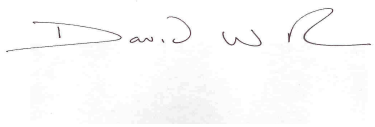
Public Document Pack

Health Policy and Performance Board

Wednesday, 6 November 2013 at 6.30 p.m.
Council Chamber, Runcorn Town Hall



Chief Executive

BOARD MEMBERSHIP

Councillor Ellen Cargill (Chairman)	**Labour**
Councillor Joan Lowe (Vice-Chairman)	**Labour**
Councillor Sandra Baker	**Labour**
Councillor Mark Dennett	**Labour**
Councillor Valerie Hill	**Labour**
Councillor Miriam Hodge	**Liberal Democrat**
Councillor Margaret Horabin	**Labour**
Councillor Chris Loftus	**Labour**
Councillor Pauline Sinnott	**Labour**
Councillor Pamela Wallace	**Labour**
Councillor Geoff Zygadllo	**Labour**
Mr J Chiocchi	**Co-optee**

Please contact Lynn Derbyshire on 0151 511 7975 or e-mail lynn.derbyshire@halton.gov.uk for further information.

The next meeting of the Board is on Tuesday, 7 January 2014

ITEMS TO BE DEALT WITH
IN THE PRESENCE OF THE PRESS AND PUBLIC

Part I

In accordance with the Health and Safety at Work Act the Council is required to notify those attending meetings of the fire evacuation procedures. A copy has previously been circulated to Members and instructions are located in all rooms within the Civic block.

Agenda Item 3

REPORT TO: Health Policy & Performance Board

DATE: 6 November 2013

REPORTING OFFICER: Strategic Director, Policy & Resources

SUBJECT: Public Question Time

WARD(s): Borough-wide

1.0 PURPOSE OF REPORT

1.1 To consider any questions submitted by the Public in accordance with Standing Order 34(9).

1.2 Details of any questions received will be circulated at the meeting.

2.0 RECOMMENDED: That any questions received be dealt with.

3.0 SUPPORTING INFORMATION

3.1 Standing Order 34(9) states that Public Questions shall be dealt with as follows:-

(i) A total of 30 minutes will be allocated for dealing with questions from members of the public who are residents of the Borough, to ask questions at meetings of the Policy and Performance Boards.

(ii) Members of the public can ask questions on any matter relating to the agenda.

(iii) Members of the public can ask questions. Written notice of questions must be given by 4.00 pm on the working day prior to the date of the meeting to the Committee Services Manager. At any one meeting no person/organisation may submit more than one question.

(iv) One supplementary question (relating to the original question) may be asked by the questioner, which may or may not be answered at the meeting.

(v) The Chair or proper officer may reject a question if it:-

- Is not about a matter for which the local authority has a responsibility or which affects the Borough;
- Is defamatory, frivolous, offensive, abusive or racist;
- Is substantially the same as a question which has been put at a meeting of the Council in the past six months; or
- Requires the disclosure of confidential or exempt information.

(vi) In the interests of natural justice, public questions cannot relate to a planning or licensing application or to any matter which is not dealt with in the public part of a meeting.

(vii) The Chairperson will ask for people to indicate that they wish to ask a question.

(viii) **PLEASE NOTE** that the maximum amount of time each questioner will be allowed is 3 minutes.

(ix) If you do not receive a response at the meeting, a Council Officer will ask for your name and address and make sure that you receive a written response.

Please bear in mind that public question time lasts for a maximum of 30 minutes. To help in making the most of this opportunity to speak:-

- Please keep your questions as concise as possible.
- Please do not repeat or make statements on earlier questions as this reduces the time available for other issues to be raised.
- Please note public question time is not intended for debate – issues raised will be responded to either at the meeting or in writing at a later date.

4.0 POLICY IMPLICATIONS

None.

5.0 OTHER IMPLICATIONS

None.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton** - none.

6.2 **Employment, Learning and Skills in Halton** - none.

6.3 **A Healthy Halton** – none.

6.4 **A Safer Halton** – none.

6.5 **Halton's Urban Renewal** – none.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

8.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

8.1 There are no background papers under the meaning of the Act.

REPORT TO: Health Policy and Performance Board

DATE: 6 November 2013

REPORTING OFFICER: Chief Executive

SUBJECT: Health and Wellbeing Minutes

WARD(s): Boroughwide

1.0 PURPOSE OF REPORT

1.1 The Minutes relating to the Health and Social Care Portfolio which have been considered by the Health & Wellbeing Board Minutes are attached at Appendix 1 for information.

2.0 RECOMMENDATION: That the Minutes be noted.

3.0 POLICY IMPLICATIONS

3.1 None.

4.0 OTHER IMPLICATIONS

4.1 None.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 **Children and Young People in Halton**

None

5.2 **Employment, Learning and Skills in Halton**

None

5.3 **A Healthy Halton**

None

5.4 **A Safer Halton**

None

5.5 **Halton's Urban Renewal**

None

6.0 RISK ANALYSIS

6.1 None.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

8.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

8.1 There are no background papers under the meaning of the Act.

HEALTH AND WELLBEING BOARD

At a meeting of the Health and Wellbeing Board on Wednesday, 17 July 2013 at Karalius Suite, Stobart Stadium, Widnes

Present: Councillors Morley and Polhill and S. Boycott, S. Banks, D. Parr, D. Johnson, D. Sweeney, J. Wilson, E. O'Meara, D. Lyon, N. Sharpe, G. Ferguson, A. McIntyre, K. Fallon, N. Rowe, J. Rule, S Yeoman.

Apologies for Absence: Councillors Philbin, and Wright and S. Baker, J. Dwyer, G. Hayles, A. Marr, M Pickup and A Williamson

Absence declared on Council business: None

ITEM DEALT WITH UNDER DUTIES EXERCISABLE BY THE BOARD

Action

HWB9 MINUTES OF LAST MEETING

The Minutes of the meeting held on 22 May 2013 were taken as read and signed as a correct record.

HWB10 LONGER LIVES - PRESENTATION

The Board received a presentation from Eileen O'Meara, Director of Public Health, which demonstrated the Longer Lives website. The Public Health England website highlighted premature mortality in the categories of cancer, heart disease and stroke, lung disease and liver disease, across every local authority in England, providing information to help them improve their community's health in these areas. In addition the website could compare Halton with local authorities who have similar levels of deprivation.

The presentation also highlighted to Members a series of graphs which compared Halton to its industrial hinterland statistical neighbours for cancer, heart disease and stroke, lung disease and liver disease.

RESOLVED: That the presentation be noted.

HWB11 BRIDGEWATER COMMUNITY HEALTHCARE NHS TRUST - PRESENTATION ON APPLICATION FOR

FOUNDATION TRUST STATUS

The Board received a presentation from Kate Fallon, Chief Executive, Bridgewater Community Healthcare NHS Trust which provided an update on the progress of the Foundation Trust application. The application was in the final stage with an inspection on 16th July, an on-site assessment by a Monitor – the independent regulator of Foundation Trusts in November and a stakeholder day in the autumn. It was anticipated that the process would take four months and a Foundation Trust licence would be received in December 2014.

It was noted that a key element of the process was the election of the Trust's Council of Governors and nominations for applications for Governors had been advertised.

RESOLVED: That the presentation be received.

HWB12 WIDNES VIKINGS - HEALTH & WELLBEING PRESENTATION

The Board was advised that Widnes Vikings Rugby League Club had been commissioned by Public Health to work on Health and Wellbeing as part of their contract. On behalf of Widnes Vikings, James Rule, Chief Executive Officer attended the meeting and gave a verbal presentation which highlighted the Clubs community programme involving local schools and community clubs. The programme involved Widnes Viking players working with local youngsters to encourage them to learn new sports and lead a healthy active lifestyle.

As part of the presentation Members viewed a DVD which showed local school children and Widnes Vikings players working together to learn new sports skills.

RESOLVED: That the presentation be received.

HWB13 SUPPORT FOR PATIENTS IDENTIFIED WITH IMPAIRED GLUCOSE REGULATION (IGR)

The Board considered a report of the Director of Public Health, which outlined a proposed Merseyside-wide project to support patients identified as having Impaired Glucose Regulation (IGR) and thereby prevent or delay the progression to type 2 diabetes. It was noted that in September 2012 a business case was developed for a standardised diabetes prevention pathway to identify and

manage patients with IGR across the Mersey Cluster. The proposed pathway was based around a five step process as follows:-

- Step 1 – Identification of high risk patients;
- Step 2 – Offer blood test;
- Step 3 – Patient invited for clinical/lifestyle review;
- Step 4 – Patient offered IGR education and lifestyle intervention; and
- Step 5 – Patients thereafter invited for annual review.

It was proposed that a range of IGR educational material be developed for those patients who chose not to participate in a lifestyle intervention but who wished to manage their condition themselves and to support those that do participate in interventions. Funding for this element had been provided through the Quality, Innovation, Productivity and Prevention (QIPP) Programme. Subsequently, Directors of Public Health across the Mersey cluster had been requested to set aside £20,000 to support the commissioning of an IGR training package.

It was noted that Halton's CCG Governing Body had confirmed its support for the pathway at its meeting on 20th September 2012 and agreed to fund annual reviews for patients known to have IGR and those identified as having IGR through health checks. It was anticipated that, subject to the delivery of the training element, the pathway would be formally launched and rolled out to GP practices in September 2013. It was noted that Directors of Public Health from all local authorities involved had given their in principle support for the new pathway. Subsequently, Directors of Public Health across the Mersey cluster had been requested to set aside £20,000 to support the commissioning of an IGR training package.

RESOLVED: That the report be noted.

HWB14 HEALTH AND WELLBEING ACTION PLANS

The Board received an update report on the progress of the development of the Health and Wellbeing Action Plans. Since the launch of the joint Health and Wellbeing Strategy for Halton 2013/16 in January 2013, work had taken place to develop Actions Plans for each of the priority areas contained within the report. A copy of the draft Action Plans for each of the following five areas was circulated to Members of the Board:-

i) Prevention and Early Detection of Cancer;

ii) Improved Child Development;
iii) Reduction in the number of falls in Adults;
iv) Reduction in the Harm from Alcohol; and
v) Prevention and early detection of mental health conditions.

RESOLVED: That

1) the contents of the report and the appendices be noted; and

2) comments be fed back to the Director of Public Health.

HWB15 CHILDREN IN CARE OF OTHER LOCAL AUTHORITIES

The Board considered a report of the Strategic Director, Children and Enterprise which:-

1. Presented an update report regarding the current numbers of Children in Care of Other Local Authorities (CICOLA's) and the possible impact on services within Halton;

2. Assessed within the context of neighbouring local authorities the numbers of Residential Children's Homes operating within Halton, the types of these services and the potential financial impact on the Borough; and

3. Offered an update regarding on-going works development in this area.

The Board was advised that Halton currently had 138 children on the CICOLA's list (11 of these had an unknown address). The main referer into the Borough was Liverpool followed by Knowsley. It was noted that there had been a significant reduction of CICOLA's moving into Halton from Boroughs many miles away. Within Halton currently there were 12 external agency children's homes operating in the Borough, this represented a reduction of three homes within the last 18 months. In total, this was 22 placements (beds) which represented a reduction of 11 beds in the last 18 months. This reduction represented a home reduction of 20% and a bed reduction of just over 33% in the last 18 months, primarily being due to the Commissioning Manager working with colleagues from the Planning Section to confirm providers had appropriate permissions.

In addition, Halton had also been in direct discussions

with OFSTED Inspectors for the local homes and shared some of the consistent practice issues. It was noted that the market reduction was highly favourable given that during this same time period there was a 10% increase in both the numbers of Children's Homes nationally and in the North West located homes as well as in the numbers of beds.

Members were also provided with feedback on the Placement Provide Forum meetings which covered Halton, St. Helens and Warrington areas and were held on a quarterly basis. Feedback from the providers had been positive in terms of the usefulness of the forum and also the networking opportunities that it provided.

RESOLVED: That further work is undertaken to get a more accurate picture on how many CICOLA's reside in Halton, ensuring that the procedures around notifications of CICOLA's were appropriately utilised.

Strategic Director Children and Enterprise

HWB16 DOMESTIC ABUSE SERVICES FOR CHILDREN, YOUNG PEOPLE AND FAMILIES

The Board considered a report which advised on the commissioning process, timeline and main elements that would encompass the new Domestic Abuse Services in Halton for children, young people and families.

As part of the proposals for the new Children's Domestic Abuse Service the following steps had taken place over the last few months:-

- Halton Domestic Abuse Forum carried out work during Autumn of 2012 to examine the impact of domestic abuse on children and young people. A draft plan was produced which was due to be refreshed alongside the Borough's Domestic Abuse Strategy later this year;

- The Domestic Abuse and Sexual Violence Co-ordinator had undertaken work to map the impact of domestic abuse across the Borough;

- In January 2013, the Forum asked the Council's Adults and Commissioning Teams to meet and look at future plans for commissioning services, particularly around a perpetrator programme and services for children and young people;

- In March 2013 funding was sourced from Children's specialist budget and a lead commissioner from the

Children's Commissioning Team was identified to undertake research and draw together the details required for a service specification to support children, young people and families;

- During April 2013, a benchmarking exercise was carried out with other local authorities;

- Throughout May 2013, there were some initial consultations with service providers and practitioners around their views of the current demand and need of families around domestic abuse services; and

- The procurement process had been drawn up and the main elements of a timeline established.

It was proposed that the four main elements to the new service were:

- Support to parents that were victims of domestic abuse which would enable parents to understand the impact of domestic abuse on how they parent and how domestic abuse had impacted on the children and young people's behaviour;

- Direct work around children/young people's safety planning where the young person was still in the situation;

- Longer term recovery work, therapeutic approach where the perpetrator was no longer within the family; and

- Support social care with the pre-court proceedings process and provide information and assessments were required.

RESOLVED: That

1) the report be noted;

2) the service delivery approach outlined within the attached draft service specification be agreed; — Strategic Director Children and Enterprise

3) children's services support Communities Directorate in the re-commission of Halton's Domestic Abuse Services; and

4) the approach that other services supporting the hidden harm and domestic abuse agenda adopt were

viable the main elements required around child safety planning be endorsed.

HWB17 PHARMACEUTICAL NEEDS ASSESSMENT

The Board considered a report of the Director of Public Health, which provided an overview of the background to the Pharmaceutical Needs Assessment,(PNA) changes which were effective from 1st April 2013, the duties of the Health and Wellbeing Board, commissioning arrangements and proposed arrangements for producing Halton's PNA. The PNA was the statutory document that stated the pharmacy needs of the local population. This included dispensing services as well as public health and other services that pharmacies may provide. It was used as the framework for making decisions when granting new contracts and approving changes to existing contracts as well as for commissioning pharmacy services. Since 1st April 2013, the Health and Wellbeing Board was responsible for producing Halton's PNA.

The Board was advised that work had been undertaken in Cheshire prior to the closure of PCTs, whereby Health and Wellbeing Boards across Cheshire, agreed a common framework for producing their PNAs. This would ensure that although each PNA would be developed locally and differ according to the local population and area, it would be in the same format and order which would make it easier to use and review. The work had recently been shared with Merseyside Public Health intelligence leads. Subsequently a Merseyside Group of public health representation from each Local Authority and the NHS England had started to meet and progress this area to develop a strategic plan for developing PNAs for each area, maximising the economies of scale, where possible, by working together in the planning, consultation and design stages, which would support at a local level to produce individual PNAs.

Each Health and Wellbeing Board was required to nominate a board-level sponsor with responsibility for the PNA, but the management of the PNA could be passed over to a Steering Group led by public health. The group would oversee the operational development and consultation for the PNA, reporting back to the Health and Wellbeing Board for approval stages of the process.

It was important to ensure that all information within the PNA was accurate and up to date, and this could be achieved by ensuring that all relevant stakeholders were

represented on the steering group. The following next steps were proposed:

- Nominate board level to sponsor for PNA;
- Nominate chairperson of Steering Group from Public Health Team;
- Recruit Steering Group who should then:
- Start to populate the PNA with information already available such as JSNA, gather information to update current PNA, ask the local community for feedback on current pharmacy services and aspirations for future pharmacy services, contact local authority planners and healthcare commissioners to determine future planning of housing, industry and healthcare.

RESOLVED: That

1) the Director of Public Health be nominated as the Board level sponsor for the Pharmaceutical Needs Assessment (PNA); — Director of Public Health

2) the financial risks associated with the PNA be logged through Halton Borough Council's risk assessment and register process; and

3) a local Steering Group be established to develop the PNA and oversee the statutory consultation.

HWB18 SUICIDE PREVENTION STRATEGY

The Board considered a report of the Director of Public Health, which provided an update on the development of a Suicide Prevention Strategy for Halton. At a local level, a recent suicide audit for Halton and St. Helens, completed in April 2013, demonstrated that the number of completed suicides for Halton remained relatively low. However, the existing Suicide Prevention Strategy needed to be updated in line with the National Strategy, published in September 2012. A Suicide Audit would provide some of the evidence to support the development of the Strategy.

It was proposed that the local Strategy follow the same format as the National Strategy by following six key areas for action:

- reduce the risk in key high risk groups;
- tailor approaches to improve mental health in specific groups;
- reduce access to the means of suicide;

- provide better information and support to those bereaved or affected by suicide;
- support the media in delivering sensitive approaches to suicide and suicidal behaviour; and
- support research, data collection and monitoring.

In order to progress the development of a local strategy, it was proposed that a Suicide Prevention Task Group be established and a workshop be organised for September to provide wider engagement with key stakeholders from across Halton.

RESOLVED: That

1) the report be noted; and

2) the development of a Suicide Prevention Strategy for Halton be supported.

Director of Public Health

HWB19 WINTERBOURNE VIEW UPDATE

The Board was advised that the Transforming Care: A national response to Winterbourne View Hospital (Department of Health Review final report) was produced in December 2012 and included an Action Plan, a copy of the Plan had been circulated to Members of the Board. The majority of areas within the Action Plan were focused at a national level with guidance disseminated to Clinical Commissioning Groups (CCGs) and the Local Authority for implementation. Areas that required CCG and Local Authority input were highlighted in the report together with an implementation date and a progress update.

RESOLVED: That

1) the report be noted; and

2) the Winterbourne View Action plan be noted.

HWB20 HEALTH AND WELLBEING BOARD REVISED TERMS OF REFERENCE

The Board was advised that the Health and Wellbeing Board had been operating in shadow form since December 2011. However, as from 1st April 2013 the Board became a statutory board of the Local Authority. As a result of this change the original Terms of Reference have been updated. The revised document removed reference to a “Shadow” Board and actions relating to the transitional period. Membership had also been updated to reflect changes. A

copy of the revised Terms of Reference had previously been circulated to Members of the Board.

RESOLVED: That

1) the contents of the report and appendices be noted;

2) a representative from Cheshire Police be added to the Board Membership;

3) any further comments be forwarded to the Strategic Director Communities; and — Strategic Director Communities

4) an updated version of the revised Terms of Reference highlighting the proposed amendments be circulated.

HWB21 URGENT CARE - PROGRESS

The Board considered an update report in relation to the current project/areas of work associated with improvements in urgent care as referenced in Halton's Accident and Emergency Recovery and Improvement Plan. During 2012 Halton Borough Council and NHS Halton Clinical Commissioning Group (HCCG) developed the Urgent Care Partnership Board to lead on the development and management of the Urgent Care system used by the Borough's population. Delivering on this agenda would provide the health and social care economy with sustainable improvements in performance and quality.

With regard to Primary Care Quality and access, the accountability for Primary Care remained with NHS England, and NHS England oversaw the quality elements of Primary Care within Halton. Evidence suggested that access remained an issue for Halton residents and as a result a Primary Care Quality Group, consisting of representatives from the Council and HCCG would be established, with a role to improve the quality and support to local practices in order for them to be able to effectively respond to the growing need for quicker and more effective access.

