles and health.

3. In response to comments and questions, it was said:

   a) population adjustments were being taken into account and there were modelling tools available to map those changes in conjunction with the interventions chosen to judge effectiveness.

   b) A Member would like more detail on building children’s resilience.

   c) A Member asked if microdata could be made available to monitor progress.

4. The Chair endorsed the comments about the need for further detail and micro targets. Dr Ghosh said that macro, mezzo and micro indicators were included to monitor progress. The Chair noted that the committee would need to work together to decide how best to monitor the progress over the lifetime of the strategy.

5. RESOLVED the Health Reform and Public Health Cabinet Committee noted the progress and proposed work in developing a Shared Delivery Plan for the Integrated Care Strategy.

321. Work Programme
(Item 11)

RESOLVED that the work programme was noted.

DECISION REPORT

From: Dan Watkins, Cabinet Member for Adult Social Care and Public Health

Dr Anjan Ghosh, Director of Public Health

To: Health Reform and Public Health Cabinet Committee – 2 July 2024

Subject: To approve the adoption of the co-created strategy in regard to low to moderate Perinatal mental health and Parent infant relationships

Decision Number: 24/00058

Classification: Unrestricted

Past Pathway of report: N/A

Future Pathway of report: Cabinet Member decision

Electoral Division: All

Is the decision eligible for call-in? Yes

Summary:
Kent County Council has been successful in receiving Family Hub Transformation Authority status and has therefore received designated Family Hub Transformation Funding.

A Start for Life Programme update was provided to Health Reform and Public Health Cabinet Committee on 11 July 2023. This provided an opportunity for members to ask any questions, help shape the programme of work and explained the governance route for future decisions.

A key decision is required to approve the adoption of the cocreated strategy in regard to low to moderate Perinatal mental health and Parent infant relationships in order to support improvement in outcomes for families over the next five years.

Recommendations:
The Health Reform and Public Health Cabinet Committee is asked to **CONSIDER** and **ENDORSE** or make **RECOMMENDATIONS** to the Cabinet Member for Adult Social Care and Public Health, on the proposed decision (appendix A) to:

a) **APPROVE** the adoption of the co-created strategy in regard to low to moderate perinatal mental health and parent-infant relationships, as detailed in the report.
b) **DELEGATE** authority to the Director of Public Health to take necessary actions, including but not limited to, allocating resources, expenditure, entering into contracts and other legal agreements, as required to implement the decision.

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1. Introduction

1.1 This strategy supports two key areas of transformation to family hubs which relate to Start for Life and are relevant to Public Health namely perinatal mental health and parent infant relationships.

1.2 Start for Life is a component of the family hubs model with a specific focus on the first 1001 days, between conception and the age of two, essential for the healthy development of babies. This focus for support was identified by the Dame Andrea Leadsom Review in 2020 and further articulated in March 2021 in publication of The Best Start for Life: A Vision for the 1,001 critical days. This was followed by the announcement of £300m government funding to support Family Hubs with a focus on parent carer panels, parenting programmes, parent infant relationships, perinatal mental health and infant feeding in April 2022. Kent was one of 75 local authorities provided with the opportunity to benefit from the £300m funding.

1.3 On 4 October 2022 the Cabinet Member for Integrated Children's Services took a key decision (Decision number 22/00094) to adopt the principle of Kent becoming a Family Hub Transformation Authority.

1.4 On 23 March 2023, a further key decision was taken under decision number 23/00015 Family Hub Transformation Funding: a) To commence development and co-design of the Family Hub model for Kent in line with Government Family Hub framework for delivery and associated plans. b) To allocate and spend funding allocated via the Family Hub Transformation Authority for 2022/23 financial year.

2. Perinatal mental health and parent infant relationships .

2.1 The requirement from the Department of Education (DfE) is to 'establish a local perinatal and parent–infant mental health strategy (with sustainable plans beyond the funding period), to support strategic planning / delivery and joined-up working across the whole system.'

2.2 An external organisation, Barnardos was commissioned in August 2023 to develop a cocreated perinatal mental health and parent infant relationship strategy.

2.3 A perinatal mental health and parent infant relationship steering group was established in August 2023, as part of our governance process and

to help us to bring key stakeholders together. This included having an external stakeholder as chair.

2.4 Opportunities were developed and offered to enable stakeholders from across the system to improve and develop their awareness and knowledge of parent infant relationships and perinatal mental health through bite sized training webinars, and full day training programmes.

2.5 A draft strategy, 'Nurturing little hearts and minds' was presented to the Start for Life Board in December 2023.

2.6 The needs of the local population were estimated by the provider of the strategy.

2.7 A total of 14,685 babies may need parent-infant relationship support in Kent over the next five years. That is 2,937 parent-infant relationships per year.

2.8 A total of 33,317 parents and carers may need perinatal mental health support in Kent at a mild-to-moderate level over the next five years. That is 6,663 per year.

2.9 The strategy contains three themed action areas:

- Relating with warmth: developing relationship-based support
- Thriving together: improving equity of support
- Leading collaboratively: nurturing a system of support.

2.10 A public consultation took place between 8 February and 3 April 2024. with presentation of materials online, digital promotion and attendance at various events across the county to enable discussion and opportunity to take or complete hard copy of the survey.

2.11 Analysis of the consultation responses was completed by the provider, Barnardos who developed the strategy. The consultation analysis is provided as an appendix to this briefing. [Appendix 1].

2.12 Minor amendments have been made to the strategy following the public consultation.

3. Financial Implications

3.1 The DfE family hub grant is a ring-fenced grant specifically for the family hubs and start for life programme which includes a focus on perinatal mental health and parent infant relationships and does not impact the council general revenue fund. This has provided opportunity to increase workforce capability and capacity to expand the reach of low to moderate perinatal mental health and parent infant relationship support and to raise awareness of support available for those with low to moderate perinatal mental health. The implementation of this strategy will be pivotal to further progressing and embedding this work.

4. Legal implications

4.1 The Council entered into a Memorandum of Understanding (MoU) with the Department for Education (DfE) which creates obligations to meet specific deadlines and timescales set by the DfE or risk losing further funding or funding claw back.

4.2 Access to the associated funding, depending on the type and level of transformation activity progressed, is conditional on compliance with the terms of the MoU and demonstration of progress toward an effective Family Hub Model.

4.3 The Council has and will enter into a number of contractual agreements to support delivery in line with Spending the Council's Money and Public Contract Regulations 2015 and aligns with Objective 3 of Securing Kent's Future.

5. Equalities implications

5.1 An Equality Impact Assessment has been completed (attached as appendix 2) and) has identified that emotional and regulation needs may impact on access and communication; race and faith may impact on access to perinatal mental health support with proposed mitigations outlined.

6. Governance

6.1 The Cabinet Member decision will provide the strategic policy position of KCC, alongside that of partner agencies such as health, regarding the specified workstreams. The key decision will delegate authority for required activity to support the further progression of co-design, expenditure of funding and resources to commence delivery to improve services as required.

7. Conclusion

7.1 This strategy sets out a considered and engaging dialogue to further develop our approach to improving low to moderate perinatal mental health and parent infant relationships, enhancing our support for families.

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8. Recommendation(s): The Health Reform and Public Health Cabinet Committee is asked to CONSIDER and ENDORSE or make RECOMMENDATIONS to the Cabinet Member for Adult Social Care and Public Health, on the proposed decision (appendix A) to:

a) **APPROVE** the adoption of the co-created strategy in regard to low to moderate perinatal mental health and parent-infant relationships, as detailed in the report.

b) **DELEGATE** authority to the Director of Public Health to take necessary actions, including but not limited to, allocating resources, expenditure, entering into contracts and other legal agreements, as required to implement the decision.

9. Background Documents

Consultation analysis report: Perinatal Mental Health and Parent Infant Relationships strategy

10 Appendices

Appendix 1 – Consultation analysis

Appendix 2 – Equality impact assessment

11. Contact details

Report Author:	Director:
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Nurturing Little Hearts and Minds: Perinatal Mental Health and Parent-Infant Relationships Strategy for Kent, 2024 - 2029

Public Consultation Report

April 2024

Contents

Executive Summary

This report sets out the findings to the public consultation of the Nurturing Little Hearts and Minds: Perinatal Mental Health and Parent-Infant Relationships Strategy for Kent.

There was broad consensus that the strategy will support perinatal mental health and parent-infant relationships:

- 61 consultees took part in this consultation, 56 of whom completed the online consultation form. Of these, 41 were residents and 14 were professionals.
- Most consultees found the strategy easy to read (74%).
- Most consultees thought that the strategy sets out what is important to improve perinatal mental health and parent-infant relationships across Kent (59%).
- Most consultees agreed with the action areas identified in the strategy (78% strongly agreed or tended to agree).

Action Area 1 - Relating with warmth: Developing relationship-based support
On average, 80% of consultees strongly agreed or tended to agree with Action Area 1. Consultees shared personal experiences that supported the need for these actions. Some consultees also expressed concerns about how this action can be implemented given the pressures on services and professionals.

Action Area 2 - Thriving together: Improving equity of support
On average, 74% of consultees strongly agreed or tended to agree with Action Area 2. There was consensus that inclusion was important, and that support should be available to a diverse range of families. However, there were some different views on how this strategy can be inclusive of both mothers and fathers.

Action Area 3 - Leading collaboratively: Nurturing a system of support
On average, 79% of consultees strongly agreed or tended to agree with Action Area 3. Consultees expressed the importance of joining up services and support. However, there were concerns about the funding that will be available to deliver this well.

Other comments
There were two themes from the additional comments that consultees provided. First, there were concerns about the use of gender additive language such as ‘Mums, Dads, and Co-parents’. Second, there were concerns about the affordability of implementing this strategy. In particular, some consultees questioned whether Kent County Council should be delivering this strategy rather than other local authority duties, such as waste and transport services.

Background

This strategy is an opportunity to support parents and carers to give their babies the best start for life.

Our earliest years of life shape the adults we become. It is a time of rapid brain development and our experiences lay the foundations for a wide range of future health and mental health outcomes. For parents and carers, having a baby can be a time of real joy and a time of challenge. It is important to support parents and carers to give their babies the best start for life.

This Nurturing Little Hearts and Minds: Perinatal Mental Health and Parent-Infant Relationships strategy is a five-year commitment to improving support for babies and their families across Kent. It sets out Kent County Council's ambition to work across sectors and services to improve perinatal menta health and parent-infant relationship support. It is in-line with the scope of the perinatal mental health and parent-infant relationship strand of the Family Hubs and Start for Life programme, focusing on early intervention and prevention.

The strategy was co-produced with parents, carers, and professionals.

The draft strategy was co-produced with more than 300 parents, carers, and professionals.

In terms of parent and carer engagement, a total of 130 parents and carers contributed to the strategy.

- 46 parents and carers completed an online survey.
- 27 parents and carers completed in-depth interviews – lasting more than 1.5 hours each.
- 46 took part in outreach activities in children's centres and other public spaces in Kent.
- 11 parents and carers joined two co-production workshops where the themes and actions were reviewed.

Parents and carers were from diverse backgrounds.

- One in ten of the parents engaged were Dads.
- Nearly one in four parents or carers engaged were from a non-White ethnicity (77.9%).
- The number of single parent households engaged was proportionate to the national average (14%, 15% respectively).
- Most parents and carers had one baby (51.6%). In total, more than one in ten were expecting a baby (12.7%) or had three or more children (11.8%).
- Nearly half of parents and carers reported they were worried about money problems or financial stress 'very often' or 'often' (49.1%).

In terms of professional engagement, a total of 180 professionals contributed to the strategy.

- 107 professionals joined two webinars, representing 38 different organisations across all sectors in Kent.
- 44 professionals completed an online survey, with 34 different roles, representing 17 different organisations.
- 29 senior leaders joined one-to-ones or roundtables, representing 13 different organisations.
- Used social media and emailed 180 professionals directly to encourage engagement.

A full list of organisations that supported the development of the strategy can be found in Appendix 1.

Formal Public Consultation

Consultation process

On 8 February 2024 an eight-week consultation was launched and ran until 5 April 2024. The consultation provided parents, carers, and professionals with the opportunity to find out more about the strategy and provide feedback. The public consultation for this strategy – Nurturing Little Hearts and Minds – was launched alongside the consultation for the Nourishing Our Next Generation strategy.

Feedback was captured via a consultation questionnaire, which was available on the Kent County Council website. Hard copies of the questionnaire were also available upon request.

A consultation stage Equality Impact Assessment (EqIA) was carried out to assess the impact the proposals could have on those with protected characteristics. The EqIA was available as one of the consultation documents and the questionnaire invited respondents to comment on the assessment that had been carried out.

Consultation engagement

There were several activities to promote engagement in the consultation process:

- Staff were available at activity events throughout the consultation period (9 events across the county and one online evening event to support engagement from parents with very young children) to engage with participants about the proposals, answer queries and encourage participation.
- Across the period of the consultation many multi-agency partnership meetings were attended to raise awareness of the consultation and share information.
- Young people were engaged directly and had the option of how they participated (for example, questionnaires, group discussions etc).

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

- Promotional material sent to Health Visiting service and community-based midwifery.
- Social media and paid Facebook advertising.
- Posters and promotional postcards in Children's Centres / Family Hubs, Youth Hubs, Kent Libraries, and Gateways.
- Emails to stakeholder organisations, including email to all early years and childcare providers that operate within the Kent Local Authority (over 1700).
- Invite to people registered on Let's talk Kent who had asked to be kept informed about new consultations.
- e-bulletin for Early Years and Childcare professionals throughout Kent.
- Media release issued at the launch of the consultation.

- Articles on Kent County Council's staff intranet and e-newsletters and email to staff groups.
- Social media campaign was implemented with different / repeated messaging over the consultation period.
- Email to stakeholders in the two weeks before the consultation closed to remind/prompt those who had not yet responded.
- The consultation website contained a short introduction and all the consultation information (the full document, summary document, Equality Impact Assessment, questionnaires, other background information, and easy read and large print documents. A Word version of the questionnaire was available for those that did not want to complete the online form. Promotional materials (and the website) included details of how to request alternative formats. A telephone number and email address were available for queries and feedback.

The consultation webpage had a total of 9,530 visits. Of these:

- 7,832 visited at least one page.
- 1516 visited multiple pages and / or downloaded documents.
- Most visits were direct (4,617) or from social media posts (3,263).

Points to note:

- Consultees completing the online survey were given the choice of which questions they wanted to answer or comment upon.
- Where consultees did not respond to a question this was recorded as 'not disclosed', where a question was not relevant to a consultee this was recorded as not applicable ('N/A').
- This report includes feedback from residents and professionals. Qualitative analysis for each stakeholder group has been reported separately.
- Consultees were given a number of opportunities to provide feedback in their own words throughout the questionnaire. This report includes thematic feedback across consultee responses.
- Feedback received by the Kent County Council team via email has been reviewed for the purpose of analysis and free text comments have been included where applicable in this report.
- Participation in consultations is self-selecting and this needs to be considered when interpreting responses.
- Kent County Council was responsible for the design, promotion, and collection of the consultation responses. Barnardo's was appointed to analyse the feedback and write this consultation report.

Overview of Consultees

Analysis of consultees that shared their feedback

A total of 61 consultees took part in this consultation:

- 56 completed the online survey.
- One resident provided feedback by email.
- One organisation provided feedback by email.
- One infant feeding support worker provided feedback by email.
- One young person provided feedback by email.
- One response was received from a group of young parents following an event at a targeted forum.

Breakdown of survey consultees

A total of 41 residents completed the survey, one of whom did not live in Kent. A total of 14 professionals completed the survey. One respondent reported that they were providing a response on behalf of Kent County Council, however, Kent County Council has confirmed that it did not submit a formal response and so this response was coded as 'other' (see Table 1).

Table 1 'How are you responding to this consultation?'

Response	Total
As a Kent resident	40
As a professional working with parents and families in Kent	14
As a resident of somewhere else, such as Medway or further afield	1
Other	1
Grand Total	**56**

Demographic overview of consultees responding to the consultation as professionals.

Several different professions completed the survey (see Table 2). Those recorded as 'Other' include an infant feeding specialist midwife, and two consultees who have more than one role.

Table 2 Profession

Response	Total
Children's Centre / Family Hub staff	5
Other	3
Breastfeeding support staff	3
Perinatal Mental Health Worker	1
Midwife or student midwife	1
Health Visitor	1
Grand Total	**14**

Demographic overview of consultees responding to the consultation as residents. Consultees were asked if they were a parent or carer (anyone who cares for a baby regularly). Most consultees were a parent, carer, or an expectant parent (73%, see Table 3).

Table 3 "Are you…?"

Response	Percentage of respondents
A parent or carer	71%
Neither of these	27%
Pregnant or an expectant parent	2%
Grand Total	**100%**

Two thirds of resident consultees were Mums, with one response from a Dad. More than a quarter of consultees did not disclose their role as a parent or carer (see Table 4).

Table 4 Role as a parent or carer

Response	Percentage
Mum	66%
Not Disclosed	27%
Auntie	2%
Grandparent	2%
Dad	2%
Grand Total	**100%**

More than two thirds of parents and carers who responded to the survey reported that they were the primary parent or carer (68%; see Table 5).

Table 5 'Are you the primary parent or carer?'

Response	Percentage
Yes	68%
Not Disclosed	27%
No	5%
Grand Total	**100%**

Consultees had experience of caring for a wide age range of children, with 40% of parents and carers currently expecting a baby or caring for a baby under the age of two (see Table 6). Consultees were not asked how many children they cared for.

Table 6 'Please select the age of the child(ren) that you regularly care for?'

Response	Percentage
Expecting a baby	7%
0-2 months of age	2%
3-6 months of age	5%
7-12 months of age	5%
13-24 months of age	22%
3-4 years old	17%
5-10 years old	22%
11-19 years old	3%
Not Disclosed	18%
Grand Total	**100%**

Consultees reported that they lived across five different Districts in Kent (see Table 7). Nearly a third of consultees came from Canterbury (30%). No responses were received from residents living in Gravesham, Sevenoaks, Tunbridge Wells, Swale, Ashford, Folkestone & Hythe, Dover, nor Thanet.

Table 7 Districts (based on the first five characters of the post code)

Response	Percentage
Canterbury	30%
Tonbridge & Malling	29%
Maidstone	23%
Dartford	13%
Not Disclosed	4%
Swanley	2%
Grand Total	**100%**

Use of services

Consultees were asked about their use of the following services:

- Children's Centres / Family Hubs
- Health Visiting
- Specialist perinatal mental health (PMH) services e.g. support from a specialist community Perinatal Mental Health nurse / midwife
- Perinatal mental health advice / support e.g. accessed a local helpline or talked to staff in the health visiting service

How often did consultees use services?

Most consultees had accessed a children's centre / family hub at some point (80%) with one in four using this service once a month or more frequently (25%). One third of consultees had accessed perinatal mental health support (33%, see Table 8). Other people in the household were reported to use services less. For example, only 7% use a children's centre / family hub once per month or more frequently, and 16% accessing perinatal mental health support (see Table 9).

How did consultees use these services?

Of those who did use services, most accessed support in person in a building. A small proportion of consultees reported using services online (2% for health visiting and 5% perinatal mental health advice; see Table 10). This pattern was comparable with how other people in the household used services (see Table 11).

Table 8 How often have you used the services below?

Response	Children's Centres / Family Hubs	Health Visiting	Specialist PMH services e.g. support from a specialist midwife	PMH advice / support e.g. accessed a local helpline
At least once a week	10%	0%	0%	0%
Once a fortnight	5%	0%	2%	2%
Once a month	10%	7%	5%	0%
Twice a year	5%	7%	0%	0%
Less regularly	17%	27%	12%	15%
Used it in the past	34%	46%	10%	15%
Never used this service	20%	12%	68%	66%
Not disclosed	0%	0%	2%	2%
Grand Total	**100%**	**100%**	**100%**	**100%**

Table 9 How often have others in your household used the services below?

Response	Children's Centres / Family Hubs	Health Visiting	Specialist PMH services e.g. support from a specialist midwife	PMH advice / support e.g. accessed a local helpline
At least once a week	2%	0%	0%	0%
Once a fortnight	0%	0%	0%	0%
Once a month	5%	2%	2%	2%
Twice a year	7%	2%	0%	0%
Less regularly	15%	24%	15%	7%
Used it in the past	12%	22%	2%	2%
Never used this service	56%	46%	78%	73%
Not disclosed	2%	2%	2%	15%
Grand Total	**100%**	**100%**	**100%**	**100%**

Table 10 How do you use the services below?

Response	Children's Centres / Family Hubs	Health Visiting	Specialist PMH services e.g. support from a specialist midwife	PMH advice / support e.g. accessed a local helpline
I don't use this service	44%	39%	83%	83%
In person at a building	51%	54%	10%	7%
Both	5%	5%	7%	5%
Online	0%	2%	0%	5%
Not disclosed	0%	0%	0%	0%
Grand Total	**100%**	**100%**	**100%**	**100%**

Table 11 How do others in your household use the services below?

Response	Children's Centres / Family Hubs	Health Visiting	Specialist PMH services e.g. support from a specialist midwife	PMH advice / support e.g. accessed a local helpline
I don't use this service	73%	73%	91%	88%
In person at a building	27%	24%	3%	0%
Both	0%	3%	6%	9%
Online	0%	0%	0%	0%
Not disclosed	0%	0%	0%	3%
Grand Total	**100%**	**100%**	**100%**	**100%**

Assessment of Equality and Diversity

Two thirds of consultees were willing to support an equality and diversity assessment (66%). A total of 34% of consultees did not wish to respond to these questions. Of these, 25% said 'No' and a small proportion (9%) reported that they were responding on behalf of an organisation questions (see Table 12). Those that did not provide equality and diversity responses were recorded as 'Not Disclosed'.

Table 12 Willingness to support the equality and diversity assessment

Response	Percentage
Yes	66%
No	25%
Responding on behalf of an organisation	9%
Grand Total	**100%**

Most consultees reported identifying as female (64%). All consultees who reported a gender also reported having the same gender as at birth (66%; see Tables 13 & 14).

Table 13 Are you…?

Response	Percentage
Female	64%
Not Disclosed	34%
Male	2%
Grand Total	**100%**

Table 14 Is your gender the same as at birth?

Response	Percentage
Yes	66%
Not Disclosed	34%
Grand Total	**100%**

Most consultees were under the age of 50 (51%), with 11% of consultees being over the age of 60 (see Table 15).

Table 15 Age group

Response	Percentage
25-34	21%
35-49	30%
50-59	2%
60-64	2%
65-74	5%
75-84	4%
Not Disclosed	36%
Grand Total	**100%**

Just over a fifth of consultees reported belonging to a particular religion or having a religious belief (21%), all of whom reported to be Christian or chose not to disclose which religion or religious belief they hold (see Tables 16 and 17).

Table 16 Do you belong to a particular religion or hold a religious belief?

Response	Percentage
No	45%
Not Disclosed	34%
Yes	21%
Grand Total	**100%**

Table 17 Type of religion

Response	Percentage
Christian	21%
Not Disclosed	34%
N/A	45%
Grand Total	**100%**

Consultees were given a definition of the Equality Act 2010 and asked if they considered themselves to be disabled, as set out in the Equality Act 2010. Most consultees reported that they did not have a disability (55%), while 9% reported that they do (n=5, see Table 18).

Of the five respondents that considered themselves to have a disability:

- three reported learning disability (including neurodivergence),
- one reported a mental health condition, and
- one reported multiple disabilities;
    - Physical impairment,

- Sensory impairment (hearing, sight or both),
- Longstanding illness or health condition, such as cancer, HIV/AIDS, heart disease, diabetes or epilepsy,
- Mental health condition,
- Learning disability.

Table 18 Disability as set out in Equality Action 2010?

Response	Percentage
No	55%
Not Disclosed	34%
Yes	9%
I prefer not to say	2%
Grand Total	**100%**

A total of six different ethnicities were reported, with most consultees reporting their ethnicity as 'White English' (55%; see Table 19).

Table 19 Ethnicity

Response	Percentage
White English	55%
Not Disclosed	34%
Other - White European	4%
Mixed White & Asian	2%
White British	2%
Other - White	2%
Other - Eastern European	2%
Grand Total	**100%**

Consultees were asked if they considered themselves to be a carer – defined as anyone who provides unpaid care for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support. A total of 18% of consultees considered themselves to be a carer (see Table 20).

Table 20 Do you consider yourself to be a carer?

Response	Percentage
No	48%
Not Disclosed	34%
Yes	18%
Grand Total	**100%**

A total of four different sexualities were reported, with most consultees reporting their sexuality to be heterosexual / straight (54%; see Table 21).

Table 21 Are you…?

Response	Percentage
Heterosexual/Straight	54%
Not Disclosed	34%
Gay woman/Lesbian	5%
Bi/Bisexual	4%
Other	2%
I prefer not to say	2%
Grand Total	**100%**

Consultation Findings

In this section, we present an overview of the findings from the public consultation. Analysis of each question is presented in turn. Where a written response did not directly answer a question, it was analysed along with 'any other comments.' A selection of quotes from written responses are included here to highlight important points, all written responses are reported in full in the appendices.

Is the strategy easy to understand?

Consultees were asked if they found the strategy easy to understand. Nearly three quarters of consultees answered 'Yes' (74%), with professionals finding the report easier to understand than residents (80% and 68% respectively, see Tables 22 and 23).

Table 22 Residents - Is the strategy easy to understand?

Residents (n=41)	
Response	**Percentage**
Yes	68%
No	24%
Not disclosed	5%
Don't know	2%
Grand Total	**100%**

Table 23 Professionals – Is the strategy easy to understand?

Professionals (n=15)	
Response	**Percentage**
Yes	80%
No	13%
Not disclosed	7%
Don't know	0%
Grand Total	**100%**

Consultees were asked for suggestions about what could make the strategy easier to understand. A total of 15 comments were received; 12 from residents and three from professionals (see Appendix 2). A common theme was that the strategy should be made shorter. However, it is likely that most consultees did not see the easy read version, with only 14 downloads of the easy read document.

"It is probably easy to ready for you but for the general public this is too complex. Please create simple 2-page document to say what you are planning to do practically." (Personal)

"It's a lengthy document for people to read through with a lot of information to absorb which is unavoidable but perhaps could put people off reading." (Professional)

Does the strategy clearly set out what is important to improve perinatal mental health and parent-infant relationships across Kent?

Most consultees reported that the strategy did clearly set out what was important to improve perinatal mental health and parent-infant relationships across Kent (59%). Residents reported more agreement than professionals (65% and 53% respectively; see Tables 24 and 25).

Table 24 Resident – 'How much do you agree or disagree that the strategy clearly sets out what is important?'

Resident (n=41)	
Response	**Percentage**
Strongly agree	35%
Tend to agree	30%
Neither agree nor disagree	8%
Tend to disagree	10%
Strongly disagree	8%
Not Disclosed	8%
Don't know	3%
Grand Total	**100%**

Table 25 Professionals – 'How much do you agree or disagree that the strategy clearly sets out what is important?'

Professional (n=15)	
Clearly Set Out What is Important?	**Percentage**
Strongly agree	13%
Tend to agree	40%
Neither agree nor disagree	13%
Tend to disagree	20%
Strongly disagree	7%
Not Disclosed	7%
Grand Total	**100%**

A total of 25 written comments were received for this question, with 19 from residents and six from professionals (see Appendix 3). Written comments expressed a diversity of views about whether the strategy sets out what is important. Of those who expressed more negative sentiment, this often related to how this strategy connects with other services, such as family hubs / children's centres, midwives, education, or the NHS.

"I completely agree with the approach to focus on the mild to moderate support needs of families in pregnancy and newborns, as this is where a great impact can be made to ensuring the family thrive in what can be very difficult first days and is likely to reduce the need for more robust interventions." Professional

"I am not sure you need to offer so much and nanny people so much. Friends, parents and family, professionals e.g. midwife/clinic nurse, doctor, charities." Parent

"You[r] plan is great and much needed. Make sure that people know about the services and where to look for help. Many people with mental health problems prefer online communication so maybe create some discussion groups in the social media where people can find information and reach out to other parents." Parent

"It focuses on the main areas of concern." Parent

"Identifies specific findings from parents / families with clear action points on how to address them." Parent

Action Area 1 - Relating with warmth: Developing relationship-based support

The actions in this area are:
1.1 Training for professionals to improve trauma informed care;
1.2 Campaigning to break the stigma of perinatal mental health and parent-infant relationship support; and
1.3 Identifying opportunities for earlier support.

There was broad support for all actions, with an average 80% of consultees strongly agreeing or tending to agree (see Table 26). This was the action that received the most agreement from consultees.

Table 26 Action Area 1: How much do you agree or disagree that the below actions will help improve perinatal mental health and parent-infant relationships across Kent?

	Action Area 1		
Response	**1.1**	**1.2**	**1.3**
Strongly Agree	59%	64%	67%
Tend to Agree	21%	14%	15%
Neither Agree nor Disagree	2%	4%	2%
Tend to Disagree	4%	4%	2%
Strongly Disagree	5%	7%	4%
Don't Know	4%	2%	4%
Not Disclosed	5%	5%	7%
Grand Total	**100%**	**100%**	**100%**

A total of 22 written comments were received for this action area, with 18 from residents and four from professionals (see Appendix 4 for all responses).

Two consultees described the importance of any training including the voice of parents and carers and being an opportunity to challenge and prejudice. This was reinforced by a response received by email from a resident.

"Please ensure training includes the voice of parents/carers, is action based and is not simply awareness based - all the research shows that awareness training has (at best) only a time limited superficial impact." Resident

"There needs to be a level of staff training that surpasses any prejudice about the age and educational level of parents." Resident

Two consultees reported concerns about the capacity of professionals to attend training and deliver care in a more relationship-centred way.

> "Training HCPs is important but the issue is these professionals are already over worked and appointment times are already stretched and clinics full. Unless you can reduce the workload so that we have time to review and address issues raised by patients how can we offer personalised care for PNMH?" Resident
>
> "Healthcare professionals need to have adequate time and work within an organisational culture that supports them in approaching their patients with empathy. The key messages from the training need to be voiced from the top down so it's not a tick box exercise and outcomes can be maximised." Resident

Finally, some consultees shared their personal experiences of services to reinforce the need for this action area.

> "You are discharged from midwifery services that make contact with you early on, and then don't have any contact with the health visitor until much later. I really struggled at around 6 months and didn't really know who to contact, and felt worried and embarrassed about contacting anyone in case it was viewed as I was failing." Resident
>
> "Having experienced birth trauma my treatment and the care/ support I received in [District of Kent] was abysmal. Complete lack of support and undiagnosed PTSD. Whereas my experience of living in [Different County outside Kent] I cannot fault the incredible HV team with all the support they gave me." Resident

Action Area 2 - Thriving together: Improving equity of support

The actions in this area are:
2.1 Harnessing data and insight to improve equity;
2.2 Supporting perinatal mental health of Dads universally; and
2.3 Reviewing the inclusivity of all perinatal mental health and parent-infant relationship service offers.

There was broad support for all actions, with an average 74% of consultees strongly agreeing or tending to agree (see Table 27).

Table 27 Action Area 2: How much do you agree or disagree that the below actions will help improve perinatal mental health and parent-infant relationships across Kent?

	Action Area 2		
Response	**2.1**	**2.2**	**2.3**
Strongly Agree	45%	48%	64%
Tend to Agree	29%	23%	13%
Neither Agree nor Disagree	5%	5%	4%
Tend to Disagree	5%	11%	7%
Strongly Disagree	7%	5%	7%
Don't Know	5%	2%	2%
Not Disclosed	4%	5%	4%
Grand Total	**100%**	**100%**	**100%**

A total of 22 written comments were received for this action area, with 18 from residents and four from professionals (see Appendix 5).

There was strong recognition of the importance of inclusivity. Consultees shared examples about how they have experienced discrimination or prejudice.

"Everyone needs to feel included in the process: children, mums and dads, and also grandparents and childminders." Resident

"As a non-birth mother in a two-mum family, I have found it hard to access support for mental health." Resident

"Dads are just as important as Mums and usually need support based of what their partners are going through. Having support for them will also encourage their partners to seek help as well." Resident

"At a basic level, dads / co-parents should be encouraged to be involved in the universal touch points with families. My husband taking the kids to development reviews or other appointments alone or even attending past the first few weeks of our children's' lives has been met with surprise. To make inroads to dealing with partners' mental health and parenting confidence etc., there needs to be a culture change." Resident

However, there was some tension between views that being inclusive of both fathers and mothers.

"Male parents and carers are notoriously hard to engage and may not want to identify as struggling with perinatal mental health difficulties. Alternative wording may be needed to enable you to offer support to make carers as intended." Professional

"2.1 The strategy discriminates against mothers (the largest and most vulnerable marginalised group in our patriarchal culture) as they have been excluded. 2.2 The definition of peri-natal means around pregnancy. Dads cannot be pregnant, therefore this language is misleading and inaccurate. I do support emotional support for fathers - but it is different to perinatal support. 2.3 The danger is that in trying to be inclusive to all, women and mothers and their unique and vital role has been excluded." Professional

Action Area 3 - Leading collaboratively: Nurturing a system of support

The actions in this area are:
3.1 Developing commissioning principles;
3.2 Building a relational pathway of support for parent-infant relationships; and
3.3 Establishing a community of practice for perinatal mental health and parent-infant relationships.

There was broad support for all actions, with an average 79% of consultees strongly agreeing or tending to agree (see Table 28).

Table 28 Action Area 3: How much do you agree or disagree that the below actions will help improve perinatal mental health and parent-infant relationships across Kent?

	Action Area 3		
Response	**3.1**	**3.2**	**3.3**
Strongly Agree	52%	57%	63%
Tend to Agree	25%	21%	18%
Neither Agree nor Disagree	5%	5%	7%
Tend to Disagree	7%	4%	4%
Strongly Disagree	5%	5%	4%
Don't Know	2%	2%	2%
Not Disclosed	4%	5%	4%
Grand Total	**100%**	**100%**	**100%**

A total of 21 written comments were received for this action area, with 16 from residents and five from professionals (see Appendix 6).

The need to join up services and support was emphasised in the written responses.

"Nothing is joined up currently." Resident

"I agree that commissioning needs to be effective, but the collaborative element is most important. We need the different parts of the system to work well together and for existing services and professionals to work as partners for families." Resident

"Absolutely agree. Make good use of VCS!" Resident

"More joined up working is very much needed like it used to be but was stripped away over the last 20 years due to funding." Professional

Funding and workforce shortages were expressed as barriers to enabling this action area to be successful.

"These are great suggestions - but how on earth will they be resourced by a council in a severe deficit?" Resident

"Again, it is staffing time and availability. We want the best for families but without the resources and staff we cannot offer these." Resident

Making this strategy a success

Consultees were asked to comment on the section of the strategy about making the strategy a success (see Appendix 7). A total of 13 comments were received, of which 11 were from residents and two were from professionals. These comments were varied, but a theme around raising awareness of services and promoting good, evidence-based practice did emerge.

"Increasing awareness across various communities, using different channels of communication (online social groups, GPs, etc)." Resident

"Individual professionals, like all people, have individual experiences and biases but I do wish that going forward NO professionals would even contemplate providing sleep training advice that is developmentally inappropriate. I have heard many examples of this still happening today and I am always shocked. It is not evidence-based and it undermines what this strategy aims to achieve (strong parent-child attachment, nurturing relationships)." Resident

"Extending training to the voluntary sector is essential so that there is a joined-up approach. Voluntary sector needs to be given correct funding to ensure security of provision." Resident

Any other comments

This section was an opportunity for consultees to share any other comments in addition to their responses to the more specific questions they were asked. Cross-cutting responses from other questions were also included in this section. A total of 25 responses were received, of which 18 were from residents and five were from professionals (see Appendix 8).

There were two main themes to these comments:

1. Concerns about gender additive language.

Although there was positive feedback from some consultees about the inclusion of Dads and other parents and carers, there were calls for a greater focus on mothers. This was also reflected in comments on the equality and diversity impact assessment (see Appendix 9) and in an email response (see Appendix 10).

"Women have babies. Breasts produce milk. Let's not mess with science and the absolute honour and privilege but otherworldly experience it is to carry and feed a baby (do not conform to the minority)." Professional

"It is a great shame that we have finally got funding for a long-overdue service to support mothers when they are at their most vulnerable, yet the word mother is not being used. This is unprecedented, deeply concerning and inaccurate because only mothers (and birthing people) can be pregnant - not other carers." Professional

2. Concerns about affordability.

There were concerns that delivering this strategy will be costly, and there were calls for greater focus on other local authority services.

"My best suggestion (to prevent money being wasted) is to look for the one or two achievable actions that can make a positive difference for new mothers and babies. We cannot fix everything here - that's like pretending we can fix the whole of society!" Resident

"Unfortunately, we cannot afford these side services. Our community charges and taxes are not being used to repair our infrastructure. We should spend money on resurfacing roads and providing schools we cannot afford these 'luxury' ideals." Resident

"If KCC is broke why are they even developing this strategy - why are they involved in pre-natal care? surely this is a role for NHS - stick to emptying the bins and fixing potholes - I know it is not glamorous but we cannot AFFORD anything else." Resident

Comments about the equality and diversity impact assessment

Consultees were given the opportunity to comment on the equality and diversity impact assessment. A total of 16 responses were received, of which 12 were from residents and 4 from professionals.

Comments were varied, highlighting a diverse range of perspectives on equality and diversity (see Appendix 9).

> “Everyone should already have the same opportunities to access these helps - no postcode lottery, no language barrier!” Resident
>
> “Intersectionality needs to be considered a lot of people have multiple factors. E.g. those who are LGBTQ+ that struggle with their mental health due to fertility treatment not working and then becoming pregnant. Or ethnic minorities that have Autism etc.” Resident
>
> “Surely equality should include all parents regardless of income. Without this integration, a "poor" and "rich" community is created, and most people end up on SMP at some point during their maternity leave, which is more tough to the people that are losing a significant amount of income.” Resident

Next Steps

This report will be shared with Kent County Council, where it will be analysed and a ‘You Said, We Did’ summary will be published highlighting any actions or changes emerging from the consultation.

Appendices

Appendix 1 – Organisations engaged in co-producing the strategy

Appendix 2 – Suggestions to make the strategy easier to read

Appendix 3 – Consultation feedback ‘Does the strategy clearly set out the ambition?’

Appendix 4 – Consultation feedback ‘Action Area 1: Relating with Warmth’

Appendix 5 – Consultation feedback ‘Action Area 2: Thriving Together’

Appendix 6 – Consultation feedback ‘Action Area 3: Leading Collaboratively’

Appendix 7 – Consultation feedback ‘Making this strategy a success’

Appendix 8 – Consultation feedback ‘Any other comments / cross cutting comments

Appendix 9 – Consultation feedback ‘Comments about the equality and diversity impact assessment’

Appendix 10 – Consultation feedback received by email

Appendix 1 – Organisations engaged in co-producing the strategy

Organisations that attended one of two online webinars

Ashford Rural Medical Services
Ashford Rural Primary Care Network
Children and Families Ltd
Children's Centre
Childrens Families Ltd
Dartford & Gravesham NHS Trust
Drapers Mills Primary Academy
East Kent Hospitals University
NHS Foundation Trust
East Kent Mind
Family Action
Folkestone & Hythe Children's Centre
Folkestone and Hythe Children'S Centre
Home-Start Dover District
Kent and Medway Integrated
Care Board
Kent and Medway NHS and Social Care
Partnership Trust
Kent Community Health
NHS Foundation Trust
Kent County Council
Kent Parents
Kent Surrey & Sussex Academic Health
Science Network
Kent Surrey & Sussex
Operational Delivery Network
Maidstone and Tunbridge Wells
NHS Trust
Mama to Mama
Mind in Bexley and East Kent
NHS
North Kent college
Open Access Children's Centre
OXPIP
Porchlight
Red Zebra
Rising Sun
Save the Children UK
Seashells Children's Centre
Swale Children's Centre
Thanet Children's Centre
The Education People
The Piggybank Day Nursery Ltd
Unknown
Wokingham Local Authority

Organisations that responded to our online survey for professionals

Ashford Borough Council
Ashford Rural Medical services
Dartford and Gravesham NHS Trust
East Kent Hospitals University NHS
Foundation Trust
East Kent Mind
Home-Start
Kent and Medway Integrated Care
Board
Kent and Medway NHS and Social Care
Partnership Trust
Kent Community NHS Foundation Trust
Kent County Council
Kent Safeguarding Children Multi-
Agency Partnership
Kent, Surrey and Sussex Neonatal ODN
Mama to Mama
My Birth Support CIC
Porchlight
Rising Sun Domestic Violence and
Abuse Charity
Save the Children UK

Organisations attending roundtables and one-to-one meetings

Baby Umbrella
Better Breastfeeding
East Kent Hospitals NHS Foundation Trust
Involve Kent
Kent and Medway ICB
Kent and Medway Integrated Care Board
Kent and Medway NHS and Social Care Partnership Trust
Kent Community Health NHS Foundation Trust
Kent County Council
Medway NHS Foundation Trust
PorchLight
Seashells Children's Centre
University of Kent

Appendix 2 – Suggestions to make the strategy easier to read

Residents:

- It depends who you want to understand it. It's a bureaucratic document full of bureaucratese terminology. It's fine for other civil servants and NGO people but normal humans won't find it straight forward.

- It's too long.

- I don't understand why this enormous, beautifully created policy document is pertinent to the county council. This is a matter for the health service. The council's only job is to facilitate the Childrens Centres, managing them effectively and ensuring they are vfm.

- Problems are not the route to solutions, witness their tendency to morph into a plethora of kindred problems in the blink of an eye. There ought to be a single STRATEGY involving all sections of society, of all ages. Advocacy of LOCAL ECONOMIES is the way forward. The benefits are immediate, and tangible. A country without local economies is a failed country.

- It is probably easy to ready for you but for the general public this is too complex. Please create simple 2-page document to say what you are planning to do practically. This is all that people need to know. No one has time to read through many pages and in reality many people will not even understand even if they read them.

- I am a professional copywriter and I am completely bamboozled by this document.1) Who is it for? Because it is NOT for parents. This is a long, intense, dense, academic document that is not suitable or usable for the public. Establish exactly who this document is for and what you want them to do with it. Currently, someone doing a Masters in Health and Social Care would find this useful for their research. A professional working in the council would find this very difficult to

read, but might glean some useful tid-bits to help inform their practise. A nurse or health visitor would struggle to understand how this information impacts their day-to-day. A parent looking for support wouldn't even manage to get past the first page.2) Reading age. The UK national reading age is 9 (Entry Level 3 according to the National Literacy Trust.) A quick assessment of this document shows it is at the Level 4, possibly Level 5 reading age (National Literacy Trust.) People at this reading level tend to be academics. It is unacceptable and renders this document useless if it is not at an accessible reading age for the target audience. If the target audience is the British public, it should aim for Entry Level 3. If it's for professionals, it should aim for Level 2 or Level 3. Being over Level 4 honestly makes this document useless except for academic purposes.3) 130 parents and carers were used in your research. It doesn't take a genius to tell you that this is a remarkably small sample size, rendering your findings very limited. You're basing strategy in the whole of Kent off of only 130 parents? I can't even begin to say how limiting and silly this is. This research would simply never fly in any scientific setting.

- Executive summary does not adequately summarise the content and excludes the voice of parents. Develop accessible summaries too, for those unable to engage with a complicated written document.

- Make it shorter and clearer as to what will actually be done. There is too much waffle.

- Could be shorter so not as much to read.

- Not everyone can access it in the formats it is. People with disabilities struggle with the access to reply and read the documents. Website is black on white with no way of changing the screen for Irens syndrome

- My suggestion would be to have the Strategy and Feedback be translated in various languages for Dartford Igbo, Yoruba, Hausa, Twi, Krio, Creole, would be particularly useful for the black community. Also, to be able to provide feedback without having to register anonymously would be helpful for those concerned leaving their details. Many black and ethnic minority women I know believe that infant feeding is a family and cultural decision rather than something that authority should be part of conversationally and therefore they may disregard consultations like this as they do not believe it applies to them. This could be a potential barrier for them getting solutions to issues they may face when requiring your services. Also, the language could be a barrier having translations available helps reach black and ethnic minorities engage. Igbo and Yoruba are two Nigerian languages commonly used in the Dartford area and Twi is a Ghanian language. Krio is the language of Sierra Leone as there are many Sierra Leoneans living in Kent. Creole is a Caribbean language. Also, where I live in Gravesend, Punjabi is predominately used by the Indian community which many parents and

grandparents tend to speak as we have one of the largest Gurdwaras here. Having resources translated to Punjabi and other ethnic minority languages could help those family members with influence such as mothers and grandmothers help to spread the KCC messages to those in need of your services.

- It is easy for me to understand, but I have experience of reading/being involved in consultations and also work in this sector. I don't think it would be easy to understand if I were outside of this.

Professionals:

- Possibly by using more images and slightly less text. Will the strategy be available in alternative formats and BSL.

- From a lay point of view, this is wordy and too full of technical information and data for a significant proportion of families to understand and comment on. In order to engage more parents in this consultation, consideration could be given to a much shorter outline, using bullet points, giving facts on what the new service intends to deliver and what it will look like.

- It's a lengthy document for people to read through with a lot of information to absorb which is unavoidable but perhaps could put people off reading.

Appendix 3 – Consultation feedback 'Does the strategy clearly set out the ambition?'

Residents:

- It sets out SOME of what's important, but it only pays lip service to the critical role of father involvement. In Dr Warren Farrell's book "The Boy Crisis" he details 85 physiological, physical and psychological effects on children that a lack of fathers has. Children without fathers in the home die younger. Boys are twice as likely to be diagnosed with autism or ADHD. Girls start puberty up to 18 months earlier. And so on. And yet fathers are relegated to a few short paragraphs on page 23.I understand WHY this is. Men are not considered to be important, particularly by the female-dominated civil service. I would suggest that the problem of solving children's misery starts with a stable family unit, a father, and a mother, married and in a home. I don't think you address that issue in any depth.

- It's important to raise various issues that parents and families face whilst raising children. Being aware of the challenges someone is facing increases the chance of people feeling listened and cared for. Offering information to families in a preventive manner can make a huge difference in the wellbeing of their families.

- As stated above words are cheap - it's resources and the proper funding of adequate numbers of professionals that is needed.

- PNMH & PIR are so important so I must ask why children's centres are closing and therefore putting another barrier to parents/carers to receive support. Why is there no increase in staff either for these services if the drive for this is so important. Reduction in staff means higher caseloads, more stressed-out staff and therefore impacting those they are working with.

- It is clear once you are able to find the information as the document is so long.

- I am not sure you need to offer so much and nanny people so much. Friends, parents and family, professionals e.g. midwife/clinic nurse, doctor, charities. Surely you can put money elsewhere whilst we are in the state we are in.

- It's all very ambiguous.

- All this work should have already been happening via Community Midwives and Health Visitors.

- As above, problems fester. Imagine if your draft and strategy started in a different way. MY EDUCATIONAL PROGRAMME IMAGINE Imagine your child … who would push seeds down in the soft ground, cover them with soil, and all the while watch plants grow. Child will harvest the crops in the fullness of time; crops are brought to the table where meals are prepared and consumed. Rounding this off, the same process is repeated time and over again by placing what is left over back on to the ground to nourish the soil … the educational value of all this would be immense. One seed at a time, one step at the time, one word at the time … and you unfurl the world. THIS IS THE MOTHER OF ALL LEARNING.

- It focuses on the main arears of concern.

- You plan is great and much needed. Make sure that people know about the services and where to look for help. Many people with mental health problems prefer online communication so maybe create some discussion groups in the social media where people can find information and reach out to other parents. It is great to have a physical place they can go to but these services could be part of the library and not necessarily separate facilities.

- Because if people want babies it is not for council taxpayers to support them - at best this is NHS or get a book as we do as young parents.

- Identifies specific findings from parents / families with clear action points on how to address them.

- Read the feedback from the professionals. What do they say time and time again? They need FUNDING. Page 45 and 46 gives NO indication of increased funding. The

professionals (who are mostly underpaid or volunteers for charities) are the experts on this. Your research means nothing unless you speak to the ACTUAL experts. They know what they need, they know where the money should go, and they know how to do it. With Kent County Council empower these incredible people to actually DO the work they are trained to do?

- There are not enough support on perinatal mental health across East Kent.

- The devil is always in the detail of implementation and given the political and financial context it is hard to see how this strategy can be properly resourced and implemented. Organisational culture change is also inherently difficult and too often strategies such as this fail due to lack of consideration of the wider context (e.g. pressure on services which means less time to fully support mental health of parents amongst the many other competing demands).

- I felt that post partum care was super poor. Looking back I was clearly struggling with breastfeeding and my mental health because of this but didn't have any help or support. Midwives visiting seemed aloof with a checklist, not really offering any support.

- It is not clear.

- It does not explain how it is actually going to implement this improvement to perinatal mental health. How are you going to reduce waiting times? How are you going to offer this to more people? How are you going to offer care for people that are suffering with perinatal mental health mildly, at the moment it seems only if you are deemed "high risk" with pre-existing mental health concerns that you get the input and support, people that are ok but mildly struggling are overlooked. How are you going to make this accessible for people who can't drive or afford the bus? How are you going to have more staff to reduce the waiting time?

Professionals:

- I read the easy read version, and how it is bullet pointed makes it clear to see the plans.

- Kent has very good infant and baby services, but these should be extended further.

- Building relationships with those professionals who have the knowledge to help with support cannot always be done on the first meeting leaving some parents/carers afraid to talk, informal groups are some of the best places for parents to open up for instance in baby massage parents often open up about how they are feeling but there is no mention of such services being offered.

- I am really pleased to discover this initiative, it is a huge positive in my missions as a professional to support parent and infant relationships and promote positive attachments, optimal brain development and better outcomes for the future. However, from what I can tell of the strategy it would be targeting particular families, demographics, those in need etc. I'm not disputing this in itself but believe that there is even more potential to reach desired outcomes through a united approach across all health professionals in all interactions with parents. I understand time and budget restrictions, but I genuinely believe that if we could even manage a short training session, e learning, online webinar etc. even just 1 hour! On normal infant behaviour (feeding, sleep, needs and all the whys) attachment and how this is fostered and the impact of a positive attachment - I think this could make a huge difference in the advice that is given and language that is used. I myself, every friend, every client has experienced at some point in their contact with midwifery or health visiting services, some kind of advice that promotes unresponsive parenting. This comes from outdated literature and societal expectations that our children need to learn to 'self-settle', shouldn't need us through the night from a young age, shouldn't be held continuously, need to be independent etc. Often this advice is unsolicited, perhaps in response to a tired mother who just needs reassurance and a listening ear, not to be told she needs to put her baby down more, stop feeding to sleep and attempt cry it out strategies. This really is such common advice in my personal and professional experience. I would love to offer my support and expertise in providing this underpinning knowledge in anyway I can. I hold a BA Honours degree in social work, 9 years' experience working with children and families. I also hold a Level 6 OCN qualification as a holistic sleep consultant which covers child development, attachment, biological norms, feeding etc. I would be happy to provide a digital resource, offer short talks with local teams, a downloadable webinar, parent drop in group etc. I am so passionate about your goals and this is the driving force behind my current business. I genuinely believe that many of societies unrealistic expectations on the parent-child relationship are significantly contributing to future mental health and relational difficulties.

- As above - too much data and information that obfuscates the important messages and intended service delivery.

- I would love to be able to build stronger relationships with my clients so that they feel safe to discuss how they are feeling emotionally, however when you only offer 3 contacts, sometimes only two if an antenatal is not offered if is very difficult to build a relationship. The amount of contacts offered by Family Nurse Partnership is best practice and allows those practitioners to build that connection with their clients, but these is offered to a very small proportion of the community and it is a shame it can not be offered to more parents. The service we provide is Monday - Friday 9-5 and I feel this excludes Dads as they are often working.

Appendix 4 – Consultation feedback 'Action Area 1: Relating with Warmth'

Residents:

- Training needs to provide safe places for staff to speak about their experiences. Sometimes staff come across as terse/indifferent, they are experiencing overload. The safe places need to be ongoing.

- Your system is too large and cumbersome for any of this to work effectively.

- There needs to be a level of staff training that surpasses any prejudice about the age and educational level of parents.

- Opportunity for earlier support - more opportunities to build relationships between professionals and parents through groups.

- The necessity for all these things is the result of the legacy of the breakdown of strong families. New parents find themselves struggling when they never had normal attachments when they were tiny babies; they may now be alone with a new baby; they may have suffered domestic abuse; they may have lost their family support.

- This is pie in the sky. All services are stretched to the limit and it is still the case that communication between different services is poor. What is the point of this and why is it the business of KCC? This is a health / SS matter.

- The answers we seek reside within learning. Learning is easy. Learning is a joy. It is interactive, collaborative, organic… it's a simple fact that learning is all embracing, multi-faceted, and we can but rejoice at the endless opportunities offered by it. There is "no" limit to what we can learn.

- As I said this is a really great initiative and will help families.

- Yes - just stop this nonsense - we cannot afford it!!!!!

- Healthcare professionals need to have adequate time and work within an organisational culture that supports them in approaching their patients with empathy. The key messages from the training need to be voiced from the top down so it's not a tick box exercise and outcomes can be maximised.

- It will be great if all these supports are free of charge and no special requirements need to meet to get the free services.

- Please ensure training includes the voice of parents/carers, is action based and is not simply awareness based - all the research shows that awareness training has (at best) only a time limited superficial impact.

- Asking questions is not enough. More needs to be done before a baby arrives to help on the journey to parenthood.

- Training HCPs is important but the issue is these professionals are already over worked and appointment times are already stretched and clinics full. Unless you can reduce the workload so that we have time to review and address issues raised by patients how can we offer personalised care for PNMH? Yes that lady needs a longer discussion and input about her health but I also have a clinic of 12 women and only a 30 minute slot per person. I can't go another or longer clinic because the GPs are kicking midwives out to bring in outside services and the children's centres are closing. So how can I offer women and their families longer appointments to discuss and look after their mental health with nowhere to see them?

- You are discharged from midwifery services that make contact with you early on, and then don't have any contact with the health visitor until much later. I really struggled at around 6 months and didn't really know who to contact, and felt worried and embarrassed about contacting anyone in case it was viewed as I was failing. Maybe a team needs to contacting new mums around this time to see if they can provide any support.

- More funding and centres like waterside in Gravesend should be set up in other areas following this model.

- Absolutely agree with this but I don't think it should come from statutory bodies i.e. health and social care. The VCS is exceptionally well placed as it is far more trusted by vulnerable people. Women experiencing poor PMH are not likely to trust a HV or similar if they feel (for example) intrusive thoughts because they are afraid of how it will impact their care/consequences for them as a parent. Care offered should be personalised and accessible, not just a one size fits all with some online only resources. Offer support in pregnancy so women know where to get it when they have their babies.

- Having experienced birth trauma my treatment and the care/ support I received in [District of Kent] was abysmal. Complete lack of support and undiagnosed PTSD. Whereas my experience of living in [Different County outside Kent] I cannot fault the incredible HV team with all the support they gave me.

Professionals:

- Health and Care professionals are not always the ones parents want to speak to it will take more than five years to change this.

- Ensure that the Actions within the strategy are implemented at the earliest stage, to give pregnant parents the time to absorb, learn, reflect and process the information available to them, instead of leaving it until when baby has arrived. Helps to prepare and then remind again what's available once baby is born.

- Again, really pro all of these actions. But keen to see a general shift in approach to all families, not just those outwardly struggling or expressing concern, but just a shift in the type of advice and information that is given from day 1. This is so often about unsolicited advice, comments made about normal infant behaviour such as 'they're just using you for comfort now' 'try to make sure they're having some time out of your arms' 'they know what they're doing'. An underlying tone that we need to encourage independence, we shouldn't just support our children for comfort only a physical need and that our children are manipulating us.

- 1.1.Trauma has to be in relation to women specifically. Sexual trauma can have a profound effect on birth and breastfeeding. Trauma of other carers is not going to have the same effect on the child and/or mother-infant dyad. 1.2 It is deeply ironic that this strategy is unwittingly perpetuating the stigma of perinatal mental health by literally erasing the words mother and women from it. 75% of women feel invisible when they become mothers. Not mentioning the word mother, or implying that a mother is interchangeable with another carer, exacerbates the problem for women. Rather than making it seem like this strategy is for everyone, it might be more appropriate to have one service for mothers and birthing people, and a different mental health service for other parents and carers whose needs for safety and support will look different. 1.3 The authors are happy to use the word dad in points 1.2 and 1.3, but they have not used the word mother. This does not feel right at all.

Appendix 5 – Consultation feedback 'Action Area 2: Thriving Together'

Residents:

- Your problem here is not 'equity' or 'inclusivity'. It is social breakdown. You can make some improvements but not like this. This is a data collecting exercise which will make jobs for bureaucrats and solve nothing.

- Everyone needs to feel included in the process: children, mums and dads, and also grandparents and childminders.

- How can you measure discrimination? Action 2 seems to be a "hollow promise" to me. How are you going to get absent fathers to engage with all this?

- Who will provide data? Can we afford this? Action at a local level (where we have staff) would make for easier to identify areas of need.

- I'm in favour of reviewing, but what does "equity" mean? To put things in terms of agreeing or disagreeing is not helpful.

- I think there is no issue with inclusion and access to services but it is more of an issue of different ethnical groups not knowing about them due to poor IT skills or poor language skills. Maybe translated materials spread into the communities will increase the reach out.

- As a non-birth mother in a two-mum family, I have found it hard to access support for mental health.

- 1 Harnessing data and insight to improve equity. - Get some Masters students to tell you how to do this. Because they'll do a much better job than is currently being done.

- It will be great if all these supports are free of charge and no special requirements need to meet to get the free services.

