From: Graham Gibbens - Cabinet Member, Adult Social Care and Public Health

Andrew Scott-Clark, Director of Public Health

To: Adult Social Care and Health Cabinet Committee, 10 March 2016

Subject: Kent Alcohol Strategy – Update

Classification: Unrestricted

Past Pathway of Paper: This is the first committee to consider this paper

Future Pathway of Paper: none

Electoral Division: All

**Summary:**
The latest Kent Alcohol Strategy (2014 -16) was launched in April 2014. The Strategy was adopted by a host of partner organisations and agreed that the Kent Drug and Alcohol Partnership (KDAP) would be the steering group for this strategy. The strategy was also showcased and highlighted by the DPH's Annual Public Health Report for 2015. This report describes the headline progress being made throughout Kent to date.

**Recommendation:**
Members of the committee are asked to:

a) note and comment on the progress to date and planned work for the next period; and

b) note that the KDAP partnership and Public Health Team would like the opportunity to bring a more detailed report to the May 2016 Cabinet Committee.

## 1. Introduction

1.1. This report presents an overview of progress towards implementing the Kent Alcohol Strategy 2014-16. The six pledges of the strategy are listed in Table 1.

Table 1: the six pledge areas of the Kent Alcohol Strategy 2014-16

| | | |
|---|---|---|
| **Improve prevention and identification** | **Improve the quality of treatment** | **Co-ordinate enforcement and responsibility** |
| **Tailor the plan to the local community** | **Target vulnerable groups and tackle health inequalities** | **Protect children and young people** |

## 2. District Action Plans

2.1 Each District has an alcohol action plan tailored to its particular alcohol-related priorities and which report to the respective Local Health and Wellbeing Boards. These plans are based upon the six pledge areas of the strategy and are facilitated by the Kent Public Health team. These include targeted activity for Adults and Children and Young People.

Notable District activity to date includes:

**West Kent:**

i. Have held a multi-partner 'alcohol summit' held in autumn 2015

ii. Have implemented a multi-agency 'place of safety' in Tunbridge Wells to facilitate the management of alcohol misuse by those participating in the Night Time Economy

**East Kent**:

i. have implemented an Alcohol Integrated Care pathway in Thanet and South Kent Coast which drew national recognition. There are plans to extend pathway across Kent in 2016.

ii. Had several projects to increase screening and referrals from hospitals, GPs and pharmacies in Thanet and South Kent Coast. More information on these projects will follow on evaluation in 2016.

2.2 Local plans incorporate the work of local Community Safety Partnerships who have an active programme around anti-social behaviour including work.

2.3 The Kent universities are undertaking work to raise awareness of alcohol harm within student populations and are participating in a nationally accredited programme. More information will be available in future updates.

2.4 District groups are asked in particular to target their 'at risk' populations e.g. women and older drinkers and work with local businesses. District Alcohol Task / Finish groups have been provided with Local Alcohol Profiles to assist them.

## 3 Campaigns and Workforce training

### 3.1 Know Your Score

3.1.1 The KCC self-assessment tool 'Know Your Score' was launched in November 2015. The number of tests completed in the first week was 2, 556 following extensive media coverage on both radio and TV in the South East region.

### 3.2 Dry January

3.2.1 Commissioned by Public Health England, information on the 2016 campaign will be available later in 2016. The Dry January 2015 campaign was very successful in Kent. Women aged between 35-45 years were the main users of

the site (80%) with the main reason for visiting was that they wanted to lose weight.

3.2.2 This is an important point to note as the general trend for alcohol related hospital admissions in women (and older people) is increasing. This type of web-based activity would appear to be a good method of reaching this group.

Table 2: Dry January sign up in Kent (Alcohol Concern, 2015)

| Year | Number of website visits for advice and information | Signed up to 1 month abstinence |
|---|---|---|
| 2014 | 1,780 | N/A |
| 2015 | 7,761 | 1,859 |

### 3.3 Workforce training

3.3.1 Face –to –face training sessions for Identification and Brief Advice (IBA) has been provided to a variety of front line workforce groups in Kent and will be reported upon at the next update. Currently training is available via the Public Health Alcohol Learning website. It is not possible to track how many individuals access this training online.

3.3.2 Organisations are encouraged to keep a record of staff who undertakes this training as far as possible. It is important that some public facing workforces in particular undertake this training. For example, those working in Social Services, Health and Housing departments.

3.3.3 A national framework, funded by Public Health England, lays out for the first time the skills social workers in all areas of practice need when working with someone with alcohol and drug problems. This will facilitate the 'Troubled Families' and 'Making Every Adult Matter' programme in due course.

## 4 Kent Community Alcohol Partnerships – Ministerial visits

4.1 These are local partnerships set up to tackle town centre and community issues that arise from alcohol misuse such as town centre disruption or illegal sales. These are supported by Kent Trading Standards. These Kent Community Alcohol Partnerships tackle anti-social behaviour of young people and children in communities. The necessity for a CAP originates with communities themselves and is led by the community. For this reason the number of CAPs will vary in response to local need and support.