Members of the Board were advised that a local Recovery and Improvement Plan centred on each A and E Department also needed to be developed. The local plans had to be submitted to Regional Directors by 31st May 2013. Within Halton, the development of the local Plan was co-ordinated via the Halton Urgent Care Partnership Board and in addition to being formally signed off by Halton CCG, had been agreed by all partners of the Board. In addition, it was

noted that prior to submission to the Regional Director, each local Plan had to go through the NHS England's North Region assurance process, this exercise had been completed.

RESOLVED: That

1) the report be noted; and

2) the Recovery and Improvement Plan be noted.

HWB22 HEALTH AND ADULT SOCIAL CARE SETTLEMENT 2015/16

The Board considered a report of the Strategic Director, Communities, which provided Members with a summary of the Government's Health and Adult Social Care settlement 2015/16 and put forward recommendations to ensure the conditions attached to funding and integration were progressed.

In order to have the necessary plans in place to comply with the integration, it was proposed that a short, time limited Task and Finish Group, chaired by the Director of Communities, to develop the plan in conjunction with guidance from the Department of Health and Department for Communities and Local Government be established. The Group would conclude its work by 30th September 2013.

In addition, a Task and Finish Finance Group was proposed to ensure that the financial elements of the settlement were considered and management of the financial components were dealt with accordingly. Both groups would report progress to the Board and the plan would also require approval through the NHS, Halton CCG Governing Body as funding would transfer from NHS Halton CCG to the Council.

The LGA had outlined an approach regarding the completion of a Sense check. It was proposed that a brief questionnaire would be circulated to all Members, Chief Executive and Leader of Halton Borough Council, Chief Officer and Chair of NHS Halton CCG, and Operational Director for Commissioning to gain commissioning understanding, direction for integration and key leadership issues that would feed into the plan as it was developed. Thereafter a number of follow-up interviews would also be required with key members of the Board.

RESOLVED: That

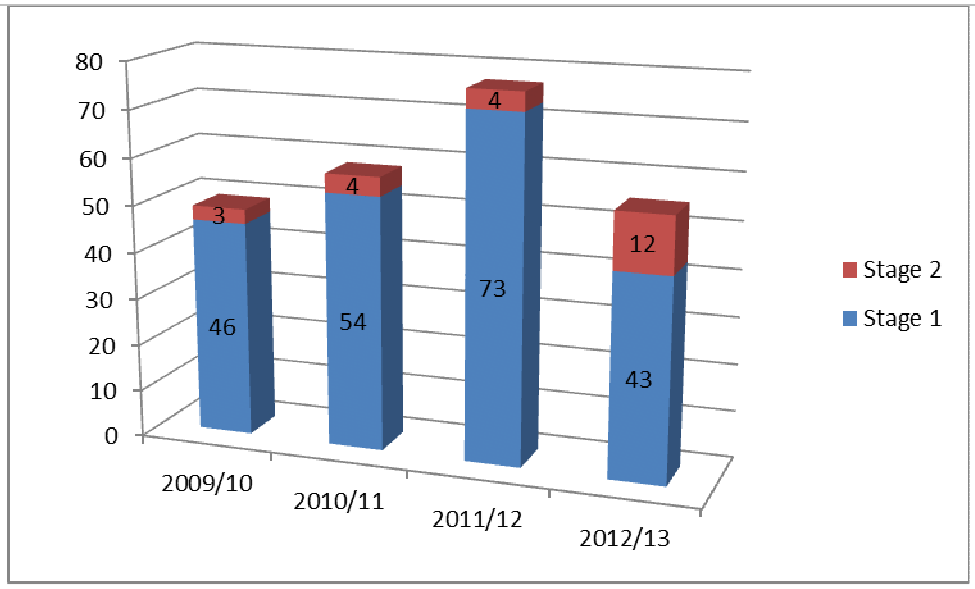
1) the contents of the report be noted; 2) the establishment of a Task and Finish Group to be chaired by the Strategic Director, Communities to progress the development of a plan and completion of a Sense check to gain commissioning understanding and direction be approved; 3) the establishment of a Task and Finish Finance Group chaired jointly by the Operational Director for Finance and Chief Officer for Halton CCG, be approved; and 4) the delivery of a workshop in October/November to agree the plan be approved.	Strategic Director Communities

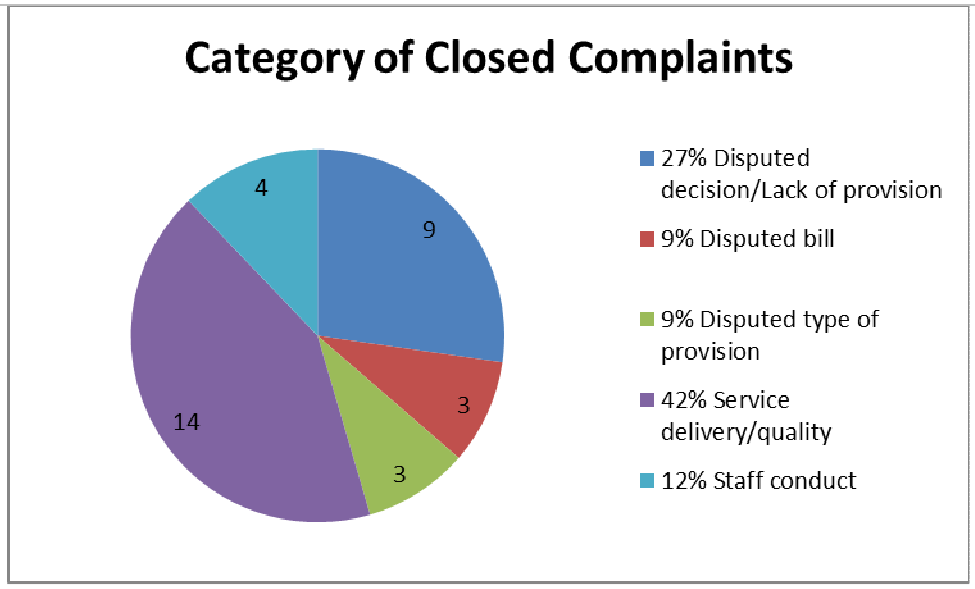
Meeting ended at 4.15 p.m.

REPORT TO:	Health Policy and Performance Board
DATE:	6 November 2013
REPORTING OFFICER:	Strategic Director, Communities
PORTFOLIO:	Health & Wellbeing
SUBJECT:	Adult Social Care Customer Care Report for the year 1st April 2012 to 31st March 2013
WARDS:	All

1.	**PURPOSE OF REPORT**
1.1	To report and provide an analysis of complaints, compliments and other enquiries processed under The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and to meet statutory requirement to publish an Annual Report.
2.	**RECOMMENDATION**
	That members of the Board: Consider and comment on any of the key learning points identified as a result of complaints.
3.	**SUPPORTING INFORMATION**
3.1	**The Adult Social Care Complaints Process** From April 2009 a common approach to handling complaints in the NHS and Adult Social Care was introduced aimed at encouraging complaints handling that is tailored for each individual and handled more flexibly. It allows a more efficient and effective way of responding to, and learning from, complaints encouraging the best outcome for the both the individual and for the organisation.
3.2	The complaints approach has a format where, right at the start, the Customer Care Team works with the person making the complaint to agree the details of the complaint and what would resolve it.
3.3	At that point, how it is to be handled and the likely timescales, taking into account complexity and complainant's availability etc, are explored and agreed, although they can be further negotiated as required. Although it can take longer, it does encourage greater focus on getting a satisfactory outcome.
3.4	Sometimes, it becomes apparent that, due to the complexity of the issues involved, a more detailed investigation is required, either by an appropriate manager or by an person independent of the authority. This may be after some initial investigation so, for the purposes of identification of these cases, we have referred to them at "Stage 2 cases" in this report. Alternatively, a

	"stage 2 case" may also be where an alternative solution has been explored (e.g. through detailed mediation or including other agencies).
3.5	If a complainant remains dissatisfied with the outcome of this statutory complaints process, they retain the right to refer their complaint to the Local Government Ombudsman.
3.6	**The Social Care Customer Care Team** From 1st April 2011 the Children and Enterprise, Customer Care Manager joined with the Communities Customer Care Team to form one amalgamated team responsible for the administration of Adult and Children Social Care Representations.
3.7	The Customer Care Team monitors the responses and records and reports learning from various types of feedback including:
	• **Statutory Complaints;** defined as "an expression of dissatisfaction or disquiet about an action, decision or apparent failings of local authority adult social care services provision, which requires a response" • **A Customer Care issue;** where people want to raise a concern but not make a formal complaint, or where clarification on an issue or concern has been sought and provided. • **MP** / **Councillor Enquiries** on behalf of a constituent. • **Representations**; the term representations is used when making collective reference to Customer Care, MP and Councillor enquiries and they are included in reports to inform learning. • **Compliments**; it is just as important that we learn what people are happy about so compliments are recorded and reported in the same way.
4.	**ANNUAL REPORT 1st April 2012 to 31st March 2013**
4.1	**Statutory Complaints closed in the year** In the following, complaints have been analysed by the majority processed in the normal way (Stage 1) and those of a more complex nature (Stage 2)
4.2	There have been 55 complaints processed under the statutory complaints procedure in the financial year. This is a significant reduction in the peak (of 77) in the preceding year but more in line with the years prior to that, as illustrated in the following graph.
4.3	**Analysis of statutory complaints processed**

	
4.4	The higher proportion of stage 2 type cases reflect the emerging practice promoted by the adults social care and health complaints regulations. These encourage a proportionate response relevant to each individual case ranging from immediate resolution, handled within the operational area concerned, through to a formal and detailed investigation for the more serious or complex complaints.
4.5	During the last financial year, we have also been developing mediation as an alternative solution to resolve complaint issues. This involves a member of the Customer Care Team, or another appropriate manager, acting as an 'honest broker', encouraging a mutually acceptable solution to be negotiated. This was successful in helping to resolve six of the 12 stage 2 type complaints and helpfully applied in the stage 1 process too.
4.6	During the year 4905 people received a service from Adult Social Care Services, of whom 1.12% of them made a complaint. This compares with levels of 1.51% last year and 1.09% the year before that.
4.7	**Outcome of closed Statutory Complaints** Of the 55 closed complaints in the year, 17 (31%) were upheld and 16 (29%) partially upheld (complaints that are partially upheld indicate a number of issues raised, some of which were not upheld). Overall 34 (60%) of complaints had elements of their complaint upheld. This is reflecting that usually, in most complaints, there is always something that could have been done better (eg communication issues).
4.8	**Category of the closed Statutory Complaints that were upheld in full or part**



4.9 **Statutory Complaints Timescales**

The complaint procedures encourage timescales to be agreed with the complainant

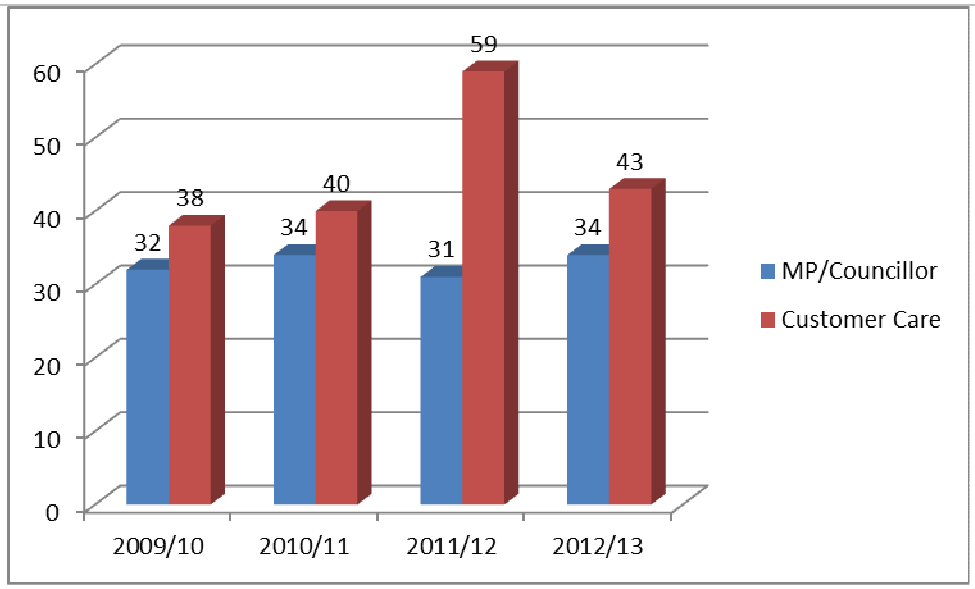
Stage 1 Completion Timescales	9/10	10/11	11/12	12/13
1. Within time agreed	N/A	93%	88%	79%
2. Within 20 days	80%	72%	52%	65%
3. Within 30 days	N/A	N/A	74%	81%
4. Within 40 days	N/A	N/A	85%	86%

Row 1 illustrates that those targets were met in 79% of cases. Whilst this is lower than last year the procedures do allow more flexibility, focusing on getting the right outcome rather than satisfying any defined process or timescale. The application of this philosophy has evolved further in the last year and, as the other lines indicate, overall turnover figures are improving, suggesting that the equilibrium between timeliness and ensuring a robust resolution is becoming better balanced.

4.10 **Analysis of complaints received**

We record complaints by specific complaint type and client groups, so that we can analyse whether there are any underlying trends or whether complaint numbers may be influenced by other factors (eg high profile cases from elsewhere in the country).

The Customer Care Team also monitors learning that emerges, both regionally and across the country, by membership of the North West and National Complaints Managers Group (which Halton currently Chairs). This involves close liaison with government departments who are responsible for the policy areas around complaint management. The complaints regulations, which are common to both Health and Adult Social Care, are currently under close scrutiny, following the findings of the Mid Staffordshire Hospital Trust

	Inquiry and other similar reports. Similarly, reports from the Local Government Ombudsman (LGO) are also monitored and learning from cases they investigate throughout the country is shared with colleagues as appropriate.
4.11	**Local Government Ombudsman (LGO)** During the year, one enquiry was received from the Local Government Ombudsman. Information was provided about that complaint and the LGO subsequently upheld Halton Borough Council's position on the case in question.
4.12	**Category of people making the complaint** Similarly to the preceding year: • 85% of complainants made are by people representing/ supporting the person using the services, this is consistent to last year which was 86%. • 75% are related, again this is consistent to the 78% last year. These statistics can be attributed to the vulnerability of individuals who access adult social care services.
4.13	**Number of Customer Care and MP/Councillor Enquiries closed in the year** (see 3.7 definition)**.**
4.14	As the table below illustrates, Customer Care type enquiries have fallen in a similar way as statutory complaints. The level of MP/ Councillor Enquiries remains consistent with previous years.
	
4.15	**Consideration and the allocation of priority of complaints** All complaints are scrutinised at an early stage, to identify the level of personal risk or other significant factors. They are considered against a matrix that considers the level of risk, along with the likelihood of

reoccurrence. From that, a priority (Low, Medium or High) is set, identifying those that require urgent action (eg action under the safeguarding procedures). The analysis of classifications set in the last year are set out below.

Low - relatively minor issues, no significant implications for the service user or the service	41 (76%)
Medium - more complex and/or significant issues, implications for the service user or the service in terms of practice, procedure or service delivery.	15 (17%)
High - most serious and complex significant implications for the service or the complainant in terms of practice, procedure or service delivery.	9 (7%)

4.16 **Complaints with Dignity and Safeguarding elements**

Complaints are also monitored to identify where there are elements relating to the safeguarding and dignity of the service user. Complaints that have any element of adult abuse, or suspected abuse, are immediately referred through the Safeguarding Procedures. In such cases, any complaints investigation is put on hold until discussions have taken place to decide the most appropriate course of action. 4 complaints received in the year were passed on for investigation under the Adult Safeguarding Procedures.

Dignity Factors contribute to a person's sense of self-respect. It means treating people who need care as individuals and enabling them to maintain the maximum possible level of independence, choice and control over their own lives.

4.17 **Provider Monitoring Feedback**

The Quality Assurance Team has a process in place where feedback on providers commissioned by the Council can be provided. Similarly they can be used to trigger any Safeguarding or Dignity issues and the learning is used to monitor and improve service delivery.

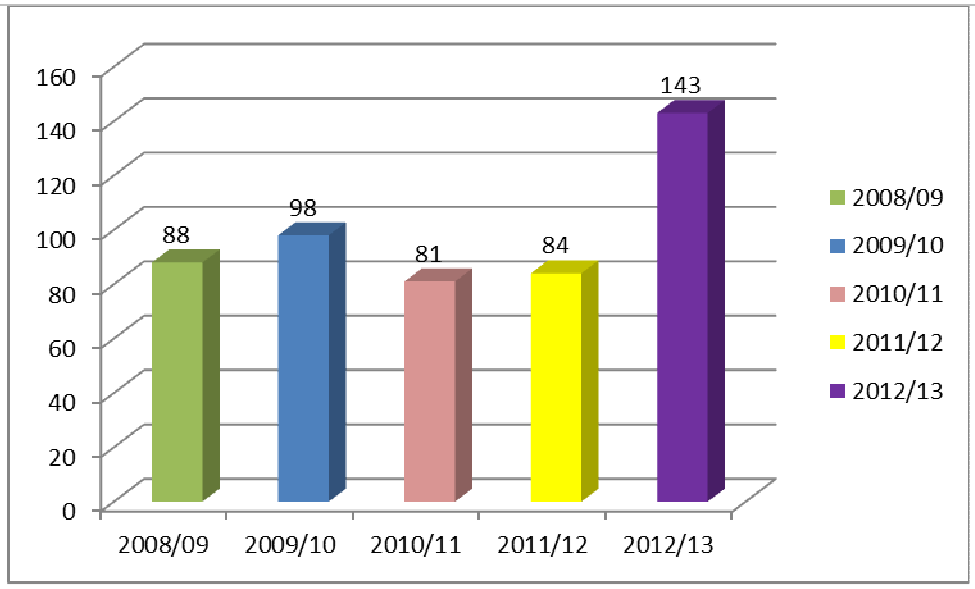
4.18 **Learning and Service improvement**

The vast majority of complaints are not due to any wilful intent, but often the unintended outcome actions of lack of actions (for example particularly communication issues such as where a lack of clarity may lead to one person misunderstanding what another means). Similarly, examination of complaints may not uphold that something has gone wrong, but may uncover a way of doing something that the individual is more comfortable with. Either way, the learning gathered from all forms of available feedback (complaints, compliments and other comments) is used to improve individual issues and fed into the service improvement process as appropriate, to inform and develop the services we provide and commission..