- Dads are just as important as Mums and usually need support based of what their partners are going through. Having support for them will also encourage their partners to seek help as well.

- It is not clear what “equity” means in this sense. It is not clear what will actually be done beyond management speak. The services offered are already often open to all (expect bookable activities).

- This needs to be an accessible service and lots of people struggle with access to a central hub. They do not drive, they do not have money for bus fare or the bus routes have now reduced

- If services are online how will the most vulnerable families be supported?

- The school curriculum needs to include more health promotion and education, so that future parents are prepared for family life experiences

- Parents to be is not clear language. There is a lot of mental health support for men locally (Mentalk, campaigns for male mental health etc) but no women’s safe spaces.

- There is very limited support for Dads at present my partner suffered with postnatal depression which made live very difficult at the start. We need to talk about the emotional changes and what’s parenthood is really like in pregnancy.

- At a basic level, dads / co-parents should be encouraged to be involved in the universal touch points with families. My husband taking the kids to development reviews or other appointments alone or even attending past the first few weeks of our children's' lives has been met with surprise. To make inroads to dealing with partners' mental health and parenting confidence etc., there needs to be a culture change.

- There is lots of targeted mental health support for men. Everything that seems to be coming out that women can access is aimed at 'parents'. So women need their own specific support.

Professionals:

- Ensure services are welcoming and available to young parents, and those with protected characteristics. Ensure that DA data is included if appropriate as this can link strongly to MH and well-being

- Male parents and carers are notoriously hard to engage and may not want to identify as struggling with perinatal mental health difficulties. Alternative wording may be needed to enable you to offer support to make carers as intended.

- The local perinatal service has stringent / discriminatory boundaries on the access to their service. This has been going unaddressed for years now.

- 2.1 The strategy discriminates against mothers (the largest and most vulnerable marginalised group in our patriarchal culture) as they have been excluded. 2.2 The definition of peri-natal means around pregnancy. Dads cannot be pregnant, therefore this language is misleading and inaccurate. I do support emotional support for fathers - but it is different to perinatal support. 2.3 The danger is that in trying to be inclusive to all, women and mothers and their unique and vital role has been excluded.

Appendix 6 – Consultation feedback 'Action Area 3: Leading Collaboratively'

Residents:

- Balint groups were common in the 1960's 1970's why do we always reinvent the wheel.

- Nothing is joined up currently.

- Not just having services inside hubs! Town and Village centres are a very good place as these often have the best transport links.

- I agree that commissioning needs to be effective, but the collaborative element is most important. We need the different parts of the system to work well together and for existing services and professionals to work as partners for families.

- Absolutely agree. Make good use of VCS!

- 3.3 is the only one which might be useful. I would suggest starting it in a single town and a single maternity hospital area to test it.

- Bring back Children's Centres - I have long believed that Kent is all too often a market leader in service provision and then abandons good practice after deciding something isn't working without giving enough time for benefits to be seen, or deciding that it isn't providing 'value for money' ... only to see the rest of the country following some years later and leaving us behind.

- Who are these “partners” you refer to repeatedly? If it’s the NHS staff, they honestly cannot take on any extra work right now!!

- Surely best practices already exist. Is this really necessary? How many expensive committees are going to be involved? and Nurturing a System of Support - what does that mean? Management speak.

- Don't forget to include the communities in the support process as they are the main ones that can support young parents.

- Literally none of this can happen without proper funding. Are you expecting volunteers or under-paid experts to do this? It's too important to be underfunded.

- It will be great if all these supports are free of charge and no special requirements need to meet to get the free services.

- These are great suggestions - but how on earth will they be resourced by a council in a severe deficit?

- There are lots of great breastfeeding charities that are not supported enough. It is not clear who else local partners refers to. The strategy needs to be much more specific.

- Again, it is staffing time and availability. We want the best for families but without the resources and staff we cannot offer these.

- Options for private EYFS, mental health, wellbeing professionals to collaborate and tender.

Professionals:

- More joined up working is very much needed like it used to be but was stripped away over the last 20 years due to funding.

- Ensure that commissioned services are accessible. 3.2 Ensure links to DA support are included within the pathways. A COP is a great idea, these are always a great way to network share expertise and so much more.

- As I have offered - I would LOVE to be able to support on this initiative in any way I can. I believe I have a huge breadth of knowledge and experience in the parent and child relationship, its importance, the norms and how to foster this. I would love to support in the wider and long term goals and to support parents to feel less pressure in what is already such a difficult time.

- When are professionals supposed to fit in this additional training?!

- As an infant feeding practitioner I feel that the language on this page does not recognise the importance of the mother-infant bond for the optimum development of the child.

Appendix 7 – Consultation feedback 'Making this strategy a success'

Residents:

- Increasing awareness across various communities, using different channels of communication (online social groups, GPs, etc).

- Give things TIME - before making those decisions!

- What's really needed in the long term is to build community - this takes time! Without improvements in family life, it is unlikely to be effective in the long term. Fixing mental health problems also takes a long time to fix, but identifying them early is surely an essential part of a midwife's work?

- Leave it to the health service and provide what support they ask for.

- What type of "Strategy"? What type of "Success"? My overall approach is based on a tested notion of KNOWLEDGEFood is the Source of all KnowledgeWater is the Source of all KnowledgeEnergy is the Source of all Knowledge.

- "offering training" is so vague. Who is training? What's their background? How will you measure success and outcomes? When will this training start? Will participants in this training be paid for taking time out of their working schedule to do it?

- You are discharged from midwifery services that make contact with you early on, and then dont have any contact with the health visitor until much later. I really struggled at around 6 months and didn't really know who to contact and felt worried and embarrassed about contacting anyone in case it was viewed as I was failing. Maybe a team needs to contacting new mums around this time to see if they can provide any support - this removes the embarrassment/shame aspect. I was engaging with children's centres and struggling with poor sleep. The lady in charge of the group promised to send me some information on methods to use for sleep that didn't involve 'cry it out', every week for 6 weeks. I also emailed her twice. The information never transpired and would have really helped in my moment of need. Being sleep deprived for 6 months is tough and is going to negatively affect your mental wellbeing.

- More face-to-face opportunities. Early interventions through designated midwife, health visitors, face to face, in person ASQ checks, 6 week checks better, professionals joined up and information sharing, early interventions from community therapies, maintenance and investment in children's centre sites not closures. Reduction in online services - most vulnerable and EAL families find these inaccessible.

- I think health staff going into schools to teach "what is normal behaviour in a baby" would be useful. Especially the schools with the greatest level of deprivation.

- Extending training to the voluntary sector is essential so that there is a joined up approach. Voluntary sector needs to be given correct funding to ensure security of provision.

- Individual professionals, like all people, have individual experiences and biases but I do wish that going forward NO professionals would even contemplate providing sleep training advice that is developmentally inappropriate. I have heard many examples of this still happening today and I am always shocked. It is not evidence-based and it undermines what this strategy aims to achieve (strong parent-child attachment, nurturing relationships). In fact, leaving a child to cry or expect them to regulate themselves prematurely would be considered an adverse childhood experience at any other time of the day, but it appears to be accepted by many as normal if it's when parents need/ want to sleep. We really need to adjust expectations around infant sleep within this broader aim and support parents through the challenges that come with what is developmentally normal and appropriate. I notice a strong emphasis on attachment in this strategy, which I think is essential. I feel that professionals should be brought up to speed on this to enable them to support attachment parenting styles; parents are often looking for coping strategies or to be told everything is normal, but it is hard. They do not want to be met with "just let your baby cry; they'll learn how to sleep". It's horrifying that this is still fairly commonplace.

Professionals:

- Groups where parents can meet other parents feeling the same way so they no longer feel alone.

- I would be interested to know exactly what interventions organisations are offering as there are some named who are not offering mental health support in reality.

Appendix 8 – Consultation feedback 'Any other comments / cross cutting comments

Residents:

- My best suggestion (to prevent money being wasted) is to look for the one or two achievable actions that can make a positive difference for new mothers and babies. We cannot fix everything here - that's like pretending we can fix the whole of society!

- Honestly, just get someone to simplify the whole thing. I would be surprised if anyone reads it.

- Keen on the notion of "start" as in "start with food", which is my trademark. Let's get started, then!

- Went to see GP about being stressed out due to feeding issues and moving home. It wasn't really resolved.

- Scrap it.

- Unfortunately, we cannot afford these side services. Our community charges and taxes are not being used to repair our infrastructure. We should spend money on resurfacing roads and providing schools we cannot afford these 'luxury' ideals.

- KCC should not be involved - scrap the whole thing and stick to core services which you are struggling to meet.

- Cancel the whole thing a waste of TAXPAYER money.

- It needs to be more than just well-intentioned words. To be honest we've all heard before what needs to and should be done. Now we need to see effective identification of need followed by effective interventions which will require more than words. In 2003 my own daughter's HUGE MH needs (postnatal psychosis which had built up over 3 pregnancies) were eventually identified almost by accident by an observant EY practitioner while she and my granddaughter were attending a Kent Children Centre - we need MORE not less of those. In 2023 my

step-daughter needed to resort to privately-funded interventions to address her MH issues related to a very traumatic ectopic pregnancy and the loss of her much wanted baby. I don't feel like much has changed in the intervening years except the closure of services.

- Too many mention of parent and not mother when that is what should be used in the context. It leaves it unclear.

- If KCC is broke why are they even developing this strategy - why are they involved in pre-natal care? surely this is a role for NHS - stick to emptying the bins and fixing potholes - I know it is not glamorous but we cannot AFFORD anything else.

- I am particularly confused as to why you are referencing UNICEF as a target or aspiration. The UN is NOT our government! UNICEF has no jurisdiction in Kent. They are not the model you should be following. Listen down, not up!

- Why do we spend money on this kind of thing - I should think you could fund a couple of social workers out of the costs of this initiative.

- I have one final comment on breast feeding. It is time to normalise formula feeding too and tell mothers that the most important part is their child to be fed. I remember that not been able to breastfeed caused a major distress to me and affected my mental health. I was convinced that every mother can breast feed and it is a matter of choice. However, this turned out not to be the case.

- One min u say you are broke and then you come up wit this - if u want a baby deal with NHS not KCC.

- It will be great that all these supports are easily accessible across the whole Kent for free of charge.

- We have several prisons in the county. The young men in them are very often fathers. Their mental health needs to be considered too.

- Whilst I agree it is incredibly important that infants need strong relationships with their mothers and other parents, there are other important reasons to improve perinatal mental health. This strategy is very infant-focused and comes across as though the only reason to improve PMH is for the sake of the infant, not to help the mother. Some focus on this would also be nice.

Professionals:

- There is absolutely no mention of groups and courses that are, and have been available for ALL families with children and young people 0-19 yrs over the last 10-15 yrs that have massively helped to reduce isolation and depression, increased

confidence in their parenting abilities and given parents and children the opportunity to interact with other parents/carers, babies and children/young people and access peer support through building friendships within the groups and courses. The strategy constantly reminds everyone that it takes a village to raise a child, well KCC have just cut services that have been doing just this over the past years. As for all Health Visitors being Solihull trained, this is correct, however the HV's are so busy that the children's centres run the parenting workshops and drop-in sessions (which are now the Kent Parenting Programme as Solihull was not allowed to be rolled out anymore thanks to KCC!!!!!)

- Women have babies. Breasts produce milk. Let's not mess with science and the absolute honour and privilege but otherworldly experience it is to carry and feed a baby (do not conform to the minority)

- It is confusing to read as the words parents and carers are used instead of mother. This makes it inaccurate in places.

- These 3 actions are essential to: embed knowledgeable, well-informed services based on: caring and listening, patient centred, accessible without barriers, to all of those families who need it most and robust information sharing among families and professionals, informed consent, communications and liaison, which is key to developing expertise, safe practice and trust. Consensus Statement 2014 advises breaching of confidentiality when a client is at risk of harm, and must be used to avoid serious consequences of ill mental health, suicide, and the lives of families who become victims of it.

- It is a great shame that we have finally got funding for a long-overdue service to support mothers when they are at their most vulnerable, yet the word mother is not being used. This is unprecedented, deeply concerning and inaccurate because only mothers (and birthing people) can be pregnant - not other carers.

- Recognise women and babies and breastfeeding (not birthing person or chest feeding).

- Please reinstate the word mother in this strategy e.g. mothers, parents and carers.

Appendix 9 – Consultation feedback 'Comments about the equality and diversity impact assessment'

Residents:

- You should consider scrapping it entirely. I know you won't but one day you're complaining about not having enough money and the next you're hiring more DEI people! It's a grift. It's snake oil.
- Shouldn't this already be in existence?
- Everyone should already have the same opportunities to access these helps - no postcode lottery, no language barrier!
- Please use sex-based language. Desexed language in health communications is likely adversely impacting the most vulnerable women the most, including those with learning difficulties, low literacy or low health literacy and low English proficiency. There needs to be an impact assessment for language used.
- The strategy is very careful to mention co-parents / carers but still include the word Dad. I think explicitly stating all these elements are all important. Thank you.
- Intersectionality needs to be considered a lot of people have multiple factors. Eg. those who are LGBTQ+ that struggle with their mental health due to fertility treatment not working and then becoming pregnant. Or ethnic minorities that have Autism etc.
- Very good to be inclusive and adhere to E&D principles, however, don't do it to the expense of women. Pregnancy and motherhood is exclusively experienced by women so don't erase or alienate them with additive language.
- Excluding the word mother from a peri-natal mental health strategy is unprecedented and does not reflect inclusion.
- Please stop marginalising women. Removing reference of breastfeeding, women, mother from literature and posters is going too far. All parent relationships should be respected but not at the cost of removing women to do this
- Who is paying for this nonsense? The taxpayer.
- Surely equality should include all parents regardless of income. Without this integration, a "poor" and "rich" community is created, and most people end up on SMP at some point during their maternity leave, which is more tough to the people that are losing a significant amount of income.

- Stop being so wet, let talent shine not tribal differences. The best person should get the job

Professionals:

- Within the EqIA ' Details of Negative Impacts for Sex' would there be relevance for the inclusion of women's maternal MH as a person experienced or experiencing DA. https://www.rcm.org.uk/media/4522/rcm-and-rcog-joint-statement-on-domestic-abuse.pdf#:~:text=Domestic%20abuse%20doubles%20the%20risk%20of%20preterm%20birth,the%20way%20a%20mother%20bonds%20with%20her%20child.

- Remember the majority not minority.

- Excluding the word mother from a peri-natal mental health strategy is unprecedented and does not reflect inclusion.

- Sadly the word mother has been erase from all sections.

Appendix 10 – Consultation feedback received by email

Summary from focus group with young mums:

- Negative impact on mother's mental health of social service practises around assessing safety for the (at the time) unborn child.

- Professionals reviewing a young person's history of trauma before each meeting and referencing it, can be very triggering for young people.

- Lack of confidentiality in speaking to mental health professionals, as they would pass info back to social workers, who would bring it up in meetings – meant that she stopped confiding in mental health workers, and her mental health declined as a result.

- Lack of housing support after leaving mother and baby unit, tenancy ended because she was in hospital, etc. Re-housed with no furniture, told by social worker that she should be able to cope with life now, slept on floor on blankets with 3-month-old. Eventually sourced furniture herself on Facebook.

- Felt that there is a discrimination against families with social services involvement.

- All young people referenced a lack of kindness and respect from maternity professionals, including no respect for consent. For example, undressing a young person while she was saying "no", rude manner, interrupting skin-on-skin bonding to change the bed, etc.

- One young person had a late-stage miscarriage, which ended in medical emergency. Again, there was no consent, no privacy screen, and they were taken to children's ward because they were under 18. The young person felt there is a need for MH support after miscarriage.

- Another young person said it would be helpful to have positive information during ante-natal period, particularly to how to bond with the baby (PIR), how to read baby's body language. not just warnings and anxiety-inducing info.

Summary of feedback from one resident (potentially identifiable information has been removed):

I completely agree with the approach to focus on the mild to moderate support needs of families in pregnancy and newborns, as this is where a great impact can be made to ensuring the family thrive in what can be very difficult first days and is likely to reduce the need for more robust interventions.

You mention training around trauma-based care and this is absolutely needed, and there is reference to the fact that this should be in its widest form… I don't think that training and educating the professionals in the services should be limited to trauma-related concerns, but to the general perinatal offer. In the last few weeks of pregnancy when a mum is tired, heavy, suffering insomnia and anxiety around the birth and during the period of the 'fourth trimester' mums and their partners can be pushed to feeling the lowest mood of their life and are at this time very vulnerable to perceived criticism. Therefore, it is so key that a passing comment or harsh word not given with the best intention can send families into mental health crisis. I have several examples of situations such as this, both from my own parenting journey and from those around me and would like to share these with you for context in relation to the vulnerability we were all in at the time.

- In the hospital setting following a difficult 5-day labour mum rang her bell on the ward to ask what she should do with her newborn as she needed to use the loo, after half an hour with no response she carried her baby to the toilet where she was promptly stopped by a midwife in front of other mums and was told sternly that she cannot carry her baby on the ward and "to leave her in her cot, there is enough people around to keep an eye on her".

- On first visit from health visitor mum was asked if she had been exercising, on reply that they hadn't really was told "maternity leave is not just an excuse to sit around".

- Midwife appointment in the first week after birth mum was told "you can get that cardigan off, it's far too hot for that for baby today".

- Midwife criticised mum for allowing grandparent to hold baby in the first two-week period and told to take baby back from them to ensure bonding and establish breastfeeding, when this was one of the first breaks mum had had from holding her newborn.

- Midwife arriving late appearing flustered and refused seat, asked mum to quickly take babies clothes off to be weighed and patting the countertop in the kitchen, when mum feeling flustered laid baby down where she had patted was quickly told “not on there, that is far too hard for them”.

- After hospitalisation for psychosis mum was asked how she was feeling during first health visitor appointment following return from hospital, to which mum replied they weren’t great, the HV returned to looking at her paperwork and asked if they had been doing tummy time with their child with no acknowledgement of her mood or considering what additional pressure the follow-up question may result.

- In isolation and kindly delivered, these instances may have a positive effect on mum, but in the condescending and scathing tone experienced they have all contributed to feelings of inadequacy as a new mum. These examples highlight the difficulty these individuals may have in approaching professionals about their mental health, as it was caused in part by those individuals themselves.

I fully support the section on page 20 that invites more sensitive and meaningful questions around mental health, as my experience was similar around being asked several times about it without feeling like I could mention anything (like intrusive thoughts) unless I was wanting serious intervention. Any professional supporting a new family should know the basics on ‘usual’ and ‘significant’ mental health concerns to put parents minds at ease and help them identify when further intervention may be helpful. The confidence to have these conversations is what’s needed with professionals and could help to reduce the cost of further services.

Relating to action 2.2, although we would like to believe a pandemic to the scale as we witnessed in 2021 is unlikely, I would like to see reference to the acknowledgement that partners cannot be excluded from the birth journey, as this put significant strain on mothers and their partners. Rules around limiting access to only mothers, whilst understandable, put a heavy burden on the mental health of both parties, especially in instances where there were complications or devastating news. The risk to the future generation and the cost to mental health services following this time must outweigh the risk to the service, who was already dealing with a mother from the household.

When scan-reading through the document and reading the “one-minute interaction’ for dads I assumed this was feedback from dads that all they received from the system was a one-minute interaction considering their own mental health or concerns, so was surprised to read this is the name of part of the strategy moving forward. I understand the concept that is trying to be achieved here, but I feel this could be negative to the

approach adopted by professions ("let's get dad out of the way with his one-minute interaction") and make dads feel insignificant in the journey.

Something my friends' husband was told by a midwife when she was in labour was "your job is to look after mum, hers is to look after baby. Make sure she's eating, showering, not doing too much round the house, try to make her life just about looking after baby". I don't know if this can be included in the approach, but this was such a helpful thing for him to hear, as it gave him purpose and useful instruction and he definitely took it seriously.

Approaches to mental health are so important, but often physical health and nutrition play a part in our mental health. When supporting a newborn baby, parents often neglect their own physical needs and, in the case of mothers, understanding body changes following labour. I had an undiagnosed double-prolapse following the birth of my son and this was minimised by professionals who told me to expect changes in that region, but could have had significant impact on the birth of my second child if it remained undiagnosed. Following advise that it could be a 7 month wait to have any physical examination of the area I was forced to go private as it was having a significant impact on my mental health. Parents need to be listened to and fully supported in their physical health in a timely manner.

Action 3 is missing the continued interaction with people supported by all systems. This is the first time I am feeding back on my experience (other than informally with my midwife in my second pregnancy) as I was acutely aware that any failings I found were cross-system and would lose significance when divided into its parts (i.e. hospital maternity unit, community midwife, specialist support services, health visiting). Joint training and shared knowledge is hugely beneficial to all services on a regular basis, but to understand the part that each team plays in someone's journey you need those individuals giving feedback to them directly. Sweden have an excellent system-approach to supporting individuals in social care called 'Esther', which was adopted in Kent Adult Social Care as a café interaction. At these events, professionals were able to hear directly from people who had positive and negative experiences in the system and were able to work together to improve and maintain the standard of service, with each area taking responsibility for its own role. Something like this would be really positive in perinatal care.

Feedback received from one organisation:

Overall, we welcome the plan and the detail it contains. We welcome anything that helps support families (whole, extended families, not just the parents) and without going through every single paragraph, we can say we are broadly happy with what is proposed.

However, we want to concentrate on our area of expertise, and that relates to baby loss, whether miscarriages, stillbirth, or infant deaths. The only references we could see (and, to be fair, we have not read every page) is in the tables describing existing services which lists:

- Short-term therapies, support, and advice to people and their families for moderate / severe mental health difficulties as a result of birth trauma and / or birth loss. Parents must have accessed support from other NHS therapy services first, such as NHS Talking Therapies, and

- Counselling for women who have experienced a range of difficulties, including the loss of a pregnancy at any stage, traumatic birth, caring for a baby on the Neonatal Intensive Care Unit, and fertility issues.

These are both important, but our understanding is that accessing these support services is pretty difficult with very limited criteria for that access and, again we understand, support is offered to mothers only, and not fathers, nor other relatives. Through our baby loss charity we support around 500 people who have lost babies, at any stage of pregnancy or after, in any circumstances, and at any time, and anecdotally we have been told by so many people that counselling, in particular, is just not available for a variety of reasons. We would encourage these services to be developed with far more fluid access criteria.

We appreciate that Baby loss relates to a minority of families, but our estimate is that there are around 1,600 babies dying each year in East Kent alone, through miscarriage, stillbirth, perinatally, or as infants. That is a massive number, equating to around one in five of all the births. It is disappointing that the plan does not really address this large, and very important group.

We do appreciate that the emphasis in the plan is around supporting babies as they start life, but that just cannot ignore all the babies who do not survive.

Setting aside the circumstances surrounding the baby deaths addressed in the Kirkup Report (and we are supporting a significant number of those families) we do hear anecdotally about poor services received by families following the loss of a baby and much of this relates to poor communication, both within maternity units and between them and other health professionals, including GPs and health visitors. We also have a real concern around the level of training and awareness around baby loss offered to staff, both within the NHS and in other agencies, including KCC and local councils. This lack of awareness is something that can be addressed and improved relatively easily, and we this is something we would encourage.

We do appreciate the implied focus on babies who survive, but we cannot forget those who do not, and their families.

Feedback received from one infant feeding support worker:

I have read the full policy and in, what I'm sure is a well-intentioned attempt to be inclusive, the words mother and woman have been largely avoided. I am very concerned that this will lead to mothers not realising that this service is for them. Especially when in this period of a woman's life (known as 'Matrescence') they are right brain and often sleep-deprived, it is very confusing language. The words 'parents and carers' have largely replaced the word 'mother'. I cannot emphasise enough that the word 'parent and carer' is not interchangeable with the word 'mother'.

p.9 "When babies receive warm and sensitive care, they develop a secure attachment relationship." It is great that the attachment needs of babies are finally being recognised more widely (it's something mothers have always known), but if we obscure the fact that babies need to form a secure attachment with their mother as the primary care giver (apart from in very rare cases where the mother is not available), we are putting babies at higher risk of neglect and abuse.
Due to the hormones of pregnancy and lactation, the mother also has specific attachment needs in relation to her baby, which no other carer (father, grandparent) has. No other carer is interchangeable with the mother - even if a baby is looked after by a great adopted mother or grandmother, they will not be able to replace the mother and this will always be missing in the babies life. It is this importance of the mother role which is the reason why perinatal mental health services are so important in the first place. e.g. p.11 - "Perinatal mental health means the way a parent or carer may think or feel" this obscures the fact that only women/those born female can get pregnant (not other carers - i.e. fathers, foster carers or grandparents). Mothers go through a massive physical and hormonal change, which is why they need support specific to them. Other carers don't.
p.13 "If a parent or carer is struggling with their mental health, it can make it more difficult to breastfeed." This language obscures the fact that only the mother, the female who birthed the child can breastfeed. Mothers will not be able to relate to this kind of language, so it is excluding to them.
p.13 "Support for parent mental health" - this obscures the fact that mothers postnatally have specific requirements for support that other carers don't have e.g. they will be recovering from pregnancy and childbirth. They will likely be sleep deprived, possibly still bleeding and recovering from scars and/or stitches depending on how old their baby is.

Women should surely be at the centre of this service, but the language reflects a blind spot towards them. We must not undervalue the importance and uniqueness of the female maternal role by using obscuring language. As with all other mammalian species, babies have in inborn need to be with their mother to ensure their survival and healthy development.

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EQIA Submission Draft Working Template

If required, this template is for use prior to completing your EQIA Submission in the EQIA App. You can use it to understand what information is needed beforehand to complete an EQIA submission online, and also as a way to collaborate with others who may be involved with the EQIA. Note: You can upload this into the App when complete if it contains more detailed information than the App asks for and you wish to retain this detail.

Section A

1. Name of Activity (EQIA Title):	Perinatal mental health [PNMH] and parent-infant relationships [PIR] Strategy
2. Directorate	Adult social care and health
3. Responsible Service/Division	Public health

Accountability and Responsibility

4. Officer completing EQIA	Sarah Deakin
5. Head of Service Note: This should be the Head of Service who will be approving your submitted EQIA.	Wendy Jeffreys
6. Director of Service Note: This should be the name of your responsible director.	Dr Anjan Ghosh

The type of Activity you are undertaking

7. What type of activity are you undertaking?

Tick if Yes	Activity Type
Yes	**Service Change** – *operational changes in the way we deliver the service to people.*
Yes	**Service Redesign** – *restructure, new operating model or changes to ways of working*
Yes	**Project/Programme** – *includes limited delivery of change activity, including partnership projects, external funding projects and capital projects.*
Yes	**Commissioning/Procurement** – *means commissioning activity which requires commercial judgement.*
Yes √	**Strategy /Policy** – *includes review, refresh or creating a new document*
	Other – workforce development

8. Aims and Objectives and Equality Recommendations – Note: You will be asked to give a brief description of the aims and objectives of your activity in this section of the App, along with the Equality recommendations. You may use this section to also add any context you feel may be required.

Early intervention is an opportunity to give every baby the best start for life.

The government has a vision to give every baby the best start for life[1]. The Family Hubs and Start for Life programme was launched to support the implementation of this vision[2]. Kent is a 'trailblazing' local authority as part of this programme. Being a trailblazer provides us with an opportunity to build on our work through the Healthy Child Programme and to share best practice in early intervention across England. As the largest county in England with more babies born each

year than any other county, we have a unique opportunity to support more babies at scale.
The largest funded element of the Family Hubs and Start for Life programme is supporting mild-to-moderate perinatal mental health and parent-infant relationships difficulties, with a particular focus on supporting families as early as possible. The funding for perinatal mental health support compliments the existing perinatal mental health funding for specialist community perinatal mental health services, as set out in the NHS Long Term plan[3].

This strategy outlines how we can best improve our perinatal mental health and parent-infant relationship support offer across Kent.

This strategy sets out our ambition to improve perinatal menta health and parent-infant relationship support across Kent. It is in-line with the scope of the perinatal mental health and parent-infant relationship strand of the Family Hubs and Start for Life programme, focusing on early intervention and prevention. Given the uncertainty of funding for this programme, this strategy balances setting an ambitious target for improvements in outcomes and care that do not necessarily require a large financial investment. We have not included ideas for actions that will be completed by other elements of the Family Hubs and Start for Life programme.

Although this strategy has been commissioned by Kent County Council, it has been co-produced with colleagues across the health and care sector in Kent. To this end, it should be viewed as a collective strategy that encourages working together across the system of support for babies, parents, and carers.

[1] The Early Years Healthy Development Review (2021): Giving Every Baby the Best Start for Life.
[1] Family Hubs and Start for Life programme: Local Authority Guide (2022).
[1] NHS England (2019): The NHS Long Term Plan.

Section B – Evidence

Note: For questions 9, 10 & 11 at least one of these must be a 'Yes'. You can continuing working on

9. Do you have data related to the protected groups of the people impacted by this activity? *Answer: Yes/No*	Yes
10. Is it possible to get the data in a timely and cost effective way? *Answer: Yes/No*	N/A
11. Is there national evidence/data that you can use? ***Answer:*** *Yes/No*	Yes
12. Have you consulted with Stakeholders? *Answer: Yes/No* *Stakeholders are those who have a stake or interest in your project which could be residents, service users, staff, members, statutory and other organisations, VCSE partners etc.*	Yes
13. Who have you involved, consulted and engaged with? *Please give details in the box provided. This may be details of those you have already involved, consulted and engaged with or who you intend to do so with in the future. If the answer to question 12 is 'No', please explain why.*	
130 parents and carers (46 parents and carers completed an online survey, 27 completed in depth	

interviews, 46 spoke through outreach activities in children's centres and other public spaces in Kent., 11 parents joined two co-production workshops where the themes and recommendations action plan were presented back to them for review.

180 professionals (107 professionals joined two webinars, representing 38 different organisations across all sectors in Kent, 44 professionals completed an online survey, with 34 different roles, representing 17 different organisations, 29 senior leaders joined one to one or roundtables, representing 13 different organisations.

14. Has there been a previous equality analysis (EQIA) in the last 3 years? *Answer: Yes/No*	No
15. Do you have evidence/data that can help you understand the potential impact of your activity? *Answer: Yes/No*	Yes
Uploading Evidence/Data/related information into the App *Note: At this point, you will be asked to upload the evidence/ data and related information that you feel should sit alongside the EQIA that can help understand the potential impact of your activity. Please ensure that you have this information to upload as the Equality analysis cannot be sent for approval without this.*	See accompanying evidence.

Section C – Impact

16. Who may be impacted by the activity? *Select all that apply.*

Service users/clients *Answer: Yes/No*	Yes	Residents/Communities/Citizens *Answer: Yes/No*	Yes
Staff/Volunteers *Answer: Yes/No*	Yes		

17. Are there any positive impacts for all or any of the protected groups as a result of the activity that you are doing? *Answer: Yes/No*	Yes

18. Please give details of Positive Impacts

The principles and framework for the Family Hubs model, as set out by central government, are built based on improving user experience by :
1. increasing access to a wider range of services in one place or under one shared umbrella;
2. improving the interface and join-up between services; and
3. having services working within practice that builds on strengths and puts families at the centre of services.

The positive impacts that we anticipate:
Service Users/Clients
Increased communication and support regards PNMH and PIR

Staff and Volunteers
Improved awareness about low to moderate perinatal mental health and confidence to have conversations about it.

Negative Impacts and Mitigating Actions

The questions in this section help to think through positive and negative impacts for people affected by your activity. Please use the Evidence you have referred to in Section B and explain the data as part of your answer.	
19.Negative Impacts and Mitigating actions for Age	
a) Are there negative impacts for age? *Answer: Yes/No (If yes, please also complete sections b, c,and d).*	Yes
b) Details of Negative Impacts for Age	Young mothers are at increased risk of experiencing perinatal mental health difficulties compared to older mums. Younger mothers are less likely to engage with services and are likely to not benefit from perinatal mental health support/services unless specifically targeted. Young people leaving care, are likely to experience a range of mental health issues that may continue into adulthood, leading to an increased risk of perinatal mental health difficulties.
c) Mitigating Actions for age	Development of perinatal mental health support/services must be targeted for younger mothers. Young mothers must be involved in the co-design of services. Care leavers may benefit from the support of the supporting family's partnership or perinatal mental health services for their perinatal mental health. They require quick access to in particular to Talking Therapies.
d) Responsible Officer for Mitigating Actions – Age	Dr Anjan Ghosh
20. Negative Impacts and Mitigating actions for Disability	
a) Are there negative impacts for Disability? *Answer: Yes/No (If yes, please also complete sections b, c,and d).*	Yes
b) Details of Negative Impacts for Disability	Studies show that women with disabilities are at an increased risk of perinatal mental illness compared to women without disabilities. Risks are greatest among women with intellectual/developmental disabilities and those with multiple disabilities. Autistic people may be at higher risk of perinatal mental health conditions given that autism and mental health conditions commonly co-occur and that autistic people face additional stressors

	that may prevent access to appropriate maternity care.
c) Mitigating Actions for Disability	Assurance of up to date awareness and understanding of autism and ADHD in family hub workforce Training for workforce to screen and support for perinatal mental health conditions for women with disabilities but particularly for autistic people.
d) Responsible Officer for Mitigating Actions - Disability	Dr Anjan Ghosh
a) Are there negative impacts for Sex? *Answer: Yes/No* *(If yes, please also complete sections b, c,and d).*	Yes
b) Details of Negative Impacts for Sex	**Mothers and deprivation** There is inconsistent evidence of an association between perinatal mental illness and greater socioeconomic deprivation however perinatal women in the most deprived groups are at a higher risk of mental health difficulties. **Mothers and employment** Studies show that mothers who are unemployed during pregnancy have an increased risk of postnatal depression compared with employed women. **Mothers and education** There is a negative association between women's low education level and their maternal depression. **Mothers and Prison** There are two prisons locally that serve women from Kent and across England. Women in prison experience high rates of mental health problems and pregnant and postpartum women may be particularly vulnerable. Longer periods of incarceration follow higher levels of postpartum depression. **Mothers and homelessness** There were 2,462 households in Kent and Medway in temporary accommodation in 2022. There is a positive association between housing

	insecurity and poor mental health outcomes. However, the extent to which homelessness and postnatal depression co-occur is relatively unknown. **Mothers and sex work** 70% of the female sex workers in the UK are mothers. Very little is known about parenting and sex workers. Studies show that sex workers have been associated with mental health difficulties (due to previous trauma/abuse) some of which have been shown to affect maternal bonding. **Mothers and substance misuse** In England the proportion of women under age 50 who are pregnant and are new presentations to drug and alcohol treatment and are a parent/adult living with children is 3%. Mental health problems during pregnancy are associated with alcohol and substance use. **Mothers and modern slavery** Pregnant women who have been trafficked are at risk of multiple health issues, particularly mental health disorders. **Dads** The percentage of men experiencing perinatal mental health difficulties varies, but in the engagement of dads for this strategy about 30-33% of dads were struggling with their mental health. Despite the need for support, 75.5% of dads did not access any support for their mental health after their babies were born. About 20% of women experience perinatal mental health difficulties.
c) Mitigating Actions for Sex	**Mothers** Support women to create and strengthen their social networks Ensure access to services doesn't require finance for example by providing free transport or outreach. Provide links to support for debt, housing,

	employment and additional support Invest in house building for affordable homes Provide peer support programmes to enable vulnerable mothers can access services Involve vulnerable mothers in the co-design of services Culturally sensitive training for the family hub workforce needs to include risks facing sex working mothers. Provide trauma informed care training for workforce Identify and provide evidence based psychotherapeutic interventions in particular for sex working mothers. Employ specialist healthcare staff to provide outreach for mothers with substance misuse issues, who can refer appropriately to drug and alcohol and/or mental health services. Training on identifying and referring people who have been trafficked is likely to benefit (mental health) care provision. Midwives and other maternity health professionals need to be aware of the multitude of physical and mental health complications that are associated with a history of human trafficking, and how these may impact upon perinatal health. There is a need for maternity specific guidelines for women who have been trafficked. **Dads** Drawing dads in to the system so that they can get support for wellbeing when they need it. Improving dads experiences in the system to improve further engagement and enable wellbeing. Providing consistent high-quality information and support

	Shifting mindsets to enable 'mature' services that involve dads as standard.
d) Responsible Officer for Mitigating Actions - Sex	Dr Anjan Ghosh
22. Negative Impacts and Mitigating actions for Gender identity/transgender	
a) Are there negative impacts for Gender identity/transgender? *Answer: Yes/No (If yes, please also complete sections b, c,and d).*	Yes
b) Details of Negative Impacts for Gender identity/transgender	There is a shortage of research on the mental health of gender diverse individuals during the perinatal period. However, small studies show that this is highly likely. This has been attributed to the stress associated with breaking gender norms and having their gender identity and right to become a parent questioned by others, anticipating discrimination, hurtful comments and fear of violence.
c) Mitigating actions for Gender identity/transgender	As the risk of mental health problems in gender-diverse individuals may increase during pregnancy and childbirth, screening for mental health concerns such as post-partum depression is warranted. Since gender-diverse individuals report a low trust in healthcare providers which may limit their health-seeking behaviour, healthcare providers need to take a proactive role in assessing and supporting their mental health during the perinatal period.
d) Responsible Officer for Mitigating Actions - Gender identity/transgender	Dr Anjan Ghosh
23. Negative Impacts and Mitigating actions for Race	
a) Are there negative impacts for Race? *Answer: Yes/No (If yes, please also complete sections b, c,and d).*	Yes
b) Details of Negative Impacts for Race	Perinatal mental health disparities persist among diverse racial and ethnic groups in the UK. Women of ethnic minority background struggle to access and engage with perinatal mental health support for many reasons. For example, women might present with mental health difficulties in different ways to white women and so they remain unacknowledged. Women might experience stigma and fear of disclosing any mental health difficulties even with family, fear of being seen to not coping and difficulties in medication adherence.

	These issues are particularly concerning for women from gypsy and traveller communities where there is significant taboo around mental health in general. There is an increased risk of perinatal mental health difficulties in asylum seeking women due to trauma of displacement and other stressors. These women are likely to experience difficulties accessing services due to language barriers and lack of awareness of the services.
c) Mitigating Actions for Race	Training for Family hub staff and particularly those involved in perinatal mental health services on awareness of perinatal mental health and its different presentation with ethnic minority women. Ethnic minority women must be involved in coproduction of perinatal mental health services. Training for staff on cultural norms, knowledge and traditions is important for all ethnic minority women but particularly so for gypsy and traveller women. Produce accessible and culturally relevant resources and education on perinatal mental health for ethnic minority women. Asylum seeking women who are experiencing perinatal mental health difficulties need to be referred to specialist mental health support offered through trusted organisations who support asylum seekers.
d) Responsible Officer for Mitigating Actions - Race	Dr Anjan Ghosh
24. Negative Impacts and Mitigating actions for Religion and belief	
a) Are there negative impacts for Religion and Belief? *Answer: Yes/No (If yes, please also complete sections b, c,and d).*	Yes
b) Details of Negative Impacts for Religion and belief	In a maternity report about Muslim women in 2022, 22% of women said that their mental health was affected in maternity. This is higher than the average of 20%. Muslim women did not always feel able to trust frontline professionals enough to disclose their anxieties because of their dismissive approach, use of insensitive language and microaggressions.

	Some professionals appear to be desensitised to the mental health needs of Muslim women and the negative attitudes of HC professionals are a barrier, which includes stereotypes of assuming women have sufficient support from extended family and networks.
c) Mitigating Actions for Religion and belief	Provide Muslim women with written information about mental health symptoms/services, including faith and cultural specialist counselling services. Improve training of workforce about how to speak about mental health and ask questions sensitively, including in a culturally appropriate manner and acquiring knowledge of barriers related to faith and culture. Triaging of mental health requests should be done by clinically trained staff. Perinatal mental health services need to be equipped to meet faith/cultural needs of Muslim women including counselling in different languages. To improve accountability, information about mental health issues should be logged in maternity records.
d) Responsible Officer for Mitigating Actions - Religion and belief	Dr Anjan Ghosh
25. Negative Impacts and Mitigating actions for Sexual Orientation	
a) Are there negative impacts for sexual orientation. *Answer: Yes/No (If yes, please also complete sections b, c,and d).*	Yes
b) Details of Negative Impacts for Sexual Orientation	From Census 2021, In Kent, 1.3% of the population identify as Gay or Lesbian. The rates of perinatal mental health problems are slightly higher in lesbian mothers in comparison to heterosexual mothers- this might be partly explained by the generally higher rates of mental health difficulties in the LGBTQ+ community. Lesbian mothers can experience poor quality relationships and social support, may be marginalised and are likely to experience stigma, discrimination and homophobia from professionals or services. The prevalence rate for perinatal mental health

	issues in LGBT+ partners is currently not known.
c) Mitigating Actions for Sexual Orientation	Cultural sensitivity training for professionals LGBTQ+ mothers included in co-design of services. Non birthing partners can be 'invisible' and need to be made more visible
d) Responsible Officer for Mitigating Actions - Sexual Orientation	Dr Anjan Ghosh
26. Negative Impacts and Mitigating actions for Pregnancy and Maternity	
a) Are there negative impacts for Pregnancy and Maternity? *Answer: Yes/No (If yes, please also complete sections b, c,and d).*	Yes
b) Details of Negative Impacts for Pregnancy and Maternity	Baby loss, baby separation, premature birth, infant ill health, domestic abuse, multiple births (twins) and negative experiences of breastfeeding, can all impact on the mental health of mothers and partners in the perinatal period.
c) Mitigating Actions for Pregnancy and Maternity	Trauma informed practice training for the workforce. This should include awareness of breastfeeding grief and trauma. Training on perinatal mental health for wider workforce including those who work with mothers experiencing baby loss, separation, domestic abuse, babies in NICU and multiple births. Training of family hub workforce in routine enquiry about perinatal mental health of mothers and partners. Awareness that this enquiry needs to be in a 'safe space.' Mothers experiencing social care require specialist perinatal mental health services, and sustained support of voluntary sector and peer support to enable engagement with services due to lack of trust with authorities. Mothers experiencing baby loss require quicker/easier referral process for perinatal mental health support An improved offer and range of perinatal mental health support which includes telehealth, internet or mobile health interventions which could be assessed at home. This will be especially appealing to mothers with multiple births who will otherwise struggle to access

	services. Training for perinatal mental health professionals in domestic abuse challenges for mothers Mental health psychotherapy support for parents with infants in NICU Workforce to provide support for mothers experiencing breastfeeding grief and trauma. Women with breastfeeding difficulties should be screened for depressive symptoms.
d) Responsible Officer for Mitigating Actions - Pregnancy and Maternity	Dr Anjan Ghosh
27. Negative Impacts and Mitigating actions for marriage and civil partnerships	
a) Are there negative impacts for Marriage and Civil Partnerships? *Answer: Yes/No (If yes, please also complete sections b, c,and d).*	Yes
b) Details of Negative Impacts for Marriage and Civil Partnerships	Mothers with supportive marital relationships have been reported less likely to develop depressive symptoms during the postnatal period. Single mothers have higher rates of psychological/emotional distress, for example major depression, dysthymia, suicide and low self-esteem, than married/partnered mothers.
c) Mitigating Actions for Marriage and Civil Partnerships	The introduction of routine procedures to screen/assess women for psychosocial risk factors in the antenatal period and highlight the need not only to ask pregnant women whether they have a partner, but also about levels of available support. Any screening procedures should include an assessment of the quality of the partner relationship.
d) Responsible Officer for Mitigating Actions - Marriage and Civil Partnerships	Dr Anjan Ghosh
28. Negative Impacts and Mitigating actions for Carer's responsibilities	
a) Are there negative impacts for Carer's responsibilities? *Answer: Yes/No (If yes, please also complete sections b, c,and d).*	Yes
b) Details of Negative Impacts for Carer's Responsibilities	Rates of adoptive parent depression are estimated to be as high as 32% but this estimate varies greatly across studies and contexts. In a UK study adoptive parents indicated higher rates of depression and anxiety compared the general population.

	Both foster and adoptive parents consistently rank children's behaviour problems as the most difficult challenge and unsurprisingly, the severity of emotional and behavioural issues among children are associated with higher levels of parental depressive symptoms and parenting stress.
c) Mitigating Actions for Carer's responsibilities	Healthcare practitioners to be more attuned to the needs of adoptive families and to provide appropriate support and interventions. Increasing adopters' awareness and understanding of the challenges of adoptive family life may also reduce barriers and stigma associated with seeking support and empower parents to access mental health support more readily.
d) Responsible Officer for Mitigating Actions - Carer's Responsibilities	Dr Anjan Ghosh

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Nurturing Little Hearts and Minds

Perinatal Mental Health & Parent-Infant Relationships Strategy for Kent

2024 – 2029

Kent Family Hub

Kent County Council
kent.gov.uk


iStock
Credit: Drazen_

Foreword:

Our vision to nurture little hearts and minds across Kent.

We have a rich history of supporting babies and their families in Kent. There is much to be celebrated in the way that parents are supported with their mental health and parent-infant relationships are nurtured. The Family Hubs and Start for Life programme has afforded us an opportunity to build on this and challenge ourselves to give every baby living in Kent the best start for life. This strategy sets out how we can better support parents and carers that are either expecting a baby or who have a baby under the age of two. More specifically, we describe how we can help improve perinatal mental health; the way that a parent or carer may think or feel, and parent-infant relationships; the way that a parent or carer builds a warm and loving relationship with their baby.

The benefits of a baby receiving good enough care are almost too endless to name. Warm, consistent, and sensitive care helps promote good social and emotional development. It also helps babies to learn and grow. Babies who are loved become children who can love others and themselves. They become parents who can love their children and provide good enough care themselves. This five-year strategy is an opportunity to support generations of babies.

Yet we know that parenting is not easy. There are many things that can make it hard to meet a baby's needs.

Recent lessons from the Covid-19 pandemic reminded us of the impact of social isolation on parenting and early child development. The cost-of-living crisis has also meant that many families are experiencing the stress and anxiety of financial pressure. Perhaps more than ever, there is a need for our communities and services to wrap around babies and their families.

Not all parents and carers will need additional support. For many, the informal support networks of family and friends is enough. But for those parents and carers who do need more help, it is important they receive it quickly to prevent difficulties from worsening. As is often said: 'it takes a village to raise a child'. This is as true today as it has ever been. I hope that this strategy holds us to account for being the village that supports babies and their families. This means that all services, sectors, professionals, and volunteers must work together – placing babies and their relationships at the forefront of our work. Together, we really can nurture little hearts and minds.

Dr Anjan Ghosh

Direct of Public Health
Kent County Council

Acknowledgements
Kent County Council commissioned Barnardo's – the UK's largest children's charity – to co-produce this strategy. We would like to thank them for this work, and to all the parents, carers, and professionals who shared their expertise, experience, and ideas with them to ensure this strategy is locally relevant to our communities across Kent.

BARNARDO'S
Changing childhoods.
Changing lives.

Contents

Content note

This strategy includes descriptions of difficulties with mental health and difficulties of caring for babies. There are anonymised quotes of real experiences from parents and carers in Kent. We understand that this may be challenging to read.

If something you read resonates with you in a difficult way, or brings up strong emotions, please know that support is available. Free and confidential support is available 24/7 from our Release the Pressure service. You can call our trained and experienced team on 0800 107 0160, or text the word **Kent** to 85258.

Executive summary

Our earliest years are critical for shaping the adults we become. The time from conception until a baby's second birthday is a time of rapid brain development. Our experiences in this time lay the foundations for a wide range of future health and mental health outcomes. It is important that every parent and carer has access to perinatal mental health support when they need it, and every parent-infant relationship is supported to be as strong as possible. This strategy sets out our vision to nurture little hearts and minds across Kent over the next five years.

The development of this strategy was commissioned to Barnardo's – the UK's largest children's charity – by Kent County Council. To be effective, it will be implemented across sectors and services in Kent, led by a multi-disciplinary and cross-sector steering group of senior leaders.

This strategy represents a significant commitment to supporting babies and their families in Kent that need 'mild-to-moderate' support. This is where someone may have a small number of difficulties or where difficulties may be just beginning and may not yet be having a big impact on their life. Focussing on mild-to-moderate difficulties means that we can offer support before any difficulties worsen. By working together, we can ensure that social and emotional development is nurtured as much as physical development.

Across Kent, we estimated that 6,663 parents and carers could benefit from mild-to-moderate perinatal mental health support every year. We also estimated that 2,937 parent-infant relationships could be strengthened by additional support every year.

We wanted to ensure this strategy reflected what is important to parents and carers, as well as those who work hard to support families across Kent. We met with 130 parents and carers and 180 professionals to consider what we should focus on over the next five years. Three action areas emerged from this engagement. Each action area has three specific actions that will help give every baby the best start for life. Three action areas emerged from this engagement. We also received feedback from 61 people through public consultation on a draft version of this strategy.

1. Relating with warmth: developing relationship-based support.

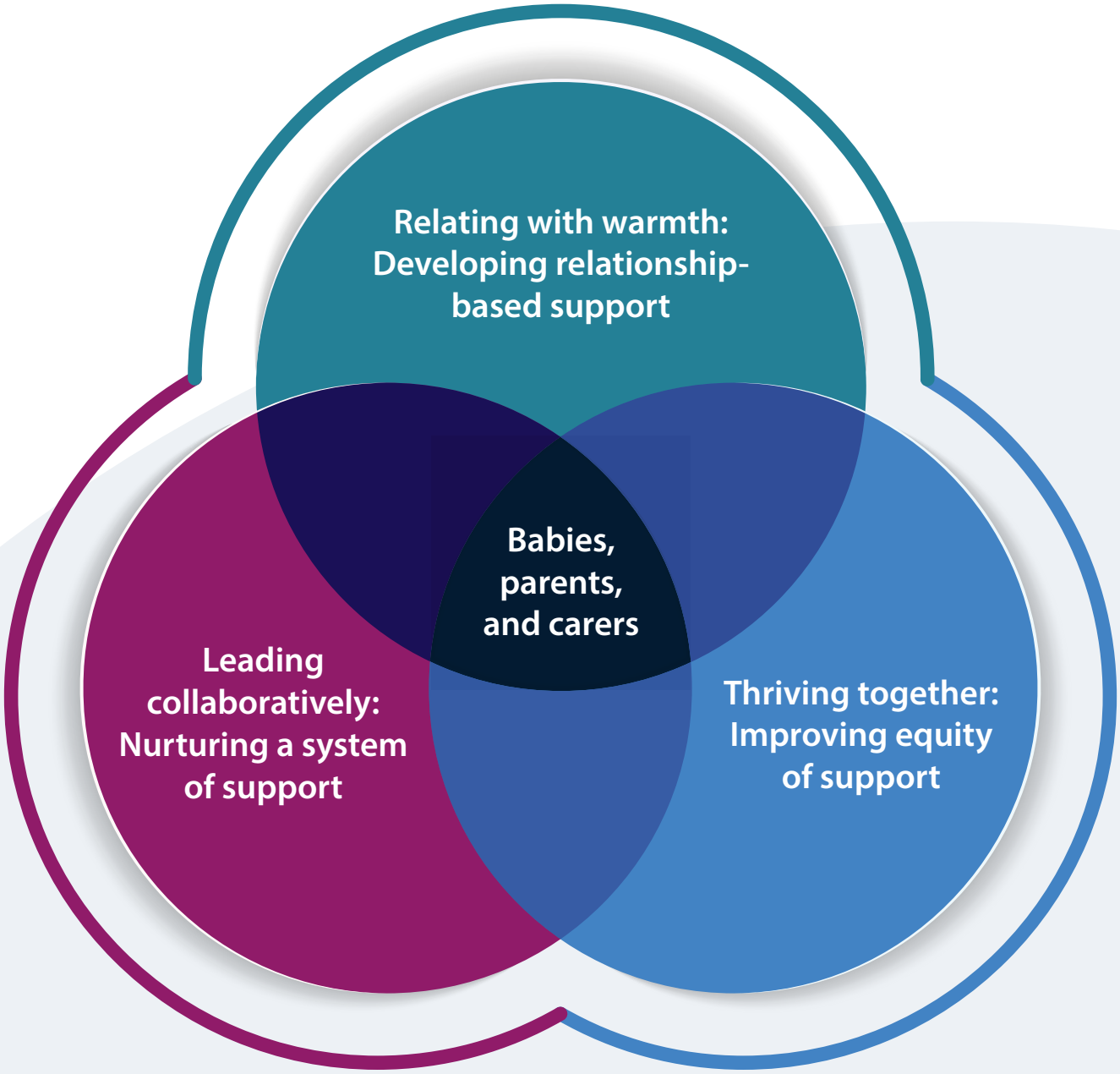
- Training for professionals to improve trauma informed care.
- Campaigning to break the stigma of perinatal mental health and parent-infant relationship support.
- Identifying opportunities for earlier support.

2. Thriving together: improving equity of support.

- Collecting and making use of data and insight to improve equity.
- Supporting perinatal mental health of Dads and Co-parents universally.
- Reviewing the inclusivity of all perinatal mental health and parent-infant relationship service offers.

3. Leading collaboratively: nurturing a system of support.

- Developing commissioning principles.
- Building a relational pathway of support for parent-infant relationships.
- Establishing a community of practice for perinatal mental health and parent-infant relationships.


Relating with warmth: Developing relationship-based support
Babies, parents, and carers
Leading collaboratively: Nurturing a system of support
Thriving together: Improving equity of support

Background:
the importance of perinatal mental health and parent-infant relationships.

Our early experiences shape the adults we become.

The time from conception until a baby's second birthday is a critical period for growth and development. We call this time the Start for Life period and our experiences in this time shape the adults we will become[1]. Neuroscientific research has confirmed what developmental psychologists have long known: experiences of warm, consistent, and loving care, lead to healthy brain development, the establishment of good immune systems and stress response systems[2]. This means that babies who receive good enough care benefit from a wide range of better outcomes throughout childhood and into adulthood. In contrast, experiencing adversity in this period is more associated with subsequent difficulties than adversity occurring in other periods over a lifetime[3]. While it is never too late to support children, the first 1,001 days really are a unique time of opportunity.

Our attachment relationships matter for future physical and mental health.

When babies receive warm and sensitive care most of the time, they develop a secure attachment relationship[4]. If babies who are securely attached could talk, they might say "I can trust that my parents or carers will be there to help and support me if I need them". If a baby's needs are not consistently responded to, for example, if they are left to cry without comfort, then they may develop an insecure attachment relationship. These babies might say "I'm not sure if I can trust that my parents or carers will be there to help me". If a baby receives harsh or critical care, for example if they are abused or neglected then they may develop a disorganised attachment relationship. These babies may say "I feel scared of my caregiver so cannot trust them to help me". The latest research tells us that babies need a network of secure attachment relationships for optimal outcomes[5] – for example, with Mum and Dad. Figure 1 is an overview of the benefits of a secure, nurturing parent-infant relationship[6].

Caring for the social and emotional needs for babies can be difficult.

Having a baby can be a time of joy and a time of challenge. There can be many reasons why parents and carers may struggle to provide the warm and consistent care that babies need. For example, poverty, housing problems, birth trauma, special educational needs or disabilities, or experiences of domestic abuse. We know that many families struggled during the Covid-19 pandemic and the current cost of living crisis is putting increased pressure on many families[7]. One particularly important factor is perinatal mental health difficulties. If parents or carers are experiencing low mood, anxiety, or other mental health difficulties when they are expecting a baby or caring for a baby, this can make it hard for them to meet their baby's social and emotional needs.

A parent or carer's own experiences of being cared for in early childhood can also have an impact. For example, if we did not receive warm and sensitive care when we were young, we might struggle to offer this to our children when we become parents.

1 Royal Foundation Centre for Early Childhood (2023), Shaping Us.
2 Harvard University Centre on the Developing Child (2007) The Science of Early Childhood Development.
3 Hambrick, P. et al (2018). Beyond the ACE score: Examining Relationships Between Timing of Developmental Adversity, Relational Health and Developmental Outcomes in Children. Archives of Psychiatric Nursing. 33. 10.
4 Ainsworth, M. D. S. (2010). Security and attachment. The secure child: Timeless lessons in parenting and childhood education, 43-53.
5 Dagan, O., et al. (2021). Configurations of mother-child and father-child attachment as predictors of internalizing and externalizing behavioral problems: An individual participant data (IPD) meta-analysis. New Directions for Child and Adolescent Development, 2021(180), 67-94.
6 Parent Infant Foundation (2023) Parent infant relationships services commissioning toolkit.
7 Best Beginnings, Home Start, & Parent Infant Foundation (2020). Babies in Lockdown.

There is a significant social and financial cost to not supporting perinatal mental health.

The cost of perinatal mental health difficulties goes beyond the potential impact on a baby's emotional and social development. There is a significant social and financial cost to unsupported perinatal mental health needs. The most common cause of maternal deaths in the perinatal period is suicide[8]. Although similar data is not routinely collected for paternal deaths in the perinatal period, the suicide rate for men is typically three times higher than women in England and Wales[9].

Analysis of the economic costs of perinatal depression, anxiety and psychosis found a total long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK. This is equivalent to a cost of just under £10,000 for every single birth in the country[10].

'Figure 1: Benefits of good parent-infant relationships, adapted from the Parent-Infant Foundation'

8 Chin, K., Wendt, A., Bennett, I. M., & Bhat, A. (2022). Suicide and maternal mortality. Current psychiatry reports, 24(4), 239-275.
9 Office for National Statistics (2021) Suicides in England and Wales.
10 Bauer et al. (2014) The costs of perinatal mental health problems.