4.2 There are currently 12 Kent CAPs and work is underway to re-shape these in Kent to target 'hotspots' and increase partnership working in support of CAP development. More information will be provided at the May Cabinet Committee Meeting.

4.3 Gareth Johnson MP and Tracey Crouch MP visited Swanscombe and Snodland in October 2015. The work in Kent was also acknowledged at Ministerial level during a national award ceremony in London in 2015

## 5 Dual Diagnosis

5.1 Substantial progress has been made to improve service access and quality of care for those individuals with a mental health condition and a substance misuse issues – referred to as 'Dual Diagnosis' (DD).

In 2015, the Kent Strategic Steering Group has overseen the development of:

i. A revised Joint Working Partnership Agreement (JWPA) which details lead agency responsibilities, protocols and procedures

ii. A Dual Diagnosis Trust policy within the Kent and Medway Partnership Trust. This policy is required to underpin the JWPA.

iii. A care pathway to support the JWPA

iv. Workforce training of both Mental Health staff and substance misuse service provider staff groups

v. Educational and networking tools and resources via shared learning events and a webpage to coordinate information

vi. A data sharing agreement has been reached for clinical staff working to substance misuse services to have access to the KMPT patient clinical record system (RIO) to expedite patient care. Work is underway to explore the inclusion of Primary Care patient record system in South Kent Coast.

5.2 It is anticipated that the final agreement of the JWPA and Care Pathway will be reached at the next Strategic Steering Group meeting in March 2016.

## 6 Alcohol Strategy: progress monitoring

6.1 The overall Kent progress towards achieving the aims of the Kent Alcohol Strategy is monitored via the Kent Drug and Alcohol Partnership Group (KDAAP).

6.2 Local District plan activity is reported to the respective local Health and Wellbeing Boards. Notable District activity is included in the KDAAP reports to inform and share good practice.

6.3 Key performance indicators are displayed in Table 3. Subsidiary indicators are also collated for purposes of evaluation at the end of the strategy.

Table 3: Kent alcohol strategy: key progress indicators

| Pledge area | Aim | Achievement | DoT |
|---|---|---|---|
| 1. Improve prevention and Identification | Screen 9% of the Kent population (18+)<br><br>Target 106,389 | 128,542 (121%)<br><br>More figures to be included. |  |
| 2. Improve the Quality of Treatment | Increase number of referrals into treatment services by 15% by 2016 [1]. | Trend increasing. |  |
| 2 Co-ordinate Enforcement and Responsibility<br><br>*These elements of the plans are largely taken from the work of Kent Community Safety Partnerships.* | 12 police operations per year will be completed e.g. CSP targeted activity within localities<br><br>Support the work the development of Kent CAPs | Achieved in 2015[2]. Ongoing in 2016.<br><br>Achieved and ongoing |  |
| 3 Tailor the plan to the local community<br><br>4 Target Vulnerable groups and Tackle Health Inequalities | Each District will develop a local alcohol action plan.<br><br>Contained in District plans as locally identified priorities. | Achieved<br><br>Ongoing. Evaluation at the end of the strategy |  <br>  |
| 6 Protect Children and Young People | Reduce alcohol related hospital admissions for those aged under 18 years | The number of admissions is decreasing. Kent is better than the national and South East region - *Appendix 1* |  |

## 7 Licensing

7.1 The availability of alcohol is a key factor in relation to reducing the impacts of alcohol related harm and anti-social behaviour. Public Health will hold an event in March 2016 for those involved with licensing decisions in Kent. The aim is to agree how Health data can be incorporated into licensing decisions. More information will follow in the next update.

## 8 New Chief Medical Officer (CMO) Guidance on Alcohol – January 2016

8.1 There has been new expert guidance for the safe limits for drinking Alcohol. This will mean that the public health team will revise and update current material to incorporate these new messages.
The alcohol limit for men has been lowered to be the same as for women. The UK's Chief Medical Officer (CMO) guideline for both men and women is that:

i. You are safest not to drink regularly more than 14 units per week. This is to keep health risks from drinking alcohol to a low level.

[1] Service Quality Assured by service monitoring of national reports on a range of service indicators and via quarterly KDAAP reports Service information available at: https://www.ndtms.net/default.aspx
[2] These include a variety of activities such as issuing Protected Public Space orders to discourage antisocial behaviour in public places and joint operations with Trading Standards for example.

ii. If you do drink as much as 14 units per week it is best to spread this evenly across the week.
iii. The Chief Medical Officer (CMO) guidance is that pregnant women should not drink any alcohol at all.
iv. If you are pregnant or planning pregnancy, the safest option is not to drink alcohol at all. This is to keep the risks to your baby to a minimum.
v. The more you drink the greater the risk to your baby.

## 9 Conclusion

9.1 Overall, good progress is being made towards the aims of the Kent alcohol strategy 2014-16.

9.2 Attention should be given to measures to develop methods of sustainable, systematic and comprehensive alcohol identification, screening and referral within statutory organisations. This should include Occupational Health and productivity considerations for Kent employers.