4.19 During the last year, improvements resulting from complaints have been developed including:

- The Council commissions care agencies to provide support to help

	people remain independent in their own homes through regular support visits. Generally these work well but there have been some individual issues reported through the complaints procedure including concerns around issues such as timeliness and consistency in who attends. The Quality Assurance Team has worked with providers where such issues have arisen to resolve specific concerns and the development of procedures and training for staff. • The Quality Assurance Team have also worked with appropriate providers to review their oxygen management policies to ensure robust practice. • Other policies have been reviewed and changes made as a result of complaints. These have included those around transfer to and discharge from hospital, ensuring proper information and assistance is provided and delays minimised. • Information sharing arrangements have also been reviewed to ensure it is passed on to relevant areas as appropriate. • Mediation has been particularly helpful in some cases where trust had broken down. It has successfully helping to develop better understanding and has also helped to uncover previously unknown key information that significantly impacted on the assessment of need and subsequent care entitlement. • Complaints have given us the opportunity to review individual assessments and decisions. Some have resulted in decisions being changed and others with a better explanation provided, to better explain the rationale behind decisions. In some cases training issues have been identified and addressed.
4.20	**Compliments** It is just as important that we record and measure compliments, as they give feedback on what people think we do well. Staff have been encouraged to forward on compliments as they are important intelligence that help feed in to the planning and review of what we do. Whilst the following graph may reflect an increase in staff sharing their compliments with the Customer Care Team it is gratifying that so many people took the time to pass compliments on to staff thanking them for what they do.
	Compliments received about social care staff



Compliments have been received across a broad range of service areas. Just a few illustrative examples include:

- "We would like to take this opportunity so that we as a family can share our ***heartfelt gratitude*** to all the staff at Oak Meadow, the ***kindness, respect, dignity, patience*** and most of all the rehabilitation that our dad has received here, is amazing. The ***transformation is unbelievable***, mentally and physically. We have not seen dad this good for at least three years!!! And it's all down to the hard work here; the transformation is unrecognisable to the condition he was in when he first arrived. On dad's behalf and ours we thank you all so very much. "

- I cannot ***praise highly enough*** the ladies from the Community Alarm Service that came out to mum. From the moment they stepped through the door ***they showed professionalism and great compassion***. What impressed me so much is that they treated mum with so much ***care and understanding*** of her predicament. It was a pleasure to be a service user and see people deliver a service so well; they are a credit to the system and hope the rest of my dealings with the service are similar.

- Please accept my ***deeply heartfelt thanks*** for all you have done for my dad. You have ***literally changed our lives*** - so much for the better! I shall never be able to thank you enough.

- I have never met such a dedicated and empathetic team of people.

- I had a home visit from Cheryl to assess my role/needs as a carer to my husband and would like to pass on my thanks for the way sensitive issues were handled. Cheryl was ***professional, compassionate and extremely helpful.***

- You all do a ***wonderful job***. The ***kindness and caring oozes out of you all***, it has been a privilege to be cared for by you.

	• A big thank you to you all for helping me through a difficult time everyone were lovely people and ***felt as though they were friends visiting me.*** • All the carers who supported and cared for my Dad through the last 6 months of his illness. ***You gave all the family so much support*** and allowed Dad the luxury of being at home when he died. Your work and service is very important and is not given the recognition it deserves. *Thank you all from the very bottom of our hearts* • With the help from Halton Home Improvement Service, they have allowed us to stay in our own home, which is a lot safer now at bath time and with the addition of the stair lift it has had a **dramatic effect on our everyday life**, Thanks. and finally Don't believe I'm being silly, to say I rely so much on Billy, Billy's the one with the long hair, allocated to my personal care, He promptly arrives at the given hour, to give me an early morning shower, He calls because I'm getting older and because I have a dislocated shoulder. Dedicated to look after guys like me as you get older and have a fall, It's Halton Carers you need to call. The ***Service they provided is first class***, I've experience this in the past. Halton carers deserve the QDJM, this medal to each one of them.
5.0	**POLICY IMPLICATIONS**
5.1	Complaint analysis can highlight where policy needs to be strengthened, reviewed, or amended to improve service delivery. Comments, Complaints and Compliments are essential feedback in developing services and policies. There are no implications identified in this year.
6.0	**RISK ANALYSIS**
6.1	Failure to implement an efficient service could result in the local authority being challenged for not dealing with complaints in a timely and efficient manner and could result in the customer not receiving a service which could then detrimental to their health, safety and wellbeing.
6.2	Whilst complaints can result in changes for individuals, collectively they are a key source of information to help us develop the services we provide or commission.
7.0	**FINANCIAL/RESOURCE IMPLICATIONS**
7.1	Learning from complaints has the potential to reduce financial consequences and help inform the development of efficient and cost effective services.
8.0	**EQUALITY AND DIVERSITY ISSUES**

8.1	No matter who complains they receive the same equality of access and provision. Consideration is given to what type of support, help and encouragement may be required for individuals to pursue their concerns. People whose first language is not English and those with communication difficulties may require support from a Translation Service or an Advocate.
8.2	Data on equality and diversity are recorded, analysed and reported upon as appropriate.
9.0	**IMPLICATIONS FOR THE COUNCIL'S PRIORITIES**
9.1	**Children and Young People in Halton** From March 2011 one Customer Care Team now services both Adults and Children's Directorates; this allows close working on relevant complaint issues. There is a close relationship between the social care services particularly to support young people during transition from Children and Young Peoples services to Adult Social Services.
9.2	**Employment, Learning and Skills in Halton** Social care aims are often closely associated with these, to improve people's life chances and to be as independent as possible. Any findings from a comment, complaint or compliment relating to this priority will be used to inform the relevant service.
9.3	**A Healthy Halton** Another core aim in social care is to prevent or delay reliance on institutional care, enabling people to be as independent as possible. Any findings from a comment, complaint or compliment relating to this priority will be used to inform the relevant service.
9.4	**A Safer Halton** Adult social care has a close relationship with protection procedures for the vulnerable adults, the frail etc. Any findings from a comment, complaint or compliment relating to this priority will be used to inform the relevant service.
9.5	**Halton's Urban Renewal** Many social care initiatives surround housing issues, enabling people to live as independently as possible in their community. Any findings from a comment, complaint or compliment relating to this priority will be used to inform the relevant service.
10.0	**LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972**

	Document	Place of Inspection	Contact Officer
	The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009	Runcorn Town Hall	John Gibbon

REPORT TO: Health Policy and Performance Board

DATE: 6 November 2013

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health and Wellbeing

SUBJECT: Business Planning 2014 -17

WARDS: Boroughwide

1.0 PURPOSE OF THE REPORT

1.1 To offer a timely opportunity for Members to contribute to the development of Directorate Business Plans for the coming financial year.

2.0 RECOMMENDATION: That the Board

1) **Note content of the report and associated appendix; and**
2) **Indicates priority areas for service development and improvement over the next 3 years.**

3.0 SUPPORTING INFORMATION

3.1 Each Directorate of the Council is required to develop a medium-term business plan, in parallel with the budget, that is subject to annual review and refresh. The process of developing such plans for the period 2014-2017 is just beginning.

3.2 At this stage members are invited to identify a small number of priorities for development or improvement (possibly 3-5) that they would like to see reflected within those plans. Strategic Directors will then develop draft plans which will be available for consideration by Policy and Performance Boards early in the New Year.

3.3 Whilst providing a Directorate context each of the Directorate Business Plans will contain appendices identifying specific Departmental activities and performance measures and targets that will provide a focus for the on-going monitoring of performance throughout the 2014 – 15 financial year.

3.4 It is important that Members have the opportunity to provide input at this developmental stage of the planning process, particularly given on-going budget pressures, to ensure that limited resources remain aligned to local priorities.

3.5 It should be noted that plans can only be finalised once budget decisions have been confirmed in March and that some target information may need to be reviewed as a result of final outturn data becoming available post March 2014.

3.6 The timeframe for plan preparation, development and endorsement is as follows:

	Information / Purpose	Timeframe
PPB	Discussion with relevant Operational / Strategic Directors concerning emerging issues, proposed priorities etc.	**October / November 2013 PPB cycle**
Portfolio Holders	Strategic Directors to discuss with Portfolio Holders emerging issues, proposed priorities etc.	October / November 2013
Directorate SMT's	To receive and endorse advanced drafts of Directorate Plans	**SMT dates to be agreed with Strategic Directors**
Corporate Management Team	To receive and comment upon / endorse advanced drafts of Directorate Plans	Early December 2013
Portfolio Holders	Strategic Directors to discuss with Portfolio Holders advanced draft plans, including relevant departmental service objectives/ milestones and performance indicators.	**Late December 2012/ January 2014**
PPB's	Advanced draft plans including details of relevant departmental service objectives/milestones and performance indicators	January 2014 PPB Cycle
Executive Board	To receive advanced drafts of Directorate Plans for approval	**7th February 2013**

4.0 POLICY IMPLICATIONS

4.1 Business Plans continue to form a key part of the Council's policy framework and will need to reflect known and anticipated legislative changes.

4.2 Elected Member engagement would be consistent with existing "Best Value Guidance" to consult with the representatives of a wide range of local persons with regards to formulating plans and strategies.

5.0 OTHER IMPLICATIONS

5.1 Directorate Plans will identify resource implications.

5.2 Such plans will form the foundation of the performance monitoring reports received by Elected Members and Management Team on a quarterly basis.

6.0 IMPLICATIONS FOR THE COUNCILS PRIORITIES

6.1 The annual review of medium-term business plans is one means by which we ensure that the strategic priorities of the Council inform, and are informed by, operational activity.

7.0 RISK ANALYSIS

7.1 The development of a Directorate Plan will allow the authority to both align its activities to the delivery of organisational and partnership priorities and to provide information to stakeholders as to the work of the Directorate over the coming year.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 Directorate Business Plans, and the determination of service objectives, are considered in the context of the Council's equality and diversity agenda.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

9.1 There are no relevant background documents to this report.

Health Policy and Performance Board
Member Briefing Note 6th November 2013

Business Planning 2014 - 17

The purpose of this briefing note is to provide members of the PPB with an overview of the key strategic issues facing the Board over the medium-term to feed into the Business Planning process 2014 - 2017.

As you will appreciate this briefing cannot cover all aspects of those service areas falling within the remit of this Board but will provide details of the primary drivers that will shape the work of the department(s) in supporting and delivering the Council's organisational priorities and business needs.

The Council continues to operate in an extremely difficult financial climate. We will need to ensure that we continue to meet our statutory responsibilities across all areas of our operations and the Directorate will continue to play a key supporting role in this endeavour, for example through effective financial management and the integration of national policy initiatives with efficient arrangements for service delivery.

2014/15

- **Integration** – commissioning between NHS Halton CCG and HBC – Health and Social Care Act 2012 – Integrated Transformation Fund
- **Mental Health**
- **Draft Care and Support Bill 2012** –
  - Eligibility and Assessments
  - Charging and Financial Assessments
  - Protecting Adults from Abuse and Neglect
- **Care Closer to Home**
  - Urgent Care
  - Integration
  - Supporting vulnerable adults to live independently with reduction in long-term care and lower packages of care in the community

Whilst the on-going financial climate continues to be challenging over the medium term there are opportunities to develop and improve services as well as important decisions that need to be taken in the medium term.

Health Policy and Performance Board
Member Briefing Note 6th November 2013

Business Planning 2014 - 17

Integration

Commissioning between NHS Halton Clinical Commissioning Group (HCCG) and HBC continues to be a priority. A revised Integrated Commissioning Framework is being developed and joint team meetings have begun between NHS HCCG, the public health commissioning team, the council's commissioning team and members of the Policy and Performance team.

Through the Health and Social Care Act 2012, a new pooled fund has been created called the Integrated Transformation Fund. Work is currently underway in developing an Integrated Plan between HBC and the NHS HCCG to enable access to the new funding arrangements for adult social care.

Mental Health

As the local older population increases and people live longer we have seen a significant increase in the number of people diagnosed with dementia. As a result of this we are developing a local dementia strategy that aims to address the needs of people with dementia and their carers. The strategy outlines the importance of early diagnosis, particularly in primary care, access to services in the community and improved quality in accommodation based service provision for example residential care.

Draft Care and Support Bill 2012

The Draft Care and Support Bill 2012 proposes a single, modern law for adult social care and support that replaces outdated and complex legislation. It focuses on many elements and all will have implications for HBC. The three main priority areas for us in the short-term are:

- The change nationally in eligibility criteria from "moderate" to "substantial" and the effects this will have on assessments;
- Charging and financial assessments;
- Increased protection for vulnerable adults from abuse and neglect with the introduction of the first statutory framework for adult safeguarding and those of our local partners

Care Closer to Home

With the proportion of older people growing and generally people living longer, often with long-term health and care needs, moving to care closer to home is the way forward. The provision of supportive and enabling care closer to home is wide ranging and includes building on initiatives that the council already has in place with prevention and early intervention, such as Telecare/Telehealth. Making greater use of technology with its mobility, flexibility and rapid transfer of information, improved ***integrated care pathways*** for users, making effective links between health, social

care and other services and building up commissioning capacity and capability, working with communities to establish outcomes that matter to them.

An ***Urgent Care Strategy*** has been developed over the last year which outlines the strategic direction for the delivery of urgent care in Halton over the next five years. It enables a common approach to provision and creates a framework within which care providers and commissioners can work to ensure seamless, high quality and appropriate care. It builds on national and local policy and aims to bring together a range of work streams that will see the cohesive implementation of the key aspects of the urgent care strategy.

REPORT TO: Health Policy & Performance Board

DATE: 6 November 2013

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Wellbeing

SUBJECT: NHS Health Checks

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To inform members of the Health Policy and Performance Board of changes to the NHS Health Check Programme.

2.0 **RECOMMENDATION: That the Board note the information contained in the report specifically with regard to the statutory requirements for local authorities contained at 3.2**

3.0 **SUPPORTING INFORMATION**

3.1 **Background**

3.1.1 From 1 April 2013, local authorities took over responsibility for the NHS Health Check programme, previously the responsibility of Primary Care Trusts (PCTs). The provision of NHS Health Check risk assessments is a mandatory requirement for local authorities. The Department of Health and Public Health England issued joint draft guidance in May 2013 to support local authorities to fufil their statutory duty to offer health checks to the local eligible population and advise on where there is scope to tailor programmes to local needs.

3.1.2 The NHS Health Check programme is a public health programme for people aged 40-74 which aims to keep people well for longer. It is a risk assessment and management programme to prevent or delay the onset of diabetes, heart and kidney disease and stroke. Together these conditions account for a third of the difference in life expectancy between the most deprived areas and the rest of the country.

3.1.3 The programme also aims to reduce levels of alcohol related harm and raise awareness of the signs of dementia and where people can go for help. Everyone attending a NHS Health Check will have their alcohol consumption risk assessed. In addition, people aged 65-74 will be informed of the signs and symptoms of dementia and sign

posted to memory clinics if needed.

3.1.4 As Health Checks is a public health programme aimed at preventing disease, people who have been previously diagnosed with the following are excluded as they should already be being managed and monitored through existing care pathways:

- Cardiovascular disease;
- Coronary heart disease;
- Chronic kidney disease (CKD);
- Diabetes;
- Hypertension;
- Atrial fibrillation;
- Transient ischaemic attack;
- Hypercholesterolaemia;
- Heart failure;
- Peripheral heart disease;
- Stroke.

Also excluded are people:

- Being prescribed statins;
- Who have previously had an NHS Health Check or any other check undertaken through the health service in England and found to have a 20% or higher risk of developing cardiovascular disease over the next 10 years.

3.1.5 Local authorities have the flexibility to cover a wider age range or include everyone aged 40 to 74 years but they are advised to consider the cost and benefits of doing so.

3.2 **Local authority responsibilities**

3.2.1 From 1 April 2013, local authorities are responsible for:

- Commissioning the risk assessment element of the programme (mandatory);
- Monitoring of offers made to complete a NHS Health Check (mandatory);
- Monitoring and seeking continuous improvement in take up of the programme (mandatory);
- Promotion/branding of the programme;
- Risk management and reduction (lifestyle interventions).

3.2.2 Commissioning and monitoring of the risk assessment element of the NHS Health Check is a mandatory public health function in the Health and Social Care Act 2012 and requirements upon councils are set out in The Local Authorities Public Health Functions and Entry to Premises by Local Healthwatch Representatives Regulations 2013. The programme is to be funded from the local

authority ring fenced Public Health budget.

3.2.3 Specifically, local authorities must make arrangements:

- for each eligible person aged 40-74 to be offered a NHS Health Check once in every five years and for each person to be recalled every five years if they remain eligible;
- so that risk assessments include specific tests and measurements;
- to ensure that the person having their health check is told their cardiovascular risk score and other results are communicated to them;
- for specific information and data to be recorded and, where the risk assessment is conducted outside the GP's practice, for that information to be forwarded to the person's GP.

3.2.4 Local authorities are also required to seek continuous improvement in the percentage of eligible individuals taking up their offer of a NHS Health Check. It is for each authority to determine how best to do this and to make their own decisions about continuous improvement bearing in mind that take up rates for Health Checks is one of the indicators in the Public Health Outcomes Framework. Whilst draft government guidance acknowledges that 100% take up is unlikely to be achieved and does not set targets, it suggests that over time authorities may wish to aspire to take up rates comparable with screening programmes (in the region of 75%). Local authorities will be required to provide data returns which will be published allowing national and local comparisons of achievement.

3.2.5 The risk reduction elements of the NHS Health Check are the shared responsibility of both councils (lifestyle interventions) and Clinical Commissioning Groups (clinical interventions). Where additional follow up and testing is required, for example, where someone is identified as being at high risk of having or developing vascular disease this remains the responsibility of primary care and is to be funded through NHS England.

3.3 The NHS Health Check risk assessments

3.3.1 The risk assessment requires a number of tests and measures to be carried out, as set out below:

- Age
- Gender
- Smoking status
- Family history of coronary heart disease
- Ethnicity

- Body mass index (BMI)
- Cholesterol level
- Blood pressure
- Physical activity level
- Cardiovascular risk score
- Alcohol Use Disorders Identification Test (AUDIT) score.

In addition those aged 65-74 should be made aware of the signs and symptoms of dementia and signposted to memory services if appropriate.

3.3.2 The use of a risk engine to calculate the individuals' risk of cardiovascular disease in the next ten years is required, and everyone who undergoes a NHS Health Check must have their cardiovascular risk score communicated to them as well as their BMI, cholesterol level, blood pressure and AUDIT score.

3.3.3 Local authorities are free to decide where Health Checks are carried out and who conducts them but must ensure that staff who carry them out are appropriately trained and are advised to ensure quality assurance systems are in place e.g. ensuring that actions taken at certain thresholds are consistent with national guidelines. Where the assessment has taken place outside of the GP practice (e.g. in a pharmacy or community setting) there is a legal requirement for the above information to be forwarded to the individual's GP.

3.4 **Guidance on risk management and lifestyle interventions**

3.4.1 Although not a statutory requirement, the risk management element of the programme, provided through lifestyle interventions, is important to ensure that the programme has long term benefits for public health. The guidance recommends that everyone receiving a health check is given individually tailored advice to help motivate them to make appropriate lifestyle changes to manage their risk (unless clinically unsafe to do so). Such advice may include referrals to:

- Local stop smoking services;
- Physical activity interventions;
- Weight management programmes;
- Alcohol use interventions.

3.4.2 The guidance recognises that those providing this advice may not be the same as those who have undertaken the risk assessment element of the health check and, there is a need, therefore, to ensure that relevant information from the health check e.g. smoking status, blood pressure, activity levels is relayed to the lifestyle intervention provider.

3.5 **Proposals for delivering NHS Health Checks in Halton**

3.5.1 Currently there are agreements in place with GP practices to deliver "Health Checks Plus" to local residents as a local enhanced service. Health Checks Plus include most of the minimum requirements of NHS Health Checks in addition to some locally developed questions around housing and fuel poverty and some medical questions which are not necessary to carry out the risk assessments.

3.5.2 Feedback from GP practices reveals that in its current form the Health Checks Plus assessment takes on average around 45 minutes per patient, far longer than the 20 minutes expected. It is likely that this is one reason why Halton consistently does not reach the required targets for invitations and for take up of Health Checks.

3.5.3 It is proposed that Health Checks are streamlined so that they include only the required information to carry out the mandatory risk assessments and including the new areas of alcohol screening and dementia awareness raising for patients aged 65 to 74.

3.5.4 GP practices are paid £1 for each eligible patient invited for a Health Check, £18 for each Health Check completed and £1 for each HC recorded on the GP system. Halton's fee represents good value for the money as it the lowest in Cheshire and Merseyside (where a 20 minute streamlined programme already operates).