A word on definitions

This strategy uses the term 'parents and carers' to encompass all those who care for babies. This inclusive terminology reflects a diverse range of caregivers, including Mums and Dads, foster carers, and kinship carers. The established use of 'parents and carers' aligns with local and national strategies that aim to support families across health, education, and care sectors. Importantly, this term ensures inclusivity for families with structures beyond the traditional Mum and Dad configuration, such as same-sex couples. However, the strategy acknowledges situations where referring to 'Mum,' 'Dad,' or 'Co-parent' might be more appropriate, such as when estimating the need for specific services.

The perinatal period usually refers to the time of pregnancy until a baby's second birthday.

Perinatal mental health means the way a parent or carer may think or feel when they are expecting a baby or caring for a baby under the age of two. Some people call this emotional wellbeing. People can experience 'perinatal mental health difficulties' in different ways, for example; it might be feeling particularly low, sad, anxious, or overwhelmed.

Parent-infant relationships refers to the quality of the relationship between a baby and their parent or carer in the perinatal period. Although we call them 'parent'-infant relationships, we mean any caregiver that regularly meets a baby's needs – for example, a mother, father, foster carer, or grandparent. We have used this term because it covers both:

- How a parent or carer feels towards their baby – e.g. do they feel as though they have bonded or connected with their baby?
- How a baby feels towards their parent or carer – e.g. how do they feel attached to their parent or carer?

Parent-infant relationships also relates to the term infant mental health. If there is a good enough relationship between a baby and their parent or carer then we could say that they have good infant mental health. This means that their social and emotional development is being well supported.

Mild-to-moderate difficulties describes the extent of a person's mental health difficulties. 'Mild' refers to difficulties that are just beginning or where a person experiences a small number of difficulties. It may be that these difficulties do not yet have a big impact on a person's daily life. 'Moderate' refers to when a person has more difficulties that can negatively impact their daily life[11].

This is not to understate how challenging it can be for babies, parents, and carers to struggle with 'mild-to-moderate' difficulties. It is possible for mild-to-moderate difficulties to escalate quickly to more complex or severe difficulties. There can also be expectations from friends, families, and the media that parents will not struggle, which can add pressure to parents and carers. The focus of this strategy is helping families with their mental health and to build a warm and loving relationship with their baby. This means that we will focus on supporting perinatal mental health and parent-infant relationship difficulties at a mild-to-moderate level if they arise.

11 National Institute for Health and Care Excellence (2011): Common mental health problems and pathways to care.

Early intervention is an opportunity to give every baby the best start for life.

The government has a vision to give every baby the best start for life[12]. The Family Hubs and Start for Life programme was launched to support the implementation of this vision[13]. Kent is a 'trailblazing' local authority as part of this programme. Being a trailblazer provides us with an opportunity to build on our work through the Healthy Child Programme and to share best practice in early intervention across England. As the largest county in England with more babies born each year than any other county, we have a unique opportunity to support more babies at scale.

The largest funded element of the Family Hubs and Start for Life programme is supporting mild-to-moderate perinatal mental health and parent-infant relationships difficulties, with a particular focus on supporting families as early as possible. The funding for perinatal mental health support compliments the existing perinatal mental health funding for specialist community perinatal mental health services, as set out in the NHS Long Term plan[14].

This strategy outlines how we can best improve our perinatal mental health and parent-infant relationship support offer across Kent.

This strategy sets out our ambition to improve perinatal menta health and parent-infant relationship support across Kent. It is in-line with the scope of the perinatal mental health and parent-infant relationship strand of the Family Hubs and Start for Life programme, focusing on early intervention and prevention. Given the uncertainty of longer-term funding for this programme, this strategy balances setting an ambitious target for improvements in outcomes and care that do not necessarily require a large financial investment. We have not included ideas for actions that will be completed by other elements of the Family Hubs and Start for Life programme.

Although this strategy has been commissioned by Kent County Council, it has been co-produced with colleagues across the health and care sector in Kent. To this end, it should be viewed as a collective strategy that encourages working together across the system of support for babies, parents, and carers.

There is an opportunity to view perinatal mental health and parent-infant relationships within a more holistic framework of family support.

Although the Family Hubs and Start for Life programme sets out distinct funded elements, it is important to have a holistic view of how we support families. The action areas presented in this strategy should be seen in the wider context of how we support babies and their families. For example, preconception care and parenting programmes are also excellent opportunities to provide support to parents and carers in a way that might prevent future perinatal mental health and parent-infant relationship difficulties from emerging.

Infant feeding is another important part of someone's journey to become a parent. Feeding a baby can be a rewarding time for many parents and carers as they meet their baby's physical needs and start to see them developing. However, it can also be a challenging experience for families. For example, if a Mum is struggling with her mental health, then it can make it more difficult to breastfeed. Likewise, difficulties with breastfeeding or breastfeeding trauma can increase parental anxiety and potentially impact how a parent or carer bonds with their baby. Support for infant feeding should be an opportunity to check in about feelings of anxiety or low mood and a chance to explore how a parent is feeling about their relationship with their baby. Similarly, support for mental health and parent-infant relationships should be a chance to explore whether issues around infant feeding are contributing to anxiety or bonding difficulties. It is important to consider this strategy alongside Kent's Infant Feeding Strategy to provide holistic care to babies and their families.

Putting babies at the centre of our strategy.

It is important that this strategy reflects the needs of those we're trying to support: babies. We were keen to co-produce this strategy, but as the word 'infant' comes from the Latin 'to have no voice' we couldn't ask babies how they would like to be supported. Instead, we were keen to hear from as many parents and carers as possible. We also heard from a wide range of professionals who support babies and their families across the NHS, local authority and voluntary sectors.

12 The Early Years Healthy Development Review (2021): Giving Every Baby the Best Start for Life.
13 Family Hubs and Start for Life programme: Local Authority Guide (2022).
14 NHS England (2019): The NHS Long Term Plan.

Co-producing this strategy

We wanted to ensure that this strategy reflects what really matters to parents and carers across Kent. We also wanted to ensure the strategy is informed by the expertise and experience of our brilliant workforce. We call this 'co-production' and we commissioned Barnardo's to co-produce this strategy in partnership with parents, carers, and professionals. They followed a two-step process to engage parents and carers, initially gathering as much insight as possible and then refining this insight together with parents and carers through workshops.

The contribution and engagement to co-produce this strategy included:

171 parents and carers

46 parents and carers completed an online survey

27 completed in depth interviews (lasting more than 1.5 hours each)

46 spoke to us through outreach activities in children's centres and other public spaces in Kent

11 parents joined two co-production workshops where the themes and recommendation action plan were presented back to them for review.

41 parents and carers responded to our public consultation on the draft version of this strategy.

195 professionals

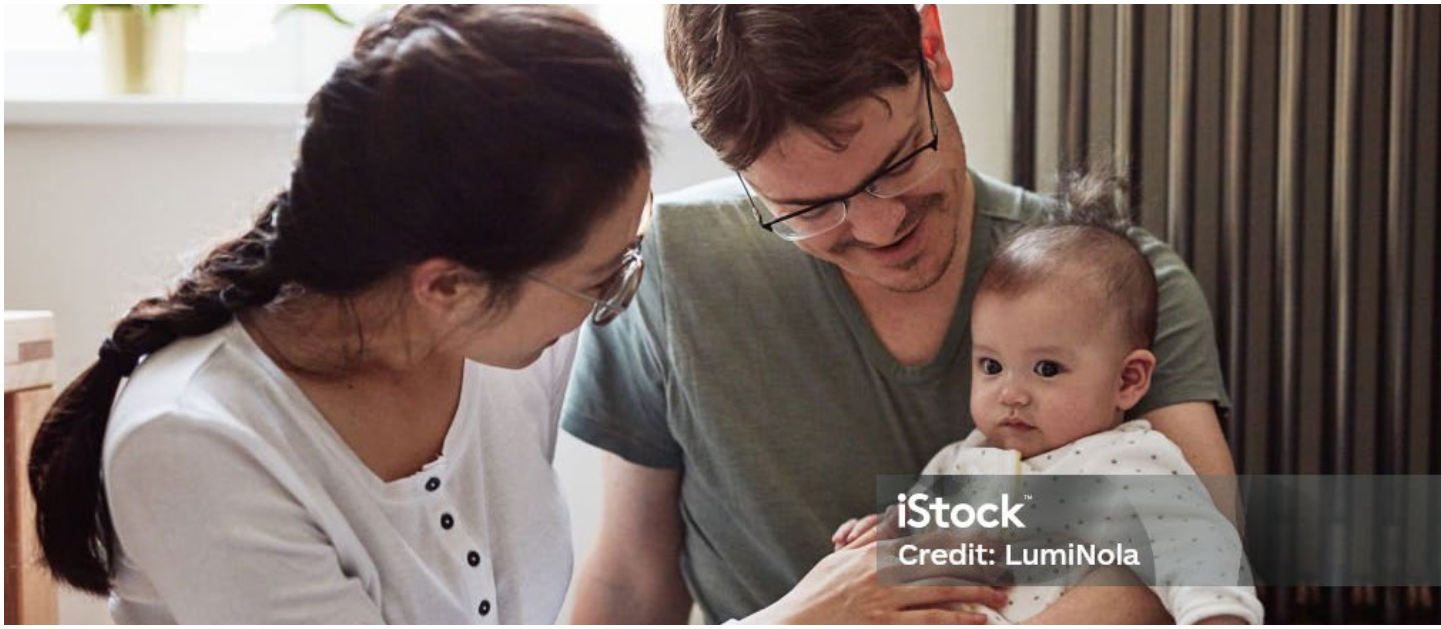
107 professionals joined two webinars, representing 38 different organisations across all sectors in Kent.

44 professionals completed an online survey, with 34 different roles, representing 17 different organisations.

29 senior leaders joined one-to-ones or roundtables, representing 13 different organisations.

15 professionals responded to our public consultation on the draft version of this strategy.

Estimating the scale of need for perinatal mental health and parent-infant relationship support across Kent.



There is an opportunity to support nearly 3,000 parent-infant relationships per year.

We estimate that a total of 14,685 babies may need parent-infant relationship support in Kent over the next five years. That is **2,937 parent-infant relationships per year.**

We estimated the level of need by looking at research and considering what this means for different groups in Kent who may be more likely to struggle[15]. This includes children living in poverty and children in care. We also looked at data for babies and young children (aged 0-5) who were referred into our child and adolescent mental health service (CAMHS) in Kent.

It is likely that 2,937 is a conservative estimate because we only looked at the type of attachment difficulties that research tells us is most closely linked with poor future outcomes. See Appendix 1 for a detailed breakdown of this analysis.

There is an opportunity to support more than 6,000 parents and carers with their perinatal mental health.

We estimate that a total of 33,317 parents and carers may need perinatal mental health support in Kent at a mild-to-moderate level over the next five years. That is 6,663 per year, or **3,560 Mums and 3,103 Dads and Co-parents.**

We understand that families are more diverse than 'Mums', 'Dads and Co-parents'. Some parents and carers may not identify with either of these words. Research about mental health difficulties usually describes 'Mums' and 'Dads' and so we have applied the same principle to estimating need across Kent.

To try and focus on mild-to-moderate perinatal mental health difficulties, we looked at depression and anxiety, which are considered common perinatal mental health difficulties. We arrived at different rates for Mums and Dads by using referral data for our Specialist Community Perinatal Mental Health Service between 2022 and 2023.

See Appendix 2 for a detailed breakdown of this analysis.

15 Parent and Infant Relationships (PAIR) Services Commissioning Toolkit (2023).

Current perinatal mental health and parent-infant relationship service offers across Kent.

To understand what additional support may be helpful, we looked at the current offer of support for perinatal mental health and parent-infant relationships across Kent. Appendix 3 shows services that are freely available across more than one locality in Kent. It also highlights whether they offer perinatal mental health support, parent-infant relationship support, or both.

It can be hard for families to find the support they need when they need it.

We heard from parents, carers, and professionals that services available for perinatal mental health and parent-infant relationship support varied significantly across different districts in Kent. This made it hard for families to understand what support was available to them. It also made it difficult for professionals to know where they can signpost or refer families for further support. Parents told us about challenges in being referred to the right services at the right time, including some referrals that were made to services that were no longer operating. Appendix 3 includes the districts where a particular service is available, demonstrating the opportunity to make support more consistent across Kent.

There is a stronger provision for specialist perinatal mental health support than parent-infant relationship support.

There were more examples of support for perinatal mental health than parent-infant relationships. This was especially true for services delivered by the NHS and targeted at Mums, rather than Dads and Co-parents. We heard that the Specialist Community Perinatal Mental Health Service was considered a strength in the current system of support. Funded as part of the NHS Long Term Plan commitment to improve access to specialist perinatal mental health services, they were well recognised as a good service for Mums experiencing moderate-to-severe perinatal mental health difficulties. They have incorporated parent-infant relationship support into their service, but do not accept referrals for parent-infant relationship difficulties alone.

Parents and carers can also access generic mental health support with some of the county-wide support for Dads and Co-parents including:

- Live Well Kent
- Mind East Kent
- NHS Talking Therapies
- Porchlight Kent
- Save the Children
- Social Prescribing

Lots of the support available for parents and carers is provided through the voluntary, community, and social enterprise sector. Elements of this provision are funded through contracts commissioned by the NHS or Kent County Council, and others operate through funds raised within the community.

Health Visitors and Midwives are an important element of the service offer for perinatal mental health and parent-infant relationships.

Health Visitors and Midwives meet every baby and family. As such, they hold a unique position within the health and care system to support perinatal mental health and parent-infant relationships. Together, they have the opportunity to identify health needs early and provide early intervention, where possible. For example, all Health Visitors in Kent are trained in the Solihull approach, which can be used to promote good parent-infant relationships.

In addition to our core Midwifery offer, Mental Health Midwives are a essential part of our maternity services and complement our specialist perinatal mental health service. In addition to providing training and support to other midwives, they offer additional specialist support to Mums identified as needing more help.

Action Areas
to Nurture Little Hearts and Minds.

Three themed action areas emerged from our co-production with parents, carers, and professionals. These will be our main areas of focus over the next five years. Each action area builds helpfully of the other two areas. By delivering across all of these, we will improve our offer of support for parents and carers across Kent. We have outlined three specific actions under each of the action areas, sharing examples of feedback we have received to highlight the importance of improving these areas.

Action Area 1

Relating with warmth: developing relationship-based support

> ***What would a baby say they want?***
> ***"My parents will be treated with warmth and kindness that helps them ask for and receive the support they need to care for me."***

There is a lot of good quality care being provided to families with babies across Kent. The case example presented below from the Family Partnership Programme illustrates that in some cases parents and carers do receive relationship-based support. However, this is sadly not always the case for every family that needs it. Many parents and carers told us that they did not receive the basics level of care that they were looking for. For example, they were sometimes left feeling unimportant, rather than receiving warm and sensitive care from professionals. If we hope that parents and carers will provide attuned and sensitive care for their babies, then they need to receive this care themselves.

"When I told that first [my healthcare professional] about my anxiety, I felt like she just judged me and dismissed my feelings."

Mum, Gravesend

"It's just tick box – [my healthcare professional] always tells me how busy she is."

Mum, Ashford

Action 1.1: Training for professionals to improve trauma informed care.

The provision of warm and sensitive care is always important, but it is critically important when families have experienced trauma. Here, we mean trauma in its widest definition. For example, it may be that a parent experienced trauma at some point in their journey to parenthood; including conception, miscarriage, labour, birth, or caring for a young baby. Or perhaps they experienced adversity in their own early childhoods, or are experiencing adversity now as they become a parent.

For care to be trauma informed, culturally responsive, and anti-racist, anyone supporting babies and their families should consider all areas of a parent or carer's life. This includes where they may have experienced adversity, discrimination, or prejudice.

> ***"It's important to… explore the parents' own relationships / attachments with their parents… What was the model of parenting and attachment that they received? Are they destined to repeat it or motivated to diverge? What cultural beliefs around parenting do they hold? Stop asking the patronising question 'oh, is this your first baby?'"***
> Director, voluntary and community sector organisation.

We will develop and roll out training to improve access to trauma informed care. This training will be available to anyone who works with parents and carers who are expecting a baby or who have a baby under the age of two. This will help to reduce the likelihood that a parent or carer may feel blamed for struggling or feel as though they are failing if they ask for support. The training will focus on helping professionals to feel confident using strengths-based language and empowering parents and carers. It will mean that professionals can better respond to the needs of parents and carers. Professionals will be encouraged to reflect on the impact of trauma in their supervision.

Action 1.2: Campaigning to break the stigma of perinatal mental health and parent-infant relationships.

Parents and professionals both shared worries about the stigma around perinatal mental health and parent-infant relationship difficulties. This stigma was a barrier to people asking for support in time, or feeling as though they could answer honestly if they were asked how they were doing. Only half of our survey respondents that reported struggling with their mental health sought support for their mental health.

The Better Health: Start for Life website launched a campaign around parent-infant relationships in 2024. We will build on this campaign to help create a common language and shared understanding about perinatal mental health and parent-infant relationship difficulties. This will help to raise awareness of these difficulties and feel more able to share their concerns. This will mean that parents and carers are less likely to feel alone, worried, and isolated.

By sharing consistent messages, we can advocate for perinatal mental health and parent-infant relationships to be talked about across all baby groups in the community. This will help to normalise the topic, reducing fear about sharing concerns, and making it easier for people to feel supported. For example, a consistent message about how normal it is to have 'intrusive thoughts' – such as the worried thought that they might accidentally harm their baby – would help new parents and carers to look out for each other.

The campaign will cover why perinatal mental health and parent-infant relationships are important, as well as what it might look like if you were to struggle. It will speak to all parents and carers – including Dads and Co-parents as well as Mums. It will help to bridge the gap between when to normalise a difficulty and when to encourage a referral for further support.

"[I would like to see] education, so that young people are aware of these issues, so it's not a surprise when it is spoken about, or something they feel worried or need to hide."

Health Visitor, NHS

"I didn't ask for support as I was scared that it may affect me negatively (in terms of social care) if I said my mental health wasn't good."

Mum, Tunbridge Wells

"I also had intrusive thoughts which I didn't feel able to bring up as I was worried about how it would be judged."

Mum, Sittingbourne

Action 1.3: Identifying opportunities for earlier support.

As a result of some of the challenges outlined above, opportunities for earlier support can be missed. To encourage parents and carers to share their concerns and access help, we will improve the quality of questions that health and care professionals ask parents and carers. By better understanding a parent or carer's background, we will be better able to tailor how we support them. We know that not all parents and carers are asked important questions. Responses to our survey confirm how important asking good questions is to parents and carers:

- One in four people told us that they were not asked about their mental health in pregnancy (26%).
- More people were asked about their mental health after their baby was born but one in ten were still not asked (11%).
- Even more strikingly, half of parents and carers were not asked about their relationship with their baby (50%), with a further 17% who weren't sure if they were asked or didn't remember being asked.

Of those who were asked, some described a sense of being asked about their mental health but not really invited to answer openly and honestly. This highlights the need to ask better questions and to ask them in a sensitive and curious way that allowed parents to be honest in their responses.

"Yes, I was asked [about my mental health] by [my healthcare professional] when she came to do my depression questionnaire... I thought it was pointless because I didn't know her, and she didn't know me. It was just a tick box exercise – waste of our time."

Mum, Folkestone.

We will ensure that parents and carers are asked meaningfully and more consistently about:

- Their perinatal mental health, using the Whooley Questions[16] and GAD2[17] questions.
- Their experience of birth trauma, "did you find any element of your birth journey traumatic?".
- Their parent-infant relationships, using the prompt questions that will be published from the Department of Health and Social Care (due 2024).

These questions should be asked of all parents and carers; Dads and Co-parents as well as Mums.

> ***"[I would like to see] support for partners. The Mum is asked about her mental health, but my husband was overlooked. I think him becoming a new Dad has been overwhelming and he could have done with some support mentally."***
> Mum, Tunbridge Wells

Asking these questions is only the first step to identifying opportunities for support. Once a parent or carer has shared their worries, it is important this is paid careful attention to and that they aren't left feeling dismissed or minimised. The responses to these questions could help parents, carers, and professionals to co-create a 'support plan', similar to a birth plan about how they can get the help they need, when they need it.

> ***"Looking back, I was struggling so much, and no one helped. There was too much normalising from [healthcare professionals] when I voiced concerns, and no one picked up on how much I was struggling."***
> Mum, Maidstone

Asking these questions should not be seen as the responsibility of one professional group, but a shared responsibility for anyone who supports babies, parents, and carers. For example, only 32% of parents and carers told us that they were asked about their mental health by their GP and only one parent told us that their GP asked about their relationship with their baby.

16 Whooley Questions for mental health screening.
17 National Institute for Health and Care Excellence (NICE, 2020), antenatal and postnatal mental health: clinical management and service guidance.

"I wasn't offered any [support for my relationship with my baby]. The hospital knew that I had a difficult birth, but they never asked because they didn't care – I was invisible to them."

Mum, Dartford

Case Example: Relational Practice at the heart of the Family Partnership Programme

Kent Community Health NHS Foundation Trust's Health Visiting Service is commissioned by Kent County Council. The Trust has implemented an early intervention intensive visiting service for families experiencing a range of vulnerabilities, including mental health.

The Family Partnership Programme was developed in collaboration with Kent Community Health NHS Foundation Trust and the Centre for Child and Parent Support at the South London and Maudsley NHS Foundation Trust utilising the Family Partnership Model. The Family Partnership Model is a strengths-based programme designed to improve several outcomes, including parent-infant attachments, parental sensitivity, and self-efficacy. The Family Partnership Programme is delivered by Family Partnership Practitioner Leads who are based within each district in Kent alongside the universal Health Visiting Service.

The programme is an example of good relational practice. Practitioners seek to build trust, confidence, and knowledge, so that the parents feel able to be honest, are open to change and are less fearful to ask for help. Additionally, the programme seeks to enable parents to develop effective social support and community ties, so that they are equipped to identify potential future problems.

Most of the parents supported so far experienced mental health difficulties (79%). Although the Family Partnership Programme is not a specific intervention for mental health difficulties, it's relational and holistic approach means that many parents were empowered to access mental health support. Indeed, approximately one in four parents were referred to mental health services alongside the programme. Almost all parents described the care they received as being extremely valuable (93 – 99%).

"I definitely felt we were in an equal partnership. We would work together on solutions to my concerns and problems I faced. I felt supported by her in the decisions I made and the parenting style I wanted to take."

Parent feedback

Action Area 2

Thriving together: improving equity of support

> ***What would a baby say they want?***
> *"My family is helped no matter who we are or where we live."*

Professionals, parents, and carers told us that support was not equally accessible to everyone. Only 2% of professionals reported that all groups were well-served by the current perinatal mental health offer. Similarly, only 5% reported all groups were well-served by the current parent-infant relationship offer. Nearly one in four parents and carers told us that they had experienced some form of discrimination (23%).

This action area shines a spotlight on the main opportunities to improve equity in accessing support and therefore give every baby and parent the best start for life.

"I felt judged because I'm only 21."
Mum, Sheerness

"We need to be routinely collecting data about ethnicity, non-attendance etc. So that we can understand why someone may not be attending."
Mental Health Commissioner

Action 2.1: Harnessing data and insight to improve equity.

By turning data into insight, we can be confident that we have an offer that meets the diverse needs across our communities. There are examples of services in Kent that use data well to ensure that they are as inclusive as possible. For example, we heard that the Specialist Community Perinatal Mental Health Service combines demographic data with information about who is missing appointments to check if there is more the service can do to improve accessibility.

We will be clear and consistent in the data that we collect and analyse to understand need and understand how we are responding to this need. This will help us to develop a rigorous approach to ensuring that services do not inadvertently discriminate against a particular group of people. We will also be clear and consistent in the outcome measures that we're using so that we can evaluate our impact across different services and sectors. This will help us to continuously improve our offer for babies and their families and highlight future commissioning opportunities, such as developing targeted services for populations who are less likely to access support or who experience the worst outcomes.

For some professionals, this was the main thing that they would like to change:

> *"[If I could change one thing it would be] having access to data to support service design and delivery. We don't use intelligence or data enough to understand the needs of families across Kent."*
> *Senior Leader, Kent County Council.*

Action 2.2: Supporting perinatal mental health of Dads and Co-parents universally.

Dads and Co-parents were consistently raised as a group that is not well-served by the current support offer across Kent. This was true for perinatal mental health and parent-infant relationships, as well as other areas of parenting like infant feeding and parenting programmes. This feedback was echoed by the Kent Dads perinatal insights work that we commissioned in 2023, which found that Dads felt 'on the outside' at all stages of the perinatal journey[18].

In addition to asking Dads and Co-parents about their mental health and relationship with their baby (see Action 1.3), we will build on the recommendation from the Kent Dads' Perinatal Support Project about implementing a simple county-wide pathway for Dads. We will ensure that all Dads and Co-parents have access to perinatal mental health support at a mild-to-moderate level. This will be co-designed with Dads and Co-parents. Examples of potential models include a peer support model that helps to build support networks, a dedicated space in Family Hubs for trained professionals to support Dads and Co-parents, or online therapy to make perinatal mental health support more accessible and tailored to the needs of Dads and Co-parents.

This is a chance for us recognise the valuable contribution that warm and loving Dads and Co-parents have on the development of their babies and young children. By offering more universal support, we can set the expectation that Dads and Co-parents will be actively involved in caring for their children and ensure they feel supported to do so. This will help to break the inter-generational pattern of Dads and Co-parents not feeling as included and active as they would like to be.

"[What would help my mental health is] to feel less like an 'add-on' to the health and social care teams. To feel more directly informed and not just someone for Mum to pass a leaflet onto".

Dad, Ashford

"I saw a Dad ask 'should I be here?' and [the healthcare professional] replied 'only if you're overly involved"

Leader, NHS Service Provider

18 Kent Dads' Perinatal Support Project (Work For All; 2023).

Action 2.3: Reviewing the inclusivity and accessibility of all service offers.

Across Kent there are many small, locally commissioned services for specific groups of parents and carers that are not available everywhere or to everyone. We heard that this is challenging:

- Parents and carers told us that it was hard to know what support was available to them.
- Professionals told us that it was hard to know where best to connect families for support.

> *"I met a mum down the road who had a new baby too – she didn't know about any groups – so she joined some of the groups that I went to."*
> Mum, Sevenoaks

As part of the Family Hubs and Start for Life programme, we are writing our Start for Life offer. This will clearly set out what is available for parents and carers who are either expecting a baby or who have a baby under the age of two. We will take this opportunity to review and clearly articulate the inclusivity of each service.

For example:

- does the service have an age criteria?
- does the service exclude parents based on their gender?
- is the language that describes the service as inclusive of all elements of our communities as possible, such as LGBTQ+ families?
- is the service available in languages other than English?
- is the support free to access or is there a cost?
- is the support available in evenings and weekends?
- is the support available online as well as in person?

As well as making it clear who can access support, this will also give us a chance to identify opportunities to improve the equity of support. This could include making recommendations about what we may need to do differently in terms of service provision to support different groups of people, such as people from Gypsy, Roma, and Traveller communities[19].

"It's impossible to make connections antenatally if you're watching a video at home. Only those who can afford it make friends antenatally e.g. NCT so we paid for NCT."

Mum, Tunbridge Wells

"37% of dads who didn't access any support during pregnancy told us that they did want support. All said that the reason for not accessing it was not knowing where to go, thinking it didn't exist or not being spoken to/advised of available support."

Dads Perinatal Mental Health Support Project.

19 Kent Public Health Observatory (2014/15), Kent 'Gypsy, Roma, and Traveller populations' Joint Health Needs Assessment.

Engaging Dads in Perinatal Mental Health Support

The Kent Dads Perinatal Support Project heard that there were two main issues faced by Dads: finding it difficult to interact with professionals and not knowing where to access support, if it was needed. They are running two small pilot interventions to address these challenges:

1 The One Minute Interaction

The 'One Minute Interaction' can be delivered to Dads by a range of professionals and community members at whatever point Dads 'bump into' the system. The 'One Minute Interaction' is supported by an information Z-card which will allow professionals to talk to Dads for 60 seconds with the aim of:

- Providing them with a positive interaction with the system of support available that encourages support-seeking in the future if or when it is needed; and
- Providing them with some basic information to support their understanding of infant development and their role in it.

2 Dads Induction Sessions

To help familiarise Dads with a place where they can access a range of support, the project will test a "Dads' induction" at children's centres. This will be similar to an inductions that might be held at a gym. Participating children's centres will hold monthly induction sessions that Dads can book onto at any point during the perinatal period. The One Minute Interaction will be an opportunity to raise interest in the induction sessions.

Together, these interventions will:

- Provide dads with positive and informative interactions about fatherhood;
- Increase dads' awareness of support available to them; and
- Create an 'entry point' into support for dads through family hubs.

Action Area 3

Leading collaboratively: nurturing a system of support

> ***What would a baby say they want?***
> ***"When my parents struggle to meet my needs, there will be a support system in place to help them help me."***

Many parents and carers have access to a good enough support system. However, where they need more support or where parents don't have a support system, we must ensure that our network of services can 'hold' babies and their families. It takes a village to raise a child, and we will take action to bring services, sectors, and professionals together to become that village. It is important that we think about the whole system of support in order to think about the whole family.

"We need to operate on [perinatal mental health and parent-infant relationships] as a meaningful whole partnership… not just commissioners and providers".
Associate Director, NHS

"[What would help is] more longer-term and joined up funding. Can't do this work on short-term contracts."
Manager, Children's Centre

Action 3.1: Developing commissioning principles.
Careful consideration must be given to how support for perinatal mental health and parent-infant relationships is commissioned. As with other health and care contracts, we heard that funding is often released at short notice, for a limited period of time, and opportunities for collaboration are limited. However, longer-term funding with partnership opportunities is particularly important during the critical 1,001 days.

> ***"We need more joint funding – looking at co-location of joint funding, more integrated working and sharing expertise."***
> Senior Leader, voluntary and community sector organisation

In collaboration with local partners, including the Integrated Care Board (ICB), we will produce best practice guiding principles for commissioning perinatal mental health and parent-infant relationships support services. These will be tested in collaboration with colleagues across sectors and services, and are likely to include:

- Funding to maximise the likelihood of continuity of care
- Longer-term funding opportunities, wherever possible
- Flexibility in funding multiple organisations to encourage better collaboration and inter-agency working
- Funding that includes the 'voice of the baby'
- Funding services that cover a wider geographical footprint
- Consistency of outcome measures and use of data

Action 3.2: Building a joined-up pathway of support. Most professionals told us they were not confident in their understanding of the current support available to families for parent-infant relationship difficulties (54%), only 12% reported that they were very confident.

We will use the Thrive[20] model to create a holistic pathway of support for parent-infant relationships. We will build on the work to develop our Start for Life offer to map out how support for parent-infant relationships fit together across Kent. This will help to show the connections between services where there may be an increased risk of parent-infant relationship difficulties, such as the neonatal unit and children's social care.

The referral pathway will include parenting programmes where there is an explicit focus on infant mental health, attachment, or parent-infant relationships.

> ***"[What would help is] referral pathways development – building networks and relationships, make it more personable, get together for perinatal professionals to link."*** Senior Leader, voluntary and community sector organisation

We heard that the referral pathway should include clarity on where professionals helping parents and carers can get access to supervision, support, advice, or guidance. This will help to put training into practice and embed a culture of reflective practice. We also hope that this will help with Action 1.3 because professionals will be more likely to ask about difficulties if they are more confident that they know where they can find more support for themselves or the family.

This action is also important for parents and carers who told us that they would value an easier referral process. We also heard that some parents were referred to inappropriate services where their needs could not be supported.

> ***"We got referred to a service that no longer exists."*** Mum, Tonbridge

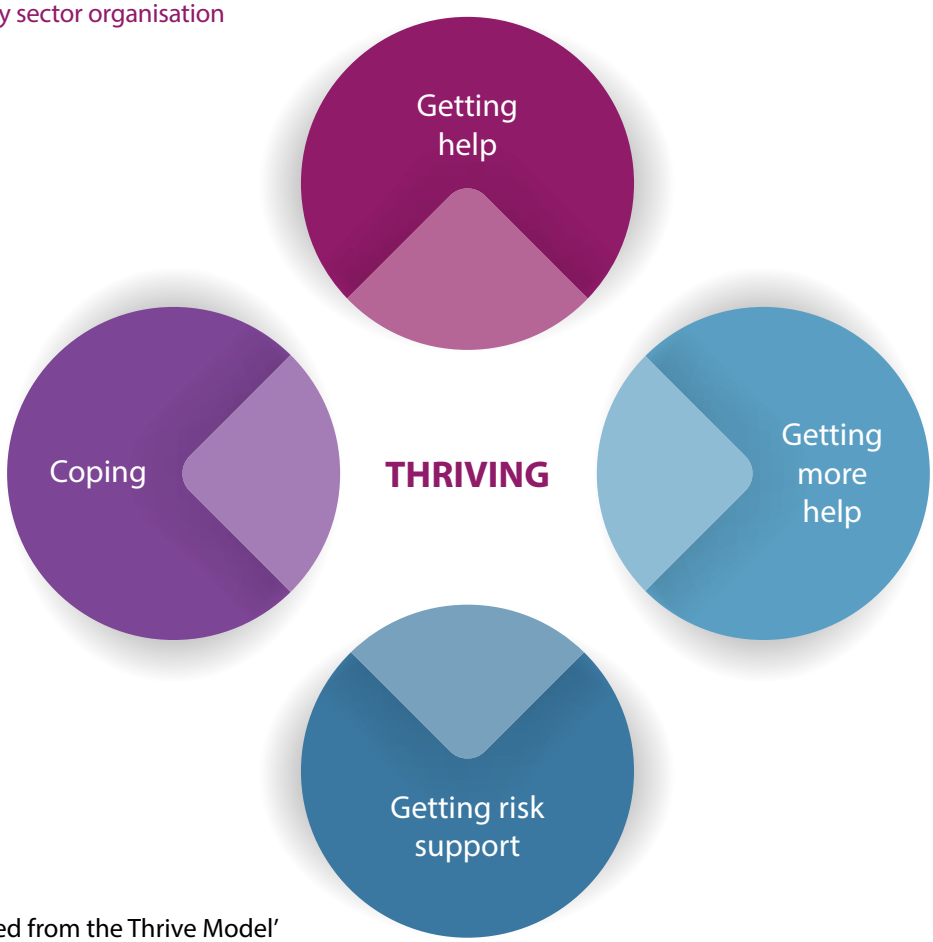


Figure 2: Adapted from the Thrive Model'

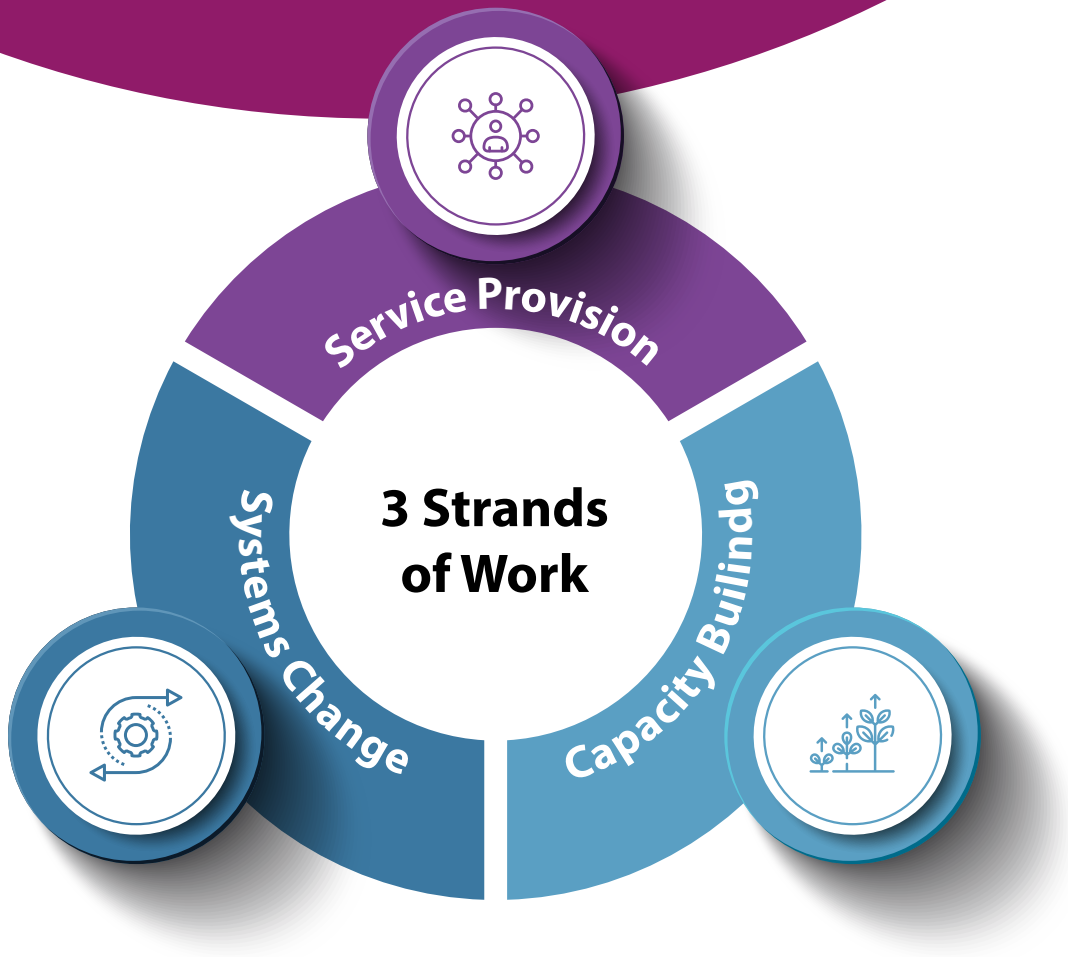
20 Wolpert, M., Harris, R., Hodges, S., Fuggle, P., James, R., Wiener, A., ...Munk, S. (2019). THRIVE Framework for system change. London: CAMHS Press.

Case Example: ABC PiP: A comprehensive service example from Northern Ireland as part of a parent-infant relationship pathway.

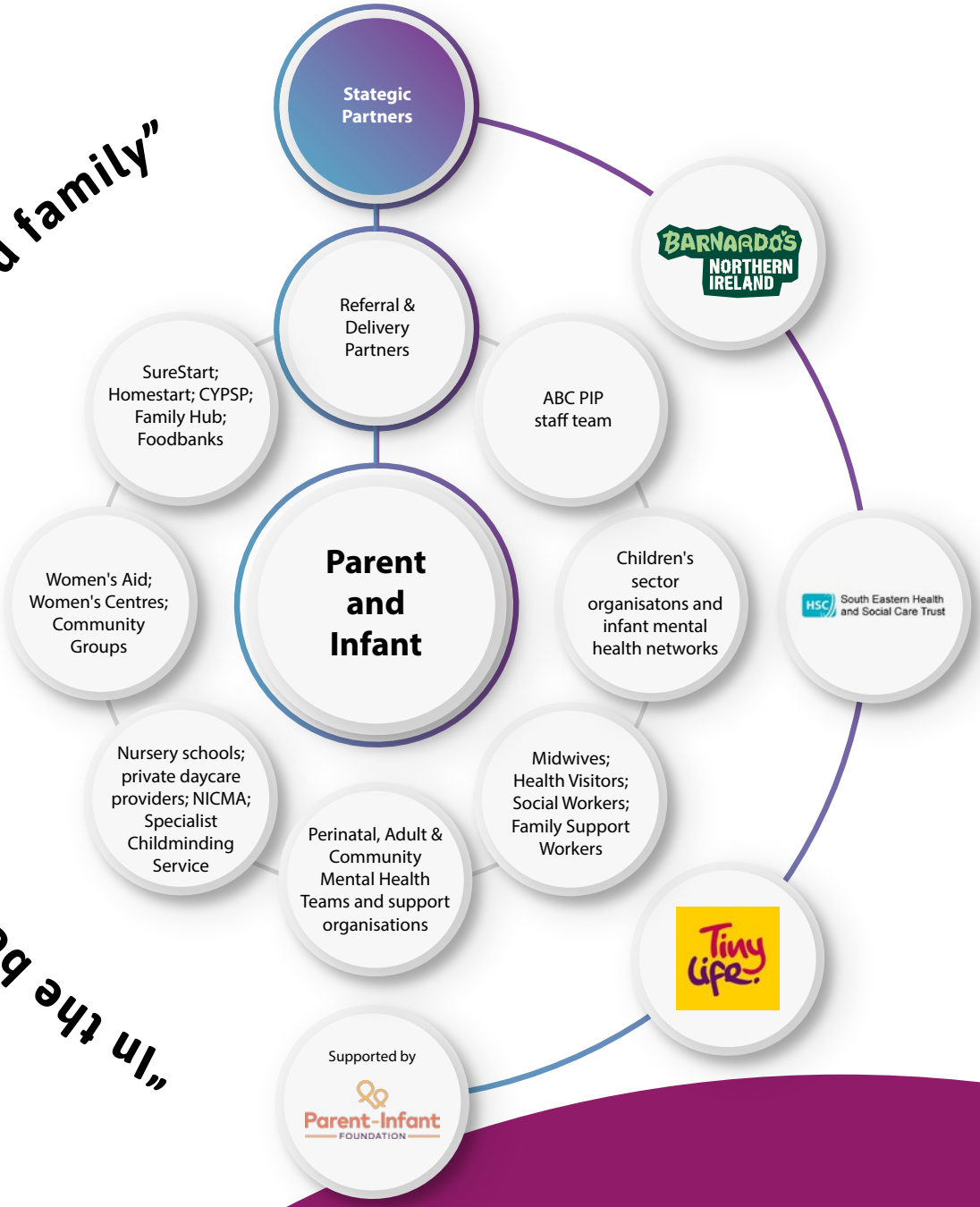
ABC PiP (Attachment, Bonding, and Communication Parent Infant Partnership) is a therapeutic service in Northern Ireland that works with the strengths of parents and carers to help them build a positive relationship with their baby. Their collaborative approach is an example of working together across sectors and services to support parent-infant relationships. The service is a strategic partnership between the South Eastern Health and Social Care Trust, Barnardo's, and Tiny Life, supported by the Parent Infant Foundation. Together, the team is made up of a variety of specialists who offer groups, one-to-one sessions, and home visits to families who are pregnant or who have a baby under the age of two.

To support parent-infant relationships, the service has three strands:

1. **Service provision** – offering direct support to families using interventions such as Video Interaction Guidance, and Five-to-Thrive.
2. **Ability building** – offering education, training, consultation and support to the network of professionals supporting babies and their families such as midwives and health visitors.
3. **System change** – creating opportunities for networking and collaboration as well as influencing at local, regional, and national levels.



"In the best interests of the children and family"



ABC PiP offers two levels of support and families referred to the service can receive a range of interventions, depending on their needs. These include:

- Tier 1 support for parents experiencing issues, such as anxiety and depression, which are impacting on parenting and the infant's social & emotional development, but who have some other positive coping skills or resources available to them.
- Tier 2 support for families with more complex difficulties, where parenting is significantly impacted by parental wellbeing or stress (e.g. parents with high anxiety and low mood) or by complex trauma history (e.g. parents who are care experienced).

Action 3.3: Establishing a community of practice.
We heard from passionate and knowledgeable colleagues across sectors and services in Kent. We are fortunate to have colleagues who are enthusiastic about supporting perinatal mental health and parent-infant relationships. However, we heard that there were limited opportunities for them to come together, share expertise, and improve their understanding of support offers across Kent.

> ***"We need to have a greater understanding of each other's roles and what we each bring to the table."***
> *Health Visitor, NHS*

We will establish a community of practice that is open to anyone working with babies, parents, and carers in Kent. The focus will be perinatal mental health and parent-infant relationships. The community of practice will include networking events and a mailing list that colleagues can join to hear about training opportunities and share resources.

Together, we can share national and local resources along with the latest research so that we continue to ensure that our support for families is based on the latest evidence.

"We need to operate on [perinatal mental health and parent-infant relationships] as a meaningful whole partnership… not just commissioners and providers".

Associate Director, NHS

"[What would help is] more opportunities to work together and build services across the different sectors. e.g. building a network with quarterly meetings to include representatives from all sectors (people on the ground not just senior leaders) and remembering to include acute services e.g. neonatal and paediatric wards."

Speech and Language Therapist, Neonatal Unit

Action Areas Summary:
A summary of the action to be taken over the next five years.

Ref	Action Area	Actions	Voices of parents and carers in Kent:
1	Relating with warmth: developing relationship-based support	1.1 Training for professionals to improve trauma informed care 1.2 Campaigning to break the stigma of perinatal mental health and parent-infant relationship support 1.3 Identifying opportunities for earlier support	"I didn't ask for support as I was scared that it may affect me negatively (in terms of social care) if I said my mental health wasn't good."
2	Thriving together: improving equity of support	2.1 Harnessing data and insight to improve equity 2.2 Supporting perinatal mental health of Dads universally 2.3 Reviewing the inclusivity of all perinatal mental health and parent-infant relationship service offers	"We don't use intelligence or data enough to understand the needs of families across Kent." "No one spoke to my husband about what he needed, which was really significant."
3	Leading collaboratively: nurturing a system of support	3.1 Developing commissioning principles 3.2 Building a relational pathway of support for parent-infant relationships 3.3 Establishing a community of practice for perinatal mental health and parent-infant relationships	"We need more joint funding – looking at co-location of joint funding, more integrated working and sharing expertise." "We need to have a greater understanding of each other's roles and what we each bring to the table."

Making this strategy a success

We asked professionals, parents, and carers what they think is needed to make this strategy a success. They highlighted several important components.

Communicating the strategy widely.
The vision and actions set out in this strategy will need to be communicated as widely as possible. This includes parents and carers as well as anyone who supports babies, parents, and carers as well as service leaders and funders. We will share this strategy on social media, in family hubs, and through an accessible format aimed specifically at parents and carers.

Governing effectively to drive the strategy forward.
Clear reporting, decision making, and accountability structures will be needed to ensure that the action areas embedded in this strategy are taken forward. This will also help to ensure that any barriers are overcome together. We envisage a multi-disciplinary and cross-sector steering group will provide the operational oversight and leadership of this strategy. This steering group will report to the Start for Life Board, which will hold ultimate accountability for this strategy.

Linking this strategy to existing strategic priorities across Kent.
This Nurturing Little Hearts and Minds Strategy fits closely with several existing strategic priorities in Kent.

Framing Kent's Future - Framing Kent's Future highlights the need to better support babies and their families[21]. The focus across Kent on reducing inequalities, prioritising preventative working fits with this strategy (see Appendix 5 for more details).

Health Needs Assessment - The most recent Health Needs Assessment for 0-4 year-olds in Kent [22](2022) emphasises the importance of investing in early intervention for perinatal mental health difficulties and their partners, use of data, workforce development, and working together as a system (see Appendix 6 for more details).

Integrated Care Strategy – Support for babies, parents, and carers is needed and provided across many sectors and services. This strategy fits with the vision of the Integrated Care Strategy to work together to make health and wellbeing better. The Integrated Care Strategy specifically highlights the ambition to 'give children and young people the best start in life'.

Health Visiting Strategy – The Kent Health Visiting Strategy[23] (2022 – 2025) has the strategic aim of providing a strengthened early intervention offer across the six high impact areas. This includes parenting programmes, perinatal mental health, and parent-infant relationships (infant mental health). The three action areas set out in this strategy relate neatly to this strategic aim.

Workforce Development: opportunities to help colleagues better support babies, parents and carers.
To support the implementation of these action areas, a continuous focus on workforce development will be needed. There have already been significant developments in how the early years workforce is supported across Kent in recent years. For example, perinatal mental health introductory training is freely available each quarter from the Specialist Community Perinatal Mental Health Service. Similar training is being commissioned for parent-infant relationships.

The professionals we heard from often had ideas about how we can ensure we have a more skilled and knowledgeable workforce. In addition to Action 1.1 to develop and roll out trauma informed training to all staff, we have broken down the ideas from colleagues into things we aren't doing that we should start and things that we are doing that we should continue.

Together, these will help to increase the knowledge, skills, and confidence of the professionals and volunteers that support families in the critical 1,001 days.

21 Kent County Council (2023) Framing Kent's Future.
22 Kent Public Health Observatory (2022) Health Needs Assessment 0-4 year-olds.
23 Kent Community Health NHS Foundation Trust (2022-25), Health Visiting Strategy.

Start

Ensuring that training opportunities are available to all professionals.
Some colleagues told us that elements of the local training offer may not be available to across professional groups. For example, training opportunities may not be extended to those in the community and voluntary sector. This was seen as particularly important as family hubs grow and the workforce within these becomes increasingly diverse. We also heard that training around perinatal mental health and parent-infant relationships should be available to commissioners.

Offering training to introduce important concepts around parent-infant relationships.
Some professionals also told us that they would value more training in understanding parent-infant relationships (19%), how a baby's brain develops (16%), and how to ask about parent-infant relationships. These are important concepts and should be grounded in the science of attachment and early development, so they aren't viewed as 'too fluffy'.

Offering training and support around asking about perinatal mental health, trauma, and parent-infant relationships.
Building on Action 1.3 to improve opportunities for earlier support, colleagues will benefit from a space where they can consider how to enquire sensitively about these areas. This may include best practice in starting difficult conversations or a chance to come together and understand the importance of asking about perinatal mental health, trauma, and parent-infant relationships.

Rolling out training in interventions that can be used to support perinatal mental health and parent-infant relationships.
There was an appetite for specific interventions that can be used to support perinatal mental health (43% of respondents to our survey for professionals) and parent-infant relationships (46% respondents). Using the Association of Infant Mental Health UK's Competency Framework[24] will help to ensure that we have colleagues who are skilled at different levels in understanding parent-infant relationships, supporting parent-infant relationship difficulties, and supervising colleagues who are supporting parent-infant relationships.

Offering opportunities for on-going learning as well as one-off training events.
Training courses to improve knowledge and confidence are just one part of the workforce development picture. Opportunities for colleagues to seek consultation, reflective practice, or supervision to consider any perinatal mental health or parent-infant relationship challenges will be an important addition. This will help to embed the knowledge and understanding of the workforce.

Actively seeking to train colleagues who may be less likely or less able to engage in a full day of training.
There are lots of reasons why some colleagues may find it hard to join a full day of training. There was a call for more active efforts to engage those who play a pivotal role in supporting parents and babies but may not join a 'standard' training programme, including:

- Foster carers
- GPs
- Midwives
- Obstetricians

"Train healthcare professionals, including midwives and obstetricians, to recognise and address perinatal mental health issues." Mum, Swale

Train colleagues in the different services that are available to support perinatal mental health and parent-infant relationships.
Some colleagues told us that they wanted more training so that they were more aware of services that are available to support perinatal mental health and parent-infant relationships. This may be an element of Action 3.3, which sets out our plans to develop a community of practice. This will help colleagues across sectors and services to build relationships and understand the support pathway available to families across different areas in Kent.

"In addition to training, the availability of experts for support, advice, guidance and consultation will be important."
– Practitioner, NHS.

24 Association of Infant Mental Health UK - Competency Framework.

Continue

Using skill mix to ensure that families get the right support at the right time.
There were excellent examples of skill mix in the Health Visiting Service. Including recent developments to recruit leads for perinatal mental health and parent-infant relationships. This skill mix will help to ensure that families get the right level of support, and will help improve capacity challenges.

Offering awareness-level training for perinatal mental health.
Some professionals do not know that they can access perinatal mental health training through the Specialist Community Perinatal Mental Health service. Continuing to roll out this offer to a wide range of colleagues will be helpful and contribute to a 'common language' around perinatal mental health.

Training professionals in video feedback interventions.
Some professionals have already signed up to participate in Video Interaction Guidance training. This training is funded by the Department of Health and Social Care. Continuing to support this training and ensuring that all our training places are allocated, and that training is implemented in practice will be important.

Training to ensure there is skilled supervisory capacity across Kent.
A funded training place is available by from the Department of Health and Social care to train an experienced clinician – such as a clinical psychologist or psychotherapist – in how to supervise interventions to help parent-infant relationship difficulties. Continuing to make use of this training will complement the work we have already started to improve access to support for parent-infant relationship difficulties.

"Band 4 roles do more [early intervention] support so that the Band 5 and 6 roles are freed up to do more of the moderate support."
Leader, NHS Service Provider

Appendices

Appendix 1 – Calculating prevalence of parent-infant relationship difficulties across Kent.

The table below shows the detail of our scale of need assessment for parent-infant relationships.

Estimating the number of parent-infant relationships in need of support per year

Item	No.	Prevalence of difficulties	Parent-infant relationship difficulties
Number of births	16,632		
16.5% - children in poverty	2,744	20%	549
3.18% - children in care	665	90%	599
Children 0-5 referred to CAMHS	519	100%	519
Remaining 0-2s	12,703	10%	1,270
Total			**2,937**

Planning assumptions:

- We calculated the number of children living in poverty as 16.5% of the birth rate[25].
- We calculated the number of babies in care as 3.18% of the birth rate[26].
- North East London NHS Foundation Trust provided data for the number of referrals for 0-5s in child and adolescent mental health services (CAMHS) between October 2021 and October 2022. Although we do not have the breakdown of how many of these were 0-2, we assumed that each of these represents a missed opportunity for earlier intervention.
- Our estimates for prevalence of difficulties are based on academic data about the prevalence of disorganised attachment. Research tells us that people who could be categorised as having a disorganised attachment style, are more likely to experience worse outcomes than any other attachment pattern[27]. We have assumed that these represent a missed opportunity for support at a 'mild-to-moderate' level. However, the prevalence of insecure attachment relationships is much higher. Therefore, it should be noted that the number of parent-infant relationships that could benefit from additional support might be higher than the estimate here suggests.

Nearly one in five parents and carers who completed our survey reported that they experienced difficulties in bonding with their baby (19.57%). If this were representative across Kent, then the scale of need for parent-infant relationship difficulties would be 3,255. However, our survey sample size is relatively small, and it is likely that parents and carers would have been more interested in completing our survey if they struggled and so 2,937 is a more conservative estimate.

25 Public Health England, Local Authority Health Profile (2019).
26 Kent Public Health Observatory, Children in Care Needs Assessment (2017).
27 O'Connor, E., Bureau, J. F., McCartney, K., & Lyons-Ruth, K. (2011). Risks and outcomes associated with disorganized/controlling patterns of attachment at age three in the NICHD study of early childcare and youth development. Infant Mental Health Journal, 32(4), 450.

Appendix 2 – Calculating prevalence of mild-to-moderate perinatal mental health difficulties across Kent.

The table below shows the detail of our scale of need assessment for mild-to-moderate perinatal mental health difficulties across Kent.

Estimating the number of Mums and Dads in need of support per year

Item	No.	Prevalence of difficulties	Number of Mums in need
Mums in Kent (number of births)	16,632	-	-
Mums referred to Kent Specialist Community Perinatal Mental Health service	2,569	-	-
Mums where referrals were rejected	623	100%	623
Mums where referrals were accepted	1,946	-	-
Number of Mums remaining	14,686	20%	2,937
Total Mums in need of support	**-**	**-**	**3,560**
			Number of Dads and Co-parents in need
Dads and Co-parents in Kent (number of births)	16,632	-	-
Number of Mums referred to Kent Specialist Community Mental Health Service	2,569	25%	642
Dads and Co-parents excluding the number of Mums referred to Community Perinatal Mental Health Services	14,063	18%	2,461
Total Dads and Co-parents in need of support	**-**	**-**	**3,103**
Combined Estimation			
Mums			3,560
Dads and Co-parents			3,103
Total			**6,663**

Overarching planning assumptions:

- We assumed there was a Mum and a Dad / Co-parent per baby born each year.
- We recognise that families are more diverse than a 'Mum and Dad / Co-parent'. We made no assumptions about family composition, but we did assume that there were the same number of Dads / Co-parents and Mums across Kent.
- Depression and anxiety are common perinatal mental health difficulties[28]. We assumed that academic prevalence data on these is most likely to represent difficulties at a mild-to-moderate level. This is in keeping with other reports on the scale of common perinatal mental health difficulties.

Planning assumptions for Mums:

- Kent and Medway NHS and Social Care Partnership Trust provided referral data for the Specialist Community Perinatal Mental Health Service (2022 – 2023).
- We excluded Mums whose referrals to the specialist community perinatal mental health service were accepted, assuming that their needs were more complex / acute.
- We assumed that all Mums who were referred but rejected from the specialist community perinatal mental health service had 'mild-to-moderate' perinatal mental health difficulties. There may be other reasons for a rejected referral, but we assumed that some mental health need remains unmet.

Planning assumptions for Dads:

- The academic literature gives a range of prevalence estimates for perinatal mental health difficulties in Dads.
- Dads are more likely to struggle with perinatal mental health if their partner also struggles[29].
- The Specialist Community Perinatal Mental Health Service did not assess or screen the mental health of the partners of Mums referred into their service.
- In the absence of this data, we assumed that every Mum referred into the Specialist Community Perinatal Mental Health Service had a partner.
- We then assumed the higher prevalence rate for the partners of Mums referred to the Specialist Community Perinatal mental health services (25%) and the lower prevalence rate for all other Dads (17.5%)[27].

28 NICE (2020). Antenatal and postnatal mental health: clinical management and service guidance.
29 Darwin Z, Domoney J, Iles J, Bristow F, Siew J and Sethna V (2021) Assessing the Mental Health of Fathers, Other Co-parents, and Partners in the Perinatal Period: Mixed Methods Evidence Synthesis. Front. Psychiatry 11:585479. doi: 10.3389/fpsyt.2020.585479

Appendix 3 – Current service offer for perinatal mental health and parent-infant relationship support.