9.3 District plans should be based around the six pledge areas of the strategy. Some key areas for further development at district plan and partnership level displayed in Table 4. This is not an exhaustive list.

Table 4: Recommended areas for action in District plans

| | | | |
|---|---|---|---|
| Embedding *systematic* screening & IBA in<br><br>*- contracts*<br>*- practice*<br>*- protocols*<br>*- systems*<br>*- assessment forms*<br>*- referral systems* | Embedding systematic training in workforces especially those working with vulnerable groups. | Incorporate screening into commissioned contracts as far as possible. | Target at local level priority groups – older drinkers and women.<br><br>*See Kent Public Health Observatory website for local profiles* |
| Increase referrals into services<br><br>*E.g. Embed and promote the KYS tool within organisations and businesses e.g. staff awareness and occupational health* | Adapt alcohol integrated care pathway for use.<br><br>*Public Health can facilitate this* | Consider CQUIN arrangements to facilitate reduction in hospital admissions / related health harms.<br><br>*e.g. KYS etc.* | Promote Mutual Aid organisations (*incorporate into care pathway)*<br><br>Partnership support at District level for neighbourhood CAPs |

## 10. Recommendation

**Recommendation:**
Members of the committee are asked to:

a) note and comment on the progress to date and planned work for the next period; and

b) note that the KDAP partnership and Public Health Team would like the opportunity to bring a more detailed report to the May 2016 Cabinet Committee.

## 11. Background Documents:

None

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Figure 1: Alcohol specific admissions – under 18s in Kent (LAPE, 2015)

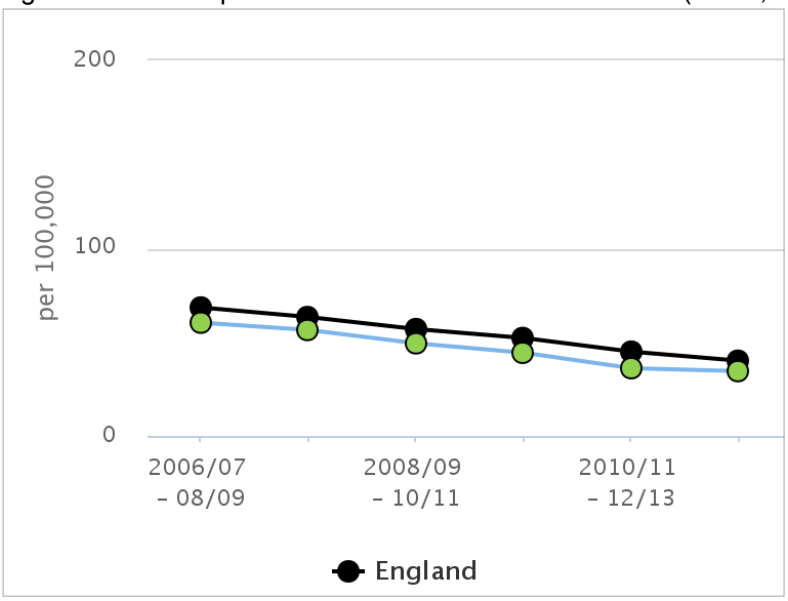


Figure 2: Alcohol specific admissions – under 18s, compared to England and South East region, 2011/12-2013/14 (LAPE, 2015)

| Area | Value | Lower CI | Upper CI |
|---|---|---|---|
| **England** | 40.1 | 39.4 | 40.7 |
| South East region | 35.6 | 34.1 | 37.2 |
| Bracknell Forest | 16.1 | 8.6 | 27.5 |
| Brighton and Hove | 63.1 | 51.0 | 77.1 |
| Buckinghamshire | 22.0 | 17.4 | 27.5 |
| East Sussex | 42.7 | 35.8 | 50.6 |
| Hampshire | 36.7 | 32.7 | 41.0 |
| Isle of Wight | 90.0 | 70.2 | 113.7 |
| Kent | 34.5 | 30.9 | 38.4 |
| Medway | 29.9 | 22.5 | 38.9 |
| Milton Keynes | 16.9 | 11.6 | 23.9 |
| Oxfordshire | 41.9 | 35.9 | 48.6 |
| Portsmouth | 37.6 | 27.7 | 49.8 |
| Reading | 17.5 | 10.4 | 27.7 |
| Slough | 18.3 | 11.3 | 28.0 |
| Southampton | 87.1 | 72.4 | 104.0 |
| Surrey | 33.5 | 29.5 | 37.9 |
| West Berkshire | 20.6 | 12.9 | 31.2 |
| West Sussex | 36.4 | 31.3 | 42.1 |
| Windsor and Maidenhead | 22.3 | 14.0 | 33.8 |
| Wokingham | 20.4 | 12.8 | 30.8 |

*Source: Calculated by Public Health England: Knowledge and Intelligence Team (North West) using data from the Health and Social Care Information Centre - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) -Mid Year Population Estimates*