3.5.5 The review of existing Health Checks also looked at the commissioned community based programmes and found that while four community based providers had signed up to deliver Health Checks Plus not one had over a two year period. The existing SLA would require that they are paid a fee per client and an additional full Health Check fee also be paid to individual practices in order to send out invitations, complete CVD risk assessment and input data onto systems in order to complete returns - which are taken wholly from GP practice systems. This makes community based provision more expensive currently.

3.5.6 Executive Board in its meeting of 3rd October 2013 agreed that Health Checks continue to be delivered by GP practices and that existing arrangements are extended until March 2016 (with an option for annual extensions up to a maximum of two years thereafter) with a variation to reflect the new programme. The Board further agreed that officers should seek to identify community based provision that is cost effective and that a pilot be run by the Public Health Team working with occupational health and human resources will seek to offer Health Checks and lifestyle advice to eligible staff of the Council as part of a healthy workplace based initiative. This will be funded from the Public Health Budget.

3.5.7 A range of well established and successful lifestyle interventions are

available for HC patients who are identified as being at risk of CVD, diabetes and other conditions. These include free weight management courses such as Fresh Start, Stop Smoking Services including the provision of free vouchers for nicotine replacement products and alcohol reduction services such as Brief Interventions. Officers are working with Halton's Health and Well Being Service and Halton Clinical Commissioning Group to ensure that GP practices can advise patients of the full range of available services and make appropriate referrals into the services on behalf of the patient and for outcomes resulting from lifestyle interventions to be monitored.

3.5.8 Currently Halton's Health and Well Being Service carries out an opportunistic assessment for individuals accessing many of the lifestyle interventions described above. This includes many of the questions undertaken as part of the Health Check. To prevent duplication and to ensure that an appropriate cardiovascular risk assessment and recording on GP systems takes place an agreement to share the information has been reached which will still allow primary care to claim a full Health Checks payment.

4.0 POLICY IMPLICATIONS

4.1 The Health and Social Care Act 2012 placed a statutory duty on local authorities to make arrangements for the delivery of NHS Health Checks in their area.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 Halton has a budget of £160,000 per annum for the delivery of Health Checks. This sits within the ring fenced Public Health budget. The value of individual agreements with GP practices range from between £997 and £17,718 per annum, however, this assumes a 100% take up rate from the eligible population for each practice.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

While HCs are specifically for people aged 40 to 74, it is anticipated that there will be indirect benefits to children and young people as a result of their parents and other family members being supported to lead a healthier lifestyle and/or prevent or delay the onset of ill health.

6.2 Employment, Learning & Skills in Halton

Improving the health of individuals can have a positive impact on their long term employability.

6.3 A Healthy Halton

HCs are a key tool in the identification, early detection and prevention of a range of health issues and can help to promote healthier lifestyles, thereby contributing to the aims and objectives of Halton's Health and Well Being Strategy. Figures from the Centre for Public Scrutiny estimate that each NHS Health Checks on average:

- Prevent 1,600 heart attacks and save 650 lives;
- Prevent over 4,000 people from developing diabetes;
- Detect at least 20,000 cases of diabetes or kidney disease allowing people to manage their condition and prevent complications.

6.4 **A Safer Halton**

None directly

6.5 **Halton's Urban Renewal**

None directly

7.0 **RISK ANALYSIS**

7.1 NHS Health Checks are a statutory requirement for local authorities. Failure to offer Health Checks in a locality could result in damage to the authority's reputation and impact on future funding levels.

7.2 A risk register has been developed by champs the public health commissioning service on behalf the Cheshire and Merseyside authorities for the transition to the newly branded NHS Health Checks. Mitigating factors have been identified and are being put in place.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 An Equality Impact Assessment has been completed for the delivery of NHS Health Checks. The assessment revealed two potential negative impacts.

The first relates to the fact that GPs are unlikely to invite pregnant women for Health Checks due to the high probability of temporarily misleading results. However provided they remain eligible pregnant women can be invited once the baby is born. In any case pregnant women are in regular contact with their GP so that any potential health issues are likely to be picked up.

The second relates to the fact that traditionally a disproportionately high proportion of Gypsies and Travellers do not register with GPs. To mitigate this impact it is proposed that pro active engagement is carried out with the Gypsy and Travelling community through the

Council's Gypsy and Traveller Co-ordinator and site wardens with a view to the Halton Health and Well Being service offering health screenings on site. The service already carries out health screenings for people who participate in its weight management programmes. While the screenings do not constitute a full health check (as blood tests are not carried out) they will indicate whether there is an increased risk of certain conditions sufficient for advice to be given and for the patient to be signposted to relevant services or health establishments.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

Document	Place of Inspection	Contact Officer
Department of Health/Public Health England draft guidance on NHS Health Checks	Runcorn Town Hall (second floor)	Joanne Sutton
Cheshire and Merseyside Health Checks risk register	Runcorn Town Hall	Joanne Sutton

REPORT TO: Health Policy & Performance Board

DATE: 6th November 2013

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health & Wellbeing / Community Safety

SUBJECT: Draft Safer Halton Partnership Drug Strategy 2014-2018

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to present the draft Safer Halton Partnership Drug Strategy 2014-2018 and accompanying evidence document.

2.0 RECOMMENDATION

That Members of the Health Policy & Performance Board:

i) note the contents of the report;
ii) comment on the draft Safer Halton Partnership Drug Strategy.

3.0 SUPPORTING INFORMATION

3.1 The National Drug Strategy 2010 changed the focus of drug service delivery from maintenance of individual's dependent misusing drugs to enabling and promoting recovery. The Substance Misuse Service is a partnership approach to improve the outcomes for individuals and families affected by drug misuse problems as well as reducing the impact of drug related crime and anti-social behaviour for the communities of Halton.

3.2 The Strategy has been drafted during a period of change as drug budgets and services transfer to Public Health England and the Police and Crime Commissioners. This provides an opportunity to draft a four year Drug Strategy with an action plan that all key partners can deliver upon.

3.3 The Strategy has been extensively consulted upon with a range of partners agencies, service users, carer groups and voluntary agencies.

3.4. The draft Strategy (Appendix A) is designed to be a short document that focuses on the strategic objectives and priorities linking to a drugs service action plan that will become the focus of the

Substance Misuse task group with quarterly themed updates to the Safer Halton Partnership Board and annual amendments and updates.

3.5 The strategy is supported by an evidence paper (Appendix B) that sets out the context in which the strategy has been developed including national and local context and supporting data and information on the issues of drug misuse within Halton.

3.6 It is important to note that the strategy has been developed during significant period of change, as Public Health transfers to the Local Authority and the National Treatment Agency transfers to Public Health England (April 2013)

3.7 The following provides a vision, objectives and priorities for the Drugs Strategy:

1) Prevent illicit and harmful drug use through positive education.
2) Reduce Illicit and other harmful drug use.
3) Restrict supply and tackle illegal activities.
4) Increase the number of people recovering from dependency on drugs.
5) Continue to make the efficient and effective use of resources

3.8 The evidence document has been enhanced by the Public Health Evidence and Intelligence team, providing a more robust overview of substance misuse within Halton.

4.0 POLICY IMPLICATIONS

4.1 The Drug Strategy will set the context for partnership working to prevent and tackle the impact of drug misuse for individuals, families and the communities of Halton.

5.0 FINANCIAL IMPLICATIONS

5.1 The budget for Substance Misuse Services are identified within the evidence paper, the action plan can be delivered within the existing budget, and staff resources at the time of drafting the Strategy, any changes in the drug service budget may impact on the delivery of the Strategy action plan.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

These are contained within the attached Strategy and Evidence Paper (Appendix A & B).

6.2 **Employment, Learning & Skills in Halton**

These are contained within the attached Strategy and Evidence Paper (Appendix A & B).

6.3 **A Healthy Halton**

These are contained within the attached Strategy and Evidence Paper (Appendix A & B).

6.4 **A Safer Halton**

These are contained within the attached Strategy and Evidence Paper (Appendix A & B).

6.5 **Halton's Urban Renewal**

These are contained within the attached Strategy and Evidence Paper (Appendix A & B).

7.0 **RISK ANALYSIS**

7.1 As described in 5.1 the Strategy is capable of delivering within existing resource, however, a reduction in budget or staffing levels will impact on service delivery.

7.2 Any reductions in drug allocations in the financial years that the Strategy covers could have an impact in delivering on key objectives.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 The Strategy specifically aims to meet the needs of drug users within the Halton area.

9.0 **LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972**

None.

Safer Halton Partnership

Drug Strategy

2014 to 2018

Draft

Contents

Foreword

The overall aim of the Safer Halton Partnership is to ensure Halton is a pleasant, safe and secure place to live and work with attractive, safe surroundings, good quality local amenities and the ability of people to enjoy life where they live.

To meet this aspiration the Halton Drug Strategy 2014 – 2018 has set key objectives and priorities to educate and inform local people and to prevent and tackle drug misuse within the borough which has a detrimental impact on individuals, families and the communities of Halton.

Halton is committed to implementing a local response to the 2010 National Drugs Strategy, which is structured around three key themes:

Reducing demand – Promoting the prevention of drug use and creating an environment where the vast majority of people who have never taken drugs continue to resist any pressures to do so, and making it easier for those that do to stop.

Restricting supply – Drugs cost the UK £15.4 billion each year. Taking action with partners to make Halton an unattractive destination for those who supply drugs by reducing demand, attacking their profits and driving up their risks.

Building recovery in communities – Working with people who want to take the necessary steps to tackle their dependency on drugs and alcohol, offering a route out of dependence by putting the goal of recovery at the heart of local activity.

To make this a reality for Halton, the Halton Drugs strategy is committed to supporting the achievement of four key aims –

(1) Prevent illicit and/or harmful drug use through positive education

This will ensure that Halton is focused upon public health promotion messages to prevent the misuse of both legal and illegal substances and the provision of positive school and community based interventions so that people in Halton can make positive choices not to start using substances.

(2) Reduce illicit and other harmful drug use

For those who do choose to take illegal and other harmful substances, Halton will work to support individuals to reduce their use, and to discourage other people from starting in the first place.

(3) Restrict supply and tackle illegal activities

Halton is committed to working in partnership with the Police and other partners to target illegal activity and to restrict supply.

(4) Increase the number of people recovering from dependency on drugs

For those people who need support in recovering from their dependency on drugs or other substances, Halton is committed to providing quality, cost effective and efficient services that focus upon the individual and their families.

Halton's approach to meeting these challenges is to focus upon the active promotion and prevention of substance misuse and to provide an integrated substance misuse service that will bring all partner agencies together so that interventions that promote recovery can adapt and be responsive to meet individual need and be provided collectively. It is essential to use public resources efficiently and effectively in a cross collaboration with key partners to provide a good quality service that focuses upon educating individuals, communities and society about the harm that drug misuse causes or the impact of crime due to drug misuse and recognises that the first part of recovery is for individuals is to acknowledge they have a drug problem and ask for help.

We are committed to using evidence to drive the very best outcomes for individuals and communities and a key focus of this strategy is to ensure that partner agencies provide services at the right time and in the right place to meet the needs of the people of Halton and to reduce the harm caused by the misuse of legal and illegal substances.

We are also committed to reviewing this strategy on an annual basis in order to build in further initiatives and actions to respond to local need. This will also enable Halton to respond to new and emerging evidence, to respond flexibly to the changing nature of the drugs trade and the outcomes being achieved.

By reducing demand, restricting supply and supporting individuals to recover, we will enable individuals and their families to live their lives to the full, local areas will be safer places to live and raise our families, and public investment will deliver greater value for money.

Our vision, objectives and priorities

Our vision is to prevent and tackle drug misuse in Halton

Partner organisations will work together to prevent and tackle the impact and harm caused by the use of drugs on the individual, families and our community.

This Strategy aims to:

(1) Prevent illicit and harmful drug use through positive education.

(2) Reduce Illicit and other harmful drug use.

(3) Restrict supply and tackle illegal activities.

(4) Increase the number of people recovering from dependency on drugs.

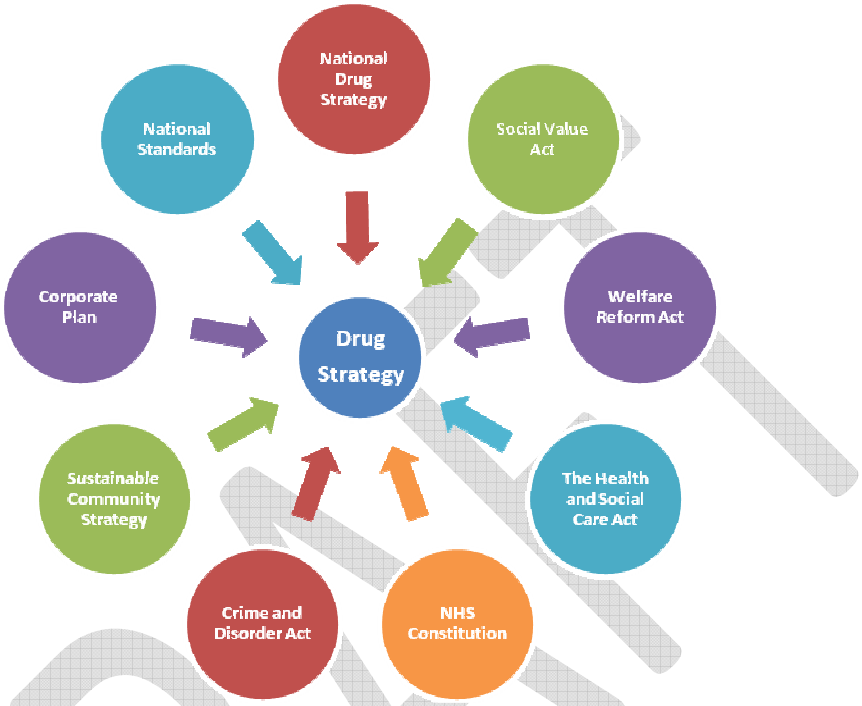
To help achieve the vision, we have adopted the objectives above with each containing a set of priorities as detailed below. The Strategy goes on to explain why each of the priorities has been selected, what we hope to achieve and how we plan to achieve it.

The above objectives will be further underpinned by a commitment to:

(5) Continue to make the efficient and effective use of resources

The Halton Picture

Halton's Drug Strategy has been developed within the context of a range of national, regional and local policies, strategies and plans as summarised in the diagram below. Further details of how these influence the Strategy can be found in the Drug Strategy evidence paper.



Drug services are essential in meeting Halton's priorities set out in the Sustainable Community Strategy, as demonstrated in the table below.

A Healthy Halton	• To improve the health and wellbeing of Halton people so they live longer, •healthier and happier lives
Employment, Learning and Skills in Halton	• Promoting education and employment services. • Providing information and advice to education and employment services.
A Safer Halton	•Tackling the impact of anti-social behaviour and drug related crime on communities
Children and Young People in Halton	• Reducing the risk of children and young people taking drugs. • Reducing the impact to children caused by parental drug misuse.
Environment and Regeneration in Halton	• Tackling the impact of anti-social behaviour and crime that impacts on Halton's communities.

Drug Issues in Halton

People

- Halton has a significant burden of risk factors associated with starting to take drugs
- Nationally the percentage of young people and adults taking drugs has been falling.
- Nationally it is estimated 12% of young people aged 11-15 have taken drugs in the last year but a local survey suggested only 6% had. This equates to between 446-891 Halton 11-15 year olds.
- Halton it is estimated that 2,662 people aged 16-24 and between 5,795 – 6,482 adults 16-59 have taken drugs in the last year
- Nationally, most people who use drugs are aged 16-29. Peaks age band is 20-24, apart from cocaine, 25-29.
- Prevalence is higher amongst those with mental health problems: up to 50% (local audit).
- It is estimated 2,057 children in Halton live with a parent who uses drugs and 253 of these live with a parent who has a drug, alcohol and mental health problem.

Health and well-being

- **Hospital admissions in Halton**
- Admissions increasing(up to 302 in 2011/12 drug-related and 138 2012/13 drug-specific (substance misuse
- Admissions rate 15-24s has decreased over last 3 years but Halton has a significantly higher rate than England (in 2008/09-2010/11 highest rate of any LA in England)
- Most drug-related admissions occur in those aged 40-44 and then 25-29. Most drug specific admissions occur in the 20-24 age group.
- Highest rate over last 2 years was in Halton Lea ward
- Strong relationship with level of deprivation

- **Treatment Services in Halton**
- The majority in treatment are male and between 20-49 years of age. Heroin was the main drug.
- % successfully retained in treatment is higher in Halton than NW or England
- % planned (completed) exits statistically significantly higher in Halton than NW & England (2012/13)
- Successful treatment for opiate users higher in Halton than NW & England but lower than comparators for non-opiate users
- Drug users are at risk of Hepatitis . The vacination rate in Halton is 21% for hepatitis B- lower than NW & England. 2/3 took up Hepatitis C vaccination

Communities

- 22% of child protection serious case reviews in Halton mentioned parental drug use (2007/09)
- National research suggests half of survivors of domestic violence use substances problematically
- 222 arrests in Halton were from drug offences (2010/11)
- Over two-thirds of Halton probation cases experienced some level of substance misuse. Nearly a third still using.
- Locally, most drug offences due to cannabis.
- Locally, levels of substance misuse were highest amongst prolific and repeat offenders.

What do we need to do

The following are based on the 2010 National Drug strategy, 'Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life'[1] and reflect Halton's commitment to tackling the harm from drug misuse.

(1) Prevent illicit and/or harmful drug use through positive education &

(2) Reduce illicit and other harmful drug use

It is not sufficient to simply treat the symptoms of drug misuse. To tackle crime and reduce harm and the costs to society, we need to reduce the demand for drugs. People should not start taking drugs and those who do should stop. For those who are dependent, their continued drug use should be challenged and individuals and their families supported to recover fully. This strategy is committed to establishing a whole-life approach to preventing and reducing the demand for drugs that will:

- ***Break inter-generational paths to dependency by supporting vulnerable families;***
- ***Provide good quality education and advice so that young people and their parents are provided with credible information to actively resist substance misuse;***
- ***Use the integration of the Public Health function into the Local Authority to encourage individuals to take responsibility for their own health;***
- ***Intervene early with young people and young adults;***
- ***Consistently enforce effective criminal sanctions to deter drug use; and***
- ***Support people to recover***

Prevention must start early. Extra support in the first years of life can reduce the risks from a range of problems and the local implementation of the Healthy Child Programme will support children's health and development, beginning at the pre-pregnancy stage.

Families, particularly those with the most complex needs, need to be supported to give their children the best possible start in life, and we will consider the role of the Family Nurse Partnership scheme to develop the parental capacity of mothers and fathers within potentially vulnerable families. The local 'Inspiring Families' project is part of a national programme to focus on helping to turn around the lives of families with multiple problems and we appreciate that the provision of tailored and co-ordinated support packages around the needs of the whole family can be effective.

All young people need high quality drug and alcohol education so that they have a thorough knowledge of their effects and harms and have the skills and confidence to choose not to use drugs. Schools and colleges have a clear role to play in preventing drug and alcohol misuse as part of their pastoral responsibilities to pupils and we will make sure staff have the information, advice and the power to provide accurate information on drugs and alcohol through effective and evidence based drug education.

[1] https://www.gov.uk/government/publications/drug-strategy-2010--2

Some young people face increased risks of developing problems with drugs. Vulnerable groups - such as those who are truanting or excluded from school, looked after children, young offenders and those at risk of involvement in crime and anti-social behaviour, those with mental ill health, or those whose parents misuse drugs or alcohol - need targeted support to prevent drug misuse and early intervention when problems first arise. Young people's substance misuse and offending are often related and share some of the same causes, with a large number of the young people seeking support for drug or alcohol misuse also being within the youth justice system.

Some family-focused interventions have the best evidence of preventing substance misuse amongst young people and have led to significant reductions in risks associated with substance misuse, mental ill health and child protection and have led to reductions in anti-social behaviour, crime, truanting and domestic violence.