Service	Overview	Perinatal Mental Health Support?	Parent-Infant Relationship Support?	Area in Kent	Level of Need (as per Thrive)	Sector
Baby Umbrella	Support for families to explore the adjustment to parenthood, difficult experiences with conception, pregnancy, birth and feeding, relationship struggles. Include listening service for emotional support. See Appendix 4 for case example with more details.	Yes	No	West Kent	Coping / Getting Help	Voluntary & Community
Dads Space	Providing a safe space for dads to talk, listen and share their experiences of fatherhood	Yes	No	North Kent	Coping / Getting Help	Voluntary & Community
Dads Unlimited	Supporting the emotional safety of men and those they care about. Supporting Dads through family separation with one-to-one mentoring, building relationships with their children, reducing parental conflict, and improving co-parenting relationships.	Yes	Yes	West Kent	Coping / Getting Help	Voluntary & Community
Families by the Sea CIC	Providing physical, mental and community support within the perinatal period for all families with a focus on our marginalised groups.	Yes	No	Thanet and East Kent	Getting Help	Voluntary & Community
Family Partnership Programme	Support for women from 28 weeks of pregnancy and their families, up to a child's first birthday to empower and help them and their family to lead a happier, healthier life.	Yes	Yes	County-wide	Getting Help	NHS

Service	Overview	Perinatal Mental Health Support?	Parent-Infant Relationship Support?	Area in Kent	Level of Need (as per Thrive)	Sector
Home-Start	Practical and emotional support from volunteers to parents of children under five.	Yes	No	Dover District, North-West Kent, Medway, South-West Kent, and Sitting-bourne & Sheppey.	Coping / Getting Help	Voluntary & Community
HUGS Helping Us Grow Stronger	Antenatal group aimed at improving mental wellbeing during pregnancy and beyond.	Yes	No	Kent-wide Virtual via Teams only	Coping / Getting Help	NHS
Neonatal Service	Support to pregnant women and their families where babies require specialist intensive care.	Yes	No	County-wide	Getting Help / Getting More Help	NHS
Perinatal Mental Health Helpline	Advice and support for anyone experiencing perinatal mental health difficulties, available 24/7.	Yes	No	County-wide	Coping / Getting Help	Local Authority
Singing Mamas	Weekly 90 minute 'me-time' to sing with other women to improve wellbeing and mental health. This is a private service, but with bursaries available for those experiencing difficulties.	Yes	No	West Kent	Coping	Voluntary & Community
Specialist Community Perinatal Mental Health Service	Assessment, diagnosis, and short-term treatment of women aged 18 and above. Available in pregnancy and for women with babies up to two years of age affected by moderate / severe perinatal mental health difficulties in the preconception, antenatal and postnatal period.	Yes	Yes	County-wide	Getting More Help / Getting Risk Support	NHS

Service	Overview	Perinatal Mental Health Support?	Parent-Infant Relationship Support?	Area in Kent	Level of Need (as per Thrive)	Sector
Thrive	Short-term therapies, support, and advice to people and their families for moderate / severe mental health difficulties as a result of birth trauma and / or birth loss. Parents would usually have accessed support from other NHS therapy services in Primary Care such as NHS Talking Therapies prior to referral to THRIVE.	Yes	No	County-wide	Getting More Help / Getting Risk Support	NHS
Perinatal On-line Course	Five session online guided self-help for parents experiencing anxiety and depression associated with the transition to parenthood. Freely available to parents and carers.	Yes	No	Dartford, Gravesham, and Swanley	Getting Help	Private
Women's Health Counselling Service	Counselling for women who have experienced a range of difficulties, including the loss of a pregnancy at any stage, traumatic birth, caring for a baby on the Neonatal Intensive Care Unit, and fertility issues.	Yes	No	East Kent	Getting Help	NHS

Appendix 4: Case Example – Baby Umbrella - using specialist practitioners and volunteer peer supporters to help improve perinatal mental health.

Baby Umbrella told us about their offer of breastfeeding and early parenting support to families across West Kent. Their vision is for every family to have access to skilled and compassionate support during their parenting journey. To support perinatal mental health, all their Specialist Practitioners and Volunteer Peer Supporters have been trained in perinatal wellbeing.

To support the transition to parenthood, they offer free, weekly open access groups with Volunteer Peer Supporters and specialist appointments. Their Practitioners also offer support for issues like sleep and feeding that can cause high levels of anxiety, which is available online or face-to-face.

Throughout the service, they take time supporting parents to understand normal baby behaviour, including a near constant need for contact and co-regulation and frequent feeding and waking through the night. They work with families to create realistic plans to cope with what can be an overwhelming realisation of what caring for a small baby is like. They are also available throughout a family's early parenting journey to talk about introducing solids, night waking in later months and years, and the transition to toddlerhood.

They also provide dedicated perinatal wellbeing support for families who need it through their Listening Service. This is a safe, private, and compassionate space where families can explore the adjustment to parenthood, difficult experiences with conception, pregnancy, birth and feeding, relationship struggles, and much more. They also signpost onto various support services in West Kent depending on need.

Almost all attendees reported an improvement in their mood (98%) and anxiety (96%) and would recommend Baby Umbrella to others (96%).

"Fabulous. Every new Mum should have access to a listening service appointment. Pregnancy/ birth and post-partum can be such an overwhelming and life changing time, I found it really helpful to be able to talk about my experiences in a supportive and objective space. It made me feel like my experiences and feelings were valid and I felt seen in a way that I hadn't before. Thank you so much Baby Umbrella!"

- Listening Service feedback (2023).

Appendix 5 – Links between Framing Kent's Future and this Strategy

Our commitment to…	Link to Nurturing Little Hearts and Minds Strategy
Levelling up Kent includes ensuring that no one is left behind because of who they are.	**Action Areas 1 & 2** – Babies are more likely to experience abuse than any other age group. They also do not have a voice of their own and so need to be proactively given a voice.
Working with our partners in the public, private, voluntary and community sector.	**Action 3.1** – This is particularly important for babies. Care and support for babies and their families often cuts across different organisations and services. We must work together to ensure that babies do not fall through the gaps in provision.
Focusing energy and resources on the most deprived 20% of the population	**Action Area 2** – Babies often experience a 'double disadvantage'. We know that babies living in deprivation are more likely to have difficult early attachment relationships.
Reshaping our commissioning practice to ensure we build strategic partnerships with our providers, through earlier engagement, more consistent and proactive commissioning practice, and a stronger focus on co-designing services	**Action 3.1** – We need longer term support to mitigate the long-term impact of a difficult start in life.
Working within the system to ensure a strong focus on preventative community services	**Action Areas 1, 2, & 3** – Supporting parents and babies experiencing mild-to-moderate difficulties is a 'double prevention' – intervening early in life and before difficulties worsen.
Embedding a whole-family approach	**Action Areas 1 & 2** – A whole-family approach is essential to improve equity of support.
Working with the ICS to support children's mental health needs so that they are met with the right level of support in a timely manner.	**Action Areas 1, 2, & 3** – The earliest opportunity to support children's mental health is during infancy and the 1001 critical days.
Making better use of data and analytics to understand current and future needs so we can improve commissioning.	**Action 2.1** – Using data will help us to reduce inequality in accessing support for perinatal mental health and parent-infant relationship difficulties.

Appendix 6 – Links between the Health Needs Assessment of 0-4 year olds and this Strategy

Our commitment to…	Link to Nurturing Little Hearts and Minds Strategy
Invest to ensure early identification of and support for poor perinatal mental health amongst pregnant women and postnatally for women and their partners.	**Action 1.3** – Ensuring a more consistent approach to asking about perinatal mental health, parent-infant relationships, and birth trauma.
Develop a robust system wide pathway for low to moderate perinatal mental health support.	**Action Area 2 & Action 3.2** – Improving equity of support for parents and carers regardless of gender will help with this, as will mapping the pathway of support.
Review and monitor the provision of support for parents and carers.	**Action Area 3 and Action 2.3** – Collaborative leadership and using the Start for Life offer publication as an opportunity to review provision.
Establish a system wide approach to preventing poor health outcomes, ensuring provision and levels of support are flexible and responsive to meet needs.	**Action Areas 1 & 2** – Creating a holistic referral pathway for parent-infant relationships and focussing on early intervention and prevention at a mild-to-moderate level of need.
Ensure services are culturally appropriate with information available in other languages, particular to the local communities.	**Action Areas 1 & 2** – Ensuring more professionals have access to trauma informed training, and work to improve equity of service offers across Kent.
Ensure data sharing and linkage is consistently being improved particularly between maternity care, early help, health visiting, social care, and early years education.	**Action 2.1** – Harnessing data and insight to improve equity.


iStock
Credit: Tom Merton

Further information

For further information about any aspect of this strategy please contact: **startforlife@kent.gov.uk**

Kent County Council

Alternative formats

If you require this strategy in an alternative format or language,
please email **alternativeformats@kent.gov.uk** or call **03000 421553**
(text relay service number: 18001 03000 421553).
This number goes to an answering machine, which is monitored during office hours.

KENT COUNTY COUNCIL – PROPOSED RECORD OF DECISION

DECISION TO BE TAKEN BY:	DECISION NO:
Cabinet Member for Adult Social Care and Public Health	24/00058

For publication:

Key decision: Yes

Title of Decision: Approve the Perinatal Mental Health and Parent Infant Relationships Strategy, 'Nurturing little hearts and minds'.

Decision: As Cabinet Member for Adult Social Care and Public Health, I propose to:

a) **APPROVE** the adoption of the co-created strategy in regard to low to moderate Perinatal Mental Health and Parent Infant Relationships as detailed in the report and
b) **DELEGATE** authority to the Director of Public Health, to take other necessary actions, including but not limited to allocating resources, expenditure, and entering into contracts and other legal agreements, as required to implement the decision.

Reason(s) for decision:

Currently there is no strategy in Kent which focuses on low to moderate perinatal mental health and parent infant relationships yet there are gaps in knowledge and support. Developing a strategy supports strategic planning / delivery and helps improves joined-up working across organisations.

It is estimated that a total of 14,685 babies may need parent-infant relationship support in Kent over the next five years and that a total of 33,317 parents and carers may need perinatal mental health support in Kent at a mild-to-moderate level over the next five years.

Development of a co-created Perinatal mental health and parent infant relationships strategy has provided opportunity to bring stakeholders together from across the system, to raise awareness of perinatal mental health, parent infant relationships and identify where there are gaps in knowledge and in support. The strategy has been made available for public consultation for a period of eight weeks February – April 2024.

Research has shown the importance and need to improve awareness and understanding of low to moderate perinatal mental health and extending the reach of this through implementation of a strategy which also focuses on parent infant relationships is valuable.

This strategy will contribute to *'Priority 1: Levelling up Kent' of the Framing Kent's Future Our Council Strategy 2022-2026'* as the themes relate to providing additional support for families at the start of their infant's life which is a preventative approach to improve the populations health and narrowing of health inequalities.

Financial Implications:
The DfE family hub grant is a ring-fenced grant specifically for the family hubs and start for life programme which includes a focus on perinatal mental health and parent infant relationships and does not impact the council general revenue fund. This has provided opportunity to increase

workforce capability and capacity to expand the reach of low to moderate perinatal mental health and parent infant relationship support and to raise awareness of support available for those with low to moderate perinatal mental health. The implementation of this strategy will be pivotal to further progressing and embedding this work.

Securing Kent's future
The proposed decision aligns with Objective 3 of Securing Kent's Future

Legal Implications: The Council entered into a Memorandum of Understanding (MoU) with the Department for Education (DfE) which creates obligations to meet specific deadlines and timescales set by the DfE or risk losing further funding or funding claw back.

Access to the associated funding, depending on the type and level of transformation activity progressed, is conditional on compliance with the terms of the MoU and demonstration of progress toward an effective Family Hub Model.

The Council has and will enter into a number of contractual agreements to support delivery in line with Spending the Council's Money and Public Contract Regulations 2015.

Equality Implications:

A Equality Impact assessment has been completed (attached as appendix 2) and has identified that emotional and regulation needs may impact on access and communication; race and faith may impact on access to perinatal mental health support with proposed mitigations outlined.

Data Protection Implications:

General Data Protection Regulations are part of current service documentation for the contract and there is a Schedule of Processing, Personal Data and Data Subjects confirming who is data controller/ processor.

Cabinet Committee recommendations and other consultation:

In February 2024 Kent County Council (KCC) launched a public consultation on two co-created strategies to gain a better understanding of whether the strategies were accessible and presented a vision that was agreed on.
https://letstalk.kent.gov.uk/start-for-life-strategies

The proposed decision will be discussed at the Health Reform and Public Health Cabinet Committee on 2 July 2024 and the outcome included in the paperwork which the Cabinet Member will be asked to sign.

Any alternatives considered and rejected:
The guidelines from DfE on family hubs outline minimum requirements which includes a co-created Perinatal mental health and parent infant relationships strategy. These are important aspects of health and wellbeing, so non-compliance was not considered.

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

....

signed date

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DECISION REPORT

From:	Dan Watkins, Cabinet Member for Adult Social Care and Public Health Dr Anjan Ghosh, Director of Public Health
To:	Health Reform and Public Health Cabinet Committee – 2 July 2024
Subject:	**The adoption of the Infant Feeding Strategy, 'Nourishing our next generation'**
Decision Number:	
Classification:	Unrestricted
Past Pathway of report:	
Future Pathway of report:	Cabinet Member decision
Electoral Division:	All

Is the decision eligible for call-in? Yes

Summary: Kent County Council (KCC) has been successful in receiving Family Hub Transformation Authority status and has therefore received designated Family Hub Transformation Funding. A Start for Life Programme update was provided to Health Reform and Public Health Cabinet Committee on the 11 July 2023. This provided an opportunity for members to ask any questions, help shape the programme of work and explained the governance route for future decisions.

A key decision is required to approve the adoption of the co-created Infant feeding strategy in order to support improvement in outcomes for children.

Recommendation(s): The Health Reform and Public Health Cabinet Committee is asked to **CONSIDER** and **ENDORSE,** or make **RECOMMENDATIONS** to the Cabinet Member for Adult Social Care and Public on the proposed decision (appendix A) to:

a) **APPROVE** the adoption of the Infant Feeding Strategy, 'Nourishing our next generation.' and to
b) **DELEGATE** authority to the Director of Public Health to take necessary actions, including but not limited to, allocating resources, expenditure, entering into contracts and other legal agreements, as required to implement the decision

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1. Introduction

1.1 This strategy supports a key area of transformation to family hubs which relates to Start for Life and is relevant to Public Health namely infant feeding.

1.2 Start for Life is a component of the family hubs model with a specific focus on the first 1001 days, between conception and the age of two, essential for the healthy development of babies. This focus for support was identified by the Dame Andrea Leadsom Review in 2020 and further articulated in March 2021 in publication of The Best Start for Life: A Vision for the 1,001 critical days. This was followed by the announcement of £300m government funding to support Family Hubs with a focus on parent carer panels, parenting programmes, parent infant relationships, perinatal mental health and infant feeding in April 2022. Kent was one of 75 local authorities provided with the opportunity to benefit from the £300m funding.

1.3 On 4 October 2022 the Cabinet Member for Integrated Children's Services took a key decision (Decision number 22/00094) to adopt the principle of Kent becoming a Family Hub Transformation Authority.

1.4 On 23 March 2023, a further key decision was taken under decision number 23/00015 Family Hub Transformation Funding: a) To commence development and co-design of the Family Hub model for Kent in line with Government Family Hub framework for delivery and associated plans. b) To allocate and spend funding allocated via the Family Hub Transformation Authority for 2022/23 financial year.

2. Infant feeding

2.1 The requirement from the Department of Education (DfE) is to co-create and embed an infant feeding strategy which ensures services are tailored to the local communities and there is a coherent and joined-up approach between staff and organisations.

2.2 We commissioned an external organisation, Better Breastfeeding in August 2023 to develop a co-created Infant Feeding Strategy.

2.3 An infant feeding steering group was established in August 2023, as part of the governance process to help bring key stakeholders together.

2.4 Opportunities have continued to be offered and shared to enable the workforces to develop their awareness and keep their knowledge of infant feeding up to date through training webinars, and full day workshops.

2.5 A draft strategy, 'Nourishing our next generation' was presented to the Start for life board in January 2024.

2.6 The strategy contains five themes:

- Ensuring that mother and families are well informed and well prepared for feeding their babies
- Providing the support mother and families need in the right place and at the right time

- Offering seamless support from an integrated and skilled workforce
- Involving the wider community
- Continuously improving our services as we learn over time.

2.7 A public consultation took place between 8 February and 3 April 2024. with presentation of materials online, digital promotion and attendance at various events across the county to enable discussion and an opportunity to complete the survey.

2.8 Analysis of the consultation responses was completed by Better Breastfeeding who developed the strategy. The consultation analysis is provided as an appendix to this briefing. (Appendix 1).

2.9 Small amendments have been made to the strategy following the public consultation.

2.10 Stakeholders from the local maternity and neonatal system who are part of the Kent and Medway Integrated Care Board (ICB) have been engaged in the process of developing this Infant Feeding Strategy and will be adopting the strategy through their governance processes.

3. Financial Implications

3.1 The DfE family hub grant is a ring-fenced grant specifically for the family hubs and start for life programme which includes a focus on perinatal mental health and parent infant relationships and does not impact the council general revenue fund. This has provided opportunity to increase workforce capability and capacity to expand the reach of low to moderate perinatal mental health and parent infant relationship support and to raise awareness of support available for those with low to moderate perinatal mental health. The implementation of this strategy will be pivotal to further progressing and embedding this work.

4. Legal implications

4.1 The council entered into a Memorandum of Understanding (MoU) with the Department for Education (DfE) which creates obligations to meet specific deadlines and timescales set by the DfE or risk losing further funding or funding claw back.

4.2 Access to the associated funding, depending on the type and level of transformation activity progressed, is conditional on compliance with the terms of the MoU and demonstration of progress toward an effective Family Hub Model.

4.3 The council has and will enter into a number of contractual agreements to support delivery in line with Spending the Council's Money and Public Contract Regulations 2015, and aligns with Objective 3 of Securing Kent's Future.

5. Equalities implications

5.1 An Equality Impact Assessment (EQIA) has been completed (attached as Appendix 2) and this has identified that there were impacts across all of the

protected characteristics. Suggested mitigations are wide ranging including training in person centred and cultural awareness, guidance on communication and sensory needs to be included in any notes.

6. Governance

6.1 The Cabinet Member decision will provide the strategic policy position of Kent County Council alongside that of partner agencies such as health, regarding the specified workstreams. The key decision will delegate authority for required activity to support the further progression of co-design, expenditure of funding and resources to commence delivery to improve services as required.

7. Conclusion

7.1 This strategy presents a framework to further develop our approach to enhancing support and information to support families on infant feeding.

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8. Recommendation(s): The Health Reform and Public Health Cabinet Committee is asked to **CONSIDER** and **ENDORSE** or make **RECOMMENDATIONS** to the Cabinet Member for Adult Social Care and Public Health on the proposed decision (Appendix A) to:

a) **APPROVE** the adoption of the Infant Feeding Strategy, 'Nourishing our next generation.' and to

b) **DELEGATE** authority to the Director of Public Health to take necessary actions, including but not limited to, allocating resources, expenditure, entering into contracts and other legal agreements, as required to implement the decision

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9. Background Documents

Consultation analysis

10. Appendices

Appendix 1 – Consultation analysis

Appendix 2 – Equality impact assessment

11. Contact details

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Consultation Report

Nourishing Our Next Generation: A five-year infant feeding strategy for Kent 2024-29

May 2024

Contents

Table of Contents

1 Executive Summary

This is the report of a consultation on Nourishing our Next Generation: a five-year infant feeding strategy for Kent 2024-29. The strategy is a partnership between Kent County Council (KCC) and Kent and Medway Maternity and Neonatal System (LMNS). Better Breastfeeding was commissioned by KCC to co-produce the strategy with parents, carers, and professionals during 2023.

The purpose set out in the draft strategy is to help give babies in Kent the best start in life and to support the health and wellbeing of mothers, with a focus on reducing health inequalities. It aims to reduce the barriers to breastfeeding so that mothers can breastfeed for as long as they would like to and to ensure that all mothers and families get the support they need with feeding their babies. The strategy is structured around five themes which are:

1. Ensuring that mothers and families are well informed and well prepared for feeding their babies.
2. Providing the support mothers and families need in the right place and at the right time.
3. Offering seamless support from an integrated and skilled workforce.
4. Involving the wider community.
5. Continuously improving our service as we learn over time.

During the consultation period, we received comments from 55 people directly, as well as some combined feedback from young parents groups visited by KCC staff. Many people had already contributed to the development of the draft strategy, with 394 mothers and 88 staff/volunteers having responded to online surveys during the co-production phase.

1.1 Feedback on the strategy

1. Most respondents found the strategy easy to understand (42 agree, 6 disagree). A few suggested it could be improved by being shorter, more concise and having a lower reading age.
2. Most respondents agree that the strategy clearly sets out what is important to achieve its aims (38 agree, 5 disagree).
3. There is strong support for all five of the strategy's themes and for every objective within those themes.

1.2 Themes arising from the consultation

The following themes were mentioned by at least 3 respondents:

1. Concern about whether the strategy is realistic. Questions are asked about whether there will be sufficient funding, staff time and volunteer hours to implement the strategy. It is suggested that the objectives should be more specific and measurable.
2. Suggestion that the strategy should include more detail about supporting formula feeding, bottle feeding and mixed feeding.
3. Emphasis of the skills and expertise of voluntary sector organisations in relation to infant feeding support and desire to see greater collaboration between the statutory and voluntary sectors.
4. Feeling that the strategy does not sufficiently acknowledge all the services that are already in place or the hard work and commitment of the staff in those services. Suggestions that it could build more on what is working or has worked in the past, such as the Beside You campaign.
5. Concern about recognition of, and payment for, infant feeding expertise and about whether there would be excessive reliance on volunteers in delivering peer support. A call for clarity about the roles of different infant feeding support workers such as breastfeeding counsellors, hospital infant feeding teams and peer supporters.
6. Request for greater clarity about who would deliver antenatal sessions. Suggestions included breastfeeding counsellors, lactation consultants, the voluntary sector, and joint delivery by midwives and health visitors. Suggestion that there is scope for streamlining this offer and reducing duplication.
7. A call for more support to be available by video call or phone call, so that mothers could access support from their own homes.
8. Suggestion that there should be flexibility about the location of support services as Family Hubs may not always be the most accessible location.
9. Suggestion that mothers should be able to self-refer to specialist infant feeding support services, and that a drop-in rather than a fixed-appointment service would better meet the needs of mothers and families.
10. Doubts about whether implementation of quality standards such as the UNICEF UK Baby Friendly Initiative is having the intended effect and calls for this to be reviewed.
11. A call to establish a local milk bank in Kent.

2 The strategy

The purpose of this consultation has been to seek feedback on Nourishing our Next Generation, which is a draft five-year infant feeding strategy for Kent. This draft strategy was co-produced in the second half of 2023 as a partnership between Kent County Council (KCC) and Kent and Medway Maternity and Neonatal System. Better Breastfeeding was commissioned by KCC to support the co-production of the strategy.

The purpose set out in the draft strategy is to help give babies in Kent the best start in life and to support the health and wellbeing of mothers, with a focus on reducing health inequalities. It aims to reduce the barriers to breastfeeding so that mothers can breastfeed for as long as they would like to and to ensure that all mothers and families get the support they need with feeding their babies. The strategy is structured around five themes which are:

1. Ensuring that mothers and families are well informed and well prepared for feeding their babies.
2. Providing the support mothers and families need in the right place and at the right time.
3. Offering seamless support from an integrated and skilled workforce.
4. Involving the wider community.
5. Continuously improving our service as we learn over time.

The strategy supports implementation of the Kent and Medway Integrated Care Strategy. It sets out how KCC will develop support for infant feeding through implementation of Start for Life and the Family Hubs Transformation Programme. It also incorporates system-wide actions for Kent as part of the implementation of Kent and Medway Local Maternity and Neonatal System's Equity and Equality Action Plan.

3 The strategy development process

The strategy has been developed through co-production. Many people have fed into this strategy, through surveys, interviews and co-production meetings.

During the strategy development phase, Better Breastfeeding:

- Interviewed infant feeding leads for maternity, neonatal and community services about the service they currently provide and produced a gap analysis of how the current service compares with expectations in national recommendations and good practice guidelines.
- Conducted a survey of mothers in Kent, which received 394 responses from across all districts.
- Conducted a survey of staff and volunteers who support mothers and families with infant feeding, which received 88 responses.
- Met with multidisciplinary groups of staff and Maternity and Neonatal Voices Partnership (MNVP) service uer chairs to review findings from the gap analysis and surveys and to plan content for the strategy.
- Reviewed findings from other completed and ongoing outreach work including:
    - University of Kent research on barriers to breastfeeding for women in deprived areas
    - Kent and Medway LMNS Equity and Equality Action Plan outreach by community organisations
    - Involve Kent research on the maternity experiences of ethnic minority women in Dartford, Swanley and Gravesham
    - Kent Dads' perinatal support project
    - Perinatal Mental Health and Parent Infant Relationships strategy.

The strategy is structured around themes emerging from our analysis of responses to our surveys, our interviews, meetings and findings from other outreach work. The objectives in the strategy are based on what mothers and staff told us is important and are also informed by national guidance and good practice guidelines, including from UNICEF, NICE and NHS England.

Development of the strategy has been overseen by the Kent Infant Feeding Strategy Group, which brings together staff responsible for commissioning and providing infant feeding support in maternity, neonatal and community settings.

4 The consultation process

The consultation was conducted by KCC and was carried out alongside the consultation for the Nurturing Little Hearts and Minds: a perinatal mental health and parent-infant relationship strategy for Kent 2024-2029.

The consultation ran from 8 February to 3 April 2024.

The consultation was hosted on KCC's Let's talk Kent website. The consultation webpage[1] contained a short introduction, the draft strategy, and Equality Impact Assessment. Feedback was captured via a consultation questionnaire, which was also available in Word and hard copy for those that did not want to or couldn't complete the online version. An Easy Read version of the draft strategy and questionnaire were also available from the website and on request.

Promotional materials (and the website and draft strategy) included details of how to request hard copies and alternative formats. A telephone number and email address were available for queries and feedback.

A consultation stage Equality Impact Assessment (EqIA) was carried out to assess the impact the strategy could have on those with protected characteristics. The EqIA was available as one of the consultation documents and the questionnaire invited respondents to comment on the assessment that had been carried out.

4.1 Promotional activities

There were several activities to promote engagement in the consultation process:

- Staff were available at activity events throughout the consultation period (nine events across the county and one online evening event to support engagement from parents with very young children) to engage with participants about the proposals, answer queries and encourage participation. A recording of the online event was made available from the consultation webpage.
- Across the consultation period many multi-agency partnership meetings were attended to raise awareness of the consultation and share information.
- Young people were engaged directly and had the option of how they participated (for example, questionnaires, group discussion etc).

[1] https://letstalk.kent.gov.uk/start-for-life-strategies

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

- Promotional material sent to Health Visiting service and community-based midwifery.
- Social media and paid Facebook advertising.
- Posters and promotional postcards in Children's Centres / Family Hubs, Youth Hubs, Kent Libraries, and Gateways.
- Emails to stakeholder organisations, including to all early years and childcare providers that operate within the Kent Local Authority area (over 1,700). With reminder sent two weeks before the consultation closed to those who had not yet responded.
- Invite to people registered on Let's talk Kent who had asked to be kept informed about new consultations about 'Children and families' and 'Public health and wellbeing' (7,456).
- E-bulletin for Early Years and Childcare professionals throughout Kent.
- Promotional banner on kent.gov homepage and links to consultation from service pages on Kent.gov
- Articles in KCC's residents' e-newsletter (approx. 7,500 subscribers)
- Briefing to KCC Members and Kent MPs and promoted Town and Parish Councils through the Kent Association of Local Councils (KALC).
- Media release issued at the launch of the consultation.
- Articles on KCC's staff intranet and e-newsletters and email to staff groups.

The consultation webpage had a total of 9,530 visits by 8,676 visitors. Of these:

- 531 downloaded the draft strategy and 28 downloaded the Easy Read version.
- 58 downloaded the Word version of the questionnaire and 13 downloaded the Easy Read questions.
- 36 downloaded the EqIA.
- Most visits to the website were direct from the weblink (4,617) or from social media posts (3,263).

Organic posts from KCC's corporate Facebook and Instagram accounts had a reach of 36,141. There were 252,527 impressions across all KCC's channels (Facebook, X, Instagram, Nextdoor and LinkedIn. Reach refers to the number of people who saw a post at least once and impressions are the number of times the post is displayed on someone's screen. The posts generated 398 clicks through to the consultation webpage. (Not all social media platforms report the same statistics).

Points to note:

- Consultees were given a number of opportunities to provide feedback in their own words throughout the questionnaire. This report includes thematic feedback across consultee responses.
- Feedback received by the KCC team via email has been reviewed for the purpose of analysis and free text comments have been included where applicable in this report.

5 Analysis and methodology

The full questionnaire is included as an appendix.

5.1 Closed (quantitative) question analysis

Respondents were asked closed questions about the strategy as a whole as follows:

- Is the draft Infant Feeding Strategy easy to understand?
- How much do you agree or disagree that the draft infant feeding strategy clearly sets out what is important to support the health and wellbeing of mothers and families with infants, with a focus on reducing health inequalities, in order to give babies in Kent the best start in life?

Respondents were asked a closed question about the strategy's five themes:

- How much do you agree or disagree that the five themes set out in the draft strategy will help to give babies in Kent the best start in life and support the health and wellbeing of mothers?

Each theme contained a number of objectives. Respondents were asked, for each objective, whether they thought it would help to achieve the purpose of that theme:

- How much do you agree or disagree that these objectives will help make sure that mothers and families are well informed and well prepared for feeding their babies?

As the total number of respondents to the questionnaire was 53, the data has been presented as numbers of respondents rather than percentages. As the questions were not mandatory, the number of respondents varies between questions.

5.2 Open (qualitative) question analysis

After each closed question, participants were invited to give more detail about their answer or to share any suggestions.

At the end of the questionnaire, participants were asked three further open questions:

- If there is any further information, details or links that you feel should be included in the final strategy, please provide them in the box below.
- We welcome your views on our equality analysis, including suggestions for anything else we should consider relating to equality and diversity. Please add any comments below.
- If there is anything else you would like to tell us about the draft strategy, please provide your comments in the box below.

Responses to the open questions have been grouped by theme. For the first questions about the whole strategy, these are presented in tables. For the questions

on the themes and objectives, we have provided a narrative outline of the issues raised, indicating how many respondents made each point.

In some cases, points were made in general questions that actually related to a specific objective. We also received some comments by email that were not arranged by theme or objective. To provide a clear overview of the issues raised, comments that relate to a specific theme or objective are analysed under the relevant theme or objective, which may be different to where the respondent actually gave that answer. Where comments were repeated in response to multiple questions, we have briefly indicated that the same point was made.

6 Who we heard from

The following feedback was received in response to the consultation:

- 52 responses to the online questionnaire
- one response to the paper questionnaire (completed by KCC staff on behalf of a young parent)
- two emails from mothers
- one email from KCC, summarising feedback collected in person from young parents

6.1 How people responded to the questionnaire

Response	No. of responses
As a Kent resident	36
As a resident of somewhere else, such as Medway or further afield	1
As a professional working with parents and families in Kent	14
Providing the official response of an organisation, group, or business	1
Total no. of responses	**52**

6.2 Professional roles of respondents

Respondents who selected that they were responding as a professional were asked to select their profession from a list, with the option to select 'Other' and write their profession.

Response	No. of responses
Breastfeeding support staff	2
Infant feeding support staff	1
Children's Centre / Family Hub staff	5
Health Visitor	1
Midwife or student midwife	1
Other: Childhood sleep consultant	1
Other: Engagement and participation officer	1
Other: Communications	1
Other: Infant feeding specialist midwife	1
Total no. of responses	**14**

6.3 How many respondents were parents/carers?

Respondents who selected that they were responding as a Kent resident or a resident of somewhere else were asked if they were a parent or carer.

Response	No. of responses
A parent or carer	30
Pregnant or an expectant parent	1
Neither of these	8
Total no. of responses	**39**

6.4 How did the parents/carers describe their role?

Most of the parents/carers who responded stated that they are a mum, with one saying they are a grandparent.

Response	No. of responses
Mum	30
Grandparent	1
Total no. of responses	**31**

6.5 Age groups of children cared for by respondents

Most of the parents/carers who responded had children under eleven years old, with the most common age group of children cared for being 13-24 months.

Response	No. of responses
Expecting a baby	4
0-2 months of age	1
3-6 months of age	4
7-12 months of age	1
13-24 months of age	17
3-4 years old	9
5-10 years old	11
11-19 years old	1
20 years old and over	1
Total no. of responses	**31**

6.6 Are respondents the primary carer for the child(ren) they regularly care for?

Most of the respondents were the primary carer for the children they regularly care for.

Response	No. of responses
Yes	29
No	2
Total no. of responses	**31**

6.7 How often did respondents use relevant services?

Respondents were asked how frequently they use the following services.

Service	At least once a week	Once a fortnight	Once a month	Twice a year	Less regularly	Used it in the past	Never used this service
Children's Centres / Family Hubs	4	0	4	3	5	14	9
Health Visiting	0	0	2	5	5	19	6
Infant feeding groups e.g. Information on feeding an infant	1	0	0	1	4	18	14
Breastfeeding support e.g. guidance on 'latching on'	0	0	0	1	4	18	15
Specialist infant feeding support e.g. guidance to re-establish breast milk supply	0	0	0	1	4	10	23

6.8 How did respondents use these services?

Those who had used the services had mainly accessed them in person at a building.

Service	In person at a building	Online	Both	I don't use this service	Total no. of responses
Children's Centres / Family Hubs	21	0	1	16	38
Health Visiting	22	1	4	11	38
Infant feeding groups	20	0	1	17	38
Breastfeeding support	17	0	3	18	38
Specialist infant feeding support	12	0	1	25	38

6.9 How often other people in the respondent's household use these services

Respondents were also asked how often other people in their household used the services. Other members of the household were much less likely to have used these services than the respondents themselves.

Service	At least once a week	Once a fortnight	Once a month	Twice a year	Less regularly	Used it in the past	Never used this service
Children's Centres / Family Hubs	0	0	2	1	3	3	25
Health Visiting	0	0	0	3	5	7	20
Infant feeding groups	1	0	0	0	4	0	30
Breastfeeding support	1	0	0	0	4	1	29
Specialist infant feeding support	0	0	1	0	4	1	29

6.10 How other people in the respondent's household use these services

Where other household members had accessed the services, this was in person at a building.

Service	In person at a building	Online	Both	They don't use this service	Total no. of responses
Children's Centres / Family Hubs	7	0	0	27	34
Health Visiting	9	0	0	25	34
Infant feeding groups	1	0	0	33	34
Breastfeeding support	2	0	0	32	34
Specialist infant feeding support	2	0	0	32	34

6.11 Sex of respondents

All respondents who answered this question were female.

Response	No. of responses
Male	0
Female	33
Total no. of responses	**33**

6.12 Gender of respondents

All respondents who answered this question stated that their gender was the same as at birth.

Response	No. of responses
The same as at birth	32
Different from at birth	0
Total no. of responses	**32**

6.13 Age of respondents

Respondents who gave their age where mainly aged 25-49.

Response	No. of responses
0-15	0
16-24	1
25-34	11
35-49	15
50-59	1
60-64	1
65-74	2
75-84	1
85 and over	0
Total no. of responses	**32**

6.14 "Do you regard yourself as belonging to a particular religion or holding a belief?"

Two thirds of respondents to this question did not regard themselves as belonging to a particular religion or holding a belief. The remaining third described themselves as Christian.

Response	No. of responses
Yes	10
No	21
Total no. of responses	**31**

6.15 "Do you consider yourself to be disabled as set out in the Equality Act 2010?"

A fifth of respondents who answered this question stated that they were disabled.

Response	No. of responses
Yes	5
No	25
I prefer not to say	1
Total no. of responses	**31**

Of the five respondents that considered themselves to have a disability:

- three reported learning disability (including neurodivergence),
- one reported a mental health condition, and
- one reported multiple disabilities;
- Physical impairment,
- Sensory impairment (hearing, sight or both),
- Longstanding illness or health condition, such as cancer, HIV/AIDS, heart disease, diabetes or epilepsy,
- Mental health condition,
- Learning disability.

6.16 Ethnicity of respondents

Most of the respondents who gave their ethnicity were white English.

Response	No. of responses
White English	27
Mixed White & Asian	1
White other	1
White British	1
British Iranian	1
Total no. of responses	**31**

6.17 Are you a carer?

One sixth of respondents to this question stated that they are a carer.

Response	No. of responses
Yes	5
No	26
Total no. of responses	**31**

6.18 Sexuality of respondents

Response	No. of responses
Heterosexual/straight	27
Bi/bisexual	1
Gay woman/lesbian	2
Other	1
Total no. of responses	**31**

7 Findings

7.1 Is the draft infant feeding strategy easy to understand?

42 respondents thought that the strategy was easy to understand, while six people thought that it wasn't.

Yes	No	Don't know	Total no. of responses
42	6	3	51

The following suggestions were made for making the strategy easier to understand

Suggestion	Mentions
Make it shorter	3
Lower the reading age	2
Less text, more bullet points and infographics	1
Fewer abbreviations	1
Use less "management speak"	1
"Was not in a format that people with disabilities could access"	1
Translate into community languages (Igbo, Yoruba, Krio, Creole, Punjabi were specifically mentioned)	1
"to be able to provide feedback without having to register anonymously would be helpful for those concerned leaving their details"	1

Comments included:

> "This needs to be shorter and more concise, truly highlighting the main principles that you want parents to comment on." (Professional working with families)

> "The reading age is WAY too high. A quick assessment shows this is at a Level 4 or 5 (National Literacy Trust) which would be PhD level. This is unacceptable for a document that is at LEAST meant to be used by professionals (aim for a level 2) or the general public (reading age average is entry level 3, which is nine-years-old.) … Please get someone to put together this document in a clear, cohesive, and readable way! Otherwise it will be utterly useless." (Mother and professional copywriter)

"Having resources translated to Punjabi and other ethnic minority languages could help those family members with influence such as mothers and grandmothers help to spread the KCC messages to those in need of your services" (Kent resident)

7.2 How much do you agree or disagree that the draft infant feeding strategy clearly sets out what is important to support the health and wellbeing of mothers and families with infants, with a focus on reducing health inequalities, in order to give babies in Kent the best start in life?

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know	Total no. of responses
25	13	6	4	1	1	50

Comments from those who strongly agree or tend to agree:

Reason	Mentions
Support for more timely and accessible services	5
The strategy is clearly expressed	3
Challenges of meeting those most in need	3
Agree in principle, some concern about whether effective implementation is realistic	3
Parents need realistic expectations about infant feeding	2
"Recognises that the strategy must be kept up to date and relevant"	1
"You have included both natural and artificial feeding in the strategy"	1
"normalising breastfeeding within the community is integral"	1
Staff attitudes: "we need to do away with that's not my job today attitude and all be willing to support when we can."	1

"there should be local support within a 30 min drive for all parents to seek help" (Childrens centre/family hub staff member)

"I work in an area which is very multicultural we do not have resources in all the languages required, if we want to use a face to face interpreter which is always best practice when supporting a client with breast feeding problems we are challenged about why we want a face to face one. The infant feeding team do not carry out home visits which would benefit some of our clients." (Health visitor)

"Many parents aren't prepared around the norms of frequent feeding, day and night. They are given inaccurate advice and told they have a 'hungry baby' or they need to 'top up' with formula. Or led to believe/diagnosed with undersupply (which is actually extremely rare)… I still think feeding past early infancy carries some stigma from some and unfortunately isn't normalised due to low rates. Imagery in even non related advertising or information would be amazing, with children of varying ages!" (Childhood sleep consultant)

Comments from those who strongly disagree or tend to disagree

Reason	Mentions
Too much emphasis on breastfeeding	2
Strategy unclear/too long	2
The service described is similar to the current service	1

Comments from those who neither agree nor disagree, or who don't know.

Reason	Mentions
Promote choice and support mothers who mixed feed or formula feed as well as those who breastfeed.	1
"You positioned the 'benefits' of breastfeeding, as opposed to the risks of formula feeding. Breastfeeding is the biological norm. The stats need to be flipped."	1
Need more specifics	1
More services needed from professionals, including a 3-6 month health visitor contact.	1

"More services are required from professionals and more money needs to go into professionals such as Health Visitors to provide additional support to universal families, not just offering the 5 mandated contacts but adding a contact at 3-6 months to review how feeding is going and also talk about weaning." (Mother of a 3-6 month old baby)

7.3 How much do you agree or disagree that the five themes set out in the draft strategy will help to give babies in Kent the best start in life and support the health and wellbeing of mothers?

Themes	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know	Total no. of responses
Theme 1: Ensuring that mothers and families are well informed and well prepared for feeding their babies.	36	12	2	0	1	0	51
Theme 2: Providing the support mothers and families need in the right place and at the right time.	36	11	3	0	1	0	51
Theme 3: Offering seamless support from an integrated and skilled workforce.	35	13	2	0	1	0	51
Theme 4: Involving the wider community.	31	13	6	0	1	0	51
Theme 5: Continuously improving our service as we learn over time.	38	8	3	1	1	0	51

Please tell us about the reason for your answer (General comments relating to the whole strategy are included here. Comments relating to specific themes are included in the analysis of responses on that theme).

Theme	**Mentions**
Need more specifics/ is it realistic?	5
General agreement with the intentions and how they are expressed	4
Seek expertise from the voluntary sector	2
Connection with parent infant relationship strategy	1
“Please message that bottle feeding is ok!”	1
We are already doing all this	1
This is not a good use of taxpayers’ money	1

There were positive comments stating agreement overall with the themes (three mentions) and that they are expressed clearly (one mention). Some said that more specifics were needed to clarify how the objectives would be achieved (three mentions) and there were questions about where the funding would come from (two mentions).

It was suggested that expertise should be sought from the voluntary sector (two mentions), at a strategic level and in relation to skills needed to support mothers. One respondent pointed out that the parent infant relationship strategy would support the infant feeding strategy as responsive parenting facilitates breastfeeding. Another asked for messaging to state that bottle feeding is OK.

Comments expressing disagreement with the themes were that all of this is already being done (one mention) and that it is not a good use of taxpayers money (one mention).

The following comments included specific suggestions:

> “I think we should have clear targets and suggestions laid out. Changing attitudes to breastfeeding at the moment it just says talk to communities about what they want - I think clearer objectives around this and how this would be monitored would be more useful. I also think clearer objectives around organisations working together would be useful, e.g. every parent informed about Beside You and Kent Baby by their midwife and health visitor, every public building has a Beside You breastfeeding sticker in a public location. These are more tangible and can be tracked and audited to see if they have been implemented.” (Communications professional working with Kent families)

> “Health professionals could really learn from The Lay infant feeding world where the Counselling skills, group facilitation are key. Antenatal classes need to be run by BFC and LC who have had additional training. HV don’t have the skill set. Also where these courses are offered is key. HV who become IBCLC seem to lack the Counselling skills, the supporting families to come to there own conclusion because the have very tight time constraints the 1:2:1 appointment slots are just not working.” (Mother)

7.4 Feedback on the themes and objectives

Theme 1 - Ensuring that mothers and families are well informed and well prepared for feeding their babies

How much do you agree or disagree that these objectives will help make sure that mothers and families are well informed and well prepared for feeding their babies?

Objectives	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know	Total no. of responses
1.1. Make nurseries and schools aware of resources for including breastfeeding in the curriculum.	27	11	7	2	4	0	51
1.2. Provide 1-1 peer support for young and/or vulnerable mothers before their baby arrives.	38	9	2	1	1	0	51
1.3. Provide group learning sessions about infant feeding for mothers to attend before and after they have their baby and make these sessions welcoming for fathers/partners.	41	7	1	1	1	0	51
1.4. Support mothers and families to know how to provide a healthy diet for themselves and their children.	40	6	2	1	2	0	51

1.5. Provide high quality, accessible information for mothers and families about infant feeding and about where they can get support.	44	3	2	1	1	0	51

Comments and suggestions on theme 1

There were four comments supporting the general case for better antenatal support, including reference to one-to-one discussion, information for partners and promoting the benefits of breastfeeding:

> “I think having the information and support in place antenatally is key. There's so much emphasis on having a birth plan, but not a postpartum plan for things that can support you once the baby has arrived.” (Mother)

> “It would have been good to have access to information about infant feeding before giving birth and for my husband to receive the information as well. So we could have more informed discussions about feeding our baby” (Mother)

> “Make feeding information especially around breastfeeding more important antenatally and provide access to peer supporter / lactation specialist for Mums to be to talk to and discuss how hard it is.” (Mother)

> “There is a need for learning about breastfeeding while pregnant and few opportunities to do so. By the time people are pregnant some have already decided not to breast feed so if you wish to widen uptake you need to better disseminate information about it's positive impact for mother and child as these benefits are not widely known.” (Mother)

A young mother commented that she didn’t get any antenatal advice on infant feeding prior to having her baby.

Three members of staff commented that some or all of this work is already happening and one mentioned feeling undermined:

> “Some of this work is already there - we have staff in place e.g. health visitors and midwives and resources like Beside You and Kent Baby with the information there, so how do we get this out to families more effectively? Does the strategy suggest more paid advertising, more staff - what is this above what we already have?” (Communications professional working with Kent families)

> “Your literature and suggestions to parents are very undermining to staff who work hard and give well meaning advice and support” (Midwife or student midwife)

Two respondents commented on the role played by the voluntary sector:

> “Look at what’s already working well in the community.

> “I don't think we should disrupt 3rd sector provision as it works so well in some areas, but it does also potentially create variation in provision across the county.” (Mother)

Two mothers asked that information about formula be included alongside antenatal support for breastfeeding.

Other comments were:

> “Misinformation about wait times and service can be a big factor. Also the heavy advertisement and pressure from the private sector preying on new families, choice is important but conflicts of interest in areas such as midwifery with midwife’s who are also LCs encouraging private appointments and such.” (Infant feeding support staff member)

> “There needs to be huge investment in this.” (Mother)

> “We cannot afford these luxury ideals with the taxes etc levied on us already. Save our roads and infrastructure first.” (Kent resident)

Objective 1.1 Make nurseries and schools aware of resources for including breastfeeding in the curriculum

One mother provided personal experience in support of the objective:

> “I think it's really important to normalise breastfeeding - my children have been breastfed their whole lives but have both learned from nursery to feed the babies/ dolls with bottles as this the "norm". This is of course, a society level change, but with all our services and things set out in this strategy we have some power to change the tide over time.”

Two respondents (an infant feeding specialist midwife and a voluntary organisation) questioned whether the objective is realistic:

> “While I agree that it's important to include learning about the function of breasts, the importance and normality of breastfeeding in everyday learning. Unless it's in the curriculum, it's just something nice to offer that may or may not be taken up in schools and nurseries. It may only be highlighted in schools where teacher have a personal passion or interest in the topic.” (Voluntary sector organisation)

One engagement professional and two mothers questioned the purpose of this objective, the two mothers stating that this is too late to influence parents’ decisions. These respondents appeared not to have understood the intention behind this objective of reaching the next generation of parents:

> “seems a bit too late - you have already tackled breastfeeding by the time you enter these settings with your children”

A grandparent expressed concern about the effect of implementing this objective:

> “I’m not sure info for schools and nurseries is a good idea as this tends to create a lot of half baked experts who often feel the right to interfere, when you will have enough well informed relevant people to help at the right time and place.”

Objective 1.2 Provide 1-1 peer support for young and/or vulnerable mothers before their baby arrives.

Three comments emphasised the value of 1-1 antenatal support, with a suggestion that this should be available to everyone:

> “Agree with antenatal support but personally I think 121s will be more effective than groups - my experience is parents don't ask questions in groups but will open up in 121s.” (Communications professional working with Kent families)

> “Offer 1-1 support to everyone to take up if needed. Some families are not perceived as vulnerable But still need this support” (Mother)

> “Make feeding information especially around breastfeeding more important antenatally and provide access to peer supporter / lactation specialist for Mums to be to talk to and discuss how hard it is.” (Mother)

Three respondents raised issues about the roles of peer supporters, in relation to recruitment, training, retention, payment and skills. One suggested that the family partnership should be funded to provide this antenatal support for vulnerable families:

> “If every expectant family was offered a 121 appointment with a volunteer, the county would need to have the capacity to offer 326 appointments each week. I'm unsure of the numbers of young and/or vulnerable mothers so cannot comment on the numbers for this, but the challenges would then lie in recruiting and training these same Mothers into a voluntary role (which raise additional challenges that are not impossible, but need much more time, money and energy to overcome).” (Voluntary organisation)

> “Yes, absolutely, but will the peer supporters be paid? You are expecting free labour from women and this just isn't acceptable. The peer supporters should also be highly trained, which should also be funded.” (Mother)

> “More money for family partnership so they're able to do 121s with vulnerable families - this is too much for volunteers, they aren't trained to support vulnerable families.” (Communications professional working with Kent families)

Objective 1.3 Provide group learning sessions about infant feeding for mothers to attend before and after they have their baby and make these sessions welcoming for fathers/partners.

One respondent commented on the importance of providing antenatal classes:

> “Increase health visiting workforce to provide effective antenatal support. Mothers retain more information antenatally. More face to face classes / groups regarding feeding are also required antenatally to give mothers information.” (Mother)

Four respondents commented on who should provide these services:

> “Antenatal classes need to be run by BFC and LC who have had additional training. HV don’t have the skill set.” (Mother)

> “THESE CLASSES ALREADY EXIST. A multitude of incredible charities are doing this ALREADY. But they are in severe need of funding, and opportunities to advertise their services. For goodness sake, these charities have been BANNED from putting their leaflets in Kent Hospitals!!” (Mother)

> “Someone has to decide who is best placed to provide antenatal education on behalf of the government and then put all efforts into that. We have a situation at the moment where both KCC and ICB are both paying NHS services to offer antenatal support. Does someone access feeding support classes given by midwifery at Maidstone birthing centre or do they access a class run at a local Children's Centre? Where are people finding out about these classes? What do people want? Why are tax payers paying for both? Are they being accessed and evaluated?” (Voluntary organisation)

> “Try to get providers to work together from the antenatal stage, shared health visitor and midwifery antenatal classes.” (Communications professional working with Kent families)

One respondent welcomed the proposed inclusion of fathers:

> “this would have been amazing to have when I was pregnant as really wanted to breastfeed and my partner had a child from a previous relationship which was bottlefed. He didn't understand all the benefits of breastfeeding so when I was struggling … he kept saying to not worry and bottle feed instead.” (Mother)

Other comments mentioned that classes need to be inclusive, that the location is important, and that there should be separate antenatal and postnatal classes.

Objective 1.4 Support mothers and families to know how to provide a healthy diet for themselves and their children.

Two respondents commented in relation to introducing solids sessions:

> “I attended an introduction to solid foods at a children centre and was the only person that turned up. Maybe remote sessions would be beneficial.” (Mother)

> “I'm worried that this wasn't already happening. Children's Centres have run introducing solids sessions for years, surely they were inviting all families to attend.” (Voluntary organisation)

One respondent commented in relation to Healthy Start vouchers:

> “I've attended meetings for the last 10 years where the plan has been to increase uptake of healthy start vouchers. I'm wondering what the barriers are and why they haven't been discovered yet. Perhaps it is the timing of sessions? or the location? If almost all expectant mothers see midwifery during their pregnancy, perhaps the midwife could ask them to complete the application form there and then.” (Voluntary organisation)

A mother commented about vitamin supplements:

> “would it be a possibility to provide breastfeeding mums with vitamin supplements on prescription whilst they are receiving free prescriptions? I found them so expensive and was struggling on SMP. Also, I had to purchase vitamin D drops for the baby which would have been much preferable on prescription but was told that wasn't an option (I also wasn't advised that was something I should be doing until a health visitor visit at 2 weeks and found it embarrassing like I had failed by not knowing this).” (Mother)

One respondent questioned the value of including this objective:

> “Everyone knows how to have a healthy diet. It's a simple Google. The problem isn't knowledge, it's money. We are in a cost of living crisis, making it impossible for families (even with two incomes) to earn enough to eat a healthy diet. This is a much larger, government issue.” (Mother)

Younger mothers, in conversation with KCC staff, suggested there is a need for support with eating disorders during breastfeeding so that milk supply is protected.

Objective 1.5 Provide high quality, accessible information for mothers and families about infant feeding and about where they can get support.

Young parents, in conversation with KCC staff, stated that they think more information on breastfeeding would be helpful. This was also supported by a respondent to the questionnaire:

> "It would have been good to have access to information about infant feeding before giving birth and for my husband to receive the information as well. So we could have more informed discussions about feeding our baby." (Mother)

Two respondents emphasised that the information is already available:

> "Women have access to lots of information via the internet. They need help knowing whether things are normal/okay and someone there in person to help a baby latch." (Mother)

> "Go to the infant feeding charities - they have an abundance of resources. Have a system in place for signposting to them!!" (Mother)

Other comments were:

> "This will just need to be fully funded as information changes daily." (Voluntary organisation)

> "Place information and resources somewhere it can be easily accessed without having to be requested." (Kent resident)

Theme 2 Providing the support mothers and families need in the right place and at the right time

How much do you agree or disagree that these objectives will help to provide the support mothers and families need in the right place and at the right time?

Objectives	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know	Total no. of responses
2.1. Work towards healthcare professionals having sufficient time to support mothers with feeding their babies.	41	6	3	0	1	0	51
2.2. Enable mothers to access additional support when and where they need it.	44	5	1	0	1	0	51
2.3. Enable breastfeeding mothers to access social support and peer support in a group setting through the Family Hubs programme.	39	7	3	0	2	0	51
2.4. Reduce waiting times for specialist support.	44	4	2	0	1	0	51
2.5. Support those mothers who have difficulty feeding as a result of their baby having a tongue-tie and enable babies who need it to access tongue-tie division without unnecessary delay.	43	5	2	0	1	0	51
2.6. Provide support for mothers who are experiencing breastfeeding grief.	39	6	4	1	1	0	51

2.7. Support mothers to access equipment that will support them with breastfeeding their baby.	40	6	4	0	1	0	51

Comments and suggestions on theme 2

Two respondents stated general support for this theme, with 2 others agreeing the importance of support being offered at the right time:

> “Access to support in a timely fashion is essential. If there is a week's wait it will probably be too late to help at that point” (Mother)

Two further respondents expressed support for the intentions but expressed some doubt about whether it would be implemented:

> “Of course we agree that all of these are important, but worry that they are not always realistic.” (Voluntary organisation)

A young mother reported that she got very little support for infant feeding after her baby was born.

One respondent stated that the objectives are too vague and suggested asking infant feeding charities for relevant research to inform the development of more measurable objectives.

Five respondents emphasised that there should be support available with bottle feeding, formula feeding and mixed feeding, e.g. where a mother is unable to breastfeed or where she chooses to formula feed:

> “There’s not enough support for mothers who have to stop breastfeeding for whatever reason. There’s still a big stigma with health care professionals if you say you are bottle feeding” (Mother)

> “It is a choice!!! If people cannot breast feed it is their choice yes they might be disappointed but it’s only a big thing because the messaging and pressure is so skewed to breastfeeding and bottlefeeding is not seen as a positive choice” (Kent resident)

> “Education on bottlefeeding is also needed, especially around how to begin transitioning babies to bottles as this can be difficult and current breastfeeding services are very reluctant to provide this support.” (Mother)

> “Information about combination feeding is missing from this strategy and it is important that it is included. … I could not find any reliable information when I asked the health visiting team, or online. The health visitors advise you to keep breastfeeding (as per the guidance) and when you stop, they can then give you advice on bottle feeding. … A friend was able to advise me that breastfeeding at the same time every day would help my supply to continue, but I was really afraid my milk supply would stop altogether and I had nowhere to turn to for professional advice.” (Mother)

Three respondents questioned the value of including this objective:

> “Unfortunately we cannot afford these side services.” (Kent resident)

> “This is not a matter for KCC” (Kent resident)

> “most of this should be happening in the outer world.” (Kent resident)

One member of staff emphasised that much of this work is already being done:

> “After baby is born there are baby massage groups, breastfeeding groups, baby groups. Parents come along and receive help and support, build relationships with other new parents and gain confidence through peer support alongside professional support.” (Children’s centre/Family Hub staff)

One respondent suggested that:

> “In the hospital after the baby is born will be the best time to help struggling mothers with breastfeeding/advice.” (Mother)

Young mothers, in conversation with KCC staff, stated that practical info on how to support the weight of the baby’s body when breastfeeding with C-section would be helpful.

Another respondent asked where neonatal care features in the strategy.

Objective 2.1 Work towards healthcare professionals having sufficient time to support mothers with feeding their babies.

One mother emphasised that she would have liked more health visitor support:

> “Email communication or phone communication more often from the health visitors after baby is born. From my experience nobody contacted me after my baby was born. … mothers can feel very lonely and unsure of the care they are providing for their baby.”