The focus for all activity with young drug or alcohol misusers should be preventing the escalation of use and harm, including stopping young people from becoming drug or alcohol dependent adults. For those young people whose drug or alcohol misuse has already started to cause harm, or who are at risk of becoming dependent, we will work with substance misuse services, youth offending, mental health and children's services to support the provision of rapid access to specialist support that tackles their drug and alcohol misuse alongside any wider issues that they face.

We are committed to diverting vulnerable young people away from the youth justice system where appropriate to facilitate the provision of more coordinated support to help individuals recover from drug dependence, including those in contact with the Criminal Justice System (CJS).

For those very few young people who develop dependency, the aim of this strategy is to support them to become drug free through structured treatment that is supported by specialist young people's services such as Child and adolescent Mental Health Services (CaMHS). For the most vulnerable young people we will ensure that a locally delivered multi-agency package of care is in place.

(3) Restrict supply and tackle illegal activities

The Police sit at the heart of local enforcement. Good neighbourhood policing will gather intelligence on local dealers, provide reassurance and visibility to the public and deter those who would otherwise terrorise neighbourhoods.

This strategy aims to strengthen coordination between the Police and local partners. The Police work with the Safer Halton Partnership, as well as other criminal justice agencies, the public, drug services and drug users themselves to understand and disrupt the drug market. Halton is a committed member of local Integrated Offender Management (IOM) which brings together the Police, Probation Service, youth offending teams, local authorities and voluntary and community groups to support and manage priority offenders, including drug misusing offenders, and divert them away from drug use and crime. We are determined to harness the energy and innovation of local partners and communities to tackle drug problems, by encouraging and supporting innovative approaches and sharing good practice around what works best.

Halton is also determined to address the issue of so called 'legal highs'. We know that these substances can pose a serious threat, especially to the health of young people. We need a swift and effective response and therefore support the Government in its work to respond to the threats caused by these new and emerging substances. We will continue to emphasise that, just because a drug is legal to possess, it does not mean it is safe and it is likely that drugs sold as 'legal highs' may actually contain substances that are illegal to possess.

(4) Increase the number of people recovering from dependency on drugs

Halton is committed to ensuring that it can offer every opportunity to those people who face up to the problems caused by their dependence on drugs and want to take steps to address them. We now need to become much more ambitious for individuals to leave treatment free of their drug or alcohol dependence so they can recover fully. We will strive to create a recovery system that focuses not only on getting people into treatment and meeting process-driven targets, but also in getting them into full recovery and off drugs for good. It is only through this permanent change that individuals will, stop harming themselves and their communities, cease offending and successfully contribute to society. An ultimate aim of this strategy is to enable individuals to become free from their dependence; something we know is the aim of the vast majority of people entering drug treatment. Supporting people to live a drug-free life is at the heart of our recovery ambition.

Recovery involves three overarching principles– wellbeing, citizenship, and freedom from dependence. it is an individual, person-centred journey, as opposed to an end state, and one that will mean different things to different people. We must therefore put the individual at the heart of any recovery system and commission a range of services to provide tailored packages of care and support. This means that local services must take account of the diverse needs of the community when delivering services.

Substitute prescribing continues to have a role to play in the treatment of heroin dependence, both in stabilising drug use and supporting detoxification. However, for too many people currently on a substitute prescription, what should be the first step on the journey to recovery risks ending there. We will focus upon those individuals on a substitute prescription and support them to engage in recovery activities.

Recovery is not just about tackling the symptoms and causes of dependence, but about enabling people to successfully reintegrate into their communities. It is also about ensuring that they have somewhere to live, something to do and the ability to form positive relationships. Those already on the recovery journey are often best placed to help, and we will support the active promotion and support of local mutual aid networks such as narcotics anonymous.

Evidence also shows that treatment is more likely to be effective, and recovery to be sustained, where families, partners and carers are closely involved. We will encourage local services to promote a whole family approach to the delivery of recovery services, and to consider the provision of support services for families and carers in their own right.

It is estimated that a third of the treatment population has child care responsibilities and for some parents, this will encourage them to enter treatment, stabilise their lives and seek support. Halton is committed to supporting those working with children and families affected by substance misuse to undertake appropriate training so they can intervene early to protect children from harm. Playing a more positive role in their child's upbringing is often a motivating factor for individuals in making a full recovery. Parents are the single most important factor in a child's wellbeing and therefore it is critical that

children and adult services are provided to support children to remain living safely within their family whilst their parent's substance misuse is being addressed. We need to ensure that local services have effective practices and integrated approaches to safeguard the welfare of children.

Evidence also suggests that housing and employment, along with appropriate support, can contribute to improved outcomes for drug users in a number of areas, such as increasing engagement and retention in drug treatment, improving health and social well-being, improving employment outcomes and reducing re-offending, and we will ensure that support is in place to work with individuals to maximise their life chances.

(5) Delivering efficient and effective outcome based services

The effective commissioning and oversight of drug prevention and treatment services is a core part of the work of the Director of Public Health. Directors play a key local leadership role around delivering public health outcomes and work with local partnerships – including Police and Crime Commissioners (PCCs), employment and housing services, and prison and probation services – to increase the ambition for recovery. The Health and Wellbeing Board looks to the Director of Public Health, along with local partners, to ensure that the drug treatment and recovery services are delivered in line with best practice and are aligned and locally led, competitively tendered and rewarded and transparent about performance.

Key to successful delivery in a recovery orientated system is that all services are commissioned with the following best practice outcomes in mind:

- ***Prevention of children, young people and adults using drugs***
- ***Freedom from dependence on drugs;***
- ***Prevention of drug related deaths and blood borne viruses;***
- ***A reduction in crime and re-offending;***
- ***Sustained employment;***
- ***The ability to access and sustain suitable accommodation;***
- ***Improvement in mental and physical health and wellbeing;***
- ***Improved relationships with family members, partners and friends; and***
- ***The capacity to be an effective and caring parent.***

Recovery can only be delivered through working with education, training, employment, housing, family support services, wider health services and, where relevant, prison, probation and youth justice services to address the needs of the whole person.

We will work with providers and professional bodies involved in drug and alcohol treatment, mental health, employment, criminal justice, housing, and family services to promote a culture of ambition, and a belief in recovery.

Drug Strategy Aims and Strategic Objectives

(1) Prevent illicit and/or harmful drug use through positive education

(2) Reduce illicit and other harmful drug use

(4) Increase the number of people recovering from dependency on drugs

(3) Restrict supply and tackle illegal activities

(5) Continue to make the effective and efficient use of resources

How will it be paid for?

From April 2013, all of the funding streams changed now all Government funding for Drugs is via Public Health (England) with the exception of the Home Office DIP funding, which transferred to the Police and Crime Commissioner. In-patient and Community treatment budgets for alcohol, used to contract provision from Mersey Care NHS Trust and Crime Reduction Initiatives (CRI) respectively also transferred into the Public Health allocation.

The following financial breakdown is based upon current direct expenditure in drug services and does not reflect all of the wider universal and targeted activity that is commissioned locally. Such expenditure, on areas as diverse as School Nursing, Health Visiting, Primary Care, or voluntary and community sector activity, can have a direct impact upon the services available to tackle drug misuse in the community, but does not fall within the direct influence of the Drug strategy and action plan. Further financial analysis across the range of activities and interventions can be found in the evidence paper.

Budget received for 2012/13 for substance misuse service (including drugs and alcohol)

Halton Borough Council (Public Health)	£1,676,290
Cheshire Police and Crime Commissioner	£43,888
Halton Borough Council (Carer Break Funding)	£19,400
Total	£1,739,578

(For further details: evidence paper pg. 67)

Implementing our priorities

At a time of financial and demographic pressure, improving quality while increasing productivity and effectiveness is vital for any improvements in care. The national strategy advocates local areas to consider the importance of drug services and the resources that are allocated to provide them.

As the Government's policy of deficit reduction continues, the impact on the public sector is significant and with the public sector having to make unprecedented decisions about the services that it continues to deliver, this ultimately impacts on service delivery and residents expectations.

It is for local commissioners to ensure that when services are decommissioned or commissioned, the needs of the whole population and the best evidence of what works are taken into account. There are four key actions to increase value for money in drug services:

- Improving the quality and efficiency of current services;
- Radically changing the way that current services are delivered so as to improve quality and reduce costs;
- Shifting the focus of services towards promotion of the prevention of drug misuse and early identification and intervention as soon as drug misuse arises; and
- Broadening the approach taken to tackle the wider social determinants and consequences of drug misuse.

The success of the strategy will depend upon partnership working in its broadest sense, if we are to achieve the best possible outcomes for everyone who lives or works in Halton. Local residents, statutory, voluntary, community and commercial organisations all have an important role to play in the delivery of the health and wellbeing agenda. This is even more imperative given the challenges brought about by the current economic climate.

The successful implementation of the strategy may mean staff working in new ways and all partners will need to ensure that the local workforce is trained and enabled to do this. In addition, the Health and Wellbeing Board in partnership with Halton Borough Council, has developed the concept of Wellbeing Areas based on the existing seven Area Forum boundaries. This is in recognition of the fact that, whilst there are common issues across the borough, there are different needs across communities and one approach does not necessarily meet the needs of all.

Priorities for action

Strategic objective 1:

Prevent illicit and harmful drug use through positive education.

- Priority 1A: To provide harm prevention and reduction advice.
- Priority 1B: To increase peer mentoring and mutual aid.

Strategic objective 2:

Reduce Illicit and other harmful drug use.

- Priority 2A: Improve identification, assessment, referral and support of children and young people affected by parental substance misuse.
- Priority 2B: Improve the substance misuse service response to drug and/or alcohol related domestic violence.

Strategic objective 3:

Restrict supply and tackle illegal activities.

- Priority 3A: Targeting specific individuals or groups identified as being particularly harmful, such as prolific offenders and organised crime gangs.
- Priority 3B: Develop an improved understanding of the local drug supply market. Targeting particularly harmful behaviours associated with drug supply, such as the use of violence and intimidation.

Strategic objective 4:

Increase the number of people recovering from dependency on drugs.

- Priority 4A: To improve identification, advice and signposting by front line health, social care, housing and criminal justice agencies.
- Priority 4B: To review and revise protocols and working arrangements with key partners.
- Priority 4C: Improve individual's physical and mental well-being.
- Priority 4D: Improve the health and wellbeing of informal carers.

Strategic objective 5:

Continue to make efficient and effective use of resources.

- Priority 5A: To review the current performance framework taking into account national guidance and local needs
- Priority 5B: To review the response of primary health care to substance misuse.
- Priority 5C: Review Community Pharmacies
- Priority 5D: Improve the service response to individuals that have been assessed as needing in-patient detoxification and/or residential rehabilitation.
- Priority 5E: Continue the partnership working between substance misuse and homelessness services to prevent homelessness, and to prevent substance misuse for those individuals that are homeless.

Strategic objective 1: Prevent illicit and harmful drug use through positive education

Priority 1A: To provide harm reduction advice.		
Why this is a priority?	**What do we want to achieve?**	**How do we plan to achieve it?**
Providing information, advice and support to prevent children, young people and adults from accessing illicit or harmful substances. The earlier individuals make informed choices about their drug use and the problems this can cause to their health and well-being the earlier they can be prevented from using, stop using drugs or ask for help to reduce their dependency.	To provide information and advice through a variety of media so that individuals and families are provided with credible information to make informed choices. Ensure service providers are delivering consistent messages in a supportive manner.	Develop a number of digital platforms to provide harm reduction advice and information. Utilise the School Nursing Service, the Health Improvement Team, Youth Services and the wider voluntary and community sector to provide consistent and relevant information, advice, training and support.
Priority 1B: To increase peer mentoring and mutual aid.		
Why this is a priority?	**What do we want to achieve?**	**How do we plan to achieve it?**
Recovery is a 'person-centred journey', which places the individual's particular needs, resources, aspirations and motivations at the centre of that journey. A recovery orientated approach therefore requires active service user participation.	The continued active involvement of individuals and carers in the planning and development of substance misuse services. Continuing to develop peer support and mutual aid as an integral component of the substance misuse treatment system.	Continue to develop the role of Patient Opinion in the shaping of services. Develop a range of activities in which peers can play an active part – recovery coaching, group facilitators, activity coordinators. Promote recovery in the community

	To address the stigma experienced by individuals, families and carers who are affected by problematic substance misuse. Continue to provide support to those individuals and families affected by another's substance misuse	through the development of mutual aid groups, volunteering opportunities and celebrations of success. Continue the close working between the substance misuse service & Halton Carers Centre Continue to provide a Carers support groups.

Strategic objective 2: Reduce Illicit and other harmful drug use

Priority 2A: Improve identification, assessment, referral and support of children and young people affected by parental substance misuse.		
Why this is a priority?	**What do we want to achieve?**	**How do we plan to achieve it?**
National figures show that a third of the adult drug treatment population has childcare responsibilities. For some parents this will encourage them to enter treatment, stabilise their lives and seek support. For others, their children may be at risk of neglect, taking on inappropriate caring roles and, in some cases, serious harm. Having a parent in drug treatment is a protective factor for children.	That all children and young people in Halton have life opportunities and are able to thrive physically and emotionally. Increase the number of parents that access substance misuse services who are registered with their local Children's Centre. To ensure that staff working with children affected by parental substance misuse have the appropriate skills, knowledge and safeguarding training. Children experience improved family relationships, fewer incidents of domestic abuse and a safer	Continue the joint working between the substance misuse treatment services e.g. Young Addaction, Team Around The Family. Ensure the substance misuse team access children's and adults safeguarding training to raise awareness. To continue to provide learning and development opportunities on the issue of substance misuse to services, that are working with children and young people. Measured by the number of YP who move

	home environment. Children will have increased self-esteem, improved social skills, and better capacity to interact effectively with peers. Children report greater levels of regular school attendance, a better learning environment at home, and increase interaction with parents.	up and down Halton's Levels of Need. Measured by Young People completing feedback evaluation sheets on recovery plan and client satisfaction form. Measured by Young People taking up offer of signposting to universal provision and through completion of recovery plan and positive discharge.
Priority 2B: Improve the substance misuse service response to drug and/or alcohol related domestic violence.		
Why this is a priority?	**What do we want to achieve?**	**How do we plan to achieve it?**
Research has shown that substance misuse, by both the victim and the perpetrator, is a factor in a significant number of domestic abuse cases.	To improve the identification of victims and perpetrators of domestic abuse by substance misuse service staff. To encourage individuals in substance misuse services to disclose that they are a victim or perpetrator of domestic abuse. To reduce the impact of parental substance misuse and domestic abuse on children and young people.	Implement 'routine enquiry' domestic abuse risk assessments at the substance misuse service. Agree referral criteria and pathways between the substance misuse service and domestic abuse services to improve co-working between the two services

Strategic objective 3: Restrict supply and tackle illegal activities

Priority 3A: Targeting specific individuals or groups identified as being a particularly harmful, such a prolific offenders and organised crime gangs.		
Why this is a priority?	**What do we want to achieve?**	**How do we plan to achieve it?**
Prolific and priority offenders (PPOs) are persistent offenders who pose the greatest threat to the safety and confidence of their community. Many of them frequently have drug problems and commit crime to support their drug habit.	To reduce the risks to the community posed by those individuals whose offending is prolific and drug related.	To continue the integrated approach to offender management between criminal justice agencies and the substance misuse treatment service. Swift access to drug treatment through the criminal justice system – Custody suites, court, prisons. Provision of treatment to support criminal justice sanctions Such as Drug Rehabilitation Requirements, Conditional Cautions and Restorative Justice interventions

Priority 3B: Developing an improved understanding of the local drug supply market.		
Why this is a priority?	**What do we want to achieve?**	**How do we plan to achieve it?**
The supply of drugs, both illicit and legal, is becoming more complex over time. Improving our understanding of the drug supply market in Halton will enable the agencies concerned to better plan and deliver the interventions that will reduce the risks associated with the market.	Develop interventions to manage emerging risks and threats associated with changing patterns of drug use and supply. Provide credible early warnings to individuals and the community with regards to contaminated drugs	To establish a multi-agency group that can share intelligence around the drug supply market. Review the current system regarding the early warning and alert process for unusual, contaminated and high strength drugs.

Strategic objective 4: Increase the number of people recovering from dependency on drugs

Priority 4A: To improve identification, advice and signposting by front line health, social care, housing and criminal justice agencies.		
Why this is a priority?	**What do we want to achieve?**	**How do we plan to achieve it?**
To make every contact count and ensure that no opportunity is missed for individuals and/or families affected by substance misuse to access appropriate advice, information and support.	An increase in the number of front line staff from across the public sector accessing substance misuse training.	By commissioning a range of learning and development opportunities for staff to improve their knowledge and awareness around the issues of substance misuse.

Priority 4B: To review and revise protocols and working arrangements with key partners		
Why this is a priority?	**What do we want to achieve?**	**How do we plan to achieve it?**
People affected by substance misuse are in contact with a range of public sector services. By providing access to advice, information and support more individuals will receive the right help at the right time. Protecting children and vulnerable adults from harm, abuse and exploitation.	An increase in referrals from front line services to the substance misuse service.	Agree and implement joint working protocols between the substance misuse service and key partner organisations, to include: • Mental health services regarding dual diagnosis • Local hospitals • Adult Social Care • Job Centre Plus • Registered Social Landlords
Priority 4C: Improve individual's physical and mental well-being.		
Why this is a priority?	**What do we want to achieve?**	**How do we plan to achieve it?**
Drug users often experience poor health, which can not only impede their ability to recover, but also have a significant financial impact on health services.	Increase the number of individuals that are tested and vaccinated with regards to blood borne viruses. Increase the number of individuals with a Health Check assessment. Increase the number of individuals referred to the	To provide screening, testing and vaccination for Blood Borne viruses. Continue to provide a needle exchange service to reduce the risk of cross infection of blood borne viruses. To provide Health Check assessments to all individuals in the treatment service.

	Health Improvement Team. A reduction in the number of drug related admissions to hospital. To address the developing agenda around substance misuse and older people. To increase the number of people recovering from addiction to over the counter or prescribed medication. Improve the response to those individuals injecting performance enhancing drugs. To improve the life chances of unborn children when expectant mums are dependent on substances.	To continue to develop services in the community that contributes towards health improvement, particularly with regard to respiratory health, sexual health, and mental well-being and the early detection and prevention of cancers. To develop an action plan to address the issue of substance misuse and older people. To develop an action plan to address the issue of individuals addicted to prescribed medication. Develop an improved service response specifically aimed at those individuals that continue to inject performance enhancing drugs To continue the existing work between Maternity Services and the substance misuse service and other services that are appropriate e.g. social care.

Priority 4D: Improve the health and wellbeing of informal carers.		
Why this is a priority?	**What do we want to achieve?**	**How do we plan to achieve it?**
Informal Carers provide regular and substantive care regular and substantive care which goes over his or her usual role as a spouse / parent / family member. This may include people that do not necessarily live with the 'Cared For' person, but without the care that they provide it would be difficult for the 'Cared For' person to maintain a sense of independence.	To continue to support informal carers to maintain their caring role, to ensure that carers health and wellbeing is promoted.	To continue to work with Halton Carers Centre to provide services and advise for informal carers. To ensure that substance misuse service provide advice and information to carers. To develop the carers group within the substance misuse service, to ensure carers have a network that they can access.

Strategic objective 5: Continue to make efficient and effective use of resources

Priority 5A: To review the current performance framework taking into account national guidance		
Why this is a priority?	**What do we want to achieve?**	**How do we plan to achieve it?**
Current reporting focuses on the drug treatment system and recovery. At present there is no formal, regular reporting of measures with regards to 'restricting supply' and 'reducing demand'.	Agree key indicators that will monitor progress with regards to the 'restricting supply' and 'reducing demand' aspects of the strategy. Agree the appropriate indicators to ensure drug treatment is of a high quality and compliant with national standards.	Agree appropriate indicators for the 'restricting supply' aspect of the strategy with Cheshire Constabulary. Revise the current performance framework for treatment services to take into account national and local indicators, compliance with NICE and other clinical standards, and Safeguarding.
Priority 5B: To review the response of primary health care to substance misuse.		
Why this is a priority?	**What do we want to achieve?**	**How do we plan to achieve it?**
With the reorganisation of the NHS, the commissioning of primary care services with regards to substance misuse has changed and is now the responsibility of the Local Authority	To have a clear definition for primary care substance misuse services within drug treatment system. To improve the clinical networking between primary care and substance misuse treatment services. To establish contract and quality assurance processes with regards to the delivery of GP Shared Care	Undertake a review of current arrangements Establish a clinical network between primary care, mental health services and substance misuse services.

Priority 5C: To review the response of Community Pharmacies to substance misuse.		
Why this is a priority?	**What do we want to achieve?**	**How do we plan to achieve it?**
With the reorganisation of the NHS, the commissioning of community pharmacy services with regards to substance misuse has changed and is now the responsibility of the Local Authority.	To increase the number of community pharmacies providing needle exchange and harm reduction advice with regards to injecting To improve the support to community pharmacies provided by substance misuse treatment services. To establish contract and quality assurance processes with regards to the delivery of the Observed Consumption and Needle Exchange Community Pharmacy services.	Undertake a review of current arrangements.
Priority 5D: Improve the service response to individuals that have been assessed as needing in-patient detoxification and/or residential rehabilitation. To review the response of primary health care to substance misuse.		
Why this is a priority?	**What do we want to achieve?**	**How do we plan to achieve it?**
Some individuals will require a more intensive programme than can be achieved in the community. Access to in-patient and/or residential rehabilitation is required in some instances in order to support the individual's recovery.	A clear pathway and supporting funding for individuals (including their children if appropriate) to access in-patient detoxification and residential rehabilitation when clinically appropriate with community based support planned on discharge to maintain recovery.	By aligning current drug and alcohol spend: tendering for a list of preferred providers; and developing an agreed pathway and criteria to access this modality of care.

Priority 5E: Continue the partnership working between substance misuse and homelessness services to prevent homelessness, and to prevent substance misuse for those individuals that are homeless		
Why this is a priority?	**What do we want to achieve?**	**How do we plan to achieve it?**
Some individuals that misuse substances can have chaotic lifestyles, present with anti-social behaviour or lack the means (£) or skills to maintain a home. This may lead to individuals staying with friends or family or becoming homeless. It is important to enable an individual to recover from their dependence that they have a stable environment and life 0pportunities. It is important to signpost those that are homeless or threatened with homelessness to the appropriate service for advice and support and to work with individuals to maintain their home (temporary or permanent).	Improve access to advice services for clients who are homeless or threatened with homelessness. To ensure those that are in temporary accommodation are offered advice and support to either prevent substance misuse or to stop their substance misuse.	To develop community focused services and increase drop in advice service across Halton. Improve accommodation referral process to minimise disruption to individuals and secure suitable temporary accommodation. The substance misuse service will continue to work with the providers of temporary accommodation offering advice and support and access to services.

Halton Drug Strategy Action Plan 2014-2015 (to be reviewed annually):

Adults (A), Children (C), Public Health (PH)

Objective 1: Prevent illicit and harmful drug use through positive education					
Priority	**Action**	**Timescale**	**Responsibility**	**Resources**	**Outcomes**
To raise awareness of the impact of substance misuse amongst individuals, children, young people and the wider community.	To provide access to information and advice on the consequences of substance misuse through opportune and chance engagement activities. The provision of training for frontline staff.		Commissioning Managers (C,A & PH)	Health Improvement Team School Nursing Service Youth Service	Provision of annual Information campaign. Use of consistent materials with key messages that are used across the Borough, agree the materials by May 2014 to be distributed to schools by September 2014. Provide training in relation to substance misuse to children's centre staff, school nurses, social care workers etc. Evidence baseline figures in 2014 and set targets 2014 onwards with an expectation that an increase in the number of frontline staff trained in substance misuse then deliver a positive intervention for individuals and children affected by substance misuse.

To provide harm reduction advice and information to individuals, families and the community to reduce the risks associated with substance misuse	Provide easily accessible harm reduction advice and information, particularly with regards to cannabis, cocaine, 'legal highs', overdose and contaminated drugs	Throughout strategy with annual review.	Commissioner Manager (C,A & PH)		Development of a digital Halton drugs advice and information hub. By March 2015 To address the increase in drug related hospital admissions. With a particular focus on the 40 – 44 age group. To address the increase of drug specific hospital admissions with a focus on the 20 – 24 age group.
To increase peer mentoring and mutual aid.	Continue to develop the role of Patient Opinion in the shaping of services by those who experience them.	Throughout strategy with bi-annual review	Commissioning manager (A)	Staff time Cost associated with Patient Opinion	Increase the number of people reporting their experiences of the service via Patient Opinion, increase awareness of Patient Opinion. Baseline data to be collected by April 2014 and target set to increase the number of people accessing the peer mentoring scheme.
	Promote recovery in the community through the development of mutual aid groups, volunteering opportunities and celebrations of success.	Throughout strategy with annual review.	Substance misuse service	Staff time	

Objective 2: Reduce Illicit and other harmful drug use					
Priority	**Action**	**Timescale**	**Responsibility**	**Resources**	**Outcomes**
Improve identification, assessment, referral and support of children and young people affected by parental substance misuse.	Continue joint working between the substance misuse treatment service and the Team Around The Family.	Throughout period of strategy with bi annual review.	Substance Misuse Service Team Around the Family YoungAddaction	Staff time	Joint working occurs between Team around the family and the substance misuse team in 100% of cases identified as there being a substance misuse issue identified within the family. 90% of the substance misuse team have up to date safeguarding training. Develop a joint training plan by May 2014. Deliver annual substance misuse training to children and young people's workforce. To include substance misuse training in the induction programme for children and young people by May 2014 Increase the number of parents that access substance misuse services who are registered with their local Children's Centre.
	Ensure the substance misuse team access children's and adults safeguarding training to raise awareness.	Throughout the strategy with annual review	Substance Misuse Service HBC Training Team	Staff time Substance misuse budget	
	To continue to provide learning and development opportunities on the issue of substance misuse to services those are working with children and young people. To develop a joint training plan across services.	Throughout period of strategy with quarterly review.	Commissioning Manager's (C & A)	Staff time Substance Misuse Budget	

					Children and Young people remain in the family home in a safe environment. Those children open to services move to through the tiers of need framework. Children and young people increase their confidence and resilience, and this is captured by services.
Improve the substance misuse service response to drug and/or alcohol related domestic violence.	Implement 'routine enquiry' domestic abuse risk assessments at the substance misuse service.	By September 2014	Substance Misuse Service Domestic Abuse Service Commissioning Manager (C &A)	Staff time	100% of cases have been assessed against the domestic abuse risk assessment. 90% of frontline substance misuse staff has received training in how to respond to a domestic abuse disclosure? The improvement of identification of victims and perpetrators of domestic abuse by substance misuse service staff Monitor the number of low, medium and high risk victims as defined by the DASH risk assessment
	Agree a referral criteria and rapid access (?) pathways between the substance misuse service and domestic abuse services.	June 2014	Substance Misuse Service Domestic Abuse Service Commissioning Manager (C &A)	Staff time	

					To encourage individuals in substance misuse services to disclose that they are a victim or perpetrator of domestic abuse. To reduce the impact that parental substance misuse has on children and young people.
Objective 3: Restrict supply and tackle illegal activities					
Priority	**Action**	**Timescale**	**Responsibility**	**Resources**	**Outcomes**
Targeting specific individuals or groups identified as being particularly harmful, such as prolific offenders and organised crime gangs.	To continue the integrated approach to offender management between criminal justice agencies and the substance misuse treatment service.	Throughout period of strategy with annual review	Cheshire Constabulary Cheshire Probation Service Substance Misuse Service	Staff time	Reductions in overall offending rates. Increase in the number of offenders retained in drug treatment. Treatment programmes tailored to meet criminal justice sanctions based on changing demands and needs. Multi-agency agreements will be developed as required.
	Swift access to drug treatment through the criminal justice system – Custody suites, court, prisons. Provision of treatment to support criminal justice sanctions. Monitoring of appropriate Treatment Outcome Profile Indicator.	Throughout period of strategy with annual review	Cheshire Constabulary Cheshire Probation Service Substance Misuse Service	Staff Time	

Develop an improved understanding of the local drug supply market.	To establish a multi-agency group that can share intelligence around the drug supply market. Review the current system regarding the early warning and alert process for unusual, contaminated and high strength drugs.	September 2014	Cheshire Constabulary Commissioning Manager (A)	Staff Time	Production of a bi-annual report on the drug supply market in Halton To increase the awareness and sharing of information in relation to contaminated drugs.

Objective 4: Increase the number of people recovering from dependency on drugs					
Priority	**Action**	**Timescale**	**Responsibility**	**Resources**	**Outcomes**
To improve identification, advice and signposting by front line health, social care, housing and criminal justice agencies.	To continue to offer drug and alcohol training to front line staff.	Throughout period of strategy with annual review.	Commissioning Manager (C & A)	Substance Misuse Budget	Increase in the number of professionals accessing the e-learning training and attending training sessions. An increase in referrals from front line service to substance misuse services.
	Promote e-learning training to front line staff.	Throughout period of strategy with annual review.	Commissioning Manager (C & A)	Substance Misuse Budget	
	To develop a screening tool for front line service to assist identification of drug or alcohol issues.	April 2014	Substance Misuse Service Front Line Services Commissioning Manager (A)	Staff time.	

To review and revise protocols and working arrangements with key partners.	To review and revise protocols and working arrangements with key partners.	June 2014	Commissioning Manager (A) and Substance Misuse Service. Partners as identified.	Staff time.	Increased number of referrals to treatment services by key agencies Reduction in drug related admissions to hospital.
Improve individual's physical and mental well-being.	To provide screening, testing and vaccination for Blood Borne viruses. To provide Health Check assessments to all individuals in the treatment service.	Throughout period of strategy with quarterly review.	Substance Misuse Service, Health Improvement Team and GP practices	Staff time to complete the appropriate actions. Cost associated with vaccinations and testing equipment. Substance Misuse Budget Health Improvement Team	Increase in number of individuals screened, tested and where appropriate vaccinated for blood borne viruses Increase in number of Health Check assessments Increase in uptake of smoking cessation and sexual health services Increase in referrals to Health Improvement Team

Objective 5: Continue to make efficient and effective use of resources					
Priority	**Action**	**Timescale**	**Responsibility**	**Resources**	**Outcomes**
To review the current performance framework taking into account national guidance and local need.	Revise the current performance framework for treatment services to take into account national and local indicators, compliance with NICE and other clinical standards and Safeguarding. Put in place a development plan to meet any identified gaps.	April 2014	Commissioning Manager (A & PH) Substance misuse service	Staff time	All substance misuse commissioned services demonstrate compliance with NICE guidance, clinical prescribing guidelines and Safeguarding Children & Adults protocols Audit against NICE guidelines by April 2014
To review the response of primary health care to substance misuse.	Undertake a review of current arrangements.	September 2014	Commissioning Manager (A & CCG)		Establishment of a clinical network between the Substance Misuse Service, GP and Mental Health services.
	Establish a clinical network between primary care, mental health services and substance misuse services.	September 2014	Commissioning Manager (HBC & CCG) Substance misuse service		
Review Community Pharmacies.	Undertake a review of current arrangements. Continue to provide a needle exchange programme.	June 2014	Commissioning Manager (PH)		To increase the number of community pharmacies providing needle exchange and harm reduction advice. Baseline data to be collected by April 2014 and targets reach targets set.

Improve the service response to individuals that have been assessed as needing in-patient detoxification and/or residential rehabilitation.	By aligning current drug and alcohol spend; tendering for a list of preferred providers; and developing an agreed pathway and criteria to access this modality of care.	April 2014	Commissioning Manager (A) Adult Social Care. Substance Misuse Service		90% of patients will gain Entry into in-patient detoxification and/or residential rehabilitation within 3 weeks of assessment.
To provide advice and support to individuals who misuse substances and families that are threatened with homelessness or are homeless. To prevent those in temporary accommodation from misusing substances.	To continue to develop information, advice and support in relation to homelessness. To continue to work with key partners to prevent homelessness. The substance misuse service to continue to work with providers of temporary accommodation to prevent substantial misuses or to enable individual to reduce their dependency.	Throughout period of strategy with annual review	Principle Manager – Housing Solutions Team Substance Misuse Service	Housing Solutions Team Substance Misuse Service	90% of families affected by substance misuse will have access to advice regarding housing and homelessness. Individuals who are dependent on substances will have either temporary or permanent accommodation based on local Homelessness criteria. Those who access temporary accommodation be supported to reduce the dependency on substances misuse and will access support and advice to reduce any dependencies on substances.

Safer Halton Partnership Drug Strategy 2013 to 2017 Performance

Indicator	**Target** *(to be reviewed and amended annually)*	**Reporting Frequency**
Criminal Justice		
Adults who have an initial assessment who are assessed by the CJIT within 28 days	80%	Quarterly
Adults assessed as needing a further intervention who are taken on to the caseload	80%	Quarterly
Adults referred to CJIT from a prison who were reported on by the CJIT	80%	Quarterly
Adults taken onto caseload who commenced in treatment	**80%**	Quarterly
Re-offending (Integrated Offender Management)	**Monitor until 2014 and set base line target**	Quarterly
Reduce offending for prolific and priority offenders from baseline	Monitor until 2014 and set base line target	Quarterly
Reduce offending for repeat offenders from baseline	Monitor until 2014 and set base line target	Quarterly
Report on the drug supply market in Halton	Monitor	Bi-annual

All Clients		
Clients waiting less than 3 weeks for first treatment intervention	95%	Quarterly
New treatment journeys engaged in effective treatment	90%	Quarterly
Increase numbers in effective treatment (OCU)	400 +	Monthly rolling 12 months
Increase the numbers in effective treatment (Non OCU)	236 +	Monthly rolling 12 months
Successful completions	50%	Quarterly
Maintain the current level of individuals starting a new treatment journey	290	Quarterly
Percentage offered Hep B screening	92%	Quarterly
Percentage of these who accept Hep B screening	31%	Quarterly
Percentage of those offered who receive a vaccination	28%	Quarterly
Percentage of current or previous injectors offered Hep C screening	90%	Quarterly
Percentage of these who accept Hep C screening	46%	Quarterly
Treatment Outcomes Profile (TOP)		
Start, Review and exit TOP compliance	80%	Quarterly

Quality of life score (TOP Outcomes) on exit	20% higher than start score	Quarterly
Hospital Admission.	Monitor until 2014 and set base line target	Quarterly
Health checks	Monitor until 2014 and set base line target	Quarterly
Drug related deaths	Monitor	Quarterly
Arrests for supplying	Monitor	Quarterly
Referrals into MARAC where drugs was a contributing factor	Monitor	Quarterly
Carers Breaks (Targets set by carers strategy group)	Monitor	Quarterly

Safer Halton Partnership

Drug Strategy

Evidence Paper
2014 to 2018

Draft

Contents

Glossary

Abstinent	Not using substances of abuse at any time.
Addiction	Physical dependence on a substance of abuse. Inability to cease use of a substance without experiencing withdrawal symptoms. Sometimes used interchangeably with the term substance dependence.
Aftercare	Treatment that occurs after completion of inpatient or residential treatment.
Alcohol Treatment Orders (ATR)	Alcohol Treatment Requirement is one on a range of community sentences available to the courts. It provides access to treatment and support programmes for offenders where alcohol use is identified as a significant factor in offending.
Antiretroviral combination therapy	Treatment for HIV/AIDS infection that employs several medications in combination to suppress the HIV virus or delay both the development of resistant viruses and the appearance of AIDS symptoms.
Assessment	A basic assessment consists of gathering key information and engaging in a process with the client that enables the counsellor to understand the client's readiness for change, problem areas, and the presence of mental illness or substance abuse disorders, disabilities, and strengths. An assessment typically involves a clinical examination of the functioning and well-being of the client and includes a number of tests and written and oral exercises.
Benzodiazepines	Group of medications having a common molecular structure and similar pharmacological activity, including anti-anxiety, sedative, hypnotic, amnestic, anticonvulsant, and muscle-relaxing effects. Benzodiazepines are among the most widely prescribed medications (e.g., diazepam, chlordiazepoxide, clonazepam, alprazolam, lorazepam).
Cognitive-Behavioural Therapy (CBT)	A therapeutic approach that seeks to modify negative or self-defeating thoughts and behaviour. CBT is aimed at both thought and behaviour change—that is, coping by thinking differently and coping by acting differently.
Crack	Cocaine (cocaine hydrochloride) that has been chemically modified so that it will become a gas vapour when heated at relatively low temperatures. Also called "rock" cocaine.
Crime Reduction Initiative (CRI)	Provider of Substance Misuse Service at Ashley House Widnes.
Detoxification	A clearing of toxins from the body. The medical and bio psychosocial procedure that assists a person who is dependent on one or more substances to withdraw from dependence on all substances of abuse.
Domestic violence	The use of emotional, psychological, sexual, or physical force by one family member or intimate partner to control another. Violent acts include verbal, emotional, and physical intimidation; destruction of the victim's possessions; maiming or killing pets; threats; forced sex; and slapping, punching, kicking, choking, burning, stabbing, shooting, and killing victims. Spouses, parents, stepparents, children, siblings, elderly relatives, and intimate partners may all be targets of domestic violence.
DSM-IV	Diagnostic and Statistical Manual, 4th edition, published by the American Psychiatric Association, a standard manual used to categorize psychological or psychiatric conditions. Delirium Tremens (DT's), a state of confusion

	accompanied by trembling and vivid hallucinations. Symptoms may include restlessness, agitation, trembling, sleeplessness, rapid heartbeat, and possibly convulsions. Delirium tremens often occurs in people with alcohol use disorders after withdrawal or abstinence from alcohol.
Drug Rehabilitation Requirement (DRR)	The DRR is a community order to provide treatment and support for crime associated with drug use. It is a voluntary punishment option for those facing criminal proceedings for drug related crimes.
Ecstasy	Slang term for methylenedioxymethamphetamine (MDMA), a member of the amphetamine family (for example, speed). At lower doses, MDMA causes distortions of emotional perceptions. At higher doses, it causes potent stimulation typical of the amphetamines.
Engagement	A client's commitment to and maintenance of treatment in all of its forms. A successful engagement program helps clients view the treatment facility as an important resource.
Hallucinogens	A broad group of drugs that cause distortions of sensory perception. The prototype hallucinogen is lysergic acid diethylamide (LSD). LSD can cause potent sensory perceptions, such as visual, auditory, and tactile hallucinations. Related hallucinogens include peyote and mescaline.
Hepatitis	An inflammation of the liver, with accompanying liver cell damage and risk of death. Hepatitis may be of limited duration or a chronic condition. It may be caused by viral infection or by chronic exposure to poisons, chemicals, or drugs of abuse, such as alcohol.
Iatrogenic opioid addiction	Addiction resulting from medical use of an opioid (i.e., under physician supervision), usually for pain management.
Integrated treatment	Any mechanism by which treatment interventions for co-occurring disorders are combined within the context of a primary treatment relationship or service setting. It recognizes the need for a unified treatment approach to meet the substance abuse, mental health, and related needs of a client, and is the preferred model of treatment.
Intensive Case Management (ICM)	a thorough, long-term service to assist clients with serious mental illness (particularly those with psychiatric and functional disabilities and a history of not adhering to prescribed outpatient treatment) by establishing and maintaining linkages with community-based service providers. ICM typically provides referrals to treatment programs, maintains advocacy for clients, provides counselling and crisis intervention, and assists in a wide variety of other basic services.
Intervention	The process of providing care to a patient or taking action to modify a symptom, an effect, or behaviour. Also the process of interacting after assessment with a patient who is substance addicted to present a diagnosis and recommend and negotiate a treatment plan. Also frequently used as a synonym for treatment. Types of intervention can include crisis intervention, brief intervention, and long-term intervention.
Marijuana	The Indian hemp plant cannabis sativa; also called "pot" and "weed." The dried leaves and flowering tops can be smoked or prepared in a tea or food. Marijuana has two significant effects. In the person with no tolerance for it, marijuana can produce distortions of sensory perception, sometimes including hallucinations. Marijuana also has depressant effects and is partially cross-tolerant with sedative-hypnotic drugs such as alcohol. Hashish (or "hash") is a combination of the dried resins and compressed flowers of the female plant.