Two respondents questioned how realistic this objective is:

> “Healthcare professionals having time to deal with these issues as they arise within existing appointments and touch points is important but potentially not very viable - where is this extra time/ resource going to come from?” (Mother)

> “We can only train so many midwives, because they all need mentors during their training and we only have so many of those. There are huge issues with midwifery training that can't be remedied quickly (funding, childcare, placement availability local). This objective is perhaps more of a ten to twenty year strategy and outside the control of local government.” (Voluntary organisation)

Another respondent suggested that the objective needs to be more specific and measurable:

> “This is utterly vague and silly. 'Work towards them having sufficient time' what does that even mean?! 'Ensure all midwives in Kent dedicate 5 minutes of every ante-natal appointment to preparing the patient for breastfeeding' perhaps? Or maybe 'Every person who has given birth will be given a minimum of 20 minutes breastfeeding support within the first 2 hours of their baby's life, 5 minutes of support every hour for the first 72 hours, and 20 minutes of support every 3 days after that until the baby is 6 weeks old.' Something MEASURABLE would be useful! And based on scientific research! Just ask infant feeding charities - they will already have the data.” (Mother)

Objective 2.2 Enable mothers to access additional support when and where they need it

Five respondents mentioned the importance of mothers being able to access additional support at home, either virtually or in person:

> “WIll you make some support available via zoom or video. Not all people will need a HCP in the room with them” (Kent resident)

> “Online services should be more available with nurse on duty who could pick up a phone call and advice.” (Mother)

> “Relating to the relaxation of mother, I feel the service should be available at home, whether through physical visits or video calls, as mothers won’t feel stressed having to get their newborn baby to appointments and impact on the time that could be spent with skin-to-skin bonding. I feel the number of visits I was asked to attend with my first child seriously impacted the success of our journey.” (Mother)

> “Also, nhs community nursery nurses should be more active as an outreach workers doing home visits especially after baby is born. This way more families will have a chance to see someone face to face.” (Mother)

Two respondents commented about the roles and pay for members of maternity infant feeding teams:

> “Infant feeding teams are needed in the local hospital paid post like Lactation consultants band 6 and infant feeding support workers band 4 look at east Kent and replicate in the other hospital except I feel the room of infant feeding support worker should be a band 4 not three and this is what it is in other areas ie Croydon, Chelsea and Westminster NHS, MTW, Medway.” (Mother)

> “I still have concerns that midwives who are suggesting families seek out additional support are referring to midwifery support workers and volunteers for more specialist help. Where else in the health system do we refer people down the hierarchy for more specialist support. Could we consider paying these people with specialist knowledge and skills more money please? … Infant feeding teams - often the most skilled person in lactation is not used clinically, and then the less skilled are those actually working clinically on the ward. If those staff then become more qualified they are being hugely underpaid. This isn't the best possible system for offering the best support for families.” (Voluntary organisation)

A voluntary sector organisational response stated:

> “I have no experience in the neonatal wards, but I have experienced resistance from staff to a breastfeeding volunteer even delivering flyers. The neonatal teams will have to be very strong and very skilled indeed to go up against the staff and consultants there.”

Objective 2.3 Enable breastfeeding mothers to access social support and peer support in a group setting through the Family Hubs programme.

Two respondents commented generally in favour of more support groups:

> “Fund more infant feeding cafes” (Mother)

> “I would have liked to benefit from a peer support group for breastfeeding mums, as it can be challenging, but you can give each other advice.” (Mother)

Another supported the idea of additional groups for specific needs:

> “Additional support groups across the County for specialist groups such as twins, LGBTQ+ etc would be amazing as numbers may not be high enough for a local in-person group to be helpful.” (Voluntary organisation)

Three respondents commented on the number and location of groups:

> “Women should be able to access social support but do not see the need for it to be in Family Hubs which are not necessarily accessible eg ones that are planned to be in libraries. VCS much better placed to offer this as trusted and easy to access” (Mother)

> “We need group in other areas not just HUBs” (Mother)

> “How will it be decided where to start new groups if areas where we need them the most are those with the lowest breastfeeding rates and those most young/vulnerable mothers who are less likely to advocate for groups or attend Family Hub co-production meetings.” (Voluntary organisation)

Two respondents expressed concern that too much would be expected of volunteers:

> “a peer support team is mentioned here, offering a 48 hour call. A volunteer offering this call worries me a little. There would need to be a really good understanding of what is normal and healthy at this age, a script so that nothing is missed in terms of what a healthy newborn looks like. These peer supporters would need additional training above and beyond the usual to cover this, and they would need to be closely monitored with someone to ask questions of immediately. Would these peer supporters be paid? would they be allowed to work with their children? would they be at home? how would we share data with them? I'm also worrying again about training enough. If 70% initiate breastfeeding of 17K births then we would need to make 32 calls each day of the year. The typical peer supporter might volunteer a couple of hours either weekly or monthly depending on their situation and would usually have a child with them. Wouldn't it be amazing if they were paid peer supporters who were able to have a case load and get to know families throughout their feeding journey.” (Voluntary organisation)

> “I just KNOW you're going to be relying on volunteers with little training. We need well paid, highly trained experts providing this support.” (Mother)

In response to the suggestion that breastfeeding peer supporters attend general baby groups as some younger mothers had found that breastfeeding groups exacerbated feelings of failure, a voluntary organisation commented:

> "I wonder what groups were being talked about, perhaps there needs to be thought into how the groups are run to encourage families to continue to attend once they no longer feel a need for support with problems. … At ___ we often pair mothers together for specific reasons with a positive response. … additional training should be given if they are to be accessing other groups. It's a totally different experience supporting at a breastfeeding group where everyone has come to receive support than attending a group where people may not welcome your attendance."

Another respondent suggested:

> "Rebranding of breastfeeding groups to infant feeding groups to make these more inclusive and encourage normalising breastfeeding." (Mother)

Objective 2.4 Reduce waiting times for specialist support

A comment was made expressing concern about waiting times for support:

> "More needs to be done to make hospital to feeding support in the community seem less without waits of over 2-3 weeks. Urgent referrals made in the Thursday are not being offered appointments until the 10-14 days later." (Mother)

Most comments on this objective focus on how waiting times can be reduced. Two comments ask for more specifics about how this can be done and one asks if there will be additional funding to support this.

A number of suggestions are made including:

- Improving infant feeding support would reduce the need for referrals to specialist support:

  > "I do think specialist support is important but where is the line about who needs that level of support. If support all round was improved hopefully the referrals would decrease." (Infant feeding support staff member)

  > "Not all problems are tongue tie staff need the skills to support families and not just refer to tongue tie services" (Mother)

- Families should be able to self-refer:

  > "Need open access to lactation consultants" (Mother)

  > "We feel that barriers can be removed by allowing families to self-refer" (Voluntary organisation)

- Change the appointment slot system:

  “How can you expect to manage breastfeeding issues with a set appointment rather than open drop ins allowing mums and babies to be relaxed and reviewed at a time that works for them and their baby.” (Mother)

  “HV who become IBCLC seem to lack the Councilling skills, the supporting families to come to there own conclusion because they have very tight time constraints the 1:2:1 appointment slots are just not working.” (Mother)

- Work with the voluntary sector:

  “We welcome conversations to work together with KCC to increase capacity and reduce waiting times. We welcome working together so that we know what might increase/decrease waiting times, help our practitioners to work together, get to know each other and even train together.” (Voluntary sector organisation)

- Issue a referral receipt:

  “There is definitely a barrier due to communication and the crossover between maternity and health visiting. Something as simple as a referral receipt sent to parents could easily overcome this by giving parents proof of referral, as well as information about what will happen next, where they can access support before then and contact information for them to use if they have any questions. This could be totally automated and an amazing, transparent way to run the service, reducing worry and chasing.” (Voluntary organisation)

There was also a comment about the location of specialist clinics:

> “The location of specialist clinics could definitely be improved. We hear from many families that they have to travel great distances to access support with little choice over the options they are given. Families travelling from Edenbridge to Maidstone for a 9am appointment who have children at school as an example. The Maidstone clinic (Molehill Copse) is not near a train station. Many families we see in Tunbridge Wells have been asked to travel to Paddock Wood as a closer option which involves 2 trains. More thought could go in to making sure that specialist services are provided at locations that are more easily accessible for vulnerable families, those without funds, those without cars and those who can't drive due to a c-section.” (Voluntary organisation)

Objective 2.5 Support those mothers who have difficulty feeding as a result of their baby having a tongue-tie and enable babies who need it to access tongue-tie division without unnecessary delay.

There were several suggestions for improving the tongue tie service and some strength of feeling, with one respondent stating:

> "Honestly the tongue tie process could not be any worse than it is currently." (Mother)

Six respondents emphasised the need for waiting times to be reduced:

> "Tongue-tie procedure delay nearly ended my breastfeeding journey. I am sure many mothers have stopped breastfeeding early due to the long waiting list." (Mother)

> "Having tongue-tie services available immediately is so key, as I waited 5 weeks with my son and by this point my nipples were wrecked and my son was so used to working around his tongue-tie that he struggled to ever get out of that habit when breastfeeding." (Mother)

> "Time and again we see families having to ask others to pay for private services because they just cannot wait." (Voluntary organisation)

> "access to timely specialist support, and tongue tie for example, are really important. Lots of people in Kent seem to need to go private to get issues corrected in time; although there is also probably some education around this required - about the fact that it does not always need correcting etc. But there is a perception in many areas that if you have a tongue tie issue you will need to pay to sort it yourself in a timely fashion, which is problematic." (Mother)

There were two comments about the location of tongue tie division services:

> "Tongue tie service is required at DVH families are currently traveling to EKHUFH Ashford or Kent and Canterbury or MTW Pembery hospital this is making one of the poorest demographic have extra travelling costs." (Mother)

> "Those living on the borders are also a challenge in West and North West Kent." (Voluntary organisation)

Other comments relating to support with tongue tie were:

> "Post tongue tie support needs improving. My baby had TT division and there was no support following this and we were left to our own devices. Following the procedure I was not given a comfy room to sit in, just a cupboard to try and feed my baby and did not get any positioning support from staff." (Mother)

> “We would also like to see families being able to access services in Kent above 12 weeks of age.” (Voluntary organisation)

> “As mentioned before, understanding of the process is really important and a receipt sent to parents telling them what the process is once they have been referred would be amazing. Parents often assume the first referral is for the procedure and don't know there will be an additional wait after seeing the infant feeding team within health visiting.” (Voluntary organisation)

> “Yes but this again is too vague.” (Mother)

Objective 2.6 Provide support for mothers who are experiencing breastfeeding grief

Two respondents commented in support of this objective:

> “I didn’t know breastfeeding grief as a concept until reading this consultation, and I think I experienced it – support with this would be helpful.” (Mother)

> “We know that a large percentage of breastfeeding journeys end prematurely, so this could be offered to everyone.” (Voluntary organisation)

Two respondents raised concerns:

> “Maybe dealing with breastfeeding grief (though important) shouldn’t be separated out to make those mothers feel that they are ‘different’” (Mother)

> “2.6 Whilst important, what is the data to show this will improve infant breastfeeding rates? This is more of a mental health issue.” (Mother)

Staff awareness beyond Family Hub staff was mentioned:

> “It's not only Family Hub staff who need to be aware, it is also Health Visitors and Midwives who need to know where to refer. … If we have peer supporters offering antenatal contacts, they would also need additinal training in this area and a place to refer on when necessary.” (Voluntary organisation)

Objective 2.7 Support mothers to access equipment that will support them with breastfeeding their baby.

A voluntary sector organisation provided extensive comments on this objective, making the following points:

- Are the schemes joined up?
- Can we see the outcome of the pilot studies?
- Pumps being available within 24 hours would be fabulous. Currently the process is a little long-winded, there are never enough pumps and families don't know what pump they need or how to access them.
- Is there provision to support families not on Healthy Start vouchers who need help with funding pumps?
- Pumps should be available out of hours and within the community. Could a delivery service be offered for isolated families? (voluntary sector could support this if funded)
- Will the pilot bra scheme continue? How do people learn about the scheme? Most women don't know their size, so pilot results would be interesting.
- If Family Hubs offer a sling hire service, please partner with existing sling libraries across Kent. People running these work really hard and would love to partner with Family Hubs to reach more families.
- Any staff handing out slings or pumps should have additional training to support parents using them safely, comfortably and effectively. They should be supported by a babywearing consultant/breastfeeding specialist for any situations outside of normal.

Other comments on this objective were:

> "Yes, but renting a mother a NHS breastpump is NOT a replacement for deliberate, careful, frequent, in-person support for feed their baby at the breast." (Mother)

> "Nobody informed me of breast shields and when my child was about 2 weeks old I stumbled upon them on a net mums blog. Managed to order one on amazon at 4am and arrived by 11am. It literally changed my experience! Would have been useful to have been recommended this before I left hospital when there was a suspected diagnosis of tongue tie." (Mother)

Theme 3 Offering seamless support from an integrated and skilled workforce

How much do you agree or disagree that these objectives will help to offer seamless support from an integrated and skilled workforce?

Objectives	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know	Total no. of responses
3.1 Continue to implement recognised quality standards in relation to infant feeding.	36	5	6	2	1	0	50
3.2. Expand availability of donor milk to all babies who would benefit from it.	37	7	4	0	1	1	50
3.3. Establish expectations for the peer support service relating to recruitment, training, supervision and integration.	37	4	5	0	1	2	49
3.4. Enable all staff and volunteers to access training and develop the competencies they need to support mothers and families with infant feeding.	38	5	3	0	2	2	50
3.5 Facilitate integration between organisations and across the multidisciplinary team, so that	41	5	2	0	1	1	50

mothers experience a seamless service.							
3.6. Engage with mothers, families and staff to co-create and continually improve infant feeding support services.	37	5	4	0	1	3	50
3.7. Plan support for those in isolated and vulnerable communities.	40	6	2	0	1	1	50
3.8. Develop a plan for providing infant feeding support in emergencies	40	4	3	0	1	2	50

Comments and suggestions on theme 3

Two respondents emphasised the need for more staff:

> “Increase health visiting workforce to allow them time to support families in the community.” (Mother)

> “There are not enough breastfeeding specialists in hospitals and none available to babies born at the weekend. This is not good enough.” (Mother)

Two staff members pointed out the work that is already taking place and the need for this to be recognised:

> “Recognise the work that staff and infant feeding teams are already putting in, tirelessly and relentlessly. Postnatal ward support for breastfeeding is incredibly hard work for midwives and msw / mcas, not to mention very time consuming with a full ward and back breaking and painful, it's a labour of love. It's very very hard work and there is literally no recognition or thanks. Working within unicef baby friendly standards is restrictive enough as it is and the training and updates we receive are already intense.” (Midwife or student midwife)

Other comments on this theme were:

> “This is the crucial part!” (Mother)

> “I do support the whole approach of education but please recognise individual choice and support it.” (Kent resident)

> “We cannot afford this” (Kent resident)

Objective 3.1 Continue to implement recognised quality standards in relation to infant feeding.

There are three comments relating to this objective, all raising concerns about whether it will be effective.

Objective 3.2 Expand availability of donor milk to all babies who would benefit from it.

There were four comments on this objective, all in support.

Three respondents suggested establishing a local milk bank:

> “Could this be expanded to enabling families in Kent being able to donate too? Perhaps a partnership with HeartsMilk Bank to have a local processing and distribution point. This could also be incorporated with the pump programme.” (Voluntary organisation)

> “As far as I am aware, there are no donor milk distributors in Kent; with the nearest ones being in London and maybe Surrey? The London ones are always at capacity but I don't know if Kent families are then benefitting from this so maybe a local run milk bank would be good.” (Mother)

> “I tried to donate my breastmilk as I ended up with so much. There was nowhere available in Kent to take it and I would have loved to have helped other struggling mums.” (Mother)

One respondent made a case for more staff training:

> “I would also like to see better education among healthcare professionals about the use of donor milk and WHO standards. I have personal experience that proves Kent midwives have zero understanding on this topic (unless based on their personal breastfeeding experience).” (Mother)

Objective 3.3 Establish expectations for the peer support service relating to recruitment, training, supervision and integration.

A voluntary organisation response provided extensive comments on this objective, including the career pathway for peer supporters:

> “Wouldn't it be amazing if there was a recognised training pathway for volunteer peer supporter to paid peer supporters, to paid hospital peer supporters to paid midwifery support workers to paid trainee midwives to midwives where paid actually means enough to live on and pay for childcare and food.” (Voluntary organisation)

And challenges of recruiting and training peer supporters:

> “recruitment, training and retention of such a huge volunteer team is a lot of work and I wonder if it's even possible. Peer supporters are generally women of childbearing age, and usually during their maternity leave. This gives us a very niche group to recruit from and very limited amount of time they will be with us for, so turnover is high. I don't think the current training strategy fits this bill, so it will need to be ramped up considerably. Challenges will include working between organisations (hospitals vs. Children's Centres vs. Health Visiting), different roles leading to different situations (no children with them in the hospital as an example). Training might be slightly different for each role. If focusing on different communities, ages, languages then additional training needs may present (lower reading levels, outside of work hours, English as a second language etc). If paid peer supporters require additional training or breastfeeding counsellors become the level required then it would need to be calculated how many would be trained over the next 5 years and how that might work as there are many different training programmes (ABM, BfN, NCT, LLL) and they would take various amounts of time to complete.” (Voluntary organisation)

One respondent commented about who should run the service:

> “HV does not understand peers support this needs to be an outside agency who has proven track record such as PSB or ABM or BFN” (Mother)

Another argued for payment of peer supporters:

> “Yes, absolutely, but will the peer supporters be paid? You are expecting free labour from women and this just isn't acceptable. The peer supporters should also be highly trained, which should also be funded.” (Mother)

Objective 3.4 Enable all staff and volunteers to access training and develop the competencies they need to support mothers and families with infant feeding.

Two respondents commented in favour of all relevant staff having a basic level of understanding around infant feeding:

> “I feel that any professional coming in to contact with a new mother should have a basic understanding of breastfeeding. When in hospital and with the subsequent visits from the community team I was told several times that “I cannot help with breastfeeding”, which is not accessing support when it’s needed and even the most basic training could give that mother confidence to keep trying.” (Mother)

> “All of those working in the perinatal period should have a basic understanding of breastfeeding and infant feeding, but there just isn't the time to give when feeding cannot be observed at an appointment if baby isn't hungry. We are still hearing of staff giving out old and outdated knowledge or just plain incorrect, so is the current training not good enough? Is it missing something? Could it be done differently (experience learning alongside a specialist)? or is it just that some professionals don't have an interest in the subject or just can't know everything about everything.” (Voluntary organisation)

Two respondents mentioned staff personal experience or commented on the suggestion of debriefing for staff, in support of this but also raising some challenges:

> “health professionals may already hold very personal views around infant feeding which do affect their practice. … Training is one thing but passion and professionals working through their own feelings around infant feeding is another. Having attended training sessions where professionals who are supposed to be offering support are still holding a lot of their own breastfeeding grief or that they don’t think it’s important as ‘fed is best’. I think this is a key factor.” (Infant feeding support staff member)

> “It's true that many staff don't have the opportunity to de-brief their own feeding journey and experiences. This in itself would be a big project taking staff away from their work and finding the right people to provide the service. Some might need more time than others and some might be resistant. It may be decided after de-briefing that some staff shouldn't be in their field. How would that be handled?” (Voluntary organisation)

Two respondents supported the principle of hands-off breastfeeding support and consent being sought for physical contact:

> “I fully support the strategy to train all professionals in a consistent approach to breastfeeding and would emphasize focus on professionals who use ‘old-school’ maternity practices (such as manipulating mum and baby to achieve a successful latch) and where there is a refusal to participate in updated practices that they are not allowed to support students. I had a student use very outdated methods to achieve a successful latch with my second child and when I asked if she was taught this in her course she advised that it hadn’t been covered in the course (if this is the case then this should also be a priority in the strategy to look at midwife teaching) and she had been shown by a current practicing midwife.” (Mother)

> “We agree that practitioners should on the most part be hands-off when supporting feeding, and consent should always be in place. We hear about unwanted hands-on situations regularly.” (Voluntary organisation)

Two further suggestions were made for the content of training:

> “I’m so glad to see ‘time’ given to new mums in the strategy, as this is so important to get a mum to feel relaxed and comfortable to achieve a successful latch. Many rooms that women are asked to ‘demonstrate’ their latch in are cold, with upright, uncomfortable chairs and the window of time is minimal. My hallelujah moment with both my children was spending time with breastfeeding specialist __ in her warm, inviting space with comfortable chairs and with __’s relaxed and unhurried approach. It was the first time that relaxing was made so important in the success of the feeding. I’d also like to see the relaxing element written into any literature that is produced for both professionals and the people they support, not just the mechanics.” (Mother)

> “Please message that bottle feeding is ok!” (Kent resident)

Two comments were made about the accessibility of training:

> “I'm wondering how you will enable GP's and Paeds to access training. It's challenging enough for midwives to find the time. There will be costs involved. How will these costs be covered?” (Voluntary organisation)

> “You've got to make training more accessible for those who want to do more and also support their communities. Driven by volunteers. Make more paid positions available to keep these vital feeding support services open.” (Mother)

A comment was made about clarifying competencies of different roles, particularly breastfeeding counsellors and peer supporters:

> “I think first we need to clarify the roles of a volunteer peer supporter, paid peer supporter and breastfeeding counsellor. We have some highly trained breastfeeding counsellors in Kent that would feel undervalued in these descriptions. They are providing specialist breastfeeding support. Within __ [our voluntary organisation] we use lactation consultants and breastfeeding counsellors and pay them the same, offering them the same roles. I'm not sure why a breastfeeding counsellor would be needed to lead a peer support group. It's either a peer support group or a breastfeeding counsellor-led group. This needs to be discussed and decided in co-production with practitioners from all levels. Paid roles need to pay enough for the needs of the role (with or without child as an example). This discussion would then lead to an idea of the recruitment and training that would be needed to cover all the roles described in this strategy - antenatal conversations, 48 hour contacts, hospital wards, community groups, community ambassadors etc.” (Voluntary organisation)

Another respondent suggested that more IBCLCs (lactation consultants) and breastfeeding counsellors could be employed within the NHS:

> “More paid positions utilising the BFC and IBCLC already trained in Kent. Why don’t they want to work in the NHS? There is more than 25 Trainined IBCLCs in Kent and even more BFCs what is the public sector doing to not employ or make it attractive to be employed. FLEXABLE working hours, locations and conditions. Why should these women be giving there time for free they need to be values and recognised for plugging the gaps of the Current NHS services.” Mother

Objective 3.5 Facilitate integration between organisations and across the multidisciplinary team, so that mothers experience a seamless service.

There were two comments in favour of greater integration between the statutory and voluntary sectors, including this from a voluntary organisation:

> “Something else we see is families accessing both health visiting and ___ (our) services for the same reason, This is another reason we would love to work more closely to make sure that families get what they need as that funding isn't wasted. … ___ (we) would like to work together within the local community to offer greater continuity of care and seamless care. We'd love to be involved in the conversation to be able to access and edit infant feeding records so that we can work smarter and not give contradicting information. We'd love to share training with practitioners across the County so that we are all singing from the same hymn sheet and get to know each other. … as a charity, we strive to fill gaps created by the local mandatory services. We do

this only with the support of families and organisations funding our work. Charities and third sector organisations cannot do anything without funding. However, we exist outside of the system for various reasons, and although we would love to work alongside the NHS, would welcome funding and support, the way we work is different for a reason. When the pandemic started we were able to get back up and running almost immediately, starting face to face before a lot of NHS services. We value our independence." Voluntary organisation

One respondent said more focus should be given to the faltering growth pathway:

> "I think more space needs to be given to what you're calling the Faltering Growth pathway. My experience of having a big baby who settled on an inadequate (in the eyes of hcps) growth trajectory was awful. The health visitor, GP and eventually paediatric team at MTW spent 5 months hounding me without offering any practical support (that came from the breastfeeding drop in). I was told more than once to stop breastfeeding, and to wean early to promote weight gain (because a spoonful of carrot would somehow help?) They missed opportunities to actually help because they jumped straight to "stop breastfeeding" - after having very high milk supply with my older child, nobody questioned reasons for low supply (retained placenta which hung around for a month). I was made to feel like a bad mother for persisting with breastfeeding." (Mother)

Objective 3.6 Engage with mothers, families and staff to co-create and continually improve infant feeding support services.

Two comments were made about the challenges of co-production:

> "Co-production is important in every aspect of services. I don't think this has been done well across Kent. I've been involved with MNVP's for many years and not seen co-production done very well. This could be improved in all areas. I've also taken part in Children's Centre meetings and there could definitely be improvements (timing, location, language used, time wasted reduced etc). It really takes a passionate new parent to go out of their way to push for change in their community. It's challenging engaging new parents for consultations and feedback. They are just super busy and don't have time. How can we make this easier?" (Voluntary organisation)

> "Think we can ask parents to feedback on services, quite difficult to get them to actually co-create, there is only so much we can ask of families to contribute time-wise and they dont always understand all the technical reasons we have with IT / IG etc that hold our hands slightly with service delivery and would involve explaining that all the time." Communications professional working with Kent families

Objective 3.7 Plan support for those in isolated and vulnerable communities

Two comments were made about the challenges of supporting those in isolated and vulnerable communities:

> “It's challenging to offer support in areas with low numbers. Are there existing services that people are already attending which could be used. Are there community leaders who could approach their community to determine the local needs? If this is something we are still striving for, yet Children's Centres were supposed to be doing already, then we obviously haven't found the solution yet.” (Voluntary organisation)

> “We have virtual groups in COVID - not sure these were well used - what is the suggestion for isolated and vulnerable communities - unless you train up people and have them working autonomously in areas, they'll always need a staff presence and could be a waste of resources to have staff in remote places without many families living there.” (Communications professional working with Kent families)

One suggestion was made about supporting these communities:

> “Would really like to see inclusion of community transport schemes in helping mothers access support, this is often a huge barrier, particularly in very remote areas,” (Mother)

Objective 3.8 Develop a plan for providing infant feeding support in emergencies.

A voluntary organisation commented in support of this objective:

> “There were a lot of errors during the pandemic, and we should learn from them and should have already started planning for the next time. Yes, we agree that infant feeding is very important and we would hate to go through another pandemic if nothing changes because we had to pick up the pieces and that's how the charity came to be. There does seem to be confusion around formula use and food banks. It's not typically something food banks are encouraged to give out, but when families are referred to health visiting the healthy start programme only covers younger parents and very low incomes. There is a missing piece that needs to be put in place so that formula can be sourced for families in need. Even food banks that are given formula don't know much about safety/preparation/types of formula/special formula/sell by dates etc and this could be extremely dangerous for vulnerable families.”

Theme 4 Involving the wider community

How much do you agree or disagree that these objectives will help to involve the wider community?

Objectives	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know	Total no. of responses
4.1. Encourage early years settings to facilitate breastfeeding and the healthy introduction of solid foods.	34	8	4	1	2	1	50
4.2 Ensure that all NHS and local authority services supporting families are compliant with the World Health Organization Code of marketing of breastmilk substitutes.	37	6	4	1	1	1	50
4.3. Encourage and support businesses and employers to adopt policies and practices that reduce barriers to breastfeeding.	40	4	3	0	2	1	50
4.4. Work with local communities to change attitudes towards breastfeeding.	37	4	6	0	1	1	49

Comments and suggestions on theme 4

One respondent described this theme as “very important”. Another argued that it should not be the top priority:

> “I haven't chosen strongly agree in this section because too often this part is focused on and it feels to me that if we take our eye off the support in the first few weeks, then these other areas are really only helping minimal families. I know it all works together, and we need everything in place for it all to work, but we'll see bigger successes if we focus more on antenatal and the first two weeks.” (Voluntary organisation)

Young mothers, in conversation with KCC staff, reported that they felt uncomfortable at the thought of breastfeeding in public, particularly as a teenager (social pressure, breasts seen as sexual by peers, etc).

A staff member questioned her workplace’s commitment to supporting breastfeeding:

> “Even the breastfeeding room in the hospital is a chair next to the toilets, what does this say about the importance we put on bf” (Midwife or student midwife)

Two staff members emphasised the work that is already happening and felt strongly that this wasn’t being sufficiently recognised:

> “we do have a local normalising breastfeeding campaign Beside You that has been running for some time but this isn't mentioned in the strategy, seems a shame to not include when this campaign is trying to do exactly what you're suggesting. Either it isn't working and needs a rethink or it needs to be built upon and expanded etc.” (Communications professional working with Kent families)

> “Its really frustrating to read a document that outlines proposals for something that is already being implemented and has been for years and years. Its insulting to read a document that outlines proposals that are already successful and in place to support our community.” (Children’s centre/Family Hub staff member)

Other comments on this objective were:

> “ensure mums who formula feed are supported to not just breastfeeding mums” (Mother)

> “Stop wasting money and replace or repair the infrastructure of our communities first” (Kent resident)

Objective 4.1 Encourage early years settings to facilitate breastfeeding and the healthy introduction of solid foods

There were two comments in support of this objective:

> “include knowledge of storing and using breastmilk in nurseries in their training so that it is something normal and accepted in every setting.” (Voluntary organisation)

> “Educating nurseries is key. There is a lot of misinformation. Helping them to help mothers continue to feed despite going back to work is essential.” (Mother)

Objective 4.2 Ensure that all NHS and local authority services supporting families are compliant with the World Health Organization Code of marketing of breastmilk substitute.

A voluntary organisation commented:

> “We agree that the local authority and NHS should be WHO code compliant. Are there still health professionals still attending courses and conferences sponsored by formula companies?”

Objective 4.3 Encourage and support businesses and employers to adopt policies and practices that reduce barriers to breastfeeding.

There were two comments about support for employers and for parents with returning to work:

> “I'd say that we see most families at __ (our support group) in the first few weeks, then at 4 months and then before going back to work. … This might also be run alongside the education for nurseries mentioned in another section. Education sessions for parents might also be useful in Family Hubs.” (Voluntary organisation)

> “With businesses it is also about discussions or that knowledge about breastfeeding when returning to work and in the antenatal workshops it would be too much to have that discussion so maybe further information alongside that already available on the KCHFT sites.” (Infant feeding support staff member)

There were four comments about breastfeeding friendly venues:

> “More money should be available for local businesses with IBCLC or BFC educating the owners to help improve the experiences” (Mother)

> “Should be able to access a list of hospitality venues signed up to a breastfeeding friendly scheme online” (Mother)

> “More breasfeeding friendly areas in Kent.” (Mother)

> “I found feeding in cafes was a bit hit and miss. Sometimes the staff were very friendly and would bring drinks over for you and other times you were left to struggle with a baby, buggy and your drinks. In addition furniture wasn't always the most suitable for breastfeeding (especially more uncommon positions). Could you consider producing guidance for local eateries about how to support breastfeeding mothers with furniture choice, customer service etc?” (Mother)

One respondent also made a suggestion about seating in public parks:

> “While breast feeding my daughter I would often pop to a local park but found the environment didn't always support feeding. One thing that was sometimes missing was shaded seating. On a hot summer's day babies feed so much more frequently and at times I struggled to find a bench that was located in the shade during the heat of the day. Is this something that could be considered for all public parks in Kent? Also could tables or shelves near seating be considered so you have somewhere to place drinks and snacks without having to balance them on you precariously?” (Mother)

Objective 4.4 Work with local communities to change attitudes towards breastfeeding.

One respondent commented in favour of this objective:

> “I like the idea of working with community assets/leaders/centres as each area will respond differently to different campaigns. I also feel that the more families that breastfeed lead to more feeding in public, and more people being exposed to breastfeeding and taking this new knowledge in to their family/work, a grass roots effort.” (Voluntary organisation)

Young parents, in conversation with KCC staff, said that they look to peers and family members for guidance on breast or bottle feeding. This demonstrates the relevance of attitudes in the wider community.

One respondent shared personal experience of being affected by attitudes from members of the public:

> “I never felt ashamed to be breastfeeding in public except for one time when someone (a female I should add!) looked me up and down in disgust. I also had trouble on one occasion on a bus when someone sat next to me and asked me to move the baby (again a female), I explained that I couldn't as they were feeding and pointed to other available seats but they wanted to remain in that seat. Another passenger on the bus (oddly a male) ended up getting involved and telling the woman to stop being ridiculous and move.” (Mother)

Another respondent suggested that this needs its own strategy:

> “how do you work with communities to change attitudes to breastfeeding - I feel this needs a strategy of its own its so big.” (Communications professional working with Kent families)

Theme 5 Continuously improving our service as we learn over time

How much do you agree or disagree that these objectives will help to continuously improve our service as we learn over time?

Objectives	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know	Total no. of responses
5.1. Provide effective oversight for implementation of the strategy through the Family Hubs Programme and the Infant feeding Steering Group	34	8	3	2	2	1	50
5.2. With engagement through the Kent and Medway Integrated Care Board, ensure resources are in place to support the implementation of the infant feeding strategy	37	7	2	2	1	1	50
5.3. Conduct a health equity audit to inform the implementation of the strategy.	34	11	1	2	1	1	50
5.4. Develop information sharing	36	8	1	1	1	2	49

agreements to centrally gather data from providers to inform the implementation of the strategy and to evaluate progress.							
5.5. Keep the strategy relevant and up-to-date.	37	7	1	1	1	1	48

Comments and suggestions on theme 5

One respondent commented on the timing of the strategy:

> "When it states about developing the strategy through the Family Hub model, surely this should have been put in place before the Family hubs are put in place as they are in place now and changes to service is happening." (Children's centre/Family Hub staff member)

Two themes were reiterated from earlier responses:

- Need for recognition of work already being done
- Concern that this is not the best use of taxpayers' money.

Objective 5.1 Provide effective oversight for implementation of the strategy through the Family Hubs Programme and the Infant feeding Steering Group

Three comments about oversight of the implementation phase focused on service user input and leadership:

> "I'm excited to see how this plays out once we start thinking about implementation. We still don't have users on the steering group though. Are there users on the ICB?" (Voluntary organisation)

> "Someone (a person/body) needs to take responsibility and ownership of this. Suggestions for improvement should be taken directly to this body. It is too easy for the issue to fall through the the gaps." (Mother)

> "This needs to be led by people passionate about its success." (Mother)

Objective 5.2 . With engagement through the Kent and Medway Integrated Care Board, ensure resources are in place to support the implementation of the infant feeding strategy

One respondent commented on this objective:

> “This will be one to watch. There doesn't seem to be an actual budget for this strategy and yet it will taken 1000's of people hours to implement and 100's of volunteers and staff will need to be recruited. Definitely a challenge. This whole strategy could fail based on this one part.” (Voluntary organisation)

Objective 5.3 Conduct a health equity audit to inform the implementation of the strategy.

One respondent commented on this objective, in favour and raising an issue about location of services:

> “This is a really important piece of work that needs to be done for all areas of Kent. Breastfeeding is slightly different to other public health issues in that you may need more support in areas or less deprivation because more people will breastfeed and numbers are just greater. This needs to be taken into account, as in areas of less deprivation, children's centres are more likely to have closed.” (Voluntary organisation)

Objective 5.4 Develop information sharing agreements to centrally gather data from providers to inform the implementation of the strategy and to evaluate progress.

There were two comments in favour of this objective:

> “Yes please come up with a streamlined robust monitoring system” (Kent resident)

> “We are really excited to see more breastfeeding data for Kent. It would be amazing to have more district level data published which can help drive this strategy implementation.” (Voluntary organisation)

Objective 5.5 Keep the strategy relevant and up-to-date.

There was one comment in favour of this objective:

> “It's important that the steering group continue and that we reassess regularly as we decide that something is or isn't working as intended.” (Voluntary organisation)

7.5 General comments

Respondents were asked two general questions at the end of the questionnaire:

- If there is any further information, details or links that you feel should be included in the final strategy, please provide them in the box below. If your suggestion relates to a specific section in the strategy, please provide details.
- Anything else? If there is anything else you would like to tell us about the draft strategy, please provide your comments in the box below. If your suggestion relates to a specific section in the strategy, please provide details.

Points not already covered earlier in the report are set out in this section:

There were five suggestions of issues to consider relating to support for mothers and families:

> “the need to monitor and safeguard mothers through this difficult hormonal period and transition. It can be a hormonal minefield especially when lacking weeks of sleep and needs high standards of care linked to the correct mental health support . Domestic and emotional support IE Homestart , is highly under rated. These situations often needs just domestic or emotional support and not the stigma and often intrusiveness of medication, and inconvenience imposed by mental health services and problems accessing them with a hard domestic situation and children. Generally where mothers are beginning to struggle and only Mild to moderate PND symptoms emerge, mothers prefer this and holistic therapies and time out from the domestic pressures. See British Psychological Society 2018 executive summary.” (Grandparent)

> “domestic abuse around birth and breastfeeding - opportunities for coercive control” (Kent resident)

> “Right now families can’t afford baby milk at its extortionate price and this should be subsidised. Not all mothers can cope with breastfeeding especially long term for a multitude of reasons and familes are going without to pay for babymilk! At 9 months old this costs a fortune.” (Grandparent)

> “Liaison and communication between all professionals , family and all concerned is crucial, and sensitivity to where some traditional family members IE dads, may not want to get heavily involved and mothers prefer it that way.” (Grandparent)

> “A focus on improving perceptions of 'extended' breastfeeding amongst all services. I experienced negative attitudes from early years settings who told me I needed to reduce breastfeeding to enable my daughter to settle into nursery (aged on 10 months!) and then also from A&E staff who told me extended breastfeeding was 'wrong' and clearly the reason why my 2 year old was 'clingy'. Absolutely shocking and disheartening. I learnt to just not

disclose that I was still breastfeeding (my daughter self weaned at the age of 3 years 10 months)" (Mother)

There were two further comments about bottle feeding:

> "This is a breastfeeding strategy, not infant feeding. Very little mention of weaning and bottle feeding. Not one image of a baby being bottle fed or eating solids. Why not just call it what it is. I am not against the overall importance of supporting women to breastfeed, but commissioning a breastfeeding organisation to develop a feeding strategy was always going to result in a very BF heavy strategy." (Mother)

> "Thank you it is the first time I have been able to share my views on infant feeding. I am not at all a anti-breast feeding at all but I am pro-choice! :) I do think there are some people that don't think they would be successful but are with support and this should definitely be encouraged. Those that struggle should be supported through positive choices which are right for them so they can put their other resources into their babies development. My daughter came on leaps and bounds when I stopped worrying about the feeding and she was a happy healthy bottle fed child." (Kent resident)

There were six comments asking for aspects of existing services to be recognised and built on. These were:

Beside you:

> "Utilise Beside You to provide information and support as part of the strategy." (Infant feeding support staff member)

> "Can we use local imagery, Beside You has lots of photography that we could use featuring local families in Kent. Not sure why we are using stock images when we have that." (Communications professional working with Kent families)

NHS services:

> "it would be good to know what's currently working or what has worked in the past and be able to have that as a starting point and go from there rather than completely changing everything again." (Voluntary organisation)

Voluntary sector:

> "Honestly, you need to consult with existing infant feeding charities that have literally done all of this research for YEARS. These organisations are packed with highly trained experts who simply need to be consulted, funded, and empowered to make large-scale change." (Mother)

> “Inclusion of the VCS is vital, very trusted by individuals who use those organisations and much more flexible and agile in offering services, don't have to adhere to lots of red tape or long processes to get things set up.” (Mother)

Respondents were asked for any comments on the Equality Impact Assessment, including suggestions for anything else that should be considered relating to equality and diversity.

There were five comments on this section:

> “consider intersectionality” (Kent resident)

> “Yes please include transgender people” (Kent resident)

> “Sex based language makes this very clear and understandable.” (Mother)

> “We have reduced access to services by closing children's centres. I'm sure this has only reduced access for those protected characteristics.” (Voluntary organisation)

> “Please the best person for the job , not filling a quota” (Kent resident)

8 Conclusions

8.1 Feedback on the strategy

1. Most respondents found the strategy easy to understand (42 agree, 6 disagree). A few suggested it could be improved by being shorter, more concise and having a lower reading age.
2. Most respondents agree that the strategy clearly sets out what is important to achieve its aims (38 agree, 5 disagree).
3. There is strong support for all five of the strategy's themes and for every objective within those themes.

8.2 Themes arising from the consultation

The following themes were mentioned by at least 3 respondents:

1. Concern about whether the strategy is realistic. Questions are asked about whether there will be sufficient funding, staff time and volunteer hours to implement the strategy. It is suggested that the objectives should be more specific and measurable.
2. Suggestion that the strategy should include more detail about supporting formula feeding, bottle feeding and mixed feeding.
3. Emphasis of the skills and expertise of voluntary sector organisations in relation to infant feeding support and desire to see greater collaboration between the statutory and voluntary sectors.
4. Feeling that the strategy does not sufficiently acknowledge all the services that are already in place or the hard work and commitment of the staff in those services. Suggestions that it could build more on what is working or has worked in the past, such as the Beside You campaign.
5. Concern about recognition of, and payment for, infant feeding expertise and about whether there would be excessive reliance on volunteers in delivering peer support. A call for clarity about the roles of different infant feeding support workers such as breastfeeding counsellors, hospital infant feeding teams and peer supporters.
6. Request for greater clarity about who would deliver antenatal sessions. Suggestions included breastfeeding counsellors, lactation consultants, the voluntary sector, and joint delivery by midwives and health visitors. Suggestion that there is scope for streamlining this offer and reducing duplication.
7. A call for more support to be available by video call or phone call, so that mothers could access support from their own homes.
8. Suggestion that there should be flexibility about the location of support services as Family Hubs may not always be the most accessible location.

9. Suggestion that mothers should be able to self-refer to specialist infant feeding support services, and that a drop-in rather than a fixed-appointment service would better meet the needs of mothers and families.
10. Doubts about whether implementation of quality standards such as the UNICEF UK Baby Friendly Initiative is having the intended effect and calls for this to be reviewed.
11. A call to establish a local milk bank in Kent.

8.2 Other suggestions made (not already addressed in the strategy)

1. Review access to interpreting for health visiting
2. Include imagery of breastfeeding past infancy in non-related Kent materials
3. Present the statistics in the strategy in terms of the risks of formula-feeding rather than the benefits of breastfeeding, on the basis that breastfeeding is the biological norm.
4. Offer antenatal 1-1 support to all parents as some are not perceived as vulnerable but still need the support.
5. Fund the Family Partnership to provide antenatal support for vulnerable families.
6. Midwives to complete Health Start application with eligible mothers antenatally.
7. Offer vitamin supplements on prescription for breastfeeding mothers and babies.
8. Provide support for those experiencing eating disorders during pregnancy.
9. Make the role of an infant feeding support worker a band 4 not a band 3.
10. Rebrand breastfeeding groups to be infant feeding groups.
11. Issue a referral receipt when a mother is referred for specialist infant feeding support, so that she has confirmation of the referral and knows where to seek support in the meantime and how to ask any questions.
12. Set up a tongue tie division service at Darent Valley Hospital.
13. Provide a comfortable room and breastfeeding support immediately after tongue tie division.
14. Can the outcomes of the pilot studies to loan breastfeeding equipment from Family Hubs be made available?
15. Provide a breast-pump delivery service for isolated families.
16. Partner with existing sling libraries if the Family Hubs offer a sling hire service.

17. Ensure staff giving out pumps or slings have ongoing training and are supported by specialists.
18. To include in staff training the importance of relaxation in supporting mothers to breastfeed.
19. Make use of community transport schemes to support isolated communities.
20. Produce guidance for local eateries about how to support breastfeeding mothers with furniture choice, customer service, etc.
21. Consider the needs of parents feeding their babies when planning seating in public parks.
22. Provide district-level data.
23. Include reference to domestic abuse around birth and breastfeeding.
24. Subsidise the cost of formula for families.

Appendix: Consultation Questionnaire

(Excluding Section 2 which related to a separate strategy and is not relevant to this report).

KCC is consulting on two draft strategies, which have been co-created with parents, families and partners as part of our activity to support and inform families to enable their infants to have the best start in life. The strategies are:

- Nurturing little hearts and minds – a perinatal mental health and parent-infant relationship strategy for Kent 2024-2029.
- Nourishing our next generation – a 5-year infant feeding strategy for Kent 2024-2029

Drafts of both strategies are available from the consultation webpage www.kent.gov.uk/startforlifestrategies

We have provided this questionnaire for you to give your feedback. Your responses will help us to finalise the strategies before they are agreed and adopted by KCC.

This questionnaire can be completed online at www.kent.gov.uk/startforlifestrategies.

If you are unable to complete the questionnaire online, please complete this Word/paper form and return it to:

- **Email:** startforlife@kent.gov.uk
- **Address:** Start for Life Strategies, Public Health Office, Sessions House, County Hall, Maidstone ME14 1XQ

You can answer all or as many of the questions as you like. If you would rather not provide feedback on both strategies, a section or question, just move on to the next one.

Please do not include any personal information that could identify you or anyone else in your responses.

If you need any help taking part in this consultation or have any questions, please contact us at startforlife@kent.gov.uk.

Please ensure your response reaches us by midnight on Wednesday 3 April 2024.

Alternative formats: If you require any of the consultation material in an alternative format or language, or Large Print copies, please email: alternativeformats@kent.gov.uk or call: 03000 42 15 53 (text relay service number: 18001 03000 42 15 53). This number goes to an answering machine, which is monitored during office hours.

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Section 1 – About you

Q1. Please tell us how you are responding to this consultation.

Please select the option from the list below that most closely represents how you are responding to this consultation. Select **one** option.

- ☐ As a Kent resident
- ☐ As a resident from somewhere else, such as Medway or further afield
- ☐ As a professional working with parents and families in Kent
- ☐ As a professional working with parents and families outside of Kent, such as Medway or further afield
- ☐ Providing the official response of an organisation, group, or business
- ☐ Other, please tell us:

Q1a. If you are a professional working with parents and families, please select from the list below your profession. Select **one** option.

- ☐ Breastfeeding support staff
- ☐ Infant feeding support staff
- ☐ Children's Centre / Family Hub staff
- ☐ General Practitioner (GP)
- ☐ Health Visitor
- ☐ Perinatal Mental Health Worker
- ☐ Midwife or student midwife
- ☐ Community Nursery Nurse
- ☐ Children's Social Worker
- ☐ Other, please tell us:

Q1b. If you are providing the official response of an organisation, group, or business or responding as a professional, please tell us the name of your organisation:

If you are responding as a professional or on behalf of an organisation, you do not need to answer questions 2, 3, and 4 please go to question 5.

If you are responding as a resident, please continue to question 2.

Q2. Are you …? Select **one** only. When we say 'parents or carers' we mean any person who looks after a baby regularly.

- ☐ A parent or carer
- ☐ Pregnant or an expectant parent
- ☐ Neither of these, please go to question 3

Q2a. If you are a parent / carer or pregnant / expectant parent, which of the following best describes your role? Select **one** only.

- ☐ Mum
- ☐ Dad
- ☐ Adoptive parent
- ☐ Co-parent
- ☐ Foster carer
- ☐ Grandparent
- ☐ Step-parent
- ☐ I prefer not to say
- ☐ Other, please tell us

Q2b. Please select the age group(s) for the child(ren) that you regularly care for:

Select **all** that apply.

- ☐ **Expecting a baby**

- [ ] 0-2 months of age
- [ ] 3- 6 months of age
- [ ] 7-12 months of age
- [ ] 13-24 months of age
- [ ] 3-4 years old
- [ ] 5-10 years old
- [ ] 11-19 years old
- [ ] 20 years old and over

Q2c. Are you the primary parent / carer for the child(ren) you regularly care for? Select **one** option. By 'primary' we mean the parent / carer with whom the child or children spends the majority of their time.

- [ ] Yes
- [ ] No

Q3. Please tell us how often <u>you</u> use the services listed below.

There will be another question later in this section where you can tell us which services other people in your household use. Select **one** option per row / service.

Service	At least once a week	Once a fortnight	Once a month	Twice a year	Less regularly	Used it in the past	Never used this service
Children's Centres / Family Hubs							
Health Visiting							
Infant feeding groups e.g. information on feeding an infant							
Breastfeeding support e.g. guidance on 'latching on'							
Specialist infant feeding support e.g. guidance to reestablish breast milk supply							
Specialist perinatal mental health services e.g. support from a specialist community PNMH nurse / midwife							
Perinatal mental health advice / support e.g. accessed a local helpline or talked to							

staff in the health visiting service							

Q3a. Please tell us how <u>you</u> use these services.

Select **one** option per row / service.

Service	In person at a building	Online	Both	I don't use this service
Children's Centres / Family Hubs				
Health Visiting				
Infant feeding groups				
Breastfeeding support				
Specialist infant feeding support				
Specialist perinatal mental health services				
Perinatal mental health advice / support				

Q4. Please tell us how often <u>other people</u> in your household use the services listed below.

Select **one** option per row / service.

Service	At least once a week	Once a fortnight	Once a month	Twice a year	Less regularly	Used it in the past	Never used this service
Children's Centres / Family Hubs							
Health Visiting							
Infant feeding groups							
Breastfeeding support							

Specialist infant feeding support							
Specialist perinatal mental health services							
Perinatal mental health advice / support							

Q4a. Please tell us how <u>other people</u> in your household use these services.

Select **one** option per row / service.

Service	In person at a building	Online	Both	They don't use this service
Children's Centres / Family Hubs				
Health Visiting				
Infant feeding groups				
Breastfeeding support				
Specialist infant feeding support				
Specialist perinatal mental health services				
Perinatal mental health advice / support				

Q5. Please tell us the first five characters of your postcode: [ ]

Please do not reveal your whole postcode. If you are responding on behalf of an organisation, please use your organisation's postcode. We use this to help us to analyse our data. It will not be used to identify who you are.

Section 2 – The draft Perinatal Mental Health (PNMH) and Parent-Infant Relationship (PIR) Strategy for Kent

(This section is not included here as it is not relevant to this report.)

Section 3 – The draft Infant Feeding Strategy for Kent

Q15. Is the draft Infant Feeding Strategy easy to understand?

Select **one** option.

- ☐ Yes
- ☐ No
- ☐ Don't know

Q15a. If you have any suggestions on how to make the strategy easier to understand, please tell us.

If your suggestion relates to a specific section/page please provide details.

Q16. How much do you agree or disagree that the draft infant feeding strategy clearly sets out what is important to support the health and wellbeing of mothers and families with infants, with a focus on reducing health inequalities, in order to give babies in Kent the best start in life? Select **one** option.

- ☐ Strongly agree
- ☐ Tend to agree
- ☐ Neither agree nor disagree
- ☐ Tend to disagree
- ☐ Strongly disagree
- ☐ Don’t know

Q16a. Please tell us about the reason for your answer.

If your suggestion relates to a specific section / page, please provide details in your answer.

The draft strategy sets out five themes:

Theme 1: Ensuring that mothers and families are well informed and well prepared for feeding their babies

Theme 2: Providing the support mothers and families need in the right place and at the right time

Theme 3: Offering seamless support from an integrated and skilled workforce

Theme 4: Involving the wider community

Theme 5: Continuously improving our service as we learn over time

Q17. How much do you agree or disagree that the five themes set out in the draft strategy will help to give babies in Kent the best start in life and support the health and wellbeing of mothers?

Select **one** option for each theme/row. You will be given the opportunity to provide feedback on each of the themes individually later in the questionnaire.

Themes	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
Theme 1: Ensuring that mothers and families are well informed and well prepared.						
Theme 2: Supporting mothers and families need in the right place and at the right time.						
Theme 3: Offering seamless support from an integrated and skilled workforce.						
Theme 4: Involving the wider community.						
Theme 5: Continuously improving our service as we learn over time.						

Q17a. Please tell us about the reason for your answer.

If your suggestion relates to a specific theme / page, please provide details in your answer.

Theme 1 - Ensuring that mothers and families are well informed and well prepared

Pages 15-18 of the draft strategy set out what we will do to achieve theme 1.

Q18. How much do you agree or disagree that these objectives will help make sure that mothers and families are well informed and well prepared for feeding their babies?

Select **one** option for each objective / row.

Objectives	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
1.1. Make nurseries and schools aware of resources for including breastfeeding in the curriculum.						
1.2. Provide 1-1 peer support for young and/or vulnerable mothers before their baby arrives.						

Objectives	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
1.3. Provide group learning sessions about infant feeding for mothers to attend before and after they have their baby and make these sessions welcoming for fathers/partners.						
1.4. Support mothers and families to know how to provide a healthy diet for themselves and their children.						
1.5. Provide high quality, accessible information for mothers and families about infant feeding and about where they can get support.						

Q18a. Do you have any comments or suggestions on the objectives for theme 1?

If your comment / suggestion relates to a specific objective, please provide details in your answer.

Theme 2 - Providing the support mothers and families need in the right place and at the right time

Pages 19-25 of the draft strategy set out what we will do to achieve theme 2.

Q19. How much do you agree or disagree that these objectives will help to provide the support mothers and families need in the right place and at the right time?

Select **one** option for each objective / row.

Objectives	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
2.1. Work towards healthcare professionals having sufficient time to support mothers with feeding their babies.						
2.2. Enable mothers to access additional support when and where they need it.						
2.3. Enable breastfeeding mothers to access social support and peer support in a group setting through the Family Hubs programme.						
2.4. Reduce waiting times for specialist support.						
2.5. Support those mothers who have difficulty feeding as a result of their baby having a tongue-tie and enable babies who need it to access tongue-tie division without unnecessary delay.						

2.6. Provide support for mothers who are experiencing breastfeeding grief.						
2.7. Support mothers to access equipment that will support them with breastfeeding their baby.						

Q20a. Do you have any comments or suggestions on the objectives for theme 2?
If your comment / suggestion relates to a specific objective, please provide details in your answer.

Theme 3 - Offering seamless support from an integrated and skilled workforce

Pages 26-33 of the draft strategy set out what we will do to achieve theme 3.

Q21. How much do you agree or disagree that these objectives will help to offer seamless support from an integrated and skilled workforce?

Select **one** option for each objective / row.

Objectives	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
3.1 Continue to implement recognised quality standards in relation to infant feeding.						
3.2. Expand availability of donor milk to all babies who would benefit from it.						
3.3. Establish expectations for the peer support service relating to recruitment, training, supervision and integration.						

Objectives	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
3.4. Enable all staff and volunteers to access training and develop the competencies they need to support mothers and families with infant feeding.						
3.5 Facilitate integration between organisations and across the multidisciplinary team, so that mothers experience a seamless service.						
3.6. Engage with mothers, families and staff to co-create and continually improve infant feeding support services.						
3.7. Plan support for those in isolated and vulnerable communities.						
3.8. Develop a plan for providing infant feeding support in emergencies.						

Q21a. Do you have any comments or suggestions on the objectives for theme 3?

If your comment / suggestion relates to a specific objective, please provide details in your answer.

Theme 4 - Involving the wider community

Pages 34-36 of the draft strategy set out what we will do to achieve theme 4.

Q22. How much do you agree or disagree that these objectives will help to involve the wider community?

Select **one** option for each objective / row.

Objectives	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
4.1. Encourage early years settings to facilitate breastfeeding and the healthy introduction of solid foods.						
4.2 Ensure that all NHS and local authority services supporting families are compliant with the World Health Organization Code of marketing of breastmilk substitute.						
4.3. Encourage and support businesses and employers to adopt policies and practices that reduce barriers to breastfeeding.						
4.4. Work with local communities to change attitudes towards breastfeeding.						

Q22a. Do you have any comments or suggestions on the objectives for theme 4?
If your comment / suggestion relates to a specific objective, please provide details in your answer.

Theme 5 - Continuously improving our service as we learn over time

Pages 37-39 of the draft strategy set out what we will do to achieve theme 5.

Q23. How much do you agree or disagree that these objectives will help to continuously improve our service as we learn over time? Select **one** option for each objective / row.

Objectives	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
5.1. Provide effective oversight for implementation of the strategy through the Family Hubs Programme and the Infant Feeding Steering Group						
5.2. With engagement through the Kent and Medway Integrated Care Board, ensure resources are in place to support the implementation of the infant feeding strategy						
5.3. Conduct a health equity audit to inform the implementation of the strategy.						
5.4. Develop information sharing agreements to centrally gather data from providers to inform the implementation of the strategy and to evaluate progress.						

Objectives	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
5.5. Keep the strategy relevant and up-to-date.						

Q23a. Do you have any comments or suggestions on the objectives for theme 5?
If your comment / suggestion relates to a specific objective, please provide details in your answer.

Q24. If there is any further information, details or links that you feel should be included in the final strategy, please provide them in the box below.

If your suggestion relates to a specific section in the strategy, please provide details.

We have completed an initial Equality Impact Assessment (EqIA) for the draft Infant Feeding Strategy for Kent.

An EqIA is a tool to assess the impact any proposals would have on the protected characteristics: age, disability, sex, gender reassignment, sexual orientation, race, religion or belief, and carer's responsibilities. The EqIA is available online at www.kent.gov.uk/startforlifestrategies or in hard copy on request.

Q25. We welcome your views on our equality analysis, including suggestions for anything else we should consider relating to equality and diversity. Please add any comments below.

Anything else?

Q26. If there is anything else you would like to tell us about the draft strategy, please provide your comments in the box below.

If your suggestion relates to a specific section in the strategy, please provide details.

Section 4 – More about you

We want to make sure that everyone is treated fairly and equally, and that no one gets left out. That's why we are asking you these questions. We will use this information only to help us make decisions and improve our services.

If you would rather not answer any of these questions, you don't have to.

It is not necessary to answer these questions if you are responding on behalf of an organisation.

Q27. Are you…? Select **one** option.

- ☐ Male
- ☐ Female
- ☐ I prefer not to say

Q28. Is your gender the same as at your birth? Select **one** option.

- ☐ Yes
- ☐ No
- ☐ I prefer not to say

Q29. Which of these age groups applies to you? Select **one** option.

0-15	☐	16-24	☐	25-34	☐	35-49	☐	50-59	☐
60-64	☐	65-74	☐	75-84	☐	85+ over	☐	I prefer not to say	☐

Q30. Do you regard yourself as belonging to a particular religion or holding a belief? Select **one** option.

- [ ] Yes
- [ ] No
- [ ] I prefer not to say

Q30a. If you answered 'Yes' to Q30, which of the following applies to you? Select **one** option.

- [ ] Christian
- [ ] Buddhist
- [ ] Hindu
- [ ] Jewish
- [ ] Muslim
- [ ] Sikh
- [ ] Other
- [ ] I prefer not to say

If you selected Other, please specify:

The Equality Act 2010 describes a person as disabled if they have a long standing physical or mental condition that has lasted, or is likely to last, at least 12 months; and this condition has a substantial adverse effect on their ability to carry out normal day-to-day activities. People with some conditions (cancer, multiple sclerosis, and HIV / AIDS, for example) are considered to be disabled from the point that they are diagnosed.

Q31. Do you consider yourself to be disabled as set out in the Equality Act 2010?
Select **one** option.

- ☐ Yes
- ☐ No
- ☐ I prefer not to say

Q31a. If you answered 'Yes' to Q31, please tell us the type of impairment that applies to you.

You may have more than one type of impairment, so select all that apply. If none of these applies to you, select 'Other' and give brief details of the impairment you have.

- ☐ Physical impairment
- ☐ Sensory impairment (hearing, sight or both)
- ☐ Longstanding illness or health condition, such as cancer, HIV / AIDS, heart disease, diabetes or epilepsy
- ☐ Mental health condition
- ☐ Learning disability
- ☐ I prefer not to say
- ☐ Other

Other, please specify:

Q32. **To which of these ethnic groups do you feel you belong?** Select **one** option. (Source 2011 Census)

White English		Mixed White & Black Caribbean	
White Scottish		Mixed White & Black African	
White Welsh		Mixed White & Asian	
White Northern Irish		Mixed Other*	
White Irish		Black or Black British Caribbean	
White Gypsy / Roma		Black or Black British African	
White Irish Traveller		Black or Black British Other*	
White Other*		Arab	
Asian or Asian British Indian		Chinese	
Asian or Asian British Pakistani		I prefer not to say	
Asian or Asian British Bangladeshi			
Asian or Asian British Other*			

*Other - If your ethnic group is not specified on the list, please describe it here:

A Carer is anyone who provides unpaid care for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support. Both children and adults can be carers.

Q33. Are you a Carer? Select **one** option.

- ☐ Yes
- ☐ No
- ☐ I prefer not to say

Q34. Are you …? Select **one** option.

- ☐ Heterosexual/Straight
- ☐ Bi/Bisexual
- ☐ Gay man
- ☐ Gay woman/Lesbian
- ☐ Other
- ☐ I prefer not to say

Thank you for taking the time to complete this questionnaire; your feedback is important to us. All feedback received will be reviewed and considered as we finalise the strategies.

We will report back on the feedback we receive, but details of individual responses will remain anonymous, and we will keep your personal details confidential.

Closing date for responses: 3 April 2024

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EQIA Submission Draft Working Template

If required, this template is for use prior to completing your EQIA Submission in the EQIA App. You can use it to understand what information is needed beforehand to complete an EQIA submission online, and also as a way to collaborate with others who may be involved with the EQIA. Note: You can upload this into the App when complete if it contains more detailed information than the App asks for and you wish to retain this detail.

Section A

1. Name of Activity (EQIA Title):	Infant Feeding Strategy
2. Directorate	Adult social care and health
3. Responsible Service/Division	Public Health

Accountability and Responsibility

4. Officer completing EQIA	Sarah Deakin
5. Head of Service Note: This should be the Head of Service who will be approving your submitted EQIA.	Wendy Jeffreys
6. Director of Service Note: This should be the name of your responsible director.	Dr Anjan Ghosh

The type of Activity you are undertaking

7. What type of activity are you undertaking?

Tick if Yes	Activity Type
	Service Change – *operational changes in the way we deliver the service to people.*
	Service Redesign – *restructure, new operating model or changes to ways of working*
	Project/Programme – *includes limited delivery of change activity, including partnership projects, external funding projects and capital projects.*
	Commissioning/Procurement – *means commissioning activity which requires commercial judgement.*
Yes	**Strategy /Policy** – *includes review, refresh or creating a new document*
	Other – Please add details of any other activity type here.

8. Aims and Objectives and Equality Recommendations – Note: You will be asked to give a brief description of the aims and objectives of your activity in this section of the App, along with the Equality recommendations. You may use this section to also add any context you feel may be required.

The Kent and Medway Interim Integrated Care Strategy identifies breastfeeding as one of the key health outcomes for children that vary between population groups and that can affect health and wellbeing outcomes in later life. It states a commitment to developing a Family Hub model that will include access to universal infant feeding services and will enable improved integration of services including in relation to infant feeding. This draft infant feeding strategy sets out how Kent County Council will develop support for infant feeding through implementation of Start for Life and the Family Hubs Transformation programme.

Start for Life focuses on the first 1001 days of life, from conception to the age of 2, and is part of the

core offer that all local authorities provide. In addition, KCC is receiving funding to develop a Family Hub model, providing multiagency, open access, community-based provision. Infant feeding advice and specialist breastfeeding support are part of the essential Start for Life offer for all families and the Family Hub model is intended to deliver enhanced infant feeding support. The strategy also incorporates system-wide actions for Kent as part of the implementation of Kent and Medway Local Maternity and Neonatal System's (LMNS) Equity and Equality Strategy. In its Equity and Equality Action Plan, the LMNS has committed to "making sure all of our maternity and neonatal services achieve the standards of infant feeding support recommended by the UNICEF UK baby friendly initiative" and "working in partnership with other organisations in Kent and Medway to improve the range of breastfeeding support across communities, including through development of family hubs." NHS England's 3 Year Delivery Plan for Maternity and Neonatal Services sets an ambition that "Women ... are provided with practical support and information that reflects how they choose to feed their babies" and says it is the responsibility of maternity and neonatal trusts to "Achieve the standard of the UNICEF UK Baby Friendly Initiative (BFI) for infant feeding, or an equivalent initiative, by March 2027.

The purpose of this strategy is to give babies in Kent the best start in life and to support the health and wellbeing of mothers, with a focus on reducing health inequalities.

It aims to reduce the barriers to breastfeeding so that mothers can breastfeed for as long as they would like to and to ensure that all mothers and families get the support they need with feeding their babies.

Section B – Evidence

the EQIA in the App, but you will not be able to submit it for approval without this information.

9. Do you have data related to the protected groups of the people impacted by this activity? *Answer: Yes/No*	Yes
10. Is it possible to get the data in a timely and cost effective way? *Answer: Yes/No*	Yes
11. Is there national evidence/data that you can use? ***Answer:*** *Yes/No*	Yes
12. Have you consulted with Stakeholders? *Answer: Yes/No* *Stakeholders are those who have a stake or interest in your project which could be residents, service users, staff, members, statutory and other organisations, VCSE partners etc.*	Yes

13. Who have you involved, consulted and engaged with?
Please give details in the box provided. This may be details of those you have already involved, consulted and engaged with or who you intend to do so with in the future. If the answer to question 12 is 'No', please explain why.

As part of the engagement process for developing this IF strategy there were:

- 394 survey responses from mothers
- 88 survey responses from staff and volunteer infant feeding supporters
- 20 individual meetings with infant feedings leads, service managers, researchers and staff
- 6 co-production meetings with groups of staff and mothers
- 36 national standards and guidelines reviewed as part of gap analysis comparing current provision against good practice
- 6 steering group meetings with membership including maternity and neonatal commissioner and providers, community service commissioner and providers, and voluntary sector breastfeeding support coordinators.

14. Has there been a previous equality analysis (EQIA) in the last 3 years? *Answer: Yes/No*	No
15. Do you have evidence/data that can help you understand the potential impact of your activity? *Answer: Yes/No*	Yes
Uploading Evidence/Data/related information into the App *Note: At this point, you will be asked to upload the evidence/ data and related information that you feel should sit alongside the EQIA that can help understand the potential impact of your activity. Please ensure that you have this information to upload as the Equality analysis cannot be sent for approval without this.*	See accompanying evidence.

Section C – Impact

16. Who may be impacted by the activity? *Select all that apply.*

Service users/clients *Answer: Yes/No*	Yes	Residents/Communities/Citizens *Answer: Yes/No*	Yes
Staff/Volunteers *Answer: Yes/No*	Yes		

17. Are there any positive impacts for all or any of the protected groups as a result of the activity that you are doing? *Answer: Yes/No*	Yes

18. Please give details of Positive Impacts

The principles and framework for the Family Hubs model, as set out by central government, are built based on improving user experience by:
1. increasing access to a wider range of services in one place or under one shared umbrella;
2. improving the interface and join-up between services; and
3. having services working within practice that builds on strengths and puts families at the centre of services.

The positive impacts that we anticipate:

Service Users/Clients
Early awareness and subsequent engagement during the ante natal period of the new service offer
Uptake of the new service increasing confidence in mums fully or partially breastfeeding.

Staff and Volunteers
Knowledge and assurance that there is additional support which is available up to the first 12 weeks of life.

Pregnancy and maternity
Reassurance that there is an additional service offer available to them and not necessarily needing them to seek it out.

Negative Impacts and Mitigating Actions

The questions in this section help to think through positive and negative impacts for people affected by your activity. Please use the Evidence you have referred to in Section B and explain the data as part of your answer.

19.Negative Impacts and Mitigating actions for Age	
a) Are there negative impacts for age? *Answer: Yes/No (If yes, please also complete sections b, c,and d).*	Yes
b) Details of Negative Impacts for Age	**Young Mothers** In April 2023, all NHS Trusts (except Maidstone & Tunbridge Wells NHS Trust) reported having more mothers aged 19 years and under than the national average (3%). For those mothers between 20-24 yrs, most Trusts (except Medway Foundation Trust) had fewer mothers than the national average (13%). Evidence suggests that the lowest incidence of breastfeeding was found among mothers aged under 30 Children of out of home care mothers (OHC) (care leavers) are less likely to breastfeed for greater than 3 months than non -OHC mothers.
c) Mitigating Actions for age	Peer counselling is the most successful intervention for increasing breastfeeding rates in young women. Prenatal education has some benefit for increasing breastfeeding in younger women. Care leavers are likely to require increased support with breastfeeding. Measures are needed to provide a secure and safe housing for care leavers , in which effective breastfeeding can occur.
d) Responsible Officer for Mitigating Actions – Age	Dr Anjan Ghosh
20. Negative Impacts and Mitigating actions for Disability	
a) Are there negative impacts for Disability? *Answer: Yes/No (If yes, please also complete sections b, c,and d).*	Yes
b) Details of Negative Impacts for Disability	It has been estimated that 9.4% of women giving birth in the UK have one or more limiting longstanding illness which may cause disability, affecting pregnancy, birth and early parenting.

	In a study by Redshaw et al (2013) most disabled women were positive about their care and reported sufficient access and involvement, but were less likely to breastfeed at least once or breastfeed partially or exclusively during the first few days. This was particularly evident in women who were physically disabled, mentally disabled and for women with more than one disability. 0.2% of women and girls in the UK have Autism Spectrum Disorder (though is likely to be an under-estimation). A study by Grant et al (Aug, 2022) found that many autistic women wanted to breastfeed, however they found it difficult. Because: (1) services were inaccessible and unsupportive to autistic mothers, meaning they did not receive help when needed. (2) becoming a mother was challenging because of exhaustion, loss of control over routines and lack of social support. (3) sensory challenges, such as being touched out and pain, which could feel unbearable.
c) Mitigating Actions for Disability	Training for staff and improving aspects of maternity care for disabled women, namely in support, communication (particularly for autistic women), and infant feeding. For autistic women in particular: Training of staff on not touching women (to show latch for example) without explicit consent Staff should receive training and tools related to autism, but this also needs to be specific to infant feeding and able to be tailored to each mothers need. Autistic mothers require continuity of care (due to social anxiety difficulties) Guidance on communication and sensory needs to be included in any notes.
d) Responsible Officer for Mitigating Actions - Disability	Dr Anjan Ghosh
a) Are there negative impacts for Sex? *Answer: Yes/No* *(If yes, please also complete sections b, c,and d).*	Yes
b) Details of Negative Impacts for Sex	In 2021, there were 16,632 registered live births

	in Kent. **Mothers and geographical variation** There is wide variation in breastfeeding prevalence in Kent. Swale (38.9%), Thanet (44.8%), Dover (45.4%), Gravesham (48.9%), Tonbridge & Malling (51.1%) all have lower than Kent average (51.3%) prevalence of breastfeeding (full/partial) at 6-8 wk review (2022/23) **Mothers and deprivation** All of the top 20 most deprived areas in Kent are in coastal areas according to the IDACI. Those living in the most deprived areas of the UK were less likely to breastfeed (11%). **Mothers and employment** Mothers working in managerial and professional occupations are more likely to breastfeed as they are likely to have the practical means to support breastfeeding. However, women who were returning to work for financial reasons were less likely to initiate breastfeeding than those who returned for other reasons. **Mothers and education** Those who left education under 18 (9%) are less likely to breastfeed. More educated mothers might be more up to date with the recommendations made by health authorities and spending more time in formal education might render mothers more willing, more likely and more able to pursue breastfeeding. **Mothers and Prison** There are two prisons locally that serve women from Kent and across England. Research shows that women from prisons have a lower rate of breastfeeding initiation and continuation than women from other groups. **Mothers and homelessness** There were 62,000 homeless families living in temporary accommodation in England at the end of 2018. The number of households in temporary accommodation has been on a rising trend, having reached 2,462 in Kent and Medway at the end of 2022. There are decreased breastfeeding initiation rates and duration in the homeless population.

	Mothers and sex work There are approx 72,800 people selling sex for money in the UK. These are mostly women, of whom approx 70% are mothers. Very little is known about parenting in this context. Whilst there are no specific studies on breastfeeding and sex workers, studies show that sex workers cite opening hours and location of services as barriers to them accessing health services. **Mothers and substance misuse** The estimated number of adults with alcohol dependence living with children in Kent (2018 to 2019) was 2 per 1000 of the population as compared to 3 per 1000 in England. In England, the proportion of women under age 50 who are pregnant and are new presentations to drug and alcohol treatment and are a parent or adult living with children is 3% and are a parent not living with children is 4% There is a dearth of information cited in UK alcohol guidelines in relation to alcohol use whilst breastfeeding. There is debate in the research literature about the safety of alcohol consumption and breastfeeding. In one study in UK, 8.5% of BF mothers drank alcohol whilst breastfeeding. **Fathers and Breastfeeding** Fathers positive attitude, involvement and support greatly influenced breastfeeding decision and commitment among mothers and was associated with increased breastfeeding rates and duration. The exclusion of fathers from breastfeeding support and preparation may result in decreased quality of life and self-efficacy among fathers.
c) Mitigating Actions for Sex	**Mothers** Breastfeeding peer support interventions are nationally (and internationally) recommended to increase breastfeeding rates and address inequalities. More targeted interventions to bolster the breastfeeding knowledge, skills, and emotional and practical support for the groups of mothers with unmet needs (financial, social), particularly mothers in areas of deprivation.

	Policies to increase breast feeding should address how both the time and circumstances of a mother's return to employment postpartum influence whether she decides to start breast feeding. Increased investment in formal education could address low BF rates. Make antenatal classes more accessible in more disadvantageous areas. Make information more easily available to those with limited access to the Internet. Improve support by qualified midwives at time of birth and in the following days. Require action to prevent homelessness. Need to invest in house building for affordable homes. Homeless BF mothers should be referred to nutritional programmes (Healthy Start). Provide early breastfeeding education for vulnerable mothers Promote breastfeeding initiation within one hour of birth for vulnerable mothers Encourage peer support groups for vulnerable mothers Specialist staff are needed to provide outreach for sex workers, in places/ways that are more accessible to them. Health care professionals need to take the time to listen to breastfeeding mothers experiencing drug and alcohol dependence and determine their individual needs. For breastfeeding mothers living in prison provide: • A regular supply of disposable breast pads • Access to a good quality breast pump • Access to private, comfortable place to express • Permission to keep personal baby items • A supply of breast milk storage bags • A fridge/freezer with lock to store expressed

	breast milk • Staff to support making appointments with midwives/GP • Opportunities and support to breastfeed and express milk during visits **Fathers** Focus on fathers as a major part of the breastfeeding family and engaging them in the preparation and support process would certainly impact positively on breastfeeding rates.
d) Responsible Officer for Mitigating Actions - Sex	Dr Anjan Ghosh
22. Negative Impacts and Mitigating actions for Gender identity/transgender	
a) Are there negative impacts for Gender identity/transgender? *Answer: Yes/No (If yes, please also complete sections b, c,and d).*	Yes
b) Details of Negative Impacts for Gender identity/transgender	In a Swedish study on gender diverse individuals and pregnancy, delivery and nursing, infant feeding preferences from Transgender individuals can vary- some breast feed and others don't. Participants that had undergone chest masculinisation surgery can be surprised to find that breast growth occurred during pregnancy and that they start lactating after birth. Medical staff were unable to provide guidance of how chest masculinisation surgery would affect their breast feeding capacity. This study (and in agreement with others) showed that breastfeeding was not associated with gender dysphoria.
c) Mitigating actions for Gender identity/transgender	Guidance from health care staff on how chest masculinisation surgery can affect breast growth and lactation in the perinatal period. More research into gender diverse individuals and their experiences of infant feeding
d) Responsible Officer for Mitigating Actions - Gender identity/transgender	Anjan Ghosh
23. Negative Impacts and Mitigating actions for Race	
a) Are there negative impacts for Race? *Answer: Yes/No (If yes, please also complete sections b, c,and d).*	Yes
b) Details of Negative Impacts for Race	From Census 2021, In Kent, 89.4% of population identify as White, 4.4% Asian, 2.6% Black, 2.3% mixed ethnicity, 1.2% other ethnic group. The greatest number of Asians was in Gravesham (11.2%), followed by Dartford

	(9.9%). 0.3% of the population identifies as Gypsy or Irish Traveller, which is higher than both the National (0.1%) and SE (0.2%) averages. 0.1% of the population identifies as Roma, which is lower than the National average (0.2%) and the same as the SE average (0.1%). According to data from the 2010 National Infant Feeding Survey, the highest incidences of breastfeeding were found from minority ethnic groups (97% for Chinese or other ethnic group, 96% for Black and 95% for Asian ethnic group). White women are among the most disadvantaged in the UK with respect to breastfeeding practices. Some studies have shown that breastfeeding rates are extremely low in England's Gypsies. Whilst national studies show relatively higher rates of breastfeeding in Roma communities, this has not been found to be the case in Kent, where breastfeeding rates are particularly low. Migrant women who move to new countries compared to those who remain in their home countries, often result in earlier discontinuation or no breastfeeding. Migrant women experience challenges to BF in host countries including public shaming, easy access to formula, and changes in their social support network (along with lower rates of BF in host population)
c) Mitigating Actions for Race	Targeted interventions to improve breastfeeding in white British native women should consider the role that culture can play in encouraging positive health behaviours. Breastfeeding support and training needs to be in line with cultural norms found in Gypsy, Roma and Traveller communities and migrant communities. Train site liaison managers in breast feeding. Provide early, inclusive, and accessible conversations antenatally about breastfeeding to encourage uptake.
d) Responsible Officer for Mitigating Actions - Race	Dr Anjan Ghosh
24. Negative Impacts and Mitigating actions for Religion and belief	
a) Are there negative impacts for Religion and Belief? *Answer: Yes/No (If yes, please*	Yes

also complete sections b, c,and d).	
b) Details of Negative Impacts for Religion and belief	From the Census 2021, In Kent, 48.5% of the population identify as Christian, 1.6% Muslim, 1.2% Hindu, 0.8% Sikh, 0.6% Buddhist, 0.1% Jewish, 0.6% other Religion and 40.9% No religion. **Religious Customs and Infant Feeding** Some women may not breastfeed in public. Some women prefer female health professionals. In some religions, there is a postnatal period where mothers should stay home. This means that mothers are unlikely to seek infant feeding support unless its provided in the home or by other methods (telephone/ online).
c) Mitigating Actions for Religion and belief	Training in person centred and cultural awareness for staff. Provide breastfeeding support at home or online for some cultures. Training women community ambassadors to support women with information, appointments and translation at hospital.
d) Responsible Officer for Mitigating Actions - Religion and belief	Dr Anjan Ghosh
25. Negative Impacts and Mitigating actions for Sexual Orientation	
a) Are there negative impacts for sexual orientation. *Answer: Yes/No (If yes, please also complete sections b, c,and d).*	Yes
b) Details of Negative Impacts for Sexual Orientation	From the Census 2021, In Kent, 90.6% of the population identify as straight or heterosexual. 1.3% of the population in Kent identify as Gay or Lesbian which is lower than the national and SE regional average (1.5%), with the greatest % of Gay or Lesbian people living in Canterbury (1.8%) and the lowest % living in Tonbridge & Malling (0.9%) . 1.1% of the population of Kent identify as Bisexual which is lower than both the national and SE regional average (1.3%). In a US study infants born to lesbian identified women were less likely to be breastfed than those born to their heterosexual counterparts. Disparities might be due to healthcare stigma- with such women experiencing difficulty accessing health care. (Jenkins et al, 2021).
c) Mitigating Actions for Sexual Orientation	Training for professionals on reducing stigma, using Inclusive language and involving non birthing parent.

	Involving LGBTQ+ parents in the co-production of services/support. Deliver community based breastfeeding educational interventions from HC professionals and peer groups.
d) Responsible Officer for Mitigating Actions - Sexual Orientation	Dr Anjan Ghosh
26. Negative Impacts and Mitigating actions for Pregnancy and Maternity	
a) Are there negative impacts for Pregnancy and Maternity? *Answer: Yes/No (If yes, please also complete sections b, c,and d).*	Yes
b) Details of Negative Impacts for Pregnancy and Maternity	Premature birth, infant ill health, domestic abuse and multiple births (twins) can all reduce rates of breastfeeding.
c) Mitigating Actions for Pregnancy and Maternity	Breastfeeding programmes should include support for breastfeeding women's emotional needs to promote positive interactions. For breastfeeding mothers experiencing premature birth/infant ill health: • Prevent mother/infant separation • Increase access to breast pumps • Provide support for milk expression • Enable skin to skin contact & kangaroo mother care • Provide lactation consultants • Provide neonatal outreach service to support premature babies to breastfeed Professionals and parents of multiples needed information and guidance about breastfeeding, bottle-feeding and weaning onto solids for multiples.
d) Responsible Officer for Mitigating Actions - Pregnancy and Maternity	Dr Anjan Ghosh
27. Negative Impacts and Mitigating actions for marriage and civil partnerships	
a) Are there negative impacts for Marriage and Civil Partnerships? *Answer: Yes/No (If yes, please also complete sections b, c,and d).*	Yes
b) Details of Negative Impacts for Marriage and Civil Partnerships	A British study of 17,308 mothers, showed that there is an association between exclusive breastfeeding at 3 months and being a mother with a partner. Single mothers were significantly less likely to breastfeed than mothers with a partner.
c) Mitigating Actions for Marriage and Civil Partnerships	Additional problem solving and assessment of barriers is needed for at risk populations such as single parents.
d) Responsible Officer for Mitigating Actions	Dr Anjan Ghosh

- Marriage and Civil Partnerships	
28. Negative Impacts and Mitigating actions for Carer's responsibilities	
a) Are there negative impacts for Carer's responsibilities? *Answer: Yes/No (If yes, please also complete sections b, c,and d).*	Yes
b) Details of Negative Impacts for Carer's Responsibilities	Pregnancy and birth are not absolute prerequisites for lactation and so it is possible for women to breastfeed adopted babies. Rates of adoptive breastfeeding are unknown in the UK, but are considered to be much lower than developing countries. It is thought that a lack of knowledge and support for breastfeeding and ways to maximise breastfeeding frequency are contributing to the low rates of adoptive breastfeeding.
c) Mitigating Actions for Carer's responsibilities	Developing increased knowledge and having support for breastfeeding will assist adoptive mothers to successfully breastfeed their adopted babies.
d) Responsible Officer for Mitigating Actions - Carer's Responsibilities	Dr Anjan Ghosh

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Nourishing our next generation

An infant feeding strategy for Kent 2024–2029

Contents

Note on use of language

This document uses the terms 'woman' or 'mother' throughout. These should be taken to include people who do not identify as women but are pregnant or have given birth.

Foreword

How we feed our babies matters at a personal level for the wellbeing of mothers, babies and their families, and it matters for all of us because of the lasting impact it can have on society as a whole.

This draft strategy sets out our ambition to enable all mothers to make informed decisions about feeding their babies, and for mothers and families to have the support they need from those around them.

We have listened to mothers in Kent who told us they would like more information before they have their baby so they can get started with realistic expectations and so they know when and how to ask for help. Mothers also told us they need support in the first days and weeks after their baby arrives and as their baby grows older. We heard how important it is for this help to be available at the right time and for it to be easy to access so issues can be resolved quickly.

A responsive approach to infant feeding sets a course for positive relationships and healthy eating later in life. Caring for a baby takes great commitment, and we can all help to ensure mothers, babies and families have the time and support they need to establish responsive and loving relationships. That's why this strategy considers all the different people and services in our wider community who can help to create the conditions for babies to be fed responsively and for mothers

to reach their infant feeding goals.

Providing seamless support around the family requires partnership working between a range of service providers and community organisations together with mothers and families themselves.

Fortunately in Kent today we are in a strong position to establish this partnership approach – both our Kent Family Hubs programme and the establishment of our Integrated Care System for Kent and Medway provide new opportunities for joint working across organisational and professional boundaries and with our local community.

We are grateful to everyone who has already sent us comments or who has participated in the development of this strategy so far. We welcome feedback and invite you to comment on this draft so that we can take account of your views as we develop the final version of our strategy.

Dr Anjan Ghosh
Director of Public Health
Kent County Council

Executive summary

Taking forward the vision set out in the Kent and Medway Integrated Care Strategy, this strategy sets out plans for infant feeding support across Kent.

This includes:

- how Kent County Council will develop support for infant feeding through the Start for Life and Family Hubs Transformation programme
- system-wide actions as part of the implementation of the Kent and Medway LMNS Equity and Equality Action Plan.

Purpose

The strategy's purpose is to give babies in Kent the best start in life and to support the health and wellbeing of mothers. It aims to reduce barriers to breastfeeding and to ensure that all mothers and families get the support they need with feeding their babies.

Why is this important?

How babies are fed has a lasting impact for mothers, babies and their families and for our society as a whole. Evidence suggests that increasing breastfeeding rates will lead to:

- a reduction in common health conditions, including obesity, diabetes, cancer, cardiovascular disease, mental illness, childhood infections and child tooth decay
- lower infant mortality
- better neurodevelopmental outcomes and higher academic attainment
- cost savings for public services and long term economic benefit

In survey responses, 25% of mothers who gave birth in the previous year told us that they didn't breastfeed for as long as they wanted to and 32% said they didn't get the support they needed to breastfeed for as long as they wanted to. Mothers told us they need staff to offer non-judgemental support with breastfeeding, bottle feeding and mixed feeding. They also told us that support from friends, family and the wider community has an impact on their decisions and experience relating to feeding their baby.

Recommended actions

Based on feedback from mothers, staff and volunteers, we identified the following five themes.

1. Ensuring mothers and families are well informed and well prepared

- Support schools to include breastfeeding in the curriculum
- Develop antenatal peer support and enable parents to access classes on infant feeding and introducing solids
- Provide clear information describing the infant feeding support services available
- Increase uptake of Healthy Start payment cards and vitamins for those on low incomes

2. Supporting mothers and families in the right place and at the right time

- Maternity and neonatal units to have Infant feeding teams and specialists with sufficient time to support mothers with feeding their babies
- Establish a peer support service and breastfeeding groups in all districts, aiming to reduce waiting times for specialist support
- Provide sufficient tongue-tie clinics in accessible locations
- Support mothers who experience breastfeeding grief
- Provide access to breast pumps and other equipment that mothers may need

3. Offering seamless support from an integrated and skilled workforce

- Implement quality standards including UNICEF Baby Friendly accreditation, and expand availability of donor breastmilk
- Review competencies across the infant feeding workforce to achieve consistent remuneration between roles, and provide training and career progression for staff and volunteers
- Provide an integrated, seamless service, coproduced with mothers, families and staff, and accessible for those in isolated and vulnerable communities
- Develop a plan for infant feeding in emergencies

4. Involving the wider community

- Support early years settings to facilitate breastfeeding and healthy introduction of solids
- Work with businesses to create and promote breastfeeding-friendly venues in the community, and to support mothers when they return to work
- Work with local communities to change attitudes and develop positive initiatives to support breastfeeding

5. Continuously improving our service as we learn over time

- Provide effective multi-agency oversight and update the strategy annually
- Allocate sufficient staff time for coordination of strategy implementation
- Take into account potential cost savings when allocating resources
- Conduct an infant feeding health equity audit
- Gather data to support ongoing evaluation

Our co-production approach

394
survey responses from mothers

88
survey responses from staff and volunteer supporters

20
individual meetings with infant feeding leads, service managers, researchers and staff

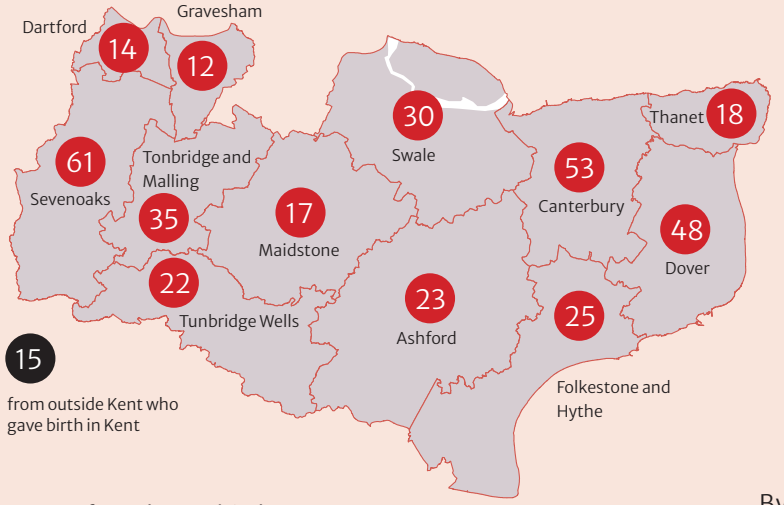
6
co-production meetings with groups of staff and mothers

36
national standards and guidelines reviewed as part of gap analysis comparing current provision against best practice

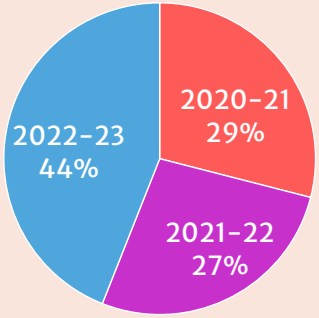
6
steering group meetings with membership including:

- maternity and neonatal commissioner and providers
- community service commissioner and provider
- voluntary sector breastfeeding support organisations

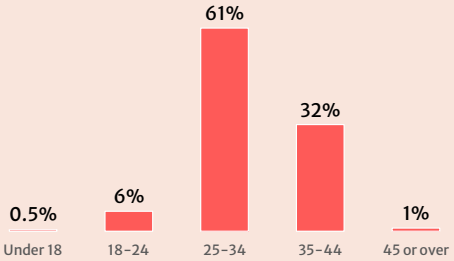
By district area:



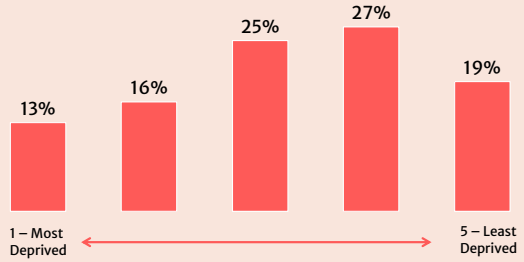
By year of giving birth:



By age of mother at birth:



By Index of Multiple Deprivation quintiles:



The policy context

The Kent and Medway Interim Integrated Care Strategy identifies breastfeeding as a key health outcome for children that varies between population groups and can affect health and wellbeing in later life.

> *"I am loving my breastfeeding journey. The bond is beautiful thing to experience"*
>
> – Mother

> *"I feel happy that I wasn't pressured to breastfeed"*
>
> – Mother

It states a commitment to developing a Family Hub model that will include access to universal infant feeding services and will enable improved integration of services including infant feeding[1].

This infant feeding strategy sets out how Kent County Council will develop support for infant feeding through implementation of the Start for Life and Family Hubs Transformation programme.

Start for Life focuses on the first 1001 days of life – from conception to age two – and is part of the core offer that all local authorities should provide.

In addition, Kent County Council is receiving funding to develop a Family Hub model, providing multiagency, open access, community-based provision. Infant feeding advice and specialist breastfeeding support are part of the essential Start for Life offer for all families, and the Family Hub model is intended to deliver enhanced infant feeding support[2].

The strategy also incorporates system-wide actions for Kent as part of the implementation of the Kent and Medway Local Maternity and Neonatal System (LMNS) Equity and Equality Action Plan.

The LMNS has committed to "making sure all of our maternity and neonatal services achieve the standards of infant feeding support recommended by the UNICEF UK Baby Friendly Initiative" and "working in partnership with other organisations in Kent and Medway to improve the range of breastfeeding support across communities, including through development of Family Hubs."[3]

NHS England's Three Year Delivery Plan for Maternity and Neonatal Services sets an ambition that "women ... are provided with practical support and information that reflects how they choose to feed their babies" and says it is the responsibility of maternity and neonatal trusts to "achieve the standard of the UNICEF UK Baby Friendly Initiative (BFI) for infant feeding, or an equivalent initiative, by March 2027."[4]

"Infant feeding refers to the feeding of a baby from birth to age two and is critical to a baby's healthy growth and development in that important period. Breastfeeding has numerous health benefits for both mother and baby, and skin-to-skin contact can be an important bonding experience. However, many mothers experience difficulties and require support to make sure that their baby is getting the nutrition that they need. Some mothers also decide that formula feeding is the correct choice for them. Education about the benefits of breast milk and options such as breast pumps should be provided, but in every case, personal choice should be respected and non-judgemental support should be offered. All parents and carers should be given the infant feeding help they need, irrespective of whether they are breastfeeding, expressing, combination feeding, or using formula."

– Family Hubs and Start for Life Programme Guide

Development of this strategy

Our approach to developing this strategy has been through co-production. Many people have fed into this strategy - through surveys, interviews and engagement meetings.

Kent County Council commissioned Better Breastfeeding to support the development of this strategy. Better Breastfeeding has:

- Interviewed infant feeding leads for maternity, neonatal and community services about the service they currently provide
- produced a gap analysis comparing current services with expectations set out in national best practice guidelines
- Conducted a survey of mothers in Kent, which received 394 responses from across all districts
- Conducted a survey of staff and volunteers who support mothers and families with infant feeding, which received 88 responses
- Met with multidisciplinary groups of staff and Maternity and Neonatal Voices Partnership (MNVP) service-user chairs to review findings

from the gap analysis and surveys and to plan content for the strategy

- Reviewed findings from other completed and ongoing outreach work including:
  - University of Kent research on barriers to breastfeeding for women in deprived areas
  - Kent and Medway LMNS Equity and Equality Action Plan outreach by community organisations
  - Research from the community organisation Involve Kent on the maternity experiences of ethnic minority women in Dartford, Swanley and Gravesham
  - Kent Dads' perinatal support project
  - Perinatal Mental Health and Parent Infant Relationships strategy

This strategy is structured around themes emerging from the analysis of responses to surveys, interviews, meetings and findings from other outreach work.

The objectives in this strategy are based on what mothers and staff told us is important and are also informed by national guidance and best practice guidelines, including from UNICEF, NICE and NHS England.

Development of the strategy has been overseen by the Kent Infant Feeding Strategy Group, which brings together staff responsible for commissioning and providing infant feeding support in maternity, neonatal and community settings.

"I was happy to bottle feed"

– Mother

"I would have liked to have breastfed for longer"

– Mother

Why infant feeding support is important

How babies are fed has a lasting impact for mothers, babies and their families and for our society as a whole. There is strong evidence for the health benefits of breastfeeding and for adopting a responsive approach to feeding.

Supporting mothers to reach their infant feeding goals

The proportion of babies born in Kent hospitals in 2022/23 whose first feed was breastmilk varied by hospital between 64.5% and 72.8% (see table). This compares with the England average of 72.9%[5]. Breastfeeding rates in Kent fall to 63.9% in the first two weeks (with 40.8% breastfeeding exclusively), and then fall again to 51% giving any breastmilk at 6–8 weeks[6]. There is significant variation between districts, with 38.9% of mothers in Swale giving any breastmilk at 6–8 weeks, compared with 65.6% in Tunbridge Wells.

25% of mothers responding to our survey who gave birth in Oct 2022–Sep 2023 told us that they didn't breastfeed for as long as they had wanted to, and 32% said they didn't get the support they needed to breastfeed as long as they wanted.

Percentage of babies in Kent whose first feed is breastmilk, 2020–2023

	2020/21	2021/22	2022/23
England	72.66%	73.14%	72.92%
Dartford & Gravesham NHS Trust	69.86%	70.42%	66.71%
East Kent Hospitals University Foundation Trust	65.62%	64.13%	64.53%
Maidstone & Tunbridge Wells NHS Trust	80.26%	78.39%	72.75%
Medway NHS Foundation Trust	54.14%	67.16%	62.36%

Source: NHS Maternity Statistics, Kent Community Health Foundation Trust

Health benefits

Increased breastfeeding rates are associated with many positive health outcomes, including:

- Lower incidence of childhood obesity[7]
- Lower incidence of type 2 diabetes for babies when they grow up and for mothers[8,9,10]
- Lower incidence of children developing type 1 diabetes[11,12]
- Fewer hospital admissions and GP visits for common childhood infections[13]
- Fewer cases of necrotising enterocolitis (NEC) in premature babies (a potentially fatal disease)[14]
- Lower incidence of sudden infant death syndrome (SIDS)[15,16,17]
- Lower incidence of breast cancer and ovarian cancer in mothers[18,19,20]
- Lower incidence of childhood leukaemia[21]
- Improved mental health for mothers and babies[22,23,24,25]
- Lower risk of developing cardiovascular disease for mothers[26,27]
- Improved heart health of preterm babies and improved outcomes for babies born with congenital heart disease[28,29]
- Lower incidence of tooth decay and dental malocclusion in children[30,31,32]
- Reduction in childhood asthma[33]

In 2021/22 the rate in Kent of emergency hospital admissions for gut infections in babies aged under one year was 154.7 per 10,000 – higher than the England average of 123 per 10,000[34].

Equity

Improving rates of breastfeeding in deprived communities can be a powerful way of reducing health inequalities.

> *"Breastfeeding is a natural safety net against the worst effects of poverty. Exclusive breastfeeding goes a long way towards cancelling out the health difference between being born into poverty or being born into affluence. It is almost as if breastfeeding takes the infant out of poverty for those few vital months in order to give the child a fairer start in life and compensate for the injustices of the world into which it was born."*
>
> – James P. Grant, Executive Director of UNICEF, 1980–1995[44]

Attainment and brain development

In addition to the health benefits of breastfeeding, individuals who were breastfed as babies have higher IQs, stay in school for longer, have a higher academic attainment and a higher income at age 30. The longer a child is breastfed, the greater these effects. Children breastfed for more than six months experience better

neurodevelopmental outcomes, including cognition, reading, writing and mathematical skills, communication skills, language development, mental health and motor skills[35].

Cost of living

For families who are bottle-feeding, the cost of formula milk significantly impacts on household budgets[36]. Families on low incomes can receive Healthy Start payments, which can be used to buy formula, but rising prices mean that Healthy Start payments are no longer sufficient to cover the full cost of any formula brand[37]. A recent survey by the British Pregnancy Advisory Service found that 65% of women feel anxious or worried by the cost of formula, and the same proportion report a negative impact on family finances as a result[38].

At a time of increased pressure on family budgets, some mothers may feel a need to return to work earlier, which may affect the length of time they feel able to breastfeed.

Economic impact and immediate cost savings

The Lancet Breastfeeding Series in 2016 evaluated the global economic impact of breastfeeding. It estimated that in richer countries the economic impact of low breastfeeding rates on cognitive abilities alone resulted in losses of $231.4 billion, equivalent to 0.53% of gross national income. For the UK this amounts to around £12 billion in lost potential[39].

The full economic benefit of improving breastfeeding rates in Kent could be hundreds of millions of pounds annually. Some of these cost savings would be realised immediately. A major 2012 study found that implementing the UNICEF Baby Friendly Initiative would pay for itself within one year, largely due to reduced infections in babies and reduced rates of NEC in premature babies[40].

In the UK, specialist formula milks are a recognised source of excess spending. Between 2008 and 2020, prescriptions of specialist formula milks for babies with cows' milk protein allergy increased by 430%, from £10 million to £53 million[41]. Increasing breastfeeding rates and reducing inappropriate prescriptions has the potential to significantly reduce this spending in Kent.

Environment

It has been estimated that exclusive breastfeeding for six months saves an estimated 95–153 kg of carbon per baby compared with formula feeding (equivalent to taking between 50,000 and 77,500 cars off the road each year in the UK). Breastfeeding also involves zero waste, whereas around 550 million baby formula cans – comprising 86,000 tons of metal and 364,000 tons of paper – are added to landfills every year[42,43].

Theme 1:
Ensuring mothers and families are well informed and well prepared

Mothers told us that they value opportunities to learn about infant feeding and they want to be well prepared before their baby arrives. Staff also told us that antenatal preparation is important.

> *"The support prior to birth from midwife and feeding support was good and gave me the confidence to feed my baby"*
>
> – Mother

In our survey, of those mothers who had attended an antenatal class, the majority attended a class run by a charity or a business rather than the public sector. Those in more deprived areas were much less likely to have attended an antenatal class.

> *"It would have been really helpful to have some classes/information sessions (particularly around challenges) beforehand as I naively thought it would be totally straightforward!"*
>
> –Mother

University of Kent research into the barriers to breastfeeding in deprived communities found:

- mothers often felt unprepared for the reality of breastfeeding and that as a result, when they experienced difficulties, they felt quickly overwhelmed
- many of the women who did not breastfeed struggled to identify role models, friends or family who had successfully breastfed
- stakeholders stressed the need for peer supporters from communities where it was not the social norm to breastfeed[45]

Some women face barriers to accessing antenatal infant feeding support; community outreach undertaken as part of Kent and Medway LMNS Equity and Equality Strategy[46] found that some women were not making contact with professionals before presenting in labour at the hospital.

> *"We run an antenatal group and one session in particular is just focussed on breastfeeding. This is a two-hour session that is incredibly informative. For most expectant mothers it is a real eye opener and definitely contributes to the mother's decision when thinking about bottle/ breastfeeding options."*
>
> – Family Learning and Involvement Worker

> *"I thought it would just come naturally [breastfeeding]. We both thought that as it is a natural thing. We didn't realise it's not always so easy for some mums. We now know many mothers struggle at first."*
>
> – Father

> *"More support in feeding twins before birth and in the first few days, most of our problems happened early on and I felt completely lost. I joined a twin feeding support group a few weeks in and so much of the knowledge on there would have been really helpful."*
>
> – Mother

Objective:	What we know:	Recommended actions:
1.1. Make nurseries and schools aware of resources for including breastfeeding in the curriculum	Attitudes towards breastfeeding are learnt early in life, and nurseries and schools have an important role to play in ensuring that young people learn about the importance of breastfeeding as they grow up.	Make nurseries and schools aware of resources for including breastfeeding in the curriculum. Breastfeeding peer supporters to visit schools – particularly in areas with the lowest breastfeeding rates.
1.2. Provide one-to-one peer support for young and/or vulnerable mothers before their baby arrives	Antenatal peer support would introduce women to sources of support while they're pregnant, help to identify mothers who may need enhanced support, and provide role models for women from communities with low rates of breastfeeding.	Offer young and/or vulnerable mothers an antenatal one-to-one conversation with a peer supporter.
1.3. Provide group learning sessions about infant feeding for mothers to attend before and after they have their baby and make these sessions welcoming for fathers/partners	Group learning sessions will help mothers and families to feel more prepared before and after their baby arrives and to have realistic expectations of feeding their babies. Offering group learning sessions through Family Hubs will reduce inequalities in access to antenatal sessions.	Offer antenatal and postnatal infant feeding education sessions for all mothers and fathers/partners or any other support person who a mother wishes to accompany her. Plan these in partnership between hospital trusts and Family Hubs, to provide a joined up service that maximises access for women and families. Work with local communities on planning the locations of these, prioritising those communities with lower rates of breastfeeding or who are less likely to access services.
1.4. Support mothers and families to know how to provide a healthy diet for themselves and their children	Sessions on introducing solid foods are currently provided in each council district, although not all mothers reported that they are aware of them.	Invite all families when their baby is around 3-4 months old to attend classes on the introduction of solid foods at around six months. Increase uptake of the Healthy Start payment card and vitamins and offer recipients advice on using them to increase the amount of fruit and vegetables in their family's diet.

Objective:	What we know:	Recommended actions:
1.5. Provide high quality, accessible information for mothers and families about infant feeding and about where they can get support	Providing clear accessible information will support mothers and families to resolve issues as they arise and to know how they can access support when they need it.	Work with staff, mothers and families to develop clear information about the different support services available and how to access them. Review existing online information sources and infant feeding apps aiming to include information about support services, businesses signed up to the Breastfeeding Friendly scheme and practical information about infant feeding. Provide this information as leaflets at family hubs and other community venues and make information available in the main community languages.

Theme 2:
Supporting mothers and families in the right place and at the right time

Many mothers responding to our survey said that getting support with infant feeding is very important to them, before they leave hospital and in the weeks and months that follow. Mothers told us they would have liked more support with breastfeeding, mixed feeding, expressing and bottle feeding.

Mothers may need support with the physical, emotional and social aspects of feeding their baby. There are a range of different professional and volunteer roles that can offer infant feeding support, and mothers may need help from different services at different times.

> *"I was a single mum with no support on breastfeeding. I was lost... I could have breastfed my baby instead of combi fed if I had received the correct support in the hospital."*
>
> – Mother

Infant feeding support can include:

- Healthcare professional support from midwives and the health visiting service
- Social support for mothers who are breastfeeding
- Additional support from a peer supporter, breastfeeding counsellor or infant feeding support worker
- Specialist support from an International Board Certified Lactation Consultant (IBCLC) or a healthcare professional with appropriate experience and training
- Mental health support
- Access to equipment, such as a breast pump

The nature of infant feeding is that it takes place over a specific period of hours, days and weeks, so support needs to be available at the right time.

In our survey, 31% of mothers who gave birth in 2022/23 had attended a baby feeding group. This varied widely by district, with over half of mothers in Sevenoaks and in Tonbridge and Malling having attended a group, compared with under 10% of those in Ashford, Dartford or Gravesham. Of those who gave birth in 2022/23 and didn't attend a group, 19% said it was because the group was too hard to get to.

> *"Once we were referred to the feeding team (over an hour from my home by car) I did feel they supported me, but it was a month after giving birth and really too late."*
>
> – Mother

The location of support matters. Constraints on a mother's ability to travel to access support may include:

- physical constraints (e.g. following a caesarean birth mothers are generally advised not to drive for six weeks)
- care commitments (e.g. needing to feed and care for their baby and any older children)
- financial constraints – especially in the context of a cost of living crisis
- whether she has someone who can drive her to appointments
- availability and accessibility of public transport

Providing a range of services at the same place and time, wherever possible, helps to reduce the amount of travel required as well as enabling mothers to access the support they need quickly. Home visits can also help when a mother is unable to travel to a clinic or group.

Where mothers are able to self-refer this minimises barriers to accessing a support service. Where this is not possible, it is important to provide rapid

> *"The breastfeeding cafe opened when baby was eight weeks old and they supported me with oversupply issues, general postnatal wellbeing and encouragement to continue breastfeeding. It made such a huge impact on me that I've trained to be a peer supporter too."*
>
> – Mother

> *"The help I got at hospital when I wasn't sure I was feeding correctly was outstanding. I was so nervous to ask being my third child but there was no judgement"*
>
> – Mother

35% of the mothers responding to our survey said they experienced difficulties with breastfeeding as a result of their baby having a tongue-tie. Research suggests that prevalence of tongue-tie is between 0.2 and 10.7%, with many tongue ties causing no problems[47].

triage to minimise waiting times and ensure urgent support needs are met in a timely way.

By ensuring mothers can access peer support and social support, and that healthcare professionals have enough time to support mothers, it is likely that the demand for specialist support – including tongue-tie procedures – will be lower and waiting times can be minimised.

We heard from staff that they would like to be able to provide support for mothers experiencing breastfeeding grief and trauma. Options for supporting these mothers to process their feelings could include specialist mental health midwives, breastfeeding counsellors, voluntary sector breastfeeding support organisations or other perinatal mental health support services.

Objective:	What we know:	Recommended actions:
2.1. Work towards healthcare professionals having sufficient time to support mothers with feeding their babies	Mothers told us they wanted health professionals to have enough time to support them with infant feeding, in hospital and at home. Mothers in the most deprived areas were significantly more likely than those in the least deprived areas to say that they needed more help with infant feeding when the health visitor visited them in the first two weeks.	Continue implementing strategies to address workforce challenges in maternity, neonatal and health-visiting services.
2.2. Enable mothers to access additional support when and where they need it	Additional infant feeding support can be provided by infant feeding support workers or peer supporters, coordinated and supervised by breastfeeding counsellors or lactation consultants. It helps mothers with basic problem solving (e.g. positioning baby at the breast, understanding what is normal, responsive feeding and self-help measures for common challenges such as blocked ducts or low milk supply/oversupply).	Each maternity service to have an infant feeding team with sufficient time and expertise to provide additional support in hospital and at home until discharge. Work in partnership with NHS England to appoint an infant feeding lead and an infant feeding team in each neonatal service, with the skills to support the unique challenges faced by mothers with babies on the neonatal unit. Establish an infant feeding peer support service that supports mothers in hospital, in support groups and at home. Peer supporters to offer a conversation within 48 hours of giving birth, as well as support by telephone and social media.

Objective:	What we know:	Recommended actions:
2.3. Enable breastfeeding mothers to access social support and peer support in a group setting through the Family Hubs programme	Mothers told us they would like more support groups local to them and at convenient times throughout the week. We also heard from staff in the public and voluntary sectors that having more groups would improve the overall support available. The University of Kent reports that mothers in deprived areas value social groups although many prefer to go to groups that are not just for breastfeeding support. Those who attend breastfeeding groups appreciate meeting other breastfeeding mothers, but sometimes if they are really struggling then comparing themselves with others in the groups can exacerbate feelings of failure[48] .	Through the Family Hubs programme, establish breastfeeding groups in each district, offering social and peer support and led by a breastfeeding counsellor or lactation consultant. Where possible hold these at the same time as health visitor clinics. Work with local families to agree the number and location of groups, sufficient that all mothers are able to access this support, and consider offering additional face-to-face or online groups where a specific need is identified – e.g. for younger mothers, geographically isolated communities, faith groups, non-English language groups or mothers of twins and multiples. Identify peer supporters who can act as community ambassadors, e.g. attending parent and baby groups in their local community to offer peer support and signposting for women who may not attend the breastfeeding groups.

Objective:	What we know:	Recommended actions:
2.4 Reduce waiting times for specialist support	Mothers told us that access to specialist support in hospital and in the community would enable them to continue breastfeeding when they encounter challenges. Staff agreed this is important. Barriers to accessing specialist support included waiting times and the practicalities and cost of travelling to a clinic, especially if it is far from home.	Review availability of specialist infant feeding support in the maternity and neonatal units, aiming for this to be available for any mother who needs it throughout the week. Review input from speech and language therapists and dietitians and explore ways of closing any gaps. Review provision of neonatal outreach services that support mothers to establish breastfeeding when they take their baby home. In the community, provide specialist support with suitable out-of-hours provision, and aim for mothers and families to access support within 48 hours. Plan locations of specialist clinics with local families to minimise the distance that mothers and families need to travel, especially for those in deprived areas.
2.5. Support those mothers who have difficulty feeding as a result of their baby having a tongue-tie and enable babies who need it to access tongue-tie division without unnecessary delay	Both mothers and staff in our survey talked about needing to avoid unnecessary delays in assessing for and treating tongue-tie. Staff also emphasised the need to ensure that other possible causes of feeding difficulties are considered and addressed.	Infant feeding difficulties to be assessed quickly by a professional with appropriate training. Provide sufficient tongue-tie division clinics in locations that are accessible for families. Consider supporting those families on low incomes with travel costs.

Objective:	What we know:	Recommended actions:
2.6 Provide support for mothers who are experiencing breastfeeding grief	Mothers can experience grief and trauma as a result of having to stop breastfeeding before they are ready[49]. In our survey 25% of mothers said they didn't breastfeed for as long as they wanted to. A common reason for choosing to formula feed was that a mother had tried breastfeeding her previous child(ren) and it hadn't worked for them.	Explore options for supporting mothers who are experiencing breastfeeding grief and trauma and ensure that training for Family Hubs staff includes awareness of this issue.
2.7. Support mothers to access equipment that will support them with breastfeeding their baby	Mothers and staff talked about needing to access breast pumps quickly in circumstances where a baby cannot be fully breastfed, e.g. where the baby is in a neonatal unit or is struggling to breastfeed due to a tongue tie, so the mother can maintain her milk supply and express milk for her baby. Some other equipment, such as maternity bras, breast pads and slings, can make breastfeeding easier, and trial Family Hub sites in Kent have conducted a pilot scheme to make some of these items available for mothers on low incomes.	Maternity and neonatal services to have sufficient double electric breast pumps for every mother who needs them, and mothers at home to be able to loan a breastpump within 24 hours of a need being identified. Review existing pilot projects and consider whether to offer breastfeeding equipment for mothers on low incomes through the Family Hubs. Consider offering a sling hire service as part of the Family Hub provision.

Theme 3:
Offering seamless support from an integrated and skilled workforce

A strong theme that emerged from feedback was the importance of high quality support.

Mothers emphasised the need for staff to be well trained, both in terms of knowledge and also understanding how to listen well and provide non-judgemental support.

They talked about this not only in relation to maternity, neonatal and health visiting, but also staff in other parts of the healthcare system needing to have an understanding of infant feeding issues.

Mothers talked about the benefits of continuity and communication between different parts of the system.

> *"The midwife and feeding team member were supportive and non judgemental in relation to how I fed my baby"*
>
> – Mother

The University of Kent found that mothers in deprived areas:

- felt that all midwives and healthcare professionals should be able to support with infant feeding, not only a specialist team
- reported receiving conflicting advice from different professionals
- emphasised the need for non-judgemental support
- wanted professionals to be willing to support with bottle feeding and mixed feeding as well as breastfeeding
- felt "unsafe" and "did not trust" their midwife due to a lack of continuity and seeing different midwives for different appointments[50]

> *"For future pandemics, please consider breastfeeding support and tongue-tie clinic a frontline service which is really needed."*
>
> – Mother

> *"I would like Health to partner better with third sector organisations and truly work in partnership with them and help grow that sector. Be able to have service level agreements with them and solve the issue of data sharing, making a more seamless service."*
>
> – Community Lactation Consultant

We heard from staff that many of the issues raised by mothers in our survey would be addressed by working towards achieving the UNICEF UK Baby Friendly Initiative's Gold Award[51].

Staff also told us they want to work in partnership across organisational boundaries and across the public and voluntary sectors, and to have accurate and up-to-date information about the range of services available for mothers and families.

Opportunities to strengthen communication and partnership working include:

- the Kent Infant Feeding Steering Group which brings together staff responsible for commissioning and providing infant feeding support in hospital and community settings along with voluntary sector breastfeeding support groups
- the establishment of Family Hubs, which aim to give families access to a broad and integrated range of services in local support centres
- the establishment of the Integrated Care System for Kent and Medway, which brings together partners including local authorities, NHS trusts and voluntary sector organisations to join up and improve local services

Kent is a large area with diverse local communities that may have different needs when it comes to infant feeding support. By working with local families, we can develop a better understanding of what will work best in different areas.

"My health visitor was fantastic and always able to answer my questions about feeding and be there when I needed her."

-Mother

"The healthcare professionals involved in my care were very knowledgeable and supportive in my breastfeeding journey."

- Mother

Objective:	What we know:	Recommended actions:
3.1. Continue to implement recognised quality standards for infant feeding	UNICEF UK Baby Friendly accreditation provides a framework through which hospital and community services can improve standards of infant feeding support. Other quality standards that include recommendations aimed at improving infant feeding support include: • Bliss Baby Charter Scheme, which aims to standardise high-quality family-centred care in neonatal units • PREM 7 which aims to improve outcomes for babies born prematurely in the South East region	Work towards Gold UNICEF UK Baby Friendly accreditation for all maternity, neonatal and community services and towards Platinum accreditation under the Bliss Baby Charter Scheme for all neonatal units. Implement the PREM 7 recommendation for all babies born under 34 weeks to receive breastmilk within 24 hours.
3.2. Expand availability of donor milk to all babies who would benefit from it	Currently babies born under 32 weeks' gestation can access donor milk. There is variation among the hospital Trusts around offering donor milk to babies born after 32 weeks.	Review access to donor breastmilk, aiming for this to be available for all babies who would benefit from it.

Objective:	What we know:	Recommended actions:
3.3. Establish ways of working for the peer support service relating to recruitment, training, supervision and integration	Peer support services work best when there is a clear set of responsibilities for paid and voluntary roles. The peer support roles will need to be accessible for mothers from a range of backgrounds, with training and volunteering accessible for those with babies and young children. Enabling career progression from voluntary to paid roles will help to support mothers into work and to retain those who have developed valuable skills. Breastfeeding counsellors are mothers who have breastfed their children but have more extensive training than most peer supporters. They are able to facilitate group learning sessions and lead peer support groups. They may also have additional expertise in taking the lead on training of peer supporters.	Recruit peer supporters from diverse backgrounds, including those demographics who are less likely to breastfeed and mothers who speak a range of community languages, ensuring that training is accessible for those with young children. Review competencies and responsibilities across the infant feeding workforce and within the Family Hubs programme to ensure consistency of remuneration between different roles. Provide clear pathways for existing breastfeeding counsellors, peer supporters or volunteers to transition into the new service and provide career progression from voluntary to paid roles.