Medically supervised withdrawal	Dispensing of a maintenance medication in gradually decreasing doses to alleviate adverse physical or psychological effects incident to withdrawal from the continuous or sustained use of opioid drugs. The purpose of medically supervised withdrawal is to bring a patient maintained on maintenance medication to a medication-free state within a target period.
Mental health program	An organized array of services and interventions with a primary focus on treating mental health disorders, whether providing acute stabilization or ongoing treatment.
Methadone	The most frequently used opioid agonist medication. Methadone is a synthetic opioid that binds to mu opiate receptors and produces a range of mu agonist effects similar to those of short-acting opioids such as morphine and heroin.
Mutual self-help	An approach to recovery that emphasizes personal responsibility, self-management, and service users' helping one another. Such programs apply a broad spectrum of personal responsibility and peer support principles, usually including 12-Step methods that prescribe a planned regimen of change.
Opioid	A type of depressant drug that diminishes pain and central nervous system activity. Prescription opioids include morphine, meperidine (Demerol), methadone, codeine, and various opioid drugs for coughing and pain. Illicit opioids include heroin, also called "smack," "horse," and "boy."
Paraphernalia	A broad term that describes objects used during the chemical preparation or use of drugs. These include syringes, syringe needles, roach clips, and marijuana or crack pipes.
Relapse	A breakdown or setback in a person's attempt to change or modify any particular behaviour. An unfolding process in which the resumption of substance abuse is the last event in a series of maladaptive responses to internal or external stressors or stimuli.
Restorative justice	Restorative justice is a process whereby parties with a stake in a specific offence resolve collectively how to deal with the aftermath of the offence and its implications for the future.
Remission	A state in which a mental or physical disorder has been overcome or a disease process halted.
Screening	A formal process of testing to determine whether a client warrants further attention at the current time for a particular disorder and, in this context, the possibility of a co-occurring substance or mental disorder. The screening process for co-occurring disorders seeks to answer a "yes" or "no" question: Does the substance abuse [or mental health] client being screened show signs of a possible mental health [or substance abuse] problem? Note that the screening process does not necessarily identify what kind of problem the person might have or how serious it might be but determines whether further assessment is warranted.
Stigma	A negative association attached to some activity or condition. A cause of shame or embarrassment.
Substance abuse	A maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances. Sometimes used interchangeably with the term substance dependence.
Substance dependence	A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by a need for increasing amounts of the substance to achieve intoxication, markedly diminished effect of the substance with continued use, the need to continue to take the substance in order to

	avoid withdrawal symptoms, and other serious behavioural effects, occurring at any time in the same 12-month period.
Therapeutic Community (TC)	A consciously designed social environment or residential treatment setting in which the social and group process is harnessed with therapeutic intent. The TC promotes abstinence from alcohol and illicit drug use, and seeks to decrease antisocial behaviour and to effect a global change in lifestyle, including attitudes and values. The TC employs the community itself as the agent of healing. The TC views drug abuse as a disorder of the whole person, reflecting problems in conduct, attitudes, moods, values, and emotional management. Treatment focuses on drug abstinence, coupled with social and psychological change that requires a multidimensional effort involving intensive mutual self-help typically in a residential setting.
Treatment	Substance abuse treatment is an organized array of services and interventions with a primary focus on treating substance abuse disorders. For the Treatment Episode Data Set, the Centre for Substance Abuse Treatment defines treatment to include the following general categories: hospital, short- and long-term residential, and outpatient. Mental health treatment is an organized array of services and interventions with a primary focus on treating mental disorders, whether providing acute stabilization or on-going treatment. These programs may exist in a variety of settings, such as traditional outpatient mental health centres (including outpatient clinics and psychosocial rehabilitation programs) or more intensive inpatient treatment units.
Treatment retention	Keeping clients involved in treatment activities and receiving required services.

Table of Figures

Table of Tables

Foreword

This document provides an overview of the impact of drugs within Halton. It is intended to provide the evidence base that supports Halton's Drug Strategy 2014 to 2018 which describes the strategic approach to tackle the impact of drug misuse within the Borough of Halton. The findings of the evidence paper will enable partners, stakeholders and the wider community to understand the impact that drug misuse has within the Borough.

This paper provides an overview of the national policies that have influenced the Drug Strategy, and in more detail the local context is provided utilising a range of resources and information as well as key statistical information to demonstrate the work that has taken place within Halton by all partners.

Halton's approach is based on a prevention and recovery model ensuring effective use of scarce resources with the ultimate aim of improving the quality of life for individual residents and communities of Halton.

For further information on this paper and the Drug Strategy 2014 -18 please contact John Williams, Halton Borough Council, on 0151 511 8857 or email john.williams@halton.gov.uk: this evidence paper is available in different formats on request.

Part One – National Context

1.1. The National Drug Strategy 2010: Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life.

Since 2001, the focus of the national drug strategy had been on a rapid expansion of treatment services for people who were using heroin and crack cocaine. This approach sought to reduce the impact of drug related crime on communities and drug related harms such as hepatitis and HIV infection to the individual.

Building on the success of this approach the Coalition's 2010 strategy recognises that the age and patterns of drug use are changing. In addition to illicit drugs, the strategy acknowledges the problems caused by addiction to legal substances such as prescribed medication and alcohol.

The ambition for individuals and families experiencing problematic drug use is also raised with an expectation that help and support will be more oriented towards recovery so that people can overcome their addiction and move on to participating fully within society.

The 2010 national strategy is structured around three themes:

1. **Reducing demand** –

   Creating an environment where the vast majority of people who have never taken drugs continue to resist any pressures to do so, and making it easier for those that do to stop. This is key to reducing the huge societal costs, particularly the lost ambition and potential of young drug users. The UK demand for illicit drugs is contributing directly to bloodshed, corruption and instability in source and transit countries, which we have a shared international responsibility to tackle.

2. **Restricting supply** –

   Drugs cost the UK £15.4 billion each year. Government action will continue to make the UK an unattractive destination for drug traffickers by attacking their profits and driving up their risks.

3. **Building recovery in communities** –

   Working with people who want to take the necessary steps to tackle their dependency on drugs and alcohol, offering a route out of dependence by putting the goal of recovery at the heart of the national strategy.

1.2. The Health & Social Care Act 2012

The Health and Social Care Act 2012 is bringing about a major reorganisation of the National Health Service. From April 2013, upper tier local authorities assumed lead responsibility for improving public health, coordinating local efforts to protect the public's health and wellbeing, for ensuring health services effectively promote population health and for addressing health inequalities. At a local level these issues are overseen by Health and Wellbeing Boards (HWBBs), whilst the national lead comes from a new agency, Public Health England. Directors of Public Health, employed by local authorities and members of Health and Wellbeing Boards, are responsible for delivering public health outcomes, of which drug and alcohol treatment is one. The National Treatment Agency, which previously had oversight of drug and alcohol treatment across the country, has been abolished, with its key functions transferring to Public Health England.

Clinical Commissioning Groups (CCGs) are the new body responsible for the design and commissioning of local health services such as acute hospital services and mental health services. CCGs are comprised of local GPs and in addition to being statutory members of HWWBs, are required by law to consult with HWBBs over their plans.

Prison health services, which include their drug and alcohol treatment services, are the responsibility of the NHS Commissioning Board. A Local Area Team (LAT) in each of the 10 regions is taking the lead for commissioning these services.

In separate developments outside of the NHS, elected Police and Crime Commissioners have replaced Police Authorities and are now responsible for ensuring effective policing and commissioning services to reduce crime within a force area. There is a good evidence base for the impact of drug treatment on reducing offending. Police and Crime Commissioners though have no statutory representation on HWBBs.

1.3. Crime & Disorder Act 1998

Section 17 of the Crime & Disorder Act, as amended by the Police and Justice Act 2006, requires responsible authorities to consider crime and disorder, of which drug and alcohol misuse is one aspect, in the exercise of all their duties, activities and decision making. Responsible authorities include Local Authorities, the Police, Fire Authorities and Health.

1.4. Welfare Reform Act 2012

The Welfare Reform Act received Royal Assent on 8th March 2012. The Act has been described as the biggest shake up of the benefits system in 60 years. It aims to simplify the system and create the right incentives to get people into work by ensuring that no individual is better off by not working. Key features of the Act that will have the most significant impact on Halton's residents are:

- Introduction of Universal Credit. The level of Universal Credit is to be capped at £26,000. While it is estimated that only a small number of Halton residents will see their income reduce as a result of the cap, some will be significantly affected. In addition, Housing Benefit is to be included in Universal Credit and will consequently be paid directly to tenants of social housing.
- Replacement of Disability Living Allowance with a Personal Independent Payment (PIP) for those of working age. Halton, which has been selected as a pilot area for the scheme, has a disproportionate amount of disabled residents and the change to PIP will involve a reduction in the numbers of those receiving financial assistance.
- Changes to Housing Benefit including the introduction of an under occupancy penalty for households whose homes are deemed to be too large for their needs. Described as the "Bedroom Tax", this change will have a very significant impact in Halton residents.

It is too early to assess the impact of other reforms such as the on-going reassessment of Incapacity Benefit claimants against the stricter criteria of the Employment Support Allowance, changes to Community Care Grants and Crisis Loans and forthcoming reforms to Council Tax benefit which will include a 10% cut in scheme funding and "localised" benefit schemes.

1.5. Children and young people

Education is one of the most effective ways of preventing drug and alcohol misuse. The National Drug Strategy outlines the need for young people to have access to universal drug and alcohol education and specifically states that school staff should have the information, advice and power to provide accurate information on drugs and alcohol via drug education as well as targeted information to support them to tackle problem behaviour in schools and work with local voluntary organisations, the police and others on prevention.

Some young people are more at risk of developing substance misuse problems than others. Areas of vulnerability can include those who have parents with substance misuse problems, those with mental

health problems and those who truant or are excluded from school. Such groups of young people at risk require a more targeted approach to help prevent drug or alcohol misuse.

Meeting the needs of these young people is best achieved by decisions that are taken at a local level as part of a broader approach to supporting vulnerable young people to enable flexible planning for local government to focus upon prevention and early intervention to reach and support vulnerable groups most effectively.

Young people who already have a serious substance misuse problem or are at risk of becoming dependent should be able to access specialist support quickly to help address their misuse as well as the wider issues that may have led to their misuse in the first place. Substance misuse services, youth offending services, mental health services and children's services need to work together to ensure the relevant support is in place for those who are most vulnerable. The relevant support for those in transition from child to adult services will also require consideration at the local level.

The National Treatment Agency (NTA) for substance misuse is responsible for overseeing intensive support for young people misusing drugs or alcohol. The latest report on young people's substance misuse (2011/12) is available to download,[1] and indicates that, on a national level:

- The overall number of young people accessing specialist substance misuse services has fallen for the third year running, to 20,688 from a peak of 24,053 in 2008-9.
- Very few are treated for Class A drugs such as heroin, cocaine or ecstasy, and the number has again reduced since last year from 770 (in 2010-11) to 631 in 2011-12. This compares to 1,979 five years ago.
- The vast majority of under-18s (92%) receive support for primary problems with cannabis or alcohol. The numbers seeing specialist services for alcohol dropped again, from 7,054 last year to 5,884 this year.
- The proportion of under-18s who left specialist services having successfully completed their programme rose to 77% in 2011-12 from 50% five years ago.
- The number of cases seen by specialist services for primary cannabis use was up from 12,784 in 2010-11 to 13,200 this year. As evidence suggests that overall young people's cannabis use is declining, the rise in numbers seeing specialist services could be down to a combination of stronger strains of the drug causing more harm, greater awareness of the issues surrounding cannabis, and specialist services being more alert and responsive to the problems the drug can cause for under-18s.

[1] http://www.nta.nhs.uk/uploads/yp2012vfinal.pdf

1.6. National Standards

Issued in November 2012, the National Institute for Clinical Excellence (NICE) quality standard on Drug Use Disorders (QS23), covers the treatment of adults (18 years or over) who misuse opioids, cannabis, stimulants or other drugs in all settings in which care is received, in particular inpatient and specialist residential, community-based treatment settings and prisons. This quality standard describes markers of high-quality, cost-effective care that, when delivered collectively, should contribute to improving the effectiveness, safety and experience of care for people with drug use disorders in the following ways: preventing people from dying prematurely; enhancing quality of life for people with long-term conditions; helping people to recover from episodes of ill health or following injury; ensuring that people have a positive experience of care; and treating and caring for people in a safe environment and protecting them from avoidable harm. These overarching outcomes are from The NHS Outcomes Framework 2012/13.

The quality standard is also expected to contribute to the following overarching outcomes from the Public Health Outcomes Framework; improving the wider determinants of health; health improvement; health protection; and preventing premature mortality.

The quality standard is also expected to contribute to the following overarching indicators from the Adult Social Care Outcomes Framework; enhancing quality of life for people with care and support needs; ensuring that people have a positive experience of care and support; safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm.

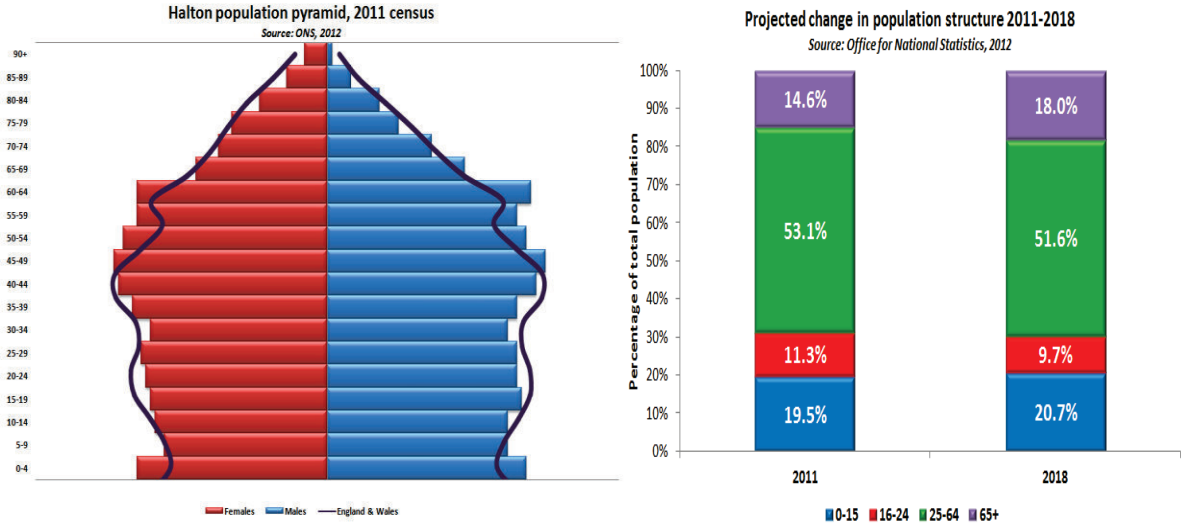
The quality standard requires that services should be commissioned from and coordinated across all relevant agencies encompassing the whole drug use disorder care pathway. An integrated approach to provision of services is fundamental to the delivery of high quality care to adults with drug use disorders.

Community, in-patient and residential drug treatment, where the service employs a doctor, nurse or social worker, are required to be registered with the Care Quality Commission (CQC). It is expected that the CQC will align any future work it does with the NICE Quality Standards.

Part Two – Demographic Profile, Risk Factors and Levels of Need

2.1 Population

Halton is a largely urban area of 125,700 (2011 Census) people. Its two biggest settlements are Widnes and Runcorn. The population is predominantly white (98.6%) with relatively little variation between wards.



Halton's population structure is slightly 'younger' than that seen across England as a whole. However, in line with the national trend, the proportion of the population in the working age bands i.e. 16-24 years and 25-64 years, is projected to fall with the younger age band i.e. 0-15 years, projected to rise slightly. The most significant shift is the proportion of the population in the older age band. If current drugs prevalence patterns continue (see section 2.5) this shift in population pattern may result in drug use continuing to fall.

2.2. Deprivation

Deprivation is a major determinant of health. Lower income levels often lead to poor levels of nutrition, poor housing conditions, and inequitable access to healthcare and other services. Deprivation, measured using the English index of Multiple Deprivation (IMD) 2010, ranks Halton as ranked 27th most deprived out of 326 local authorities (a ranking of 1 indicates the area is the most deprived).

The 2010 IMD shows that deprivation in Halton is widespread with 60,336 people (48% of the population) in Halton living in 'Lower Super Output Areas' (LSOA's) that are ranked within the most deprived 20% of areas in England.

2.3 Health

In terms of Health and Disability, the IMD identifies 53 SOA's (Super Output Areas) that fall within the top 20% most health deprived nationally and that approximately 40,000 people in Halton (33% of the population) live in the top 4% most health deprived areas in England. At ward level, Windmill Hill is the most deprived area in terms of health. However, health deprivation is highest in a LSOA within Halton Castle, ranked 32nd most deprived nationally.

Health is also a key determinant of achieving a good quality of life and the first priority of Halton's Sustainable Community Strategy. This states that 'statistics show that health standards in Halton are amongst the worst in the country and single it out as the aspect of life in the Borough in most urgent need of improvement'.

2.4. Risk factors

Most adult drug users have their first drug use experience in mid-to-late adolescence. Indeed, the highest proportion of drug use is in the 16-24 year age group. Most young people do not use illicit drugs or binge drink, and among those who do only a minority will develop serious problems. Some young people are more at risk of developing substance misuse problems than others. Risk factors include[1]:

Physiological factors:

- Physical disabilities.

Economic factors:

- Neighbourhood deprivation and disintegration.

Family factors:

- Belonging to families who condone substance misuse;
- Parental substance use;
- Poor and inconsistent family management; and
- Family conflict.

Psychological and behavioural factors:

- Mental health problems;
- alienation;
- Early peer rejection;
- Early persistent behaviour problems;
- Academic problems;
- Low commitment to school;
- Association with drug using peers;
- Attitudes favourable to drug use; and
- Early onset of drug or alcohol use.

There are some identifiable groups or categories of young people who are more likely than others to experience 'multiple' risk factors. These groups include:

- Young offenders;
- Looked after children;
- Young homeless;
- Young people involved in prostitution.
- Children whose parents misuse drugs;
- Young people who truant or are excluded from school; and

While not all young people in these groups do or will use drugs, these groupings can provide a valuable mechanism for targeting preventive action and early interventions towards some of the most vulnerable young people. Local data and/or estimated numbers are available on some of the above risk factors and vulnerable groups.