Objective:	What we know:	Recommended actions:
3.4. Enable all staff and volunteers to access training and develop the competencies they need to support mothers and families with infant feeding	Mothers told us they would like staff to: • have the opportunity to debrief their own experiences of infant feeding • be able to support with establishing breastfeeding and identifying common problems • adopt a "hands off" approach to infant feeding support • be able to support with bottle feeding and mixed feeding • provide non-judgemental support and offer information without pressure • know the limits of their own knowledge and when to signpost to further support	Develop a Kent-wide competency framework[52] that sets out for all staff and volunteers the training and competencies they need to support mothers and families with infant feeding, including debriefing personal experiences. Enable staff to access training on how to support mothers of twins and multiples. Enable paediatricians and GPs to access infant feeding training. Review training needs for staff not covered under Baby Friendly Initiative accreditation, such as dietitians, pharmacists, obstetricians, radiologists, breast surgeons, dentists, physiotherapists, perinatal mental health staff, early help staff and Family Partnership Programme staff. Continue promoting the importance of responsive feeding with all those who work in early years.

Objective:	What we know:	Recommended actions:
3.5. Facilitate integration between organisations and across the multidisciplinary team so mothers experience a seamless service	We heard from staff that they would like to understand more about the service delivered by other parts of the system, that they would like to work in an integrated way with other teams, and that they would find multidisciplinary training helpful.	Aim for every child to have an infant feeding record that parents or carers can access at any time and that can be viewed and updated by professionals supporting them. Establish a community of practice for infant feeding support, including multidisciplinary training sessions for staff and volunteerss. Every hospital trust to have a hospital-wide infant feeding policy. Continue developing our Faltering Growth pathway. Ensure that mothers in geographical boundary areas experience a seamless service. Explore opportunities for partnership working and integration including with voluntary sector breastfeeding support organisations, social prescribing partners, the family partnership programme and Family Hub coaches.
3.6. Engage with mothers, families and staff to co-create and continually improve infant feeding support services	Mothers told us that the quality of the hospital environment can affect their ability to get started with breastfeeding. Options could include provision of sidecar cribs which allow mothers easier access to their baby[53], enabling fathers to stay on the ward overnight and room decor that helps mothers feel more relaxed and at home. Maternity and Neonatal Voices Partnerships (MNVPs) bring together mothers and families with staff who commission and provide maternity and neonatal services to review services and co-produce service developments.	Work with MNVPs to support continuous improvement of infant feeding support including reviewing aspects of the hospital environment that could help mothers to establish breastfeeding. Work with local communities, especially in areas with lower breastfeeding rates, to plan the provision of groups and clinics and to understand what support would be most valuable to local mothers and families.

Objective:	What we know:	Recommended actions:
3.7. Plan support for those in isolated and vulnerable communities	Mothers and families living in rural areas with poor transport links may need additional support to access infant feeding support, especially if they have a low household income.	Identify areas that are remote with poor transport links, especially if they are also deprived areas, and support mothers there to access services. Include infant feeding support in planning the Family Hubs outreach work to isolated and/or vulnerable communities.
3.8. Develop a plan for providing infant feeding support in emergencies	Mothers told us that in an emergency, such as during the COVID pandemic, infant feeding support should be seen as an essential service. Many families are experiencing ongoing food insecurity due to the rising cost of living. The Kent Resilience Forum (KRF) is a partnership of organisations and agencies who work together to improve the resilience of Kent and Medway and to ensure a coordinated response to emergencies that may impact on communities.	Develop a plan for enabling mothers and families to access infant feeding support services in emergencies, and ask the Kent Resilience Forum to consider the needs of babies and young children in planning for emergencies. Take account of UNICEF UK Baby Friendly Initiative guidance on supporting families with babies under 12 months experiencing food insecurity. Support food banks to know how and where to refer families who are experiencing hardship to obtain infant formula or access infant feeding support and to register for the Healthy Start payment card and vitamins[54].

Theme 4:
Involving the wider community

The whole community has a role to play in making it easier for mothers to breastfeed for as long as they want to and ensuring that all mothers and families feel supported in feeding their babies.

> *"If you have a family who are supportive, and not try to put you off when things get a bit tricky, it makes the world of difference. It is important for your family and friends to respect your wishes and, although it gets tricky at times, understand why you want this for your child and for yourself."*
>
> – Mother

One fifth of mothers in our survey said they felt uncomfortable or very uncomfortable to breastfeed their baby in public places in their neighbourhood. This was higher among younger mothers, with 47% of mothers aged 18–24 saying they felt uncomfortable or very uncomfortable.

Among mothers who decided to continue breastfeeding after they returned to work, 30% said they felt mostly unsupported or not at all supported to do so by their employer. This number was 63% among mothers living in the 20% most deprived areas.

> *"My work have supported me greatly and my breastfeeding journey continues 22 months on."*
>
> – Mother

> *"I would love a list of places where mothers and babies are welcomed. I found that I felt so self-conscious when breastfeeding in certain places that it put me off of going out."*
>
> – Mother

Objective:	What we know:	Recommended actions:
4.1. Encourage early years settings to facilitate breastfeeding and the healthy introduction of solid foods	Early Years settings have a role in helping children to establish healthy eating habits and supporting mothers who wish to express breastmilk for their baby when they return to work.	Raise awareness of the *Eat Better Start Better* guide and Public Health England example menus[55] for early years settings with private nurseries and childcare providers[56]
4.2. Ensure that all NHS and local authority services supporting families are compliant with the WHO Code of Marketing of Breastmilk Substitutes	The International Code of Marketing of Breastmilk Substitutes (the Code) is an international health policy framework published by the World Health Organisation in order to protect breastfeeding. It aims to ensure that parental decisions about feeding babies are made based on full and impartial information rather than misleading, inaccurate or biased marketing claims[57]. It is particularly important that health professionals advising parents are not influenced by commercial interests.	Ensure that healthcare workers supporting families in Kent comply with the WHO Code and do not attend training sponsored by formula companies.
4.3. Encourage and support businesses and employers to adopt policies and practices that reduce barriers to breastfeeding	Businesses have responsibilities towards breastfeeding employees, and public sector employers can act as exemplars to other local employers[58]. Kent County Council has launched a Breastfeeding Friendly scheme aimed at encouraging businesses such as cafes and restaurants to make their spaces welcoming for breastfeeding mothers.	Develop model policies for supporting local authority and NHS staff who are breastfeeding and returning to work and share these with local employers. Continue to promote the Breastfeeding Friendly scheme to local businesses and with pregnant women and mothers.

Objective:	What we know:	Recommended actions:
4.4. Work with local communities to change attitudes towards breastfeeding	It can be challenging for mothers to maintain breastfeeding in communities where bottle feeding is the social norm. To generate a shift in attitudes, the Family Hubs and Start for Life programme guide[59] suggests involving local people in identifying community assets, and NICE *Quality Standard QS148 Community engagement: improving health and wellbeing* describes how this can create a positive basis for working with local communities[60]. Kent County Council is working with the University of Kent to develop a communications plan to normalise breastfeeding in communities with the lowest breastfeeding rates.	In communities with the lowest breastfeeding rates, work with local people to identify community assets, such as buildings, facilities, skills, knowledge, social networks and relationships. Work with local people to create positive initiatives, using these assets, that can help to create a more breastfeeding friendly environment for mothers and babies.

Theme 5:
Continuously improving our service as we learn over time

Implementation of this strategy will require partnership working between all the organisations involved in commissioning and providing infant feeding support services, working with mothers and families, local communities, the voluntary sector and other stakeholders.

It will require effective systems and resources to ensure that the actions are taken forward over the next five years, and that we continually evaluate our progress and adapt our approach as we learn over time.

In implementing the strategy, we will identify the actions that require system-wide coordination through Kent and Medway Integrated Care System and those which are the responsibility of Kent County Council through the Start for Life and Family Hubs programme.

The following data is currently monitored by Kent County Council:

- Breastmilk at first feed
- Infants fully breastfed at 10-14 days
- Infants partially breastfed at 10-14 days
- Infants receiving any breastmilk at 6-8 weeks

Some additional data is collected by the hospital trusts, such as breastfeeding at discharge, and data for babies in the neonatal units.

Objective:	What we know:	Recommended actions:
5.1. Provide effective oversight for the implementation of the strategy through the Family Hubs Programme and the Infant Feeding Steering Group	The development of this strategy has been overseen by the Kent Infant Feeding Steering Group. This will also oversee the implementation of the strategy.	Monitor and review the infant feeding strategy for Kent through the governance processes agreed by Kent County Council and the Local Maternity and Neonatal System of the Kent and Medway Integrated Care Board.
5.2. With engagement through the Kent and Medway Integrated Care Board, ensure resources are in place to support the implementation of the infant feeding strategy	Implementation of the strategy will require staff time for coordination and funding for implementing service changes. We expect that, across the Integrated Care System, this expenditure will be more than offset by cost savings resulting from increasing breastfeeding rates.	Allocate sufficient staff resource to coordinate implementation of the strategy. To support decisions about expenditure, aim to understand both the costs of implementation and the potential cost savings across the system from investing in infant feeding support . Where appropriate, consider joint commissioning of services between Kent and Medway ICB and Kent County Council.
5.3. Conduct a health equity audit to inform the implementation of the strategy	A health equity audit examines how health determinants, access to relevant health services, and related outcomes are distributed across the population. Health determinants encompass a range of factors including, but not limited to, individual characteristics, individual behaviours, the environment we live in, and broader social and economic factors.	Conduct a health equity audit to understand the social determinants of infant feeding methods in Kent. We will take account of this in the way that we implement the infant feeding strategy.

Objective:	What we know:	Recommended actions:
5.4. Develop information sharing agreements to centrally gather data from providers to inform the implementation of the strategy and to evaluate progress	Drawing on data collected by Kent County Council and hospital trusts, it will be important for us to evaluate the impact of the strategy during the implementation phase and at the end of the five-year implementation period.	Develop a set of indicators to support monitoring of the progress of this strategy and collect relevant data consistently and reliably.
5.5. Keep the strategy relevant and up to date	Over the course of five years, we expect that new information will emerge and that we will learn over time as a result of monitoring the impact of our work. To make optimal use of our resources we will need to adapt our approach and the strategy will need to be amended to reflect this.	Review the infant feeding strategy for Kent annually, considering any emerging issues and agreeing any amendments to the strategy or implementation plan.

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47 Tongue-tie and frenotomy in infants with breastfeeding difficulties: achieving a balance (2014) Power, RF and Murphy, JF, Archives of Disease in Childhood https://pubmed.ncbi.nlm.nih.gov/25381293/

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51 About the Baby Friendly Initiative, UNICEF https://www.unicef.org.uk/babyfriendly/about/

52 Infant Feeding Support Competencies Framework (March 2023) https://ukbreastfeeding.org/infant-feeding-support-competencies/

53 Side-Car Cribs & Bedside Cots, Basis https://www.basisonline.org.uk/hcp-side-car-cribs-bedside-cots

54 Supporting families with children under 12 months experiencing food insecurity: a guide for local authorities and health boards, UNICEF https://www.unicef.org.uk/babyfriendly/local-authorities-guide

55 Example menus for early years settings in England (November 2017) Public Health England https://www.gov.uk/government/publications/example-menus-for-early-years-settings-in-england

56 Eat Better Start Better: a practical guide (2017) Action for Children https://foundationyears.org.uk/eat-better-start-better/

57 The international code of marketing of breastmilk substitutes, UNICEF, https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/international-code-marketing-breastmilk-substitutes-resources/the-code/

58 Commissioning infant feeding services: a toolkit for local authorities (June 2016) Public Health England https://www.gov.uk/government/publications/infant-feeding-commissioning-services

59 Family Hubs and Start for Life programme guide (August 2022) Department for Education and Department of Health & Social Care https://www.gov.uk/government/publications/family-hubs-and-start-for-life-programme-local- authority-guide

60 Community engagement: improving health and wellbeing: Quality Standard QS148 (March 2017) NICE https://www.nice.org.uk/guidance/qs148

Further information

For further information about any aspect of this strategy please contact:
startforlife@kent.gov.uk

Kent County Council

Alternative formats

If you require this strategy in an alternative format or language please email alternativeformats@kent.gov.uk or call 03000 421553 (text relay service number: 18001 03000 421553). This number goes to an answering machine, which is monitored during office hours.

KENT COUNTY COUNCIL – PROPOSED RECORD OF DECISION

DECISION TO BE TAKEN BY:	DECISION NO:
Cabinet Member for Adult Social Care and Public Health	24/00057

For publication:

Key decision: Yes

Title of Decision: Approve the adoption of the Infant feeding strategy, 'Nourishing our next generation.'

Decision: As Cabinet Member for Adult Social Care and Public Health, in consultation with the Cabinet Member for Integrated Children's Services, I propose to:

a) **APPROVE** the adoption of the Infant feeding strategy, 'Nourishing our next generation.' and to

b) **DELEGATE** authority to the Director of Public Health to take necessary actions, including but not limited to, allocating resources, expenditure, entering into contracts and other legal agreements, as required to implement the decision.

Reason for decision:
Currently there is not an infant feeding strategy in Kent. Developing a strategy supports strategic planning and delivery and helps joined up working across organisations.

In 2022 there were 16,394 live births in Kent. Research continues to show the importance of easy access to infant feeding support and consistency of information.

Development of a cocreated Infant feeding strategy has provided an opportunity to bring stakeholders together from across the system, to engage with families and identify where there are gaps in knowledge and in support. The strategy has been made available for public consultation for a period of eight weeks February – April 2024.

This strategy will contribute to *'Priority 1: Levelling up Kent' of the Framing Kent's Future Our Council Strategy 2022-2026'* as the themes relate to providing additional support for families at the start of their infant's life which is a preventative approach to improve the populations health and narrowing of health inequalities.

Financial Implications: The DfE family hub grant is a ring-fenced grant specifically for the family hubs and start for life programme which includes a focus on perinatal mental health and parent infant relationships and does not impact the council general revenue fund. This has provided opportunity to increase workforce capability and capacity to expand the reach of low to moderate perinatal mental health and parent infant relationship support and to raise awareness of support available for those with low to moderate perinatal mental health. The implementation of this strategy will be pivotal to further progressing and embedding this work.

Securing Kent's Future
The proposed decision aligns with Objective 3 of securing Kent's Future

Legal Implications:.
The council entered into a Memorandum of Understanding (MoU) with the Department for Education (DfE) which creates obligations to meet specific deadlines and timescales set by the DfE or risk losing further funding or funding claw back.

Access to the associated funding, depending on the type and level of transformation activity progressed, is conditional on compliance with the terms of the MoU and demonstration of progress toward an effective Family Hub Model.

The council has and will enter into a number of contractual agreements to support delivery in line with Spending the Council's Money and Public Contract Regulations 2015, and aligns with Objective 3 of Securing Kent's Future.

Equality Implications: An Equality Impact Assessment had been completed and this has identified that there were impacts across all the protected characteristics. Suggested mitigations are wide ranging including training in person centred and cultural awareness, guidance on communication and sensory needs to be included in any notes.

Data Protection implications:
General Data Protection Regulations are part of current service documentation for the contract and there is a Schedule of Processing, Personal Data and Data Subjects confirming who is data controller/ processor.

Cabinet Committee recommendations and other consultation:

In February 2024 Kent County Council launched a public consultation on two co-created strategies to gain a better understanding of whether the strategies were accessible and presented a vision that was agreed on.
Infant feeding strategy

The proposed decision will be discussed at the Health Reform and Public Health Cabinet Committee on 2 July 2024 and the outcome included in the paperwork which the Cabinet Member will be asked to sign.

Any alternatives considered and rejected:

The guidelines from DfE on family hubs outline minimum requirements which includes a cocreated Infant feeding strategy. This is an important part of health and non-compliance was not considered.

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

....
signed date

KEY DECISION REPORT

From: Dan Watkins, Cabinet Member for Adult Social Care and Public Health

Dr Anjan Ghosh, Director of Public Health

To: Health Reform and Public Health Cabinet Committee, 2 July 2024

Subject: Kent Young Person Drug and Alcohol Contract Commissioning

Decision no: 24/00056

Key Decision : Yes - it involves expenditure or savings of more than £1m

Classification: Unrestricted

Past Pathway of report: N/A

Future Pathway of report: Cabinet Member Decision

Electoral Division: All

Is the decision eligible for call-in? Yes

Summary:

The Public Health Service Transformation programme (PHSTP) aims to improve all services in receipt of the Public Health Grant, to ensure that services are efficient, evidence-based and deliver the outcomes and best value. This report outlines proposed changes to the substance misuse service model following review as part of the PHSTP and asks for committee endorsement.

Young persons' drug and alcohol services are funded from the PH Grant and cost around £800k per annum in Kent.

Following a comprehensive review of services (including interdependencies with other Children and Young People services and Family Hubs), options appraisal and business case development, the recommendation is to make enhancements to the current model and specification.

Following approval of the key decision, a procurement process will be run to select suppliers for the new service and this will follow the new Provider Selection Regime legislation that applies to health care services. We will aim to ensure this approach will support continuity of service, minimise risks such as destabilisation of the workforce and support spending of additional Office for Health Improvement and Disparities (OHID) funding which is designed to boost numbers in treatment and improve quality. Key changes will align to the national drugs strategy, to the Kent drug and alcohol strategy and also to Kent County Council's strategic plan.

Recommendation(s):

The Cabinet Committee is asked to **CONSIDER** and **ENDORSE** or make recommendations to the Cabinet Member for Adult Social Care and Public Health on the proposed decision as set out in the Proposed Record of Decision. (Appendix A) to:

I. **APPROVE** the procurement and award of a contract for the Kent Young Persons Drug and Alcohol Service effective from 1 February 2025 to 31 January 2027 (two years with two additional extension options, one for two years and the second for one year)

II. **DELEGATE** authority to the Director of Public Health to take relevant actions, including but not limited to, entering into and finalising the terms of relevant contracts or other legal agreements, as necessary, to implement the above decision

III. **DELEGATE** authority to the Director of Public Health, in consultation with the Cabinet Member for Adult Social Care and Public Health, the exercise of any extensions permitted in accordance with the extension clauses within the contract.

IV. **CONFIRM** that future Office for Health Improvement and Disparities (OHID) grant funding (if received) be deployed against this area of work in accordance with key decision 22/00041

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1. Introduction

1.1 This report seeks approval for the proposed preferred option for the service delivery model from February 2025 onwards. This is to enhance the specification with collaboration from stakeholders and people with lived experience.

1.2 The report also seeks endorsement for the procurement of the Kent Young Persons Drug and Alcohol service as the current contract expires on 31 January 2025.

1.3 Kent County Council (KCC) commissions this service as part of its statutory responsibilities and as a condition of its Public Health Grant. Kent Drug and Alcohol Services aim to reduce the harm caused by drugs and alcohol and improve the health and wellbeing of Kent's population. The local authority's Public Health Grant requires the Authority to "have regard to the need to improve the take up of, and outcomes from, its drug and alcohol misuse treatment services."

1.4 Professor Dame Carol Black's Review of Drugs1 was commissioned by the Home Office and the Department of Social Care to inform government thinking on what more can be done to tackle the harm that drugs and alcohol cause underpinning the 10-year drug strategy. Following this review, government published a 10-year drug strategy named From Harm to Hope and subsequently awarded local authorities with 3 year grant funding to supplement existing substance misuse services. For Kent County Council this totals circa £11.4m over the three years April 2022 to March 2025. The recommendations in this paper are in line with Professor Dame Carol Black's recommendations and the national From Harm to Hope Strategy which identify the need to maximise the stability and consistency of services to benefit both the young person and the workforce.

2. Strategic alignment and background

2.1 The provision of Kent Drug and Alcohol Services aligns with the local and national strategies. Locally, the services support the levelling up agenda and integrated model of care outlined in KCC Strategic plan 2022-26 under Priority 1 - Levelling up Kent and Priority 4: New Models of Care.

2.2 This provision also aligns to Securing Kent's Future 2022-2026 under Objective 3: Policy choices and scope of Council's ambitions, by evaluating the statutory minimum requirements in order to create efficiencies.

2.3 This service supports delivery of the Kent Drug and Alcohol Strategy, 2023-2028 'Better Prevention, Treatment and Recovery and Community Safety', which identifies 13 strategic priorities across three main areas: Prevention, Improving Treatment and Recovery and Community Safety. The Young Persons Drug and Alcohol Service specifically contributes to achieving the objectives of prevention, early intervention, and system-approach to the improvement of treatment.

2.4 Nationally, the service supports the 2021 10-Year Drug Strategy and associated investment linked to national objectives of improving numbers in treatment, continuity of care from prison to community, quality of treatment and reduction in drug and alcohol related mortality. As a result of the additional investment from Central Government to sustain these national strategic objectives, Kent is in receipt of £11,424,253 investment via a number of OHID grants over the period April 2022 to March 2025 (of which £382,000 is anticipated to go to the Young Persons' service). This additional funding is linked to maintaining the level of investment from the Public Health Grant and to the commitment of successfully achieving established local targets.

2.5 The additional funding received has supported increasing funding to existing services and implementing new services. Examples include:

- The Sunlight Project which is a programme for young people aged between 7-13 who are affected by someone else's substance use
- A Cognitive Behavioural Therapy (CBT) worker to support young

[1] Department of Health and Social Care (2021) Dame Carol Black's Independent Review of Drugs https://www.gov.uk/government/publications/review-of-drugs-phase-two-report/review-of-drugs-part-two-prevention-treatment-and-recovery

people accessing the service with low level mental health needs

- Additional staff to reduce caseloads, increase capacity and improve quality
- Senior Practitioner Roles for staff with specialisms such as supporting 18-24 year olds or engaging young people through social media.

2.6 In April 2022, the government announced a £302 million investment in family hubs and the Start for Life programme for the creation of a network of family hubs in 75 upper-tier local authorities identified across England. The programme's objective is to join up and enhance services delivered through transformed family hubs in local authority areas, ensuring all parents and carers can access the support they need when they need it. KCC is 1 of the 75 local authorities taking part in the scheme and is 1 of only 14 trailblazers for the programme.

2.7 A public consultation on the Family Hubs Services took place in Summer 2023. Papers from the Children's Young People and Education Cabinet Committee on the 21st November 2023, set out how Family Hubs will support the delivery of a range of services for children, young people and families, including drug and alcohol support.

3. Current contracts

Young Persons Drug and Alcohol Service

3.1 The Young Persons Drug and Alcohol Service contract, as delivered by We Are With You (With You), commenced on 01 January 2018 to provide an integrated substance misuse service for 11-18 year olds in Kent, with the flexibility to provide interventions for those aged 18-24.

3.2 The Service operates a peripatetic model and is closely integrated with other local services and support networks such as Integrated Children's Services (ICS), Children and Young People's Mental Health Service (CYPMHS), and Youth Offending Teams. Alongside their 1:1 offer, With You runs early intervention groups including a preventative programme (RisKit) for young people who could be at risk of developing substance misuse issues. With You also provides a youth diversion scheme (Re-Frame) aimed at reducing criminality in young people found in possession of illegal substances by Kent Police. The service offers individualised support for parents around their child's substance use and workforce development training programmes for external practitioners working with young people.

3.3 Throughout the life of the contract the Service has proactively worked with Public Health Commissioners to enhance their core offer via additional funding streams, for example the Moving Parents and Children Together (M-PACT) Programme and the Sunlight Project (for those impacted by someone else's substance use).

3.4 Public Health undertook a formal contract review in 2022, which concluded with the core recommendation to extend the contract until 31 March 2024. This was based on the service performing well (Kent delivered similar or better overall outcomes to national rates) and delivering overall good value for money.

Further Extension

3.5 The substantial increase in funding as a result of the OHID grants created a difficult situation to procure services which support a highly vulnerable cohort of young people during a time of volatile funding. Considerations included:

- If services were procured in line with the original anticipated end dates then there would be a significant drop in funding after the first year of the new contract which presents a risk to these young people..
- By commencing a competitive procurement for new contracts without knowledge of the funding available, the council could not offer funding assurance to bidders which could impact on the commercial proposals put forward in tenders, thereby jeopardising the value for money offered. In addition, it may lead to contract instability as there would likely be the need to renegotiate the contract during delivery.

3.6 In August 2023, a key decision (23/00032) was taken to extend the contract by a further period of 10 months to allow clarity to be obtained over future funding streams. The 10 month extension was from 1 April 2024 to 31 January 2025.

4. Public Health Service Transformation programme (PHSTP)

4.1 Kent County Council (KCC) Public Health is leading a transformation programme designed to improve service delivery to communities, particularly targeting underserved communities. The transformation work aims to ensure that services are efficient, evidence-based, deliver outcomes and best value.

4.2 The Health Reform and Public Health committee has received regular updates on this programme of work and helped to shape its development.

4.3 PHSTP sets out a seven stage process and substance misuse services have completed the initial six stages of this programme. The last stage is implementation.

4.4 Other Public Health services within scope of the transformation programme that relate to the Kent Young Persons' Drug and Alcohol Contract include Family Hubs, Sexual Health and the Kent School Public Health Service.

4.5 Key themes identified over the course of the programme are as follows:

Proforma

4.5.1 There are service pressures, such as increasing demand for low level mental health support, but also service opportunities given the uplifts, such as the implementation of a CBT worker

4.5.2 Recruitment and retention is a challenge in a sector which requires a highly trained, specialist workforce.

4.5.3 There is a need for harm reduction education amongst professionals who support young people to ensure information provided is correct and supportive, rather than punitive

4.5.4 There are good partnerships, including with Integrated Children's Service and Youth Offending Teams

Stakeholder workshops

4.5.5 Retaining and building on existing partnerships is key for effective working and delivery of services which complement each other, such as working with partners to tackle underage vaping

4.5.6 Investment in earlier intervention/prevention is key in order to prevent people accessing the system at a stage where their health and wellbeing has already been impacted

4.5.7 Providers reported increasing complexity amongst the people they are supporting; the presence of co-occurring conditions, such as mental health, and poly-drug use are becoming increasingly common

4.5.8 Young people need to feel valued and like they are listened to; including the service user voice needs to move away from a tokenistic act and become more meaningful.

5. Commissioning service model

5.1 The vision for the service is that:

"Kent Drug and Alcohol Services will be safe, high quality, easy to access and focused on recovery. They will be there for all people who need them, each step of the way into recovery and good health. Those working in the services will be highly trained and supported. They will understand the difficult journey people make to be free of addiction, advocating for all people to get the best treatment and recovery they can. They will be 'trauma informed' and this means they will be compassionate, challenge stigma and remove barriers to treatment particularly for the most vulnerable. They will work hand in hand with those with lived experience of addictions and all health and social care partners to get the best results possible. Embedded into the heart of the community, these will be evidence-based services, working with all partners to ensure there is hope and recovery for everyone."

5.2 The service delivers interventions through a variety of methods including:

- Support in the community (youth hubs, community centres, cafes etc) offering advice and support with substance use through a trauma informed, harm reduction approach and psychosocial interventions

- Support in schools, running early intervention harm reduction groups and a preventative programme called RisKit, specifically for young people who engage in risk taking behaviours, including substance use

- Re-Frame which works with Kent Police to identify young people, who come to the Police's attention for Class B and C drug possession (excluding those where intent to supply is suspected) and works with the young person as an alternative to criminal proceedings, to educate them around substance use, with the intention of reducing their future offending.

- The Sunlight Project which is a pilot aimed at supporting 7-11 year olds

impacted by someone else's substance use via a self-esteem / resilience building programme delivered in schools.

5.3 Expected outcomes from the service include:

- Reduce drug and/or alcohol-related harm caused to young people, their families and communities.
- Improved long-term emotional, mental and physical health, well-being, and quality of life for young people, their parents and carers and their families, affected by drug and/or alcohol use.
- Well-informed and supported families, children and young people, including but not limited to improved resilience and improved relationships with family members and friends.
- Increased engagement in positive activities with prosocial peers, education, and training.
- Improved public health and reduced health inequalities in Kent, including but not limited to; prevention of drug and/or alcohol-related deaths, teenage pregnancy and blood borne viruses.

5.4 As part of the Public Health Service Transformation Programme, a long list of options was explored in order to identify potential changes to the existing delivery model for drug and alcohol services in Kent.

5.5 The OHID grant requirement to maintain Public Health Grant investment into the services at or above the levels reported in 2020–2021 meant that whilst it was possible to consider efficiencies, any savings made needed to remain invested in the services.

5.6 Options considered but rejected included:

- Keep current service the same - no change/ do nothing - The drug landscape has changed since the current service was tendered; it is important that services are fit for purpose and meet the young person's presenting needs and therefore this was a non-viable option
- Discontinue/ decommission current service - Decommissioning the service was concluded as a non-viable option that would place KCC in breach of the Public Health Grant conditions.
- Combine the service with adult services – the offer for young people is distinct from that offered to adults and requires expertise and specialist knowledge i.e., delivering drug education and harm reduction in a way that is tailored appropriately. It was felt that combining the services ran the risk of diluting the offer.
- Alignment with the Children and Young People (CYP) service transformation; the decision was made to proceed separately due to the imminent contract end dates for the Young Persons service. Implications and opportunities as part of the CYP transformation

will be considered in due course.

5.7 The preferred option identified was to enhance the specifications with collaboration from stakeholders and young people with lived experience. The proposed changes thus far are included as Appendix B. Advantages include:

- The opportunity to draw upon local and front-line expertise when identifying potential service improvements
- Increased buy-in of all stakeholders as a result of collaboration
- Focus on achievable improvements, such as defining efficient pathways
- Anticipated changes to the specifications are ones that can happen within the current financial envelope

5.8 Following award of the relevant supplier, co-design activity will take place with suppliers, stakeholders and young people with lived experience to refine specifications based on the high level commissioning model. It will not be possible to carry out this work ahead of contract award as this may unfairly advantage certain suppliers, should a competitive procurement process be deemed necessary.

6. Financial implications

6.1 The funding for this contract would be funded entirely from the Public Health Grant and, should OHID confirm additional grant funding beyond March 2025 linked to the 10-year national drug and alcohol strategy 'From Harm to Hope', this would be used for additional activity within the contract. The additional grant-funded activity could include a continuation of activity currently funded by the existing OHID grants but innovation would also be considered, should funding allow.

6.2 The estimated financial commitment for a five year contract for the Kent Young Persons Drug and Alcohol Service is £4,099,533.88 This equates to an average of approximately £820,000 annually.

6.3 The above values reflect a 1% per year annual uplift to the contract (with the exclusion of the first year). The uplift reflects the need to retain the workforce; services have highly specialised roles and high, complex caseloads.

6.4 In terms of affordability, the annual increase in the Public Health Grant is only generally known for the current year, so it is not possible to know with certainty that there will be sufficient Public Health Grant to fund the increase. If the Public Health Grant increases prove to be insufficient then savings will need to be delivered elsewhere in the programme.

7. Commercial implications

7.1 Initially, commissioners conducted a make or buy assessment to establish whether it is possible to deliver the service in-house. KCC currently lacks the specialism, clinical governance and infrastructure required to deliver specialist

drug and alcohol interventions.

7.2 The Health Care Services (Provider Selection Regime) Regulations 2023 (PSR) is a new set of rules, effective from 1 January 2024, for procuring health care services in England (this includes substance misuse services) and must be followed by organisations termed 'relevant authorities'. The relevant authorities to which the PSR applies are NHS England, NHS trusts and foundation trusts, Integrated Care Boards, and local and combined authorities.

7.3 Commissioners will procure the services in line with the above legislation and will follow appropriate governance routes, including obtaining the relevant approvals from the Commercial and Procurement Oversight Board.

8. Equalities Implications

8.1 An Equalities Impact Assessment (EQIA) has been completed for the service. Current evidence suggests there is no negative impact and this recommendation is an appropriate measure to advance equality and create stability for vulnerable young people. The EQIA is attached as Appendix C.

8.2 Providers are required to conduct annual EQIAs as per contractual obligations.

9. Data Protection Implications

9.1 General Data Protection Regulations are part of current service documentation for the contract and there is a Schedule of Processing, Personal Data and Data Subjects confirming who is data controller/ processor. There is also an existing Data Protection Impact Assessment (DPIA) relating to the data that is shared between Kent County Council, the provider and the Office for Health Improvement and Disparities (previously named Public Health England) and the services.

9.2 The DPIA will be updated following contract award and prior to the contract commencement date, to ensure it continues to have the most up-to date information included and reflect any changes to data processing as a result of the specification enhancements.

10. Legal Implications

10.1 Under the Health and Social Care Act 2012 [8], Directors of Public Health (DPH) in upper tier (UTLA) and unitary (ULA) local authorities have a specific duty to protect and enhance the population's health.

10.2 KCC commissions these services as part of its statutory responsibilities and as a condition of its Public Health Grant. Kent Drug and Alcohol Services aim to reduce the harm caused by drugs and alcohol and improve the health and wellbeing of the people of Kent. The local authority's Public Health Grant requires the Authority to "have regard to the need to improve the take up of, and outcomes from, its drug and alcohol misuse treatment services."

10.3 The recommissioning of these services will fall under the Provider Selection Regime (PSR) introduced under the Health and Care Act 2022. Appropriate

legal advice will be sought in collaboration with the Governance, Law and Democracy team and will be utilised to ensure compliance with relevant legislation. The Provider Selection Regime is still in its infancy and so commissioners will be working closely with the legal team as well as the Commercial and Procurement Team.

11. Conclusions

11.1 Integrated Commissioning is seeking approval to proceed with the proposed preferred option for service delivery model from February 2025 onwards; this will see enhancements made to the specification in collaboration with stakeholders and young people with lived experience to support improvements in services and outcomes.

11.2 Integrated Commissioning are also seeking approval to procure the Kent Young Persons Drug and Alcohol Service contract, in line with the Provider Selection Regime.

11.3 This approach has been endorsed by the Commercial Procurement and Oversight Board and the outcome of the procurement process will be presented prior to award in line with KCC's informal governance processes.

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12. Recommendation(s):

12.1 The Cabinet Committee is asked to **CONSIDER** and **ENDORSE** or make recommendations to the Cabinet Member for Adult Social Care and Public Health on the proposed decision as set out in the Proposed Record of Decision. (appendix A) to:

I. **APPROVE** the procurement and award of a contract for the Kent Young Persons Drug and Alcohol Service effective from 1 February 2025 to 31 January 2027 (two years with two additional extension options, one for two years and the second for one year)

II. **DELEGATE** authority to the Director of Public Health to take relevant actions, including but not limited to, entering into and finalising the terms of relevant contracts or other legal agreements, as necessary, to implement the above decision

III. **DELEGATE** authority to the Director of Public Health, in consultation with the Cabinet Member for Adult Social Care and Public Health, the exercise of any extensions permitted in accordance with the extension clauses within the contract.

IV. **CONFIRM** that future Office for Health Improvement and Disparities (OHID) grant funding (if received) be deployed against this area of work in accordance with key decision 22/00041

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13. Background Documents

13.1 Framing Kent's Future - Our Council Strategy 2022-2026
13.2 HM Government (2021) From Harm to Hope - A Ten Year Drugs Plan to Cut Crime and Save Lives
13.3 Department of Health and Social Care (2021) Dame Carol Black's Independent Review of Drugs https://www.gov.uk/government/publications/review-of-drugs-phase-two-report/review-of-drugs-part-two-prevention-treatment-and-recovery
13.4 Kent Drug and Alcohol Strategy 2023-2028 (Kent Drug and Alcohol Strategy 2023-2028)
13.5 2022 Kent Drug Needs Assessment Drug Needs Assessment (kpho.org.uk)
13.6 2021 Alcohol Needs Assessment Alcohol needs Assessment 2021 (kpho.org.uk)
13.7 2022 Kent Rough Sleepers Needs Assessment - Search - Kent Public Health Observatory (kpho.org.uk)
13.8 Drug and Alcohol Needs Assessment for Children and Young People CYP-Substance-Misuse-Final-Draft-July2016-v2.0.pdf (kpho.org.uk)
13.9 Public Health Indicators – PHOF Public Health Outcomes Framework - GOV.UK (www.gov.uk)

14. Contact details

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KENT COUNTY COUNCIL – PROPOSED RECORD OF DECISION

DECISION TO BE TAKEN BY:	DECISION NO:
Dan Watkins, Cabinet Member for Adult Social Care and Public Health	24/00056

For publication *[Do not include information which is exempt from publication under schedule 12a of the Local Government Act 1972]*

Key decision: YES

Subject Matter / Title of Decision

Kent Young Persons Drug and Alcohol Contract Commissioning

Decision:

As Cabinet Member for Adult Social Care and Public Health, I propose to:

I. **APPROVE** the procurement and award of a contract for the Kent Young Persons Drug and Alcohol Service effective from 1 February 2025 to 31 January 2027 (two years with two additional extension options, one for two years and the second for one year)

II. **DELEGATE** authority to the Director of Public Health to take relevant actions, including but not limited to, entering into and finalising the terms of relevant contracts or other legal agreements, as necessary, to implement the above decision

III. **DELEGATE** authority to the Director of Public Health, in consultation with the Cabinet Member for Adult Social Care and Public Health, the exercise of any extensions permitted in accordance with the extension clauses within the contract.

IV. **CONFIRM** that future Office for Health Improvement and Disparities (OHID) grant funding (if received) be deployed against this area of work in accordance with key decision 22/00041

Reason(s) for decision:

Kent County Council has statutory responsibility as a condition of its Public Health Grant to provide specialist Substance Misuse Services aimed at reducing the harm caused by drugs and alcohol and to improve the health and wellbeing of the people of Kent.

The current Kent Young Persons Drug and Alcohol contract is due to expire on 31 January 2025 and therefore a key decision is required to plan for beyond this date.

Financial Implications

The funding for this contract would be funded entirely from the Public Health Grant and, should OHID confirm additional grant funding beyond March 2025 linked to the 10-year national drug and alcohol strategy 'From Harm to Hope', this would be used for additional activity within the contract. The additional grant-funded activity could include a continuation of activity currently funded by the

existing OHID grants but innovation would also be considered, should funding allow.

The estimated financial commitment for a five year contract for the Kent Young Persons Drug and Alcohol Service is £4,099,533.88 This equates to an average of approximately £820,000 annually.

The above values reflect a 1% per year annual uplift to the contract (with the exclusion of the first year). The uplift reflects the need to retain the workforce; services have highly specialised roles and high, complex caseloads.

In terms of affordability, the annual increase in the Public Health Grant is only generally known for the current year, so it is not possible to know with certainty that there will be sufficient Public Health Grant to fund the increase. If the Public Health Grant increases prove to be insufficient then savings will need to be delivered elsewhere in the programme.

Additional OHID grant funding is only currently confirmed until 31 March 2025. Should this funding be extended beyond that point, it will be treated as a contract variation and will be in addition to the above estimated values and will require the providers to deliver additional activity.

A key decision (22/00041) has already been taken to accept and deploy the additional money received, therefore a further decision would not be required for deployment of further funding.

Legal Implications

Under the Health and Social Care Act 2012 [8], Directors of Public Health (DPH) in upper tier (UTLA) and unitary (ULA) local authorities have a specific duty to protect and enhance the population's health.

KCC commissions these services as part of its statutory responsibilities and as a condition of its Public Health Grant. Kent Drug and Alcohol Services aim to reduce the harm caused by drugs and alcohol and improve the health and wellbeing of Kent's population. The local authority's Public Health Grant requires the Authority to "have regard to the need to improve the take up of, and outcomes from, its drug and alcohol misuse treatment services."

The recommissioning of these services will fall under the Provider Selection Regime (PSR) introduced under the Health and Care Act 2022. Appropriate legal advice will be sought in collaboration with the Governance, Law and Democracy team and will be utilised to ensure compliance with relevant legislation; the Provider Selection Regime is still in its infancy and so commissioners will be working closely with this team as well as the Commercial and Procurement Team.

Equalities implications

An Equality Impact Assessment (EQIA) has been completed for the service. Current evidence suggests there is no negative impact and this recommendation is an appropriate measure to advance equality and create stability for vulnerable young people.

Providers are required to conduct annual EQIAs as per contractual obligations.

Data Protection implications

General Data Protection Regulations are part of current service documentation for the contract and there is a Schedule of Processing, Personal Data and Data Subjects confirming who is data controller/ processor. There is also an existing Data Protection Impact Assessment (DPIA) relating to the data that is shared between KCC, the current providers and the Office for Health Improvement

and Disparities (previously named Public Health England) and the services.

DPIAs will be updated following contract award to ensure they continue to have the most up-to date information included and reflect any changes to data processing as a result of the specification enhancements.

Cabinet Committee recommendations and other consultation:

The proposed decision will be discussed at the Health Reform and Public Health Cabinet Committee on the 2 July 2024.

Any alternatives considered and rejected:

Keep current service the same - no change/ do nothing - The drug landscape has changed since the current service was tendered; it is important that services are fit for purpose and meet the young person's presenting needs and therefore this was a non-viable option

Discontinue/ decommission current service - Decommissioning the service was concluded as a non-viable option that would place KCC in breach of the Public Health Grant conditions.

Combine the service with adult services – the offer for young people is distinct from that offered to adults and requires expertise and specialist knowledge i.e., delivering drug education and harm reduction in a way that is tailored appropriately. It was felt that combining the services ran the risk of diluting the offer.

Alignment with the Children and Young People (CYP) service transformation; the decision was made to proceed separately due to the imminent contract end dates for the Young Persons service. Implications and opportunities as part of the CYP transformation will be considered in due course.

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

....

signed date

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Appendix B - Proposed changes to Kent Young Person Drug and Alcohol Service Specifications:

1.1 Refining pathways for 18-25 year olds so it is clear which service supports this cohort, depending on their circumstances; adult services should be supporting any individuals who are physically dependent on alcohol or using opiates. Clear transition pathways between young person and adult services need to be in place and the choices of the person accessing the service should be respected, should an individual prefer to be seen by the young persons' service, wherever clinically possible.

1.2 Inclusion of trauma-informed principles. Although we ask services to work in a trauma informed way, we don't often provide examples of what we expect this to look like in practice. This could include:

1.2.1 The use of therapeutic tools e.g. Grounding, Soothing, Coping and Regulating Cards; Signs of Safety 3 Houses tool

1.2.2 Using visual metaphors to respond to stress and trauma

1.2.3 Utilising the 'Human Givens' approach

1.3 Specific pathways for children impacted by someone else's substance use. Adult and young persons services working together to identify these young people, develop pathways, and deliver joint interventions, thus expanding the impact on families.

1.4 A requirement for the provider to engage with appropriate research projects; the substance use landscape will change over the life of the contract and it is important that services respond flexibly and are able to adapt.

1.5 Define the requirement for Quality Improvement Leads that work in conjunction with other providers and across the system to ensure learning is shared and embedded.

1.6 Inclusion of "Harm Reduction" into contract/service name; this will enhance the focus on the ethos of the service, which is harm reduction, rather than abstinence.

1.7 Education around County Lines; this is a particular issue in Kent due to the proximity to London. Whilst it is the police's responsibility, education from the provider may act as a preventative measure.

1.8 Specify "facilitate access to" needle exchange; the young persons' service is not expected to operate a needle exchange, however they still need to have regard to providing harm reduction, where required.

1.9 Added reporting of opportunistic smoking quits; there is not currently a stop smoking offer for those under the age of 18 in Kent. The service is positioned well to deliver stop smoking advice as part of Making Every Contact Count (MECC), but this should not become the focus of

interventions.

Appendix C - Kent Young Person Drug and Alcohol Equality Impact Assessment

EQIA Submission Form
Information collected from the EQIA Submission

EQIA Submission – ID Number
Section A

EQIA Title
Children and Young Persons Drug and Alcohol Service Recommission

Responsible Officer
Max Guest - CED SC

Approved by (Note: approval of this EqIA must be completed within the EqIA App)
Jessica Mookherjee - CED SC

Type of Activity

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

Accountability and Responsibility

Directorate
Adult Social Care and Health
Responsible Service
Integrated Commissioning
Responsible Head of Service
Jessica Mookherjee - CED SC
Responsible Director
Anjan Ghosh - CED SC

Aims and Objectives

The Public Health Service Transformation Programme aims to:

Improve services for our communities; targeting those who need them most; informed by evidence and ensuring join up and alignment internally as well as with other related services

Maximise impact of investment; spending where it can have the biggest impact. This will ensure Public Health Services are efficient and reprofile funding into a new prevention proposition

Quality assure services against best practice; ensuring they are safe and effective

Ensure services are fit for the future, sustainable and responsive to need (political, economic, social, technological, legal, international and environmental) and continue to be affordable. This will include managing changes in demand, ensuring provider capacity and capability, insights–led changing trends in society and utilising new technology.

Section B – Evidence

Do you have data related to the protected groups of the people impacted by this activity?

Yes

It is possible to get the data in a timely and cost effective way?

Yes

Is there national evidence/data that you can use?

Yes

Have you consulted with stakeholders?

Yes

Who have you involved, consulted and engaged with?

Service Provider & Stakeholder Engagement Workshops

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

Yes

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

Yes

Section C – Impact

Who may be impacted by the activity?

Service Users/clients

Service users/clients

Staff

Staff/Volunteers

Residents/Communities/Citizens

Residents/communities/citizens

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

Yes

Details of Positive Impacts

The service's specification is being refined to ensure all protected groups are able to have equal access and benefit from the service.

The service attends LGBTQ+ events and has an LGBTQ+ lead who monitors and shares any new training, information or guidance to the wider teams as it becomes available. LGBTQ+ is a regular agenda item on practice development days focusing on different areas of knowledge and promoting open and regular conversation.

Staff wear LGBTQ+ support badges on their lanyards to signify to service users that it is an LGBTQ+ inclusive space. The current incumbent provider works closely with the local support charity, BE You project, to support young people and ensure that the agency is aware of We Are With You's support.

Religious events are on the service's calendar to recognise and celebrate different religions and beliefs and their festivals and celebrations and to ensure there is a mindfulness of periods where young people of specific faiths may be fasting or have additional periods of prayer or observance which may impact their ability to engage with support at that time.

All staff receive training around diversity and inclusion. Kent's young persons team have also had training around unconscious bias in the last twelve months.

The service provides information in different formats, including web-based information (such as digital and social media), printed information and in easy-read formats. The service facilitates adjustments to individual needs e.g. providing written and verbal information, access to interpreter services, considering sensory needs when deciding on settings for neurodiverse service users. Specific funding for coaching staff on supporting the neurodivergent community is being pursued.

The service has service user's involvement intrinsic in their service model: VOICE (Valued, Opportunities, Involvement, Choice, Equality), which is We Are With You's young persons' participation service, which will provide important contribution development to ensure further co-production of the service offer and accessibility.

The service has a safeguarding lead who will lead and support staff to link in with maternity specialists and social care to ensure expecting mothers get the specialist support they need. The service is delivered in family friendly venues such as Children's Centres to ensure that parents with dependent children are able to access services.

Negative impacts and Mitigating Actions

19.Negative Impacts and Mitigating actions for Age
Are there negative impacts for age?
No. Note: If Question 19a is "No", Questions 19b,c,d will state "Not Applicable" when submission goes for approval
Details of negative impacts for Age
Not Completed
Mitigating Actions for Age
Not Completed
Responsible Officer for Mitigating Actions – Age
Not Completed

20. Negative impacts and Mitigating actions for Disability
Are there negative impacts for Disability?
No. Note: If Question 20a is "No", Questions 20b,c,d will state "Not Applicable" when submission goes for approval
Details of Negative Impacts for Disability
Not Completed
Mitigating actions for Disability
Not Completed
Responsible Officer for Disability
Not Completed

21. Negative Impacts and Mitigating actions for Sex
Are there negative impacts for Sex
No. Note: If Question 21a is "No", Questions 21b,c,d will state "Not Applicable" when submission goes for approval
Details of negative impacts for Sex
Not Completed
Mitigating actions for Sex
Not Completed
Responsible Officer for Sex
Not Completed

22. Negative Impacts and Mitigating actions for Gender identity/transgender
Are there negative impacts for Gender identity/transgender
No. Note: If Question 22a is "No", Questions 22b,c,d will state "Not Applicable" when submission goes for approval
Negative impacts for Gender identity/transgender
Not Completed
Mitigating actions for Gender identity/transgender

Not Completed
Responsible Officer for mitigating actions for Gender identity/transgender
Not Completed
23. Negative impacts and Mitigating actions for Race
Are there negative impacts for Race
No. Note: If Question 23a is "No", Questions 23b,c,d will state "Not Applicable" when submission goes for approval
Negative impacts for Race
Not Completed
Mitigating actions for Race
Not Completed
Responsible Officer for mitigating actions for Race
Not Completed
24. Negative impacts and Mitigating actions for Religion and belief
Are there negative impacts for Religion and belief
No. Note: If Question 24a is "No", Questions 24b,c,d will state "Not Applicable" when submission goes for approval
Negative impacts for Religion and belief
Not Completed
Mitigating actions for Religion and belief
Not Completed
Responsible Officer for mitigating actions for Religion and Belief
Not Completed
25. Negative impacts and Mitigating actions for Sexual Orientation
Are there negative impacts for Sexual Orientation
No. Note: If Question 25a is "No", Questions 25b,c,d will state "Not Applicable" when submission goes for approval
Negative impacts for Sexual Orientation
Not Completed
Mitigating actions for Sexual Orientation
Not Completed
Responsible Officer for mitigating actions for Sexual Orientation
Not Completed
26. Negative impacts and Mitigating actions for Pregnancy and Maternity
Are there negative impacts for Pregnancy and Maternity
No. Note: If Question 26a is "No", Questions 26b,c,d will state "Not Applicable" when submission goes for approval
Negative impacts for Pregnancy and Maternity
Not Completed
Mitigating actions for Pregnancy and Maternity
Not Completed
Responsible Officer for mitigating actions for Pregnancy and Maternity
Not Completed
27. Negative impacts and Mitigating actions for Marriage and Civil Partnerships
Are there negative impacts for Marriage and Civil Partnerships
No. Note: If Question 27a is "No", Questions 27b,c,d will state "Not Applicable" when submission goes for approval
Negative impacts for Marriage and Civil Partnerships
Not Completed
Mitigating actions for Marriage and Civil Partnerships

Not Completed
Responsible Officer for Marriage and Civil Partnerships
Not Completed
28. Negative impacts and Mitigating actions for Carer's responsibilities
Are there negative impacts for Carer's responsibilities
No. Note: If Question 28a is "No", Questions 28b,c,d will state "Not Applicable" when submission goes for approval
Negative impacts for Carer's responsibilities
Not Completed
Mitigating actions for Carer's responsibilities
Not Completed
Responsible Officer for Carer's responsibilities
Not Completed

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DECISION REPORT

From: Dan Watkins, Cabinet Member for Adult Social Care and Public Health

Dr Anjan Ghosh, Director of Public Health

To: Health Reform Public Health Cabinet Committee, 2 July 2024

Subject: Kent Adult Drug and Alcohol Treatment Contracts – re-commissioning

Decision no:

Key Decision : Yes - it involves expenditure or savings of more than £1m

Classification: Unrestricted

Past Pathway of report: N/A

Future Pathway of report: Cabinet Member Decision

Electoral Division: All

Is the decision eligible for call-in? Yes

Summary:

The Public Health Service Transformation programme (PHSTP) aims to improve all services in receipt of the Public Health Grant, to ensure that services are efficient, evidence-based and deliver the outcomes and best value. This report outlines proposed changes to the substance misuse service model following review as part of the (PHSTP) and asks for committee endorsement.

Adult drug and alcohol services are funded from the Public Health Grant and cost around £8.8m per annum.

Following a comprehensive review of services, options appraisal and business case development, the recommendation is to make enhancements to the current model and specification.

Following approval of the key decision, a procurement process will be run to select suppliers for the new service and this will follow the new Provider Selection Regime legislation that applies to health care services. We will aim to ensure this approach will support continuity of service, minimise risks such as destabilisation of the workforce and support spending of additional Office for Health Improvement and Disparities (OHID) funding which is designed to boost numbers in treatment and improve quality. Key changes will align to the national drugs strategy, to the Kent drug and alcohol strategy and also to Kent County Council's strategic plan.

Recommendation(s):

The Cabinet Committee is asked to **CONSIDER** and **ENDORSE** or make **RECOMMENDATIONS** to the Cabinet Member for Adult Social Care and Public Health on the proposed decision as set out in the Proposed Record of Decision. (Appendix A) to:

I. **APPROVE** the procurement and award of contracts for the East and West Kent Community Drug and Alcohol Services effective from 1 February 2025 to 31 January 2029 (four years with two additional two-year extension options),

II. **DELEGATE** authority to the Director of Public Health to take relevant actions, including but not limited to, entering into and finalising the terms of relevant contracts or other legal agreements, as necessary, to implement the above decision

III. **DELEGATE** authority to the Director of Public Health, in consultation with the Cabinet Member for Adult Social Care and Public Health, the exercise of any extensions permitted in accordance with the extension clauses within the contract.

IV. **CONFIRM** that future Office for Health Improvement and Disparities (OHID) grant funding (if received) be deployed against this area of work in accordance with key decision 22/00041

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1. Introduction

1.1 This report seeks approval for the proposed preferred option for service delivery models from February 2025 onwards. This is to enhance the specification with collaboration from stakeholders and people with lived experience.

1.2 The report also seeks endorsement for the procurement of the East Kent Community Drug and Alcohol Service and West Kent Community Drug and Alcohol Service as the current contracts expire on 31 January 2025.

1.3 KCC commissions these services as part of its statutory responsibilities and as a condition of its Public Health Grant. Kent Drug and Alcohol Services aim to reduce the harm caused by drugs and alcohol and improve the health and wellbeing of Kent's population. The local authority's Public Health grant requires the Authority to "have regard to the need to improve the take up of, and outcomes from, its drug and alcohol misuse treatment services."

1.4 Professor Dame Carol Black's Review of Drugs[1] was commissioned by the Home Office and the Department of Social Care to inform government thinking

[1] Department of Health & Social Care (2021) Dame Carol Black's Independent Review of Drugs https://www.gov.uk/government/publications/review-of-drugs-phase-two-report/review-of-drugs-part-two-prevention-treatment-

on what more can be done to tackle the harm that drugs and alcohol cause underpinning the 10-year drug strategy. Following this review, government published a 10-year drug strategy named From Harm to Hope and subsequently awarded local authorities with 3 year grant funding to supplement existing substance misuse services. For Kent County Council this totals circa £11.4m over the three years April 2022 to March 2025. The recommendations in this paper are in line with Professor Dame Carol Black's recommendations and the national From Harm to Hope Strategy which identify the need to maximise the stability and consistency of services to benefit both the person in receipt of care and support and the workforce.

2. Strategic alignment and background

2.1 The provision of Kent Drug and Alcohol Services aligns with the local and national strategies. Locally, the services support the levelling up agenda and integrated model of care outlined in KCC Strategic plan 2022-26 under Priority 1 - Levelling up Kent and Priority 4: New Models of Care.

2.2 This provision also aligns to Securing Kent's Future 2022-2026 under Objective 3: Policy choices and scope of Council's ambitions, by evaluating the statutory minimum requirements in order to create efficiencies.

2.3 This service supports delivery of the Kent Drug and Alcohol Strategy, 2023-2028 'Better Prevention, Treatment and Recovery and Community Safety', which identifies 13 strategic priorities across three main areas: Prevention, Improving Treatment and Recovery and Community Safety. The Young Persons Drug and Alcohol Service specifically contributes to achieving the objectives of prevention, early intervention, and system-approach to the improvement of treatment.

2.4 Nationally, the Kent drug and alcohol services support the 2021 10-Year Drug Strategy and associated investment linked to national objectives of improving numbers in treatment, continuity of care from prison to community, quality of treatment and reduction in drug and alcohol related mortality. As a result of the additional investment from Central Government to sustain these national strategic objectives, Kent is in receipt of £11,424,253 investment via a number of OHID grants over the period April 2022 to March 2025, of which £7,628,000 is anticipated to go to the Adult Drug and Alcohol Services. This additional funding is linked to maintaining the level of investment from the Public Health Grant and to the commitment of successfully achieving established local targets.

2.5 The additional funding received has supported increasing investment to existing services and implementing new services. Examples include:

- The establishment of a Kent Lived Experience Recovery Organisation; Reach Out and Recover (ROAR)
- Additional staff to reduce caseloads, increase capacity and improve quality
- Specialist staff such as complex case workers, criminal justice workers,

and-recovery

and inclusion workers to ensure the most vulnerable individuals are identified and supported.

- A service to support people into treatment who are sleeping rough or are at risk of sleeping rough.
- A service to support people who are already in treatment that require housing support in order to maintain their recovery journey.
- Additional funding for tier four placements including residential rehabilitation and inpatient detoxification.

3. Current contracts

Kent Community Adult Drug and Alcohol Services

3.1 Kent Community Adult Drug and Alcohol Services are currently formed by two contracts, both of which are due to come to an end on 31 January 2025. These are as follows:

- East Kent Community Drug and Alcohol Service, delivered by The Forward Trust awarded in 2017.
- West Kent Community Drug and Alcohol Service, delivered by Change Grow Live (CGL) awarded in 2016.

3.2 The East Kent and West Kent Drug and Alcohol services deliver open access drug and alcohol treatment and harm reduction services for adults aged 18+ through a range of interventions including structured psychosocial support, clinical interventions, access to residential rehabilitation and inpatient detoxification, provision of needle exchange and Naloxone. Throughout the lives of the contracts, the services have worked in partnership with commissioners to enhance their service offer via various funding streams.

3.3 Commissioners undertook a formal review of the West Kent contract in 2020 and the East Kent contract in 2021, both of which concluded with the core recommendation to align the end of both contracts to 31 March 2024.This was based on the good performance of the services, both of which performed well against targets and regional and national averages, delivering overall good value for money, and avoiding disruption to vulnerable people by recommissioning the services during the Covid-19 pandemic.

Further Extension

3.4 The substantial increase in funding as a result of the OHID grants created a difficult situation to procure services which support a highly vulnerable cohort of people during a time of volatile funding. Considerations included:

3.4.1 If services were procured in line with the original anticipated end dates then there would be a significant drop in funding after the first year of the new contract which presents a risk to the person in receipt of care and support..

3.4.2 By commencing a competitive procurement for new contracts without knowledge of the funding available, the council could not offer funding assurance to bidders which could impact on the commercial proposals put

forward in tenders, thereby jeopardising the value for money offered. In addition, it may lead to contract instability as there would likely be the need to renegotiate the contract during delivery.

3.5 In August 2023, a key decision (23/00032) was taken to extend both contracts by a further period of ten months to allow clarity to be obtained over future funding streams. The ten month extension was from 1 April 2024 to 31 January 2025.

4. Public Health Service Transformation programme (PHSTP)

4.1 Kent County Council (KCC) Public Health is leading a transformation programme designed to improve service delivery to communities, particularly targeting underserved communities. The transformation work aims to ensure that services are efficient, evidence-based, deliver outcomes and best value.

4.2 The Health Reform and Public Health Committee has received regular updates on this programme of work and helped to shape its development.

4.3 PHSTP sets out a seven stage process and substance misuse services have completed the initial six stages of this programme. The last stage is implementation.

4.4 Key themes identified over the course of the programme are as follows:

Proforma

4.5.1 The current services perform well compared to national average

4.5.2 There are good partnerships and working relationships in place with other services, such as One You Kent, Probation and the Hepatitis C Trust.

4.5.3 There are service pressures, such as recruitment and retention of a skilled workforce, as well as opportunities for innovation and service development given the uplifts

4.5.4 Training across the system is required to tackle the stigma and discrimination to this cohort of people

4.5.5 People enter treatment at quite a late stage in their treatment journey, meaning there are often severe physical health issues to be addressed alongside the substance use

4.5.6 The whole system will benefit from clearer, more defined pathways between services such as hospitals, criminal justice and tier four services (inpatient detoxification and residential rehabilitation)

Stakeholder workshops

4.5.7 Retaining and building on existing partnerships is key for effective working and delivery of services which complement each other, such as working with Health colleagues to define pathways in and out of inpatient detoxification

4.5.8 Investment in earlier intervention/prevention is key in order to

prevent people accessing the system at a stage where their health and wellbeing has already been impacted

4.5.9 Providers reported increasing complexity amongst the people they are supporting; the presence of co-occurring conditions, such as mental health, and poly-drug use are becoming increasingly common

4.5.10 The person's voice is key; there needs to be a move towards a more meaningful and collaborative relationship with those with lived experience.

5. Commissioning service model

5.1 The vision for the service is that:

"Kent Drug and Alcohol Services will be safe, high quality, easy to access and focused on recovery. They will be there for all people who need them, each step of the way into recovery and good health. Those working in the services will be highly trained and supported. They will understand the difficult journey people make to be free of addiction, advocating for all people to get the best treatment and recovery they can. They will be 'trauma informed' and this means they will be compassionate, challenge stigma and remove barriers to treatment particularly for the most vulnerable. They will work hand in hand with those with lived experience of addictions and all health and social care partners to get the best results possible. Embedded into the heart of the community, these will be evidence-based services, working with all partners to ensure there is hope and recovery for everyone."

5.2 The service delivers interventions through a variety of methods:

- Psychosocial support on both a group and one-to-one basis, utilising techniques such as motivational interviewing and cognitive behavioural approaches.
- Clinical interventions include prescribing for detoxification, opiate substitution therapy, and relapse prevention medications
- Harm reduction, including screening for blood borne viruses, vaccinations for hepatitis B, provision of needle exchange and Naloxone (used to quickly reverse an opioid overdose)
- Access to community or inpatient detoxification, and to community or residential rehabilitation

5.3 Expected outcomes from the service include:

- Deliver a highly effective drug and alcohol treatment and recovery service for the people of Kent.
- Increase numbers of appropriate people in need of drug and alcohol treatment accessing services from the 2022 baseline, prioritising increasing numbers of the most vulnerable.

- Contribute towards the reduction of drug and alcohol related harms in Kent
- Contribute to the reduction in drug and alcohol related morbidity and mortality
- Improve the quality and availability of support to families and carers (including parents and children)
- Develop, enhance and innovate, as necessary, high quality models of drug and alcohol treatment and recovery delivery.

5.4 As part of the Public Health Service Transformation Programme, a long list of options was explored in order to identify potential changes to the existing delivery model for drug and alcohol services in Kent.

5.5 The OHID grant requirement to maintain Public Health Grant investment into the services at or above the levels reported in 2020–2021 meant whilst it was possible to consider efficiencies, any savings made needed to remain invested in the services.

5.6 Options considered but rejected included:

- Keep current service the same - no change/ do nothing - The drug landscape has changed since the current service was tendered; it is important that services are fit for purpose and meet people's presenting needs and therefore this was a non-viable option
- Discontinue/ decommission the current service - Decommissioning the service was concluded as a non-viable option that would place KCC in breach of the Public Health Grant conditions.
- Split the service in two – one focusing on detox and treatment and the other focusing on recovery - it was deemed that this would add confusion to an already complex system within Kent.
- Bring pharmacy contracting responsibilities in-house - established relationships are already in place with providers, bringing pharmacy provision in-house risks limiting the pool of available pharmacies, which in turn may create a barrier for people in terms of access.
- Stop using fixed premises and move to a co-location model – it is important that drug and alcohol services have a physical presence in accessible areas in order to provide drop-ins and needle exchange. Removing this presence risks missing opportunities to help people at the point they are motivated to seek support.

5.7 The preferred option identified was to enhance the specifications with collaboration from stakeholders and people with lived experience. The proposed changes thus far are included as Appendix B. Advantages include:

- The opportunity to draw upon local and front-line expertise when identifying potential service improvements
- Increased buy-in of all stakeholders as a result of collaboration

- Focus on achievable improvements, such as defining efficient pathways
- Anticipated changes to the specifications are ones that can happen within the current financial envelope

5.8 Following award of the contracts to relevant suppliers, co-design activity will take place with suppliers, stakeholders and people with lived experience to refine specifications based on the high level commissioning model. It will not be possible to carry out this work ahead of contract award as this may unfairly advantage certain suppliers, should a competitive procurement process be deemed necessary.

6. Financial implications

6.1 The funding for these contracts would be funded entirely from the Public Health Grant and, should OHID confirm additional grant funding beyond March 2025 linked to the 10-year national drug and alcohol strategy 'From Harm to Hope', this would be used for additional activity within the contract. The additional grant-funded activity could include a continuation of activity currently funded by the existing OHID grants however innovation would also be considered, should funding allow.

6.2 The estimated financial commitment for an eight year contract for the East Kent Drug and Alcohol Service is £43,461,175.80. This equates to an average of approximately £5.5m annually.

6.3 The estimated financial commitment for an eight year contract for the West Kent Drug and Alcohol Service is £30,291,915.85. This equates to an average of approximately £3.8m annually.

6.4 The above values reflect a 1% per year annual uplift to the contracts (with the exclusion of the first year). This uplift reflects the need to retain the workforce; services have highly specialised roles and high, complex caseloads. This makes it difficult to retain staff, especially given Kent's proximity to London, with higher wages available there.

6.5 In terms of affordability, the annual increase in the Public Health Grant is only generally known for the current year, so it is not possible to know with certainty that there will be sufficient Public Health Grant to fund the increase. If the Public Health Grant increases prove to be insufficient then savings will need to be delivered elsewhere in the programme.

6.6 Additional OHID grant funding is only currently confirmed until 31 March 2025. Should this funding be extended beyond that point, it will be treated as a contract variation and will be in addition to the above estimated values and will require the providers to deliver additional activity.

6.7 A key decision (22/00041) has already been taken to accept and deploy the additional money received, therefore a further decision would not be required for deployment of further funding.

7. Commercial implications

7.1 The scope of this paper covers the two contracts previously mentioned; the procurement process detailed below will apply to each of the contracts individually.

7.2 Initially, commissioners conducted a make or buy assessment to establish whether it is possible to deliver the services in-house. KCC currently lacks the specialism, clinical governance and infrastructure required to deliver specialist drug and alcohol interventions.

7.3 The Health Care Services (Provider Selection Regime) Regulations 2023 (PSR) is a new set of rules, effective from 1 January 2024, for procuring health care services in England (this includes substance misuse services) and must be followed by organisations termed 'relevant authorities'. The relevant authorities to which the PSR applies are NHS England, NHS trusts and foundation trusts, Integrated Care Boards, and local and combined authorities.

7.4 Commissioners will procure the services in line with the above legislation and will follow appropriate governance routes, including obtaining the relevant approvals from the Commercial and Procurement Oversight Board.

8. Equalities Implications

8.1 Equalities Impact Assessments have been completed for each of the services in scope. Current evidence suggests that there is no negative impact and this recommendation is an appropriate measure to advance equality and create stability for vulnerable people. The EQIAs are attached as Appendices C and D.

8.2 Providers are required to conduct annual EQIAs as per contractual obligations.

9. Data Protection Implications

9.1 General Data Protection Regulations are part of current service documentation for the contract and there is a Schedule of Processing, Personal Data and Data Subjects confirming who is data controller/ processor. There is also an existing Data Protection Impact Assessment (DPIA) relating to the data that is shared between Kent County Council, the provider and the Office for Health Improvement and Disparities (previously named Public Health England) and the services.

9.2 DPIAs will be updated following contract award, and prior to the contract commencement date, to ensure they continue to have the most up-to date information included and reflect any changes to data processing as a result of the specification enhancements.

10. Legal Implications

10.1 Under the Health and Social Care Act 2012 [8], Directors of Public Health (DPH) in upper tier (UTLA) and unitary (ULA) local authorities have a specific duty to protect and enhance the population's health.

10.2 KCC commissions these services as part of its statutory responsibilities and as a condition of its Public Health Grant. Kent Drug and Alcohol Services aim to

reduce the harm caused by drugs and alcohol and improve the health and wellbeing of the people of Kent. The local authority's Public Health Grant requires the Authority to "have regard to the need to improve the take up of, and outcomes from, its drug and alcohol misuse treatment services."

10.3 The recommissioning of these services will fall under the Provider Selection Regime (PSR) introduced under the Health and Care Act 2022. Appropriate legal advice will be sought in collaboration with the Governance, Law and Democracy team and will be utilised to ensure compliance with relevant legislation. The Provider Selection Regime is still in its infancy and so commissioners will be working closely with the legal team as well as the Commercial and Procurement Team.

11. Conclusions

11.1 Integrated Commissioning is seeking approval to proceed with the proposed preferred option for service delivery model from February 2025 onwards; this will see enhancements made to the specification in collaboration with stakeholders and people with lived experience to support improvements in services and outcomes.

11.2 Integrated Commissioning is also seeking approval to procure the East Kent Drug and Alcohol Service and West Kent Drug and Alcohol Service contracts, in line with the Provider Selection Regime.

11.3 This approach has been endorsed by the Commercial Procurement and Oversight Board and outcome of the procurement process will be presented prior to award in line with KCCs informal governance processes.

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12. Recommendation(s):

12.1 The Cabinet Committee is asked to **CONSIDER** and **ENDORSE** or make **RECOMMENDATIONS** to the Cabinet Member for Adult Social Care and Public Health on the proposed decision as set out in the Proposed Record of Decision. (appendix A) to:

I. **APPROVE** the procurement and award of contracts for the East and West Kent Community Drug and Alcohol Services effective from 1 February 2025 to 31 January 2029 (four years with two additional two-year extension options),

II. **DELEGATE** authority to the Director of Public Health to take relevant actions, including but not limited to, entering into and finalising the terms of relevant contracts or other legal agreements, as necessary, to implement the above decision

III. **DELEGATE** authority to the Director of Public Health, in consultation with the Cabinet Member for Adult Social Care and Public Health, the exercise of any extensions permitted in accordance with the extension clauses within the contract.

IV. **CONFIRM** that future Office for Health Improvement and Disparities (OHID) grant funding (if received) be deployed against this area of work in accordance with key decision 22/00041

---

13. Background Documents

13.1 Framing Kent's Future - Our Council Strategy 2022-2026
13.2 HM Government (2021) From Harm to Hope - A Ten Year Drugs Plan to Cut Crime and Save Lives
13.3 Department of Health & Social Care (2021) Dame Carol Black's Independent Review of Drugs https://www.gov.uk/government/publications/review-of-drugs-phase-two-report/review-of-drugs-part-two-prevention-treatment-and-recovery
13.4 Kent Drug and Alcohol Strategy 2023-2028 (Kent Drug and Alcohol Strategy 2023-2028)
13.5 2022 Kent Drug Needs Assessment Drug Needs Assessment (kpho.org.uk)
13.6 2021 Alcohol Needs Assessment Alcohol needs Assessment 2021 (kpho.org.uk)
13.7 2022 Kent Rough Sleepers Needs Assessment - Search - Kent Public Health Observatory (kpho.org.uk)
13.8 Drug & Alcohol Needs Assessment for Children and Young People CYP-Substance-Misuse-Final-Draft-July2016-v2.0.pdf (kpho.org.uk)
13.9 Public Health Indicators – PHOF Public Health Outcomes Framework - GOV.UK (www.gov.uk)

14. Contact details

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Relevant Director:

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

KENT COUNTY COUNCIL – PROPOSED RECORD OF DECISION

DECISION TO BE TAKEN BY:	DECISION NO:
Dan Watkins, Cabinet Member for Adult Social Care and Public Health	

For publication *[Do not include information which is exempt from publication under schedule 12a of the Local Government Act 1972]*

Key decision: YES

Key decision criteria. The decision will:

a) result in savings or expenditure which is significant having regard to the budget for the service or function (currently defined by the Council as in excess of £1,000,000); or

b) be significant in terms of its effects on a significant proportion of the community living or working within two or more electoral divisions – which will include those decisions that involve:

- *the adoption or significant amendment of major strategies or frameworks;*
- *significant service developments, significant service reductions, or significant changes in the way that services are delivered, whether County-wide or in a particular locality.*

Subject Matter / Title of Decision

Kent Adult Drug and Alcohol Treatment Contracts – re-commissioning

Decision:

As Cabinet Member for Adult Social Care and Public Health I agree to:

I. **APPROVE** the procurement and award of contracts for the East and West Kent Community Drug and Alcohol Services effective from 1 February 2025 to 31 January 2029 (four years with two additional two-year extension options),

II. **DELEGATE** authority to the Director of Public Health to take relevant actions, including but not limited to, entering into and finalising the terms of relevant contracts or other legal agreements, as necessary, to implement the above decision

III. **DELEGATE** authority to the Director of Public Health, in consultation with the Cabinet Member for Adult Social Care and Public Health, the exercise of any extensions permitted in accordance with the extension clauses within the contract.

IV. **CONFIRM** that future Office for Health Improvement and Disparities (OHID) grant funding (if received) be deployed against this area of work in accordance with key decision 22/00041

Reason(s) for decision:

Kent County Council has statutory responsibility as a condition of its Public Health Grant to provide specialist Substance Misuse Services aimed at reducing the harm caused by drugs and alcohol and to improve the health and wellbeing of the people of Kent.

The two contracts under the Adult Kent Drug and Alcohol Services are due to expire on 31 January

2025 and a key decision is required to plan for beyond this date.

Financial Implications

The funding for these contracts would be funded entirely from the Public Health Grant and, should OHID confirm additional grant funding beyond March 2025 linked to the 10-year national drug and alcohol strategy 'From Harm to Hope', this would be used for additional activity within the contract. The additional grant-funded activity could include a continuation of activity currently funded by the existing OHID grants however innovation would also be considered, should funding allow.

The estimated financial commitment for an eight year contract for the East Kent Drug and Alcohol Service is £43,461,175.80. This equates to an average of approximately £5.5m annually.

The estimated financial commitment for an eight year contract for the West Kent Drug and Alcohol Service is £30,291,915.85. This equates to an average of approximately £3.8m annually.

The above values reflect a 1% per year annual uplift to the contracts (with the exclusion of the first year). This uplift reflects the need to retain the workforce; services have highly specialised roles and high, complex caseloads. This makes it difficult to retain staff, especially given Kent's proximity to London, with higher wages available there.

In terms of affordability, the annual increase in the Public Health Grant is only generally known for the current year, so it is not possible to know with certainty that there will be sufficient Public Health Grant to fund the increase. If the Public Health Grant increases prove to be insufficient then savings will need to be delivered elsewhere in the programme.

Additional OHID grant funding is only currently confirmed until 31 March 2025. Should this funding be extended beyond that point, it will be treated as a contract variation and will be in addition to the above estimated values and will require the providers to deliver additional activity.

A key decision (22/00041) has already been taken to accept and deploy the additional money received, therefore a further decision would not be required for deployment of further funding.

- **Legal Implications**

Under the Health and Social Care Act 2012 [8], Directors of Public Health (DPH) in upper tier (UTLA) and unitary (ULA) local authorities have a specific duty to protect and enhance the population's health.

KCC commissions these services as part of its statutory responsibilities and as a condition of its Public Health Grant. Kent Drug and Alcohol Services aim to reduce the harm caused by drugs and alcohol and improve the health and wellbeing of the people of Kent. The local authority's Public Health Grant requires the Authority to "have regard to the need to improve the take up of, and outcomes from, its drug and alcohol misuse treatment services."

The recommissioning of these services will fall under the Provider Selection Regime (PSR) introduced under the Health and Care Act 2022. Appropriate legal advice will be sought in collaboration with the Governance, Law & Democracy team and will be utilised to ensure compliance with relevant legislation; the Provider Selection Regime is still in its infancy and so commissioners will be working closely with this team as well as the Commercial and Procurement Team.

- **Equalities implications**

Equalities Impact Assessments have been completed for each of the services in scope. Current evidence suggests that there is no negative impact and this recommendation is an appropriate measure to advance equality and create stability for vulnerable people. The EQIAs are attached as

Appendices B and C.

Providers are required to conduct annual EQIAs as per contractual obligations.

- **Data Protection implications**

General Data Protection Regulations are part of current service documentation for the contract and there is a Schedule of Processing, Personal Data and Data Subjects confirming who is data controller/ processor. There is also an existing Data Protection Impact Assessment (DPIA) relating to the data that is shared between Kent County Council, the provider and the Office for Health Improvement and Disparities (previously named Public Health England) and the services.

DPIAs will be updated following contract award to ensure they continue to have the most up-to date information included and reflect any changes to data processing as a result of the specification enhancements.

Cabinet Committee recommendations and other consultation:

The proposed decision will be discussed at the Health Reform and Public Health Cabinet Committee on 2 July 2024.

Any alternatives considered and rejected:

- Keep current service the same - no change/ do nothing - The drug landscape has changed since the current service was tendered; it is important that services are fit for purpose and meet people's presenting needs and therefore this was a non-viable option

- Discontinue/ decommission the current service - Decommissioning the service was concluded as a non-viable option that would place KCC in breach of the Public Health Grant conditions.

- Split the service in two – one focusing on detox and treatment and the other focusing on recovery - it was deemed that this would add confusion to an already complex system within Kent.

- Bring pharmacy contracting responsibilities in-house - established relationships are already in place with providers, bringing pharmacy provision in-house risks limiting the pool of available pharmacies, which in turn may create a barrier for people in terms of access.

- Stop using fixed premises and move to a co-location model – it is important that drug and alcohol services have a physical presence in accessible areas in order to provide drop-ins and needle exchange. Removing this presence risks missing opportunities to help people at the point they are motivated to seek support.

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

....

signed date

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Appendix B - Proposed changes to Kent Adult Drug and Alcohol Service Specifications:

1.1 Refining pathways for 18-25 year olds so it is clear which service supports this cohort, depending on their circumstances; adult services should be supporting any individuals who are physically dependent on alcohol or using opiates. The choice of the person accessing the service should also be respected, should an individual prefer to be seen by the young persons' service, wherever clinically possible.

1.2 Inclusion of trauma-informed principles. Although we ask services to work in a trauma informed way, we don't often provide examples of what we expect this to look like in practice. This could include:

1.2.1 The use of therapeutic tools e.g. Grounding, Soothing, Coping and Regulating Cards; Signs of Safety 3 Houses tool

1.2.2 Using visual metaphors to respond to stress and trauma

1.2.3 Utilising the 'Human Givens' approach

1.3 Specific pathways for children impacted by someone else's substance use. Adult and young persons services working together to identify these young people, develop pathways, and deliver joint interventions, thus expanding the impact on families.

1.4 A requirement for providers to engage with appropriate research projects; the substance use landscape will change over the life of the contract and it is important that services respond flexibly and are able to adapt.

1.5 Define the requirement for Quality Improvement Leads that work in conjunction with other providers and across the system to ensure learning is shared and embedded.

1.6 Clearly set out the offer for vulnerable groups, including the need for women-specific groups, particularly amongst those who may have experienced trauma.

1.7 Define pathways with criminal justice, including police, probation and prisons; a high proportion of people who access the service will come into contact with criminal justice and it is vital that a joined-up support offer is available.

1.8 Outline the need for improved tier 4 pathways; tier 4 services include inpatient detoxification and residential rehabilitation. There is a need for Kent services to have a uniform approach and to ensure vulnerabilities are accounted for, such as those who are rough sleeping.

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Appendix C – West Kent Drug and Alcohol Contract Equalities Impact Assessment (EQIA)

EQIA Submission Form
Information collected from the EQIA Submission

EQIA Submission – ID Number
Section A

EQIA Title
West Kent Drug and Alcohol Service Contract Recommission

Responsible Officer
Max Guest - CED SC

Approved by (Note: approval of this EqIA must be completed within the EqIA App)
Jessica Mookherjee - CED SC

Type of Activity

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

Accountability and Responsibility

Directorate
Adult Social Care and Health
Responsible Service
Integrated Commissioning
Responsible Head of Service
Victoria Tovey - CED SC
Responsible Director
Anjan Ghosh - CED SC

Aims and Objectives

The Public Health Service Transformation Programme aims to:

Improve services for our communities; targeting those who need them most; informed by evidence and ensuring join up and alignment internally as well as with other related services

Maximise impact of investment; spending where it can have the biggest impact. This will ensure Public Health Services are efficient and reprofile funding into a new prevention proposition

Quality assure services against best practice; ensuring they are safe and effective

Ensure services are fit for the future, sustainable and responsive to need (political, economic, social, technological, legal, international and environmental) and continue to be affordable. This will include managing changes in demand, ensuring provider capacity and capability, insights–led changing trends in society and utilising new technology.

Section B – Evidence

Do you have data related to the protected groups of the people impacted by this activity?

Yes

It is possible to get the data in a timely and cost effective way?

Yes

Is there national evidence/data that you can use?

Yes

Have you consulted with stakeholders?

Yes

Who have you involved, consulted and engaged with?

Service Provider & Stakeholder Engagement Workshops

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

No

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

Yes

Section C – Impact

Who may be impacted by the activity?

Service Users/clients
Service users/clients

Staff
Staff/Volunteers

Residents/Communities/Citizens
Residents/communities/citizens

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

Yes

Details of Positive Impacts

The service's specification is being refined to ensure all protected groups are able to have equal access and benefit from the service.

A specific women's pathway is being developed to recognise the different needs and experiences of this group. This will support a bespoke recovery offer for this cohort moving forwards. This pathway will be complimented when anticipated recruitment for a women's worker is complete.

A specific pathway for the neurodivergent community will also be developed.

The contract will continue to fund an LGBTQ+ Inclusion Worker to support the services across West Kent - this worker will not only support this cohort directly, but will continue to upskill and educate all frontline staff on some of the isses this group may face and how best to engage with support this cohort. They will also share appropriate resources and partner agency details.

The service supports a wide range of underserved groups. A particular focus for the service is supporting those with co-occurring conditions such as mental and/or physical health needs.

In order to ensure accessibility for those with additional needs, the service offers a number of different options when it comes to service delivery e.g. residential rehab, detox, community treatment, day programme, blended offer (online and face to face). Similarly, a number of different referral options enable users to access the service through whichever option is most convenient.

Kent's new Lived Experience Recovery Organisation will develop close links with the West Kent service to ensure further co-production of the service offer and accessibility, this will include leads in areas such as

families and advocacy.

Negative impacts and Mitigating Actions

19.Negative Impacts and Mitigating actions for Age

Are there negative impacts for age?

No. Note: If Question 19a is "No", Questions 19b,c,d will state "Not Applicable" when submission goes for approval

Details of negative impacts for Age

Not Completed

Mitigating Actions for Age

Not Completed

Responsible Officer for Mitigating Actions – Age

Not Completed

20. Negative impacts and Mitigating actions for Disability

Are there negative impacts for Disability?

No. Note: If Question 20a is "No", Questions 20b,c,d will state "Not Applicable" when submission goes for approval

Details of Negative Impacts for Disability

Not Completed

Mitigating actions for Disability

Not Completed

Responsible Officer for Disability

Not Completed

21. Negative Impacts and Mitigating actions for Sex

Are there negative impacts for Sex

No. Note: If Question 21a is "No", Questions 21b,c,d will state "Not Applicable" when submission goes for approval

Details of negative impacts for Sex

Not Completed

Mitigating actions for Sex

Not Completed

Responsible Officer for Sex

Not Completed

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

Are there negative impacts for Gender identity/transgender

No. Note: If Question 22a is "No", Questions 22b,c,d will state "Not Applicable" when submission goes for approval

Negative impacts for Gender identity/transgender

Not Completed

Mitigating actions for Gender identity/transgender

Not Completed

Responsible Officer for mitigating actions for Gender identity/transgender

Not Completed

23. Negative impacts and Mitigating actions for Race

Are there negative impacts for Race

No. Note: If Question 23a is "No", Questions 23b,c,d will state "Not Applicable" when submission goes for approval

Negative impacts for Race

Not Completed

Mitigating actions for Race

Not Completed

Responsible Officer for mitigating actions for Race
Not Completed
24. Negative impacts and Mitigating actions for Religion and belief
Are there negative impacts for Religion and belief
No. Note: If Question 24a is "No", Questions 24b,c,d will state "Not Applicable" when submission goes for approval
Negative impacts for Religion and belief
Not Completed
Mitigating actions for Religion and belief
Not Completed
Responsible Officer for mitigating actions for Religion and Belief
Not Completed
25. Negative impacts and Mitigating actions for Sexual Orientation
Are there negative impacts for Sexual Orientation
No. Note: If Question 25a is "No", Questions 25b,c,d will state "Not Applicable" when submission goes for approval
Negative impacts for Sexual Orientation
Not Completed
Mitigating actions for Sexual Orientation
Not Completed
Responsible Officer for mitigating actions for Sexual Orientation
Not Completed
26. Negative impacts and Mitigating actions for Pregnancy and Maternity
Are there negative impacts for Pregnancy and Maternity
No. Note: If Question 26a is "No", Questions 26b,c,d will state "Not Applicable" when submission goes for approval
Negative impacts for Pregnancy and Maternity
Not Completed
Mitigating actions for Pregnancy and Maternity
Not Completed
Responsible Officer for mitigating actions for Pregnancy and Maternity
Not Completed
27. Negative impacts and Mitigating actions for Marriage and Civil Partnerships
Are there negative impacts for Marriage and Civil Partnerships
No. Note: If Question 27a is "No", Questions 27b,c,d will state "Not Applicable" when submission goes for approval
Negative impacts for Marriage and Civil Partnerships
Not Completed
Mitigating actions for Marriage and Civil Partnerships
Not Completed
Responsible Officer for Marriage and Civil Partnerships
Not Completed
28. Negative impacts and Mitigating actions for Carer's responsibilities
Are there negative impacts for Carer's responsibilities
No. Note: If Question 28a is "No", Questions 28b,c,d will state "Not Applicable" when submission goes for approval
Negative impacts for Carer's responsibilities
Not Completed
Mitigating actions for Carer's responsibilities
Not Completed

Responsible Officer for Carer's responsibilities
Not Completed

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Appendix D – East Kent Drug and Alcohol Contract Equalities Impact Assessment (EQIA)

EQIA Submission Form
Information collected from the EQIA Submission

EQIA Submission – ID Number

Section A

EQIA Title
East Kent Drug and Alcohol Service Contract Recommission

Responsible Officer
Max Guest - CED SC

Approved by (Note: approval of this EqIA must be completed within the EqIA App)
Jessica Mookherjee - CED SC

Type of Activity

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

Accountability and Responsibility

Directorate
Adult Social Care and Health
Responsible Service
Integrated Commissioning
Responsible Head of Service
Victoria Tovey - CED SC
Responsible Director
Anjan Ghosh - CED SC

Aims and Objectives

The Public Health Service Transformation Programme aims to:

Improve services for our communities; targeting those who need them most; informed by evidence and ensuring join up and alignment internally as well as with other related services

Maximise impact of investment; spending where it can have the biggest impact. This will ensure Public Health Services are efficient and reprofile funding into a new prevention proposition

Quality assure services against best practice; ensuring they are safe and effective

Ensure services are fit for the future, sustainable and responsive to need (political, economic, social, technological, legal, international and environmental) and continue to be affordable. This will include managing changes in demand, ensuring provider capacity and capability, insights–led changing trends in society and utilising new technology.

Section B – Evidence

Do you have data related to the protected groups of the people impacted by this activity?

Yes

It is possible to get the data in a timely and cost effective way?

Yes

Is there national evidence/data that you can use?

Yes

Have you consulted with stakeholders?

Yes

Who have you involved, consulted and engaged with?

Service Provider & Stakeholder Engagement Workshops

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

No

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

Yes

Section C – Impact

Who may be impacted by the activity?

Service Users/clients

Service users/clients

Staff

Staff/Volunteers

Residents/Communities/Citizens

Residents/communities/citizens

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

Yes

Details of Positive Impacts

The service's specification is being refined to ensure all protected groups are able to have equal access and benefit from the service.

A specific women's pathway is being developed to recognise the different needs and experiences of this group. This will support a bespoke recovery offer for this cohort moving forwards and the women's only group 'Worth' has been designed to support and empower women to make positive changes. Women specific recovery housing also exists, offering personalised support as well as help with resettlement.

A specific pathway for the neurodivergent community will also be developed.

The contract will continue to fund an LGBTQ+ Inclusion Worker - this worker will not only support this cohort directly, but will continue to upskill and educate all frontline staff on some of the isses this group may face and how best to engage with support this cohort. They will also share appropriate resources and partner agency details.

To support the Nepalese speaking community in Kent, a Nepalese speaking group has been established, allowing service provision to recognise Nepalese social and cultural contexts and enabling service users to recover in their own language.

The service supports a wide range of underserved groups. A particular focus for the service is supporting those with co-occurring conditions such as mental and/or physical health needs.

In order to ensure accessibility for those with additional needs, the service offers a number of different options when it comes to service delivery e.g. residential rehab, detox, community treatment, day programme, blended offer (online and face to face). Similarly, a number of different referral options enable

users to access the service through whichever option is most convenient.

Kent's new Lived Experience Recovery Organisation will develop close links with the East Kent service to ensure further co-production of the service offer and accessibility, this will include leads in areas such as families and advocacy.

Negative impacts and Mitigating Actions

19.Negative Impacts and Mitigating actions for Age

Are there negative impacts for age?

No. Note: If Question 19a is "No", Questions 19b,c,d will state "Not Applicable" when submission goes for approval

Details of negative impacts for Age

Not Completed

Mitigating Actions for Age

Not Completed

Responsible Officer for Mitigating Actions – Age

Not Completed

20. Negative impacts and Mitigating actions for Disability

Are there negative impacts for Disability?

No. Note: If Question 20a is "No", Questions 20b,c,d will state "Not Applicable" when submission goes for approval

Details of Negative Impacts for Disability

Not Completed

Mitigating actions for Disability

Not Completed

Responsible Officer for Disability

Not Completed

21. Negative Impacts and Mitigating actions for Sex

Are there negative impacts for Sex

No. Note: If Question 21a is "No", Questions 21b,c,d will state "Not Applicable" when submission goes for approval

Details of negative impacts for Sex

Not Completed

Mitigating actions for Sex

Not Completed

Responsible Officer for Sex

Not Completed

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

Are there negative impacts for Gender identity/transgender

No. Note: If Question 22a is "No", Questions 22b,c,d will state "Not Applicable" when submission goes for approval

Negative impacts for Gender identity/transgender

Not Completed

Mitigating actions for Gender identity/transgender

Not Completed

Responsible Officer for mitigating actions for Gender identity/transgender

Not Completed

23. Negative impacts and Mitigating actions for Race

Are there negative impacts for Race

No. Note: If Question 23a is "No", Questions 23b,c,d will state "Not Applicable" when submission goes for approval
Negative impacts for Race
Not Completed
Mitigating actions for Race
Not Completed
Responsible Officer for mitigating actions for Race
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24. Negative impacts and Mitigating actions for Religion and belief
Are there negative impacts for Religion and belief
No. Note: If Question 24a is "No", Questions 24b,c,d will state "Not Applicable" when submission goes for approval
Negative impacts for Religion and belief
Not Completed
Mitigating actions for Religion and belief
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Responsible Officer for mitigating actions for Religion and Belief
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25. Negative impacts and Mitigating actions for Sexual Orientation
Are there negative impacts for Sexual Orientation
No. Note: If Question 25a is "No", Questions 25b,c,d will state "Not Applicable" when submission goes for approval
Negative impacts for Sexual Orientation
Not Completed
Mitigating actions for Sexual Orientation
Not Completed
Responsible Officer for mitigating actions for Sexual Orientation
Not Completed
26. Negative impacts and Mitigating actions for Pregnancy and Maternity
Are there negative impacts for Pregnancy and Maternity
No. Note: If Question 26a is "No", Questions 26b,c,d will state "Not Applicable" when submission goes for approval
Negative impacts for Pregnancy and Maternity
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Mitigating actions for Pregnancy and Maternity
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Responsible Officer for mitigating actions for Pregnancy and Maternity
Not Completed
27. Negative impacts and Mitigating actions for Marriage and Civil Partnerships
Are there negative impacts for Marriage and Civil Partnerships
No. Note: If Question 27a is "No", Questions 27b,c,d will state "Not Applicable" when submission goes for approval
Negative impacts for Marriage and Civil Partnerships
Not Completed
Mitigating actions for Marriage and Civil Partnerships
Not Completed
Responsible Officer for Marriage and Civil Partnerships
Not Completed
28. Negative impacts and Mitigating actions for Carer's responsibilities
Are there negative impacts for Carer's responsibilities

No. Note: If Question 28a is "No", Questions 28b,c,d will state "Not Applicable" when submission goes for approval
Negative impacts for Carer's responsibilities
Not Completed
Mitigating actions for Carer's responsibilities
Not Completed
Responsible Officer for Carer's responsibilities
Not Completed

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From:	Dan Watkins, Cabinet Member for Adult Social Care and Public Health Dr Anjan Ghosh, Director of Public Health
To:	Health Reform and Public Health Cabinet Committee – 2 July 2024
Subject:	**Performance of Public Health Commissioned Services (Quarter 4 2023/2024)**
Classification:	Unrestricted
Previous Pathway of Paper:	None
Future Pathway of Paper:	None
Electoral Division:	All

Is the decision eligible for call-in? *N/A*

Summary: This paper provides an overview of the Key Performance Indicators (KPI) for Public Health commissioned services. In the latest available quarter, January to March 2024, of 15 Red Amber Green (RAG) rated KPIs ten were rated Green and five Amber.

To ensure we are focusing the attention of the committee on priority areas and driving providers to deliver continuous improvement, this Cabinet Committee paper proposes several changes to the KPI targets for 2024/2025.

Recommendation(s): The Health Reform and Public Health Cabinet Committee is asked to **NOTE** the performance of Public Health commissioned services in Q4 2023/2024 and the proposed KPI target changes for 2024/2025.

1. Introduction

1.1 A core function of the Health Reform and Public Health Cabinet Committee is to review the performance of services that fall within its remit.

1.2 This paper provides an overview of the Key Performance Indicators (KPI) for the Public Health services commissioned by Kent County Council (KCC) and includes the KPIs presented to Cabinet via the KCC Quarterly Performance Report (QPR). Appendix 1 contains the full table of KPIs and performance over the previous five quarters. This table includes benchmarking (England, region, nearest neighbour) where available.

2. Overview of Performance

2.1 Of the 15 targeted KPIs for Public Health commissioned services, ten achieved the target (Green) and five were below target although did achieve the floor standard (Amber).

3. Health Visiting

3.1 In this quarter, the Health Visiting Service delivered 16,587 mandated universal health and wellbeing reviews, slightly lower than the previous quarter (16,789). Three of the five mandated contacts met or exceeded the target. The proportion of antenatal contacts delivered this quarter was 39%, slightly below the 43% target. In addition, the proportion of new birth visits delivered within 10–14 days at 94.8%, was slightly below the 95% target. In 2023/2024, the service delivered 66,846 (87.1% of those due) mandated health and wellbeing reviews, slightly lower than the previous year (68,852; 87.7% of those due). Therefore, the service performed slightly below the annual target of 68,000. Notably, the total number of mandated health and wellbeing reviews due in 2023/2024 (76,758) was 2.2% (1,715) lower than the previous year, partially explaining the reduced KPI performance.

3.2 In this quarter, the provider Kent Community Health Foundation Trust (KCHFT) has identified a data reporting error related to the way data has been recorded since migration to a different IT system. This has resulted in over-reporting of the activity related to antenatal contacts that affects Q1–Q4 2023/2024. This has since been rectified and the data for indicators PH04 and PH14 (see Appendix 1) has been updated within this paper. The antenatal contact is the first delivery point of the Healthy Child Programme. The delivery of antenatal contacts is prioritised for families allocated to a targeted or specialist caseload following the receipt of a maternity notification form from Midwifery. The service also, where possible, prioritises delivery to first-time parents. For those families where an antenatal contact could not be completed a welcome letter is sent to the families.

3.3 The revised data now shows a reduction in KPI compliance and commissioners will work closely with KCHFT to address this. The underperformance is a direct result of Health Visiting workforce challenges that are being experienced in the North and West Kent Teams. The service is taking several actions to address the workforce challenges which are, in part, aligned with the Health Visiting Strategy implementation. Further steps include implementing a recruitment and retention premium, utilisation of agency and StaffBank, and proactive recruitment to vacancies. Virtual support is also being provided by Health Visiting teams in East Kent which have a more favourable position in terms of their workforce.

4. Adult Health Improvement

4.1 In Q4 2023/2024, there were 8,894 NHS Health Checks delivered to the eligible population. This represents an increase of 21% from the 7,322 checks delivered in the previous quarter and an increase of 15% from the 7,703 checks delivered

in the same quarter of the previous year (2022/2023). A total of 31,379 checks were delivered in the 12 months to March 2024, exceeding the target of 23,844.

4.2 The number of first invitations sent out during this quarter was 24,320 compared to the previous quarters, 20,433 (Q3) and 20,020 (Q2). Of the total 24,320 first invites sent in Q4 2023/2024, 3,428 were SMS invites under the SMS invitation pilot. This represents an increase from 2,739 SMS invites in the previous quarter. Commissioners continue to progress the Public Health Transformation Programme and look at different models that may support uptake.

4.3 Due to an increase in the number of GPs engaging with the programme and a consistent year-on-year increase in the number of health checks delivered since COVID-19, it has been proposed that the target for health checks delivered is increased from 23,844 to 31,000 in continued support of the programmes Covid recovery. KCHFT continues to work hard encouraging GPs to sign up to the programme to ensure equitable access for the whole county.

4.4 The Stop Smoking Service supported 879 people to successfully quit smoking this quarter, achieving a quit rate of 57%. In Q4 2023/2024, the service continued its work with the Lung Health Check Scheme by working alongside the NHS to support people identified through this scheme to access stop smoking support. This has proven successful with people identified through the scheme being highly motivated to quit smoking. The service and KCC are continuing to explore how the service can support this offer as it is rolled out wider across the county.

4.5 It is proposed that an additional indicator for the Stop Smoking Service focused on the number of people setting a quit date will commence from Q1 2024/2025. As part of the Stopping the Start initiative, KCC has been given a grant to support more people in Kent to quit smoking. The indicator being used to measure the success of this programme is the number of people setting a quit date. Commissioners, Public Health Specialists, and Consultants recently attended the Health Reform and Public Health Cabinet Committee to discuss plans as to how this funding will be best used to achieve government targets on quit dates set. For 2024/2025, this indicator will not be RAG rated as service procurement is ongoing, and therefore the service will not be operational until September 2024 at the earliest. Targets will be addressed for 2025/2026 when sufficient data is available.

4.6 In the current quarter, the number of referrals to the One You Kent (OYK) Lifestyle Service increased compared to the previous quarter, with more people electing to engage with the service post-Christmas. This increase in referrals is despite the data for the Maidstone OYK service not being available at the time of reporting due to changes in personnel within Maidstone Borough Council. Services have continued to focus on working with people located in Quintiles 1 and 2 with 56% (2,046) of people being from these areas.

4.7 The service has increased the number of health walks that are run across the county leading to 28,091 health walk attendances in 2023/2024, an increase of 13% (3,305) compared to the previous year. The walks provide the opportunity

for members of the public to take part in regular physical activity and reduce social isolation by engaging with others while walking. The service will continue to explore ways to increase these in 2024/2025.

4.8 From Q1 2024/2025, an additional OYK indicator has been proposed that will demonstrate another key aspect of the service. This indicator will focus on the weight management element of the service by monitoring how many people start and complete the weight loss programme.

5. Sexual Health

5.1 In Q4 2023/2024, 8,586 (99%) patients were offered a full sexual health screen, achieving the 95% target. In this quarter, the proportion of genitourinary medicine (GUM) appointments set within four working days following triage consistently exceeded the target (90%) for the second successive quarter, showing continued improvement. Additionally, in this quarter the reported positivity rate for chlamydia (6.1%) was the lowest since Q1 2020/2021 while the number of tests taken was the highest since Q1 2020/2021, demonstrating the effectiveness of the sexual health service. The Integrated Commissioning Team is currently working on the Public Health Transformation Programme objectives for shaping the future of KCC-commissioned sexual health services, and this continues to be a key priority moving into 2024/2025.

5.2 From Q1 2024/2025, the sexual health KPI is proposed to be replaced with the number and percentage of first-time patients receiving a full sexual health screen to focus on the service outcomes. This will demonstrate the extent to which the service achieves sexually transmitted infections (STI) screening coverage for first-time patients and encourages the service to focus on quick identification and treatment of previously undiagnosed STIs.

6. Drug and Alcohol Services

6.1 In Q4 2023/2024, Community Drug and Alcohol Services continued to perform above target for the proportion of successful completions from drug and alcohol treatment (27%). Whilst overall numbers in treatment have improved, the number of opiate users in treatment in Kent is declining. At the latest Kent Combatting Drugs Partnership, partners came together to review some of the barriers and generate solutions to getting more opiate users into treatment. This included the provision of breakfast and supper clubs to improve engagement and looking to increase pharmacy access for those who are prescribed Opiate Substitution Therapy. Commissioners, providers, and individuals from Kent's Lived Experience Recovery Organisation will also be supporting the Office for Health Improvement and Disparities (OHID) with an upcoming opiate diagnostic conversation to understand the picture nationally. This will be a continued focus as we move to new contracts.

6.2 The Young People's Drug and Alcohol Service received 158 referrals in Q4 2023/2024 with 124 referrals suitable for structured treatment – an increase of 7% from the previous quarter (116). Of the 34 young people who were not suitable for structured treatment, 15 were offered a brief intervention – this

includes advice, information, and harm reduction. The remaining 19 young people were deemed to be 'inappropriate'. The provider is required to submit a breakdown of these young people for discussion at quarterly contract monitoring; common themes include not responding to multiple attempts/methods of contact, being referred without consent (this is always addressed with the referrer), moving out of the area, requiring an onward referral to a more appropriate service, or the young person stating they do not want support from the service. The latter is the most common reason – 14 young people this quarter representing 73.7% of those deemed inappropriate. The provider reports that "disguised compliance" is common in young people, where they consent to the referral to please the person making the referral or to avoid negative consequences, such as exclusion from school. In instances where the young person decides they do not want support from the service, the referrer is informed. Young people can always be re-referred should circumstances change.

6.3 The amount of young people exiting treatment in a planned way was slightly below the target, achieving 84% during Q4 2023/2024. This represents 41 planned exits, two transfers and six unplanned exits, the latter mainly due to non-engagement with treatment although these clients have engaged in some interventions. Young people who have not engaged with treatment are sent an SMS survey to understand if there was anything different that could have encouraged them to engage with support and all feedback is reviewed. The service always works with referrers and parents/carers (where consent is given) to maximise the chances of engagement. Of those young people who exited treatment in a planned way, 27% reported abstinence (target = 24%). It is recognised that not all young people wish to achieve abstinence, so the service also monitors health and wellbeing outcomes. This quarter, out of 46 responses 65.2% of young people indicated an improvement in their satisfaction with life, 21.7% reported an improvement in their anxiety levels, and 54.3% reported feeling happier.

6.4 As of Q4 2023/2024, the service is fully recruited and working with commissioners on a referral generation plan, which is expected to have a positive impact on the number in structured treatment.

7. Mental Health and Wellbeing Service

7.1 In Q4 2023/2024, Live Well Kent and Medway (LWKM) completed the first year of the contract with good outcomes continuing to be achieved, including 96% of people reporting improvements in their personal goals during the quarter. The service continues to integrate with the Community Mental Health Framework (Community Mental Health Transformation). For example, workers from both providers have been trained in a cognitive behavioural therapy (CBT) 'lite' intervention, which will be offered in all geographical areas following a successful pilot in Thanet since May 2023.

8. Conclusion

8.1 Ten of the 15 KPIs remain above target and were RAG-rated Green.

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

9. Proposed KPI Changes (2024/2025)

9.1 Directorates are expected to review their KPIs and activity measures annually. This is to ensure we are focusing the committee's attention on priority areas and driving providers to deliver continuous improvement. Table 1, below, outlines the proposed changes for Public Health commissioned services. It should be noted that the data for the indicators that are proposed to be removed will continue to be held and monitored.

9.2 All other KPIs and their targets are to remain the same. Performance Indicator Definition forms (PIDs) are available on request.

Table 1: Proposed changes for 2024/25.

KPI	Change	Reason
PH16: No. (%) of infants receiving a 6–8 week review by the health visiting service	Indicator to be removed	Indicator regularly achieving target. No longer a priority for HRPH CC to scrutinise
PH23: No. (%) of infants who are totally or partially breastfed at 6–8 weeks (health visiting service)	Indicator to be removed	Indicator regularly achieving target. No longer a priority for HRPH CC to scrutinise
PH17: No. (%) of infants receiving a 1-year review at 15 months by the health visiting service	Indicator to be removed	Indicator regularly achieving target. No longer a priority for HRPH CC to scrutinise
PH18: No. (%) of children receiving a 2–2½ year review by the health visiting service	Indicator to be removed	Indicator regularly achieving target. No longer a priority for HRPH CC to scrutinise
PH14: No. (%) of mothers receiving an antenatal contact by the health visiting service	Target increased from 43% to 50%	This reflects the target within the existing contract
PH06: No. of adults accessing structured treatment substance misuse services (12-month rolling)	New substance misuse indicator Target: 5,998	One of the aspirations of the from harm to hope drug strategy is to increase the number of people accessing drug and alcohol treatment in UK. Therefore, this measure has been RAG-rated.
PH01: No. of the eligible population aged 40–74 years old receiving an NHS Health Check (12-month rolling)	Target increased from 23,844 to 31,000	There has been an increase in the number of GPs engaging with the programme and a consistent year-on-year increase in the number of NHS Health Checks delivered since COVID-19. The increased target will support and encourage this continued recovery.
PH26: No. of people setting a quit date with smoking cessation services	New smoking cessation indicator Target: 6,252	As part of the Stopping the Start initiative, KCC has been given a grant to support more people in Kent to quit smoking. This indicator will be used to

		measure the success of this programme.
PH27: No. (%) of clients that complete the Weight Loss Programme	New One You Kent indicator Target: 60%	This indicator will focus on service outcomes. It will focus on the effectiveness of a key aspect of the service (weight management).
PH24: No. (%) of all new first-time patients (at any clinic) offered a full sexual health screen	Indicator to be removed – replaced with below	This indicator will be replaced with PH28 to encourage a focus on outcomes.
PH28: No. (%) of all new first-time patients (at any clinic) receiving a full sexual health screen (excluding online referrals)	New sexual health indicator Target: 72%	This indicator will focus on service outcomes. This indicator demonstrates the extent to which the service achieves Sexually Transmitted Infections (STI) screening coverage for first-time patients and encourages the service to focus on quick identification and treatment of previously undiagnosed STIs

10. Recommendation(s): The Health Reform and Public Health Cabinet Committee is asked to **NOTE** the performance of Public Health commissioned services in Q4 2023/2024 and the proposed KPI target changes for 2024/2025.

11. Background Documents

None

12. Appendices

Appendix 1: Public Health commissioned services KPIs and activity.

13. Contact Details

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

	Indicator Description	Target 22/23	Target 23/24	Q4 22–23	Q1 23–24	Q2 23–24	Q3 23–24	Q4 23–24	DoT	Benchmarking* England	Region	Neighbour
► Health Visiting												
PH04	No. of mandated health and wellbeing reviews delivered by the health visiting service (12 month rolling)	65,000	68,000	68,852 (G)	68,446 (G)	67,949 (A)	67,011 (A)	66,846 (A)	↓	-	-	-
PH14	No. (%) of mothers receiving an antenatal contact by the health visiting service	43%	43%	1,706 57%(G)	1,634 48%(G)	1,391 42%(A)	1,152 37%(A)	1,226 39%(A)	↑	-	-	-
PH15	No. (%) of new birth visits delivered by the health visitor service within 10–14 days of birth	95%	95%	3,463 93%(A)	3,550 94%(A)	3,730 94.6%(A)	3,604 94%(A)	3,596 94.8%(A)	↔	84%	84%	87%
PH16	No. (%) of infants receiving a 6–8 week review by the health visiting service	85%	85%	3,453 90%(G)	3,472 93%(G)	3,768 94%(G)	3,650 93%(G)	3,443 93%(G)	↔	82%	83%	82%
PH23	No. (%) of infants who are totally or partially breastfed at 6–8 weeks (health visiting service)	-	-	1,812 50%	1,866 52%	2,043 52%	1,971 52%	1,999 55%	↑	52%	61%	52%
PH17	No. (%) of infants receiving a 1-year review at 15 months by the health visiting service	85%	85%	3,896 93%(G)	3,796 92%(G)	4,004 93%(G)	4,088 93%(G)	3,898 94%(G)	↑	87%	86%	91%
PH18	No. (%) of children receiving a 2–2½ year review by the health visiting service	80%	80%	3,417 85%(G)	3,536 89%(G)	3,578 91%(G)	3,818 93%(G)	3,969 93%(G)	↔	78%	81%	79%
► Substance Misuse Treatment												
PH13	No. (%) of young people exiting specialist substance misuse services with a planned exit	85%	85%	37 90%(G)	37 88%(G)	53 84%(A)	52 84%(A)	41 84%(A)	↔	-	-	-
PH03	No. (%) of people successfully completing drug and/or alcohol treatment of all those in treatment (12 month rolling)	25%	25%	1,275 25%(G)	1,291 25%(G)	1,349 26%(G)	1,407 26%(G)	1,503 27%(G)	↑	21%	23%	22%
► Lifestyle and Prevention												
PH01	No. of the eligible population aged 40–74 years old receiving an NHS Health Check (12 month rolling)	23,844	23,844	25,114 (G)	26,565 (G)	28,722 (G)	30,188 (G)	31,379 (G)	↑	-	-	-
PH11	No. (%) of people quitting at 4 weeks, having set a quit date with smoking cessation services	52%	55%	786 54%(A)	612 54%(A)	690 50%(A)	690 58%(G)	879 57%(G)	↓	55%	55%	57%
PH25	No. (%) of clients currently active within One You Kent services being from the most deprived areas in Kent	-	55%	1,929 59%(G)	1,794 62%(G)	1,833 52%(A)	1,896 58%(G)	2,046 56%(G)	↓	-	-	-
► Sexual Health												
PH24	No. (%) of all new first-time patients offered a full sexual health screen (chlamydia, gonorrhoea, syphilis, HIV)	92%	95%	8,230 98%(G)	8,517 98%(G)	8,643 98%(G)	8,458 99%(G)	8,586 99%(G)	↔	-	-	-
► Mental Wellbeing												
PH22	No. (%) of Live Well Kent clients who would recommend the service to family, friends, or someone in a similar situation	90%	98%	721 99%(G)	NCA	271 99.6%(G)	250 97%(A)	374 94%(A)	↓	-	-	-

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

Commissioned Services Annual Activity

Indicator Description		2018/19	2019/20	2020/21**	2021/22	2022/23	2023/24	DoT	Benchmarking England	Benchmarking Region	Benchmarking Neighbour
PH09	Participation rate of Year R (aged 4–5 years) pupils in the National Child Measurement Programme	95% (G)	95% (G)	85% (G)	88% (A)	93% (G)	NCA	↑	94%	95%	94%
PH10	Participation rate of Year 6 (aged 10–11 years) pupils in the National Child Measurement Programme	94% (G)	94% (G)	9.8% (A)	87% (A)	90% (G)	NCA	↑	93%	91%	93%
PH05	No. receiving an NHS Health Check over the 5-year programme (cumulative: 2018/19 to 2022/23, 2023/24 to 2027/28)	36,093	76,093	79,583	96,323	121,437	31,379	-	-	-	-
PH06	No. of adults accessing structured treatment substance misuse services	4,900	5,053	4,944	5,108	5,084	5,480	↑	-	-	-
PH07	No. accessing KCC-commissioned sexual health service clinics	76,264	71,543	58,457	65,166	58,012	61,508	↑	-	-	-

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

Key(s)

RAG Ratings

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

DoT (Direction of Travel) Alerts

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

Relates to two most recent time frames

Date Quality Note

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

HEALTH REFORM AND PUBLIC HEALTH CABINET COMMITTEE
WORK PROGRAMME
(updated 12 June 2024)

Item	Cabinet Committee to receive item
Verbal Updates – Cabinet Member and Corporate Director	Standing Item
Work Programme 2021/22	Standing Item
Update on COVID-19	Temporary Standing Item
Key Decision Items	
Performance Dashboard	January, March, July, September
Update on Public Health Campaigns/Communications	Biannually (January and July)
Draft Revenue and Capital Budget and MTFP	Annually (November)
Annual Report on Quality in Public Health, including Annual Complaints Report	Annually (November)
Risk Management report (with RAG ratings)	Annually (March)

17 SEPTEMBER 2024		
1	Intro/ Web announcement	Standing Item
2	Apologies and Subs	Standing Item
3	Declaration of Interest	Standing Item
4	Minutes	Standing Item
5	Verbal Updates – Cabinet Member and Corporate Director	Standing Item
6	Public Health Performance Dashboard – Quarter 1 2024/25	Regular Item
7	Implications of Climate Change for Public Health	Member Requested Item
8	Update on Public Health Campaigns/Communications	Regular Item (deferred from 2 July)
9	Update on Gypsy Roam Traveller health, including child immunisations and suicide prevention	
10	Preventative Agenda	Member requested Item (deferred from 2 July)
11	Healthy Weight Management Strategy	Deferred from 14 May 2024 meeting
12	Work Programme	Standing Item
19 NOVEMBER 2024		
1	Intro/ Web announcement	Standing Item
2	Apologies and Subs	Standing Item
3	Declaration of Interest	Standing Item
4	Minutes	Standing Item

5	Verbal Updates – Cabinet Member and Corporate Director	Standing Item
6	Draft Revenue and Capital Budget and MTFP (TBC)	Annual Item
7	Annual Report on Quality in Public Health, including Annual Complaints Report	Annual Item
8	Young People and Mental Health	Member Requested Item
8	Work Programme	Standing Item
21 JANUARY 2025		
1	Intro/ Web announcement	Standing Item
2	Apologies and Subs	Standing Item
3	Declaration of Interest	Standing Item
4	Minutes	Standing Item
5	Verbal Updates – Cabinet Member and Corporate Director	Standing Item
6	Public Health Performance Dashboard – Quarter 2 2024/25	Regular Item
7	Update on Public Health Campaigns/Communications	Regular Item
8	Work Programme	Standing Item
11 MARCH 2025		
1	Intro/ Web announcement	Standing Item
2	Apologies and Subs	Standing Item
3	Declaration of Interest	Standing Item
4	Minutes	Standing Item
5	Verbal Updates – Cabinet Member and Corporate Director	Standing Item
6	Public Health Performance Dashboard – Quarter 3 2024/25	Regular Item
7	Risk Management report (with RAG ratings)	Annual Item
8	Work Programme	Standing Item
1 JULY 2025		
1	Intro/ Web announcement	Standing Item
2	Apologies and Subs	Standing Item
3	Declaration of Interest	Standing Item
4	Minutes	Standing Item
5	Verbal Updates – Cabinet Member and Corporate Director	Standing Item
6	Public Health Performance Dashboard – Quarter 4 2024/25	Regular Item
7	Update on Public Health Campaigns/Communications	Regular Item
8	Work Programme	Standing Item

ITEMS FOR CONSIDERATION THAT HAVE NOT YET BEEN ALLOCATED TO A MEETING
Mental Health for Younger People + Young Minds Presentation – added by Andrew Kennedy on 24/01/2022 – Young People, Body Image, and Mental Health (Requested by Mr J Meade 05/09/23) (Expected November 2024)
Substantive item on Social Prescribing – added by Andrew Kennedy 31/03/2023 – (ongoing updates to be presented to committee)
Benchmarking and Learning from Best Practice – added by Mr R Streatfeild 23/01/24 – July meeting to covered as part of Dashboard and performance paper

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