Table 1: Relative rates of social risk factors for the development of substance misuse problems, Halton and England

	Risk factor	Numbers affected locally	Percentage of population affected	Comparison to England	Relative Risk
1	Deprivation (% population in top 10% most deprived areas, IMD 2010)	7,792 (based on 2013 population estimate 0-18 years)	26%	10%	2.6
2	Children living in poverty (under 20 years) (2010)	7,800	26.5%	20.6%	1.29
3	Unauthorised school absences (2011/12)	192	1.2%	1.0%	1.2
4	School exclusions (2011/12)	Fixed period: 790 Permanent: 10	Fixed period: 4.41% Permanent: 0.07%	Fixed period: 4.05% Permanent: 0.07%	Fixed period: 1.1 Permanent: 0.0
5	Not in Education, Employment of Training (NEET) (2012)	383 (January 2013)	7%	5.7%	1.23
6	Young offenders: (2012)	74 juvenile first time entrants to the criminal justice system, 12 months ending September 2012	599, per 100,000 people aged 10-17 receiving first reprimand, warning or conviction	593, per 100,000 people aged 10-17 receiving first reprimand, warning or conviction	1.1
7	Looked After Children (2013)	145	51 per 10,000 children under 18 years	60 per 10,000 children under 18 years	0.85

Sources: 1 – Office of National Statistics; 2 – HM Revenue & Customs; 3 -5,7: Department for Education; 6 – Ministry of Justice

Estimated number of children who live with a parent with substance misuse problems

There are a number of impacts experienced by children living with parents who are substance misusers and/or problematic drinkers. Almost 4 million people in the 16–65 age group in the UK are dependent on alcohol and/or drugs. Assuming (conservatively) that every substance misuser will negatively affect at least two of their close family, this suggests that about 8 million family members (spouses, children, parents, siblings) in the UK are living with the negative consequences of someone else's drug or alcohol misuse[2]. Figure 1 summarises of the impacts this can have.

Figure 1: Negative effects of living with a parent with a substance misuse problem

Children

- behavioural disturbance, antisocial behaviour (conduct disorders)
- emotional difficulties
- behavioural problems and underachievement at school
- social isolation, because they feel that it is too problematic or shameful to bring friends home, or because they are not able to go out with friends as they have responsibilities of caring for other family members (e.g. siblings or the misusing parents)
- 'precocious maturity'

They also tend to have a more difficult transition from childhood to adolescence and increased likelihood of being referred to social services because of child protection concerns

Adolescents

Two common patterns often emerge:

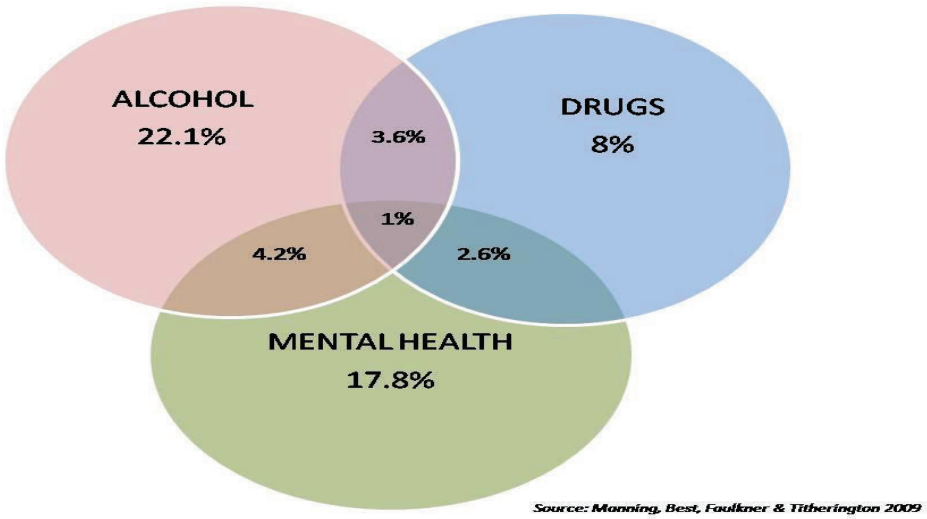
- increasing introspection and social isolation, with friendship difficulties (e.g. the young person is
- unlikely to visit or invite friends to their own home), anxiety or depression (for which psychoactive
- medication may be prescribed); attempts to escape their family home (e.g. by leaving home at an early age or entering into a long-term relationship)
- development of strong peer relationships which are kept separate from their own family; these
- relationships may themselves involve early alcohol or drug use, participation in sub-cultures perceived to be 'deviant', in antisocial activity, unsafe sex and unplanned and/or early pregnancy

Adulthood

Some of the problems of childhood and adolescence can continue into adulthood there is some (although not as great as previously thought) evidence that adult offspring of substance-misusing parents have greater problems in terms of substance misuse or areas of adulthood adjustment

Research[3] suggests that about 22% of children under the age of 16 live with at least one adult drinking to hazardous levels, 8% with an adult who has a substance misuse problem and 17.8% with an adult with mental health problems. Many individuals experience more than one of these problems. Figure 2 shows the estimated percentages of children exposed to various combinations of alcohol, illicit drugs and mental health problems.

Figure 2: cumulative risk of harm estimated from the National Adult Psychiatric Morbidity Survey



Applying the findings from this study to the local population of under 16 year olds can give an estimate of the numbers of children likely to be exposed to various combinations of substance misuse and mental health problems.

Table 2: Estimated percentages of children under the age of 16 living with an adult with substance misuse problems

Percentage of children exposed to various types of substance misuse	Estimated number of 0-16 years olds locally (25,335 population estimate 2013)
8% living with an illicit drug user	2,027
3.6% living with a problem drinker who also uses drugs	912
2.6% living with a drug user who has concurrent mental health problems	659
1%% living with a problem drinker who has concurrent mental health problems and uses drugs	253

Source: Manning, Best, Faulkner &Titherington, 2009 & ONS 2013

However, studies also show that children can and do grow through difficult circumstances without ill effects and many show great resilience. Practitioners working with parents with substance misuse problems should aim to work on family disharmony, reducing conflict, and work on inconsistent, neglectful and ambivalent parenting. This will to reduce risk, develop protective factors and promote resilience in young people.

Estimated Prevalence of Mental Health Conditions

Recent research has shown that having a mental health problem increases the chances of a person's developing substance misuse problems, independently of adverse childhood impacts[4].

Research by Green et al[5] showed that 7.7% of 5-10 year olds and 11.4% of 11-16 year olds were likely to have experienced a mental health disorder. As well as age differences, there were gender differences, with prevalence being greater amongst boys (11.4%) than girls (7.8%). Applying prevalence rates for the different mental health disorders to the 2013 population estimates for Halton residents aged 5 to 19, the numbers likely to have mental health disorders and been estimated. Numbers for all types and each type do not add us as some children will have more than one disorder.

Table 3: Estimated number of children with mental health disorders, by age group and gender, 2013

			Mental Health Disorder		Conduct Disorder		Emotional Disorder		Hyperkinetic Disorder		Less Common Disorders		Totals
Gender	Age group	Population	Percentage	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage	Number	
females	5 to 10	4,586	5.1%	234	2.8%	129	2.5%	115	0.4%	18	0.4%	18	514
	11 to 16	4,485	10.3%	462	5.1%	229	6.1%	274	0.4%	18	1.1%	49	1032
	17 to 19	2,170	10.3%	224	5.1%	111	6.1%	132	0.4%	7	1.1%	24	498
males	5 to 10	4,784	10.2%	488	6.9%	330	2.2%	105	2.7%	129	2.2%	105	1117
	11 to 16	4,476	12.6%	564	8.1%	363	4.0%	179	2.4%	107	1.6%	72	1285
	17 to 19	2,387	12.6%	301	8.1%	193	4.0%	96	2.4%	57	1.6%	38	685
persons	5 to 10	9,370	7.7%	722	4.9%	459	2.4%	225	1.6%	150	1.3%	122	1556
	11 to 16	8,961	11.5%	1031	6.6%	591	5.0%	448	1.4%	125	1.4%	125	2320
	17 to 19	4,557	11.5%	524	6.6%	301	5.0%	228	1.4%	64	1.4%	64	1181
total all ages		22,888		2277		1351		901		339		311	5179

Source: Green 2005 & ONS 2012

The numbers for 17-19 year olds may be underestimates as mental health problems are more prevalent in 18 year olds than 15 year olds as studies in New Zealand[6] and the USA[7] have shown. Other studies confirm the finding that the late teens and early twenties are periods of especially high risk of mental disorder– possibly the highest of any stage in the life course[8]. Young people over the age of 16 were included in the Adult Psychiatric Morbidity Survey in England 2007[9]. The mental disorders classified in the adult's survey are different to children's disorders. The adult mental disorders are:

- Depressive episodes
- Obsessive compulsive disorders
- Psychotic disorders

The Adult Psychiatric Morbidity Survey (APMS) was a point prevalence survey of UK residents aged between 16 and 75 years old. Prevalence estimates for young people aged 16 to 24 are presented in Table 3 and applied to the estimated Halton population of 16-19 year olds at 2013 and projected population for 2021 (the population aged 16-19 is projected to fall from 6090 in 2013 to 5455). These estimates assume no change in prevalence over this time.

Table4: Estimated number of children aged 16-19 with neurotic disorders

	Men			Women			Persons		
		Estimated Numbers			Estimated Numbers			Estimated Numbers	
	%	2013	2021	%	2013	2021	%	2013	2021
mixed anxiety and depressive disorder	*8.2%*	257	221	*12.3%*	364	340	*10.2%*	621	556
Generalised anxiety disorder	*1.9%*	60	51	*5.3%*	157	146	*3.6%*	219	196
Depressive episode	*1.5%*	47	40	*2.9%*	86	80	*2.2%*	134	120
All phobias	*0.3%*	9	8	*2.7%*	80	75	*1.5%*	91	82
Obsessive compulsive disorder	*1.6%*	50	43	*3.0%*	89	83	*2.3%*	140	126
Panic disorder	*1.4%*	44	38	*0.8%*	24	22	*1.1%*	67	60
Any Common Mental Health Disorder	*13.0%*	407	350	*22.2%*	656	613	*17.5%*	1066	955

Source: McManus et al 2009 and ONS 2012

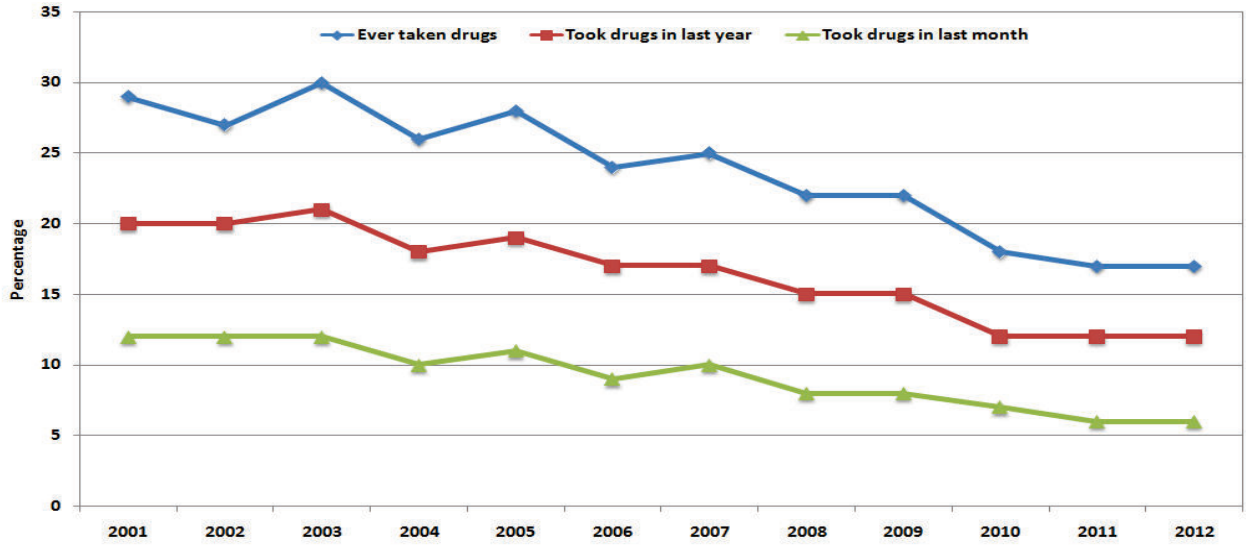
2.5. Estimated Prevalence of substance misuse in Halton

Data from service provision will only show the number of people with substance misuse problems who are in treatment. This does not give an overall figure of total drug users in the community. There are likely to be a number unknown to services, sometimes called 'unmet need' or 'hidden populations'. There is no routinely available data at a local level on these total numbers. However, annual national surveys do allow an estimation to be made. Such figures are likely not to be exact, due to local variations in levels of risk. They do however provide a snapshot of the expected prevalence of drug use in Halton.

2.5.1. Drug misuse among children (11 - 15 years)[10]

In England, there has been an overall decrease in drug use reported by 11- 15 year olds since 2001. The prevalence of lifetime drug use fell from 29% in 2001 to 17% in 2012. There were also decreases in the proportion of pupils who reported taking drugs in the last year from 20% in 2001 to 12% in 2012 and in the last month from 12% in 2001 to 6% in 2012.

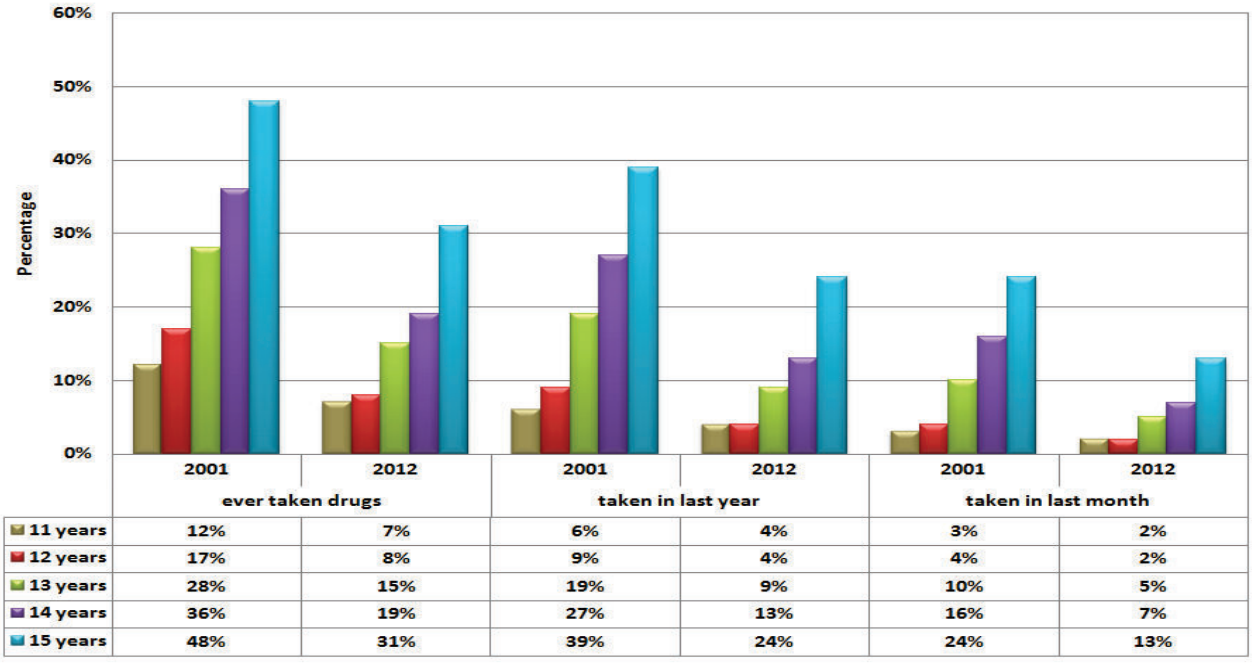
Figure 3: National trend in drug use amongst 11-15 year olds, 2001 to 2012



Source: Fuller E. et al (2013)

Reported drug use was more common among older pupils; for example, 4% of 11 year olds said they had used drugs in the last year, compared with 24% of 15 year olds in 2012. As seen in previous years cannabis was the most widely used drug in 2012; 7.5% of pupils reported taking it in the last year, a long term decrease from 13.4% in 2001.

Figure 4: Percentage of young people who have ever taken drugs, taken them in the last year and taken them in the last month, by age, national picture 2012 compared to 2001

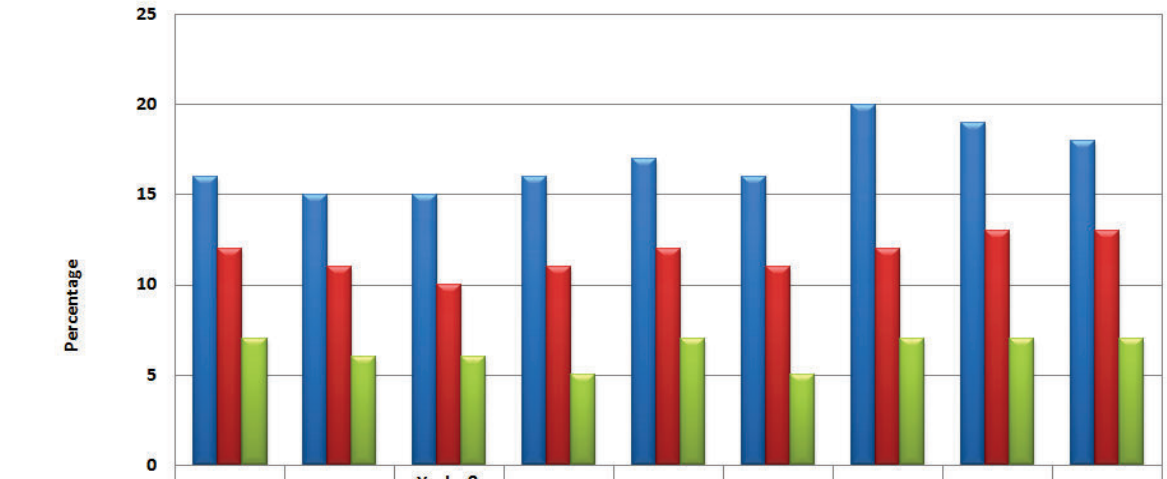


	2001	2012	2001	2012	2001	2012
	ever taken drugs		taken in last year		taken in last month	
11 years	12%	7%	6%	4%	3%	2%
12 years	17%	8%	9%	4%	4%	2%
13 years	28%	15%	19%	9%	10%	5%
14 years	36%	19%	27%	13%	16%	7%
15 years	48%	31%	39%	24%	24%	13%

Source: Fuller E. et al (2013)

The proportions of pupils who had ever tried drugs were generally higher in the south of England than elsewhere. In regions in the North and Midlands, between 15% and 17% reported having tried drugs but this proportion was 19% in the South East and South West and 20% in London. There was a similar but not identical pattern in the proportions of pupils who has taken drugs in the last year which varied between 10% in the East and West Midlands to 15% in the South West.

Figure 5: Regional variation in levels of drug use amongst 11 to 15 year olds.



	North East	North West	Yorks & the Humber	East Midlands	West Midlands	East of England	London	South East	South West
Ever	16	15	15	16	17	16	20	19	18
In the last year	12	11	10	11	12	11	12	13	13
In the last month	7	6	6	5	7	5	7	7	7

Source: Fuller E. et al (2013)

Using the national and regional prevalence for 2012, and applying it to the 2013 mid-year population estimate of Halton 11-15 year olds (7,427), gives the following local estimates of the numbers who have ever taken drugs.

Figure 6: estimated number of Halton 11-15 year olds who have ever taken drugs, 2013

	North West prevalence (%)	England prevalence (%)	Halton estimated number
Ever taken drugs	15%	17%	1,114 - 1,263
Taken drugs in last year	11%	12%	817 - 891
Taken drugs in last month	6%	6%	446

Source: Fuller E. Et al (2013) & ONS (2013)

Nationally, the number of young people (aged 18 and under) accessing specialist substance misuse services during 2011/12 was 20,688. This is a decrease of 1,267 individuals (5.8%) since 2010-11 and a decrease of 2,840 individuals (12.1%) since 2009-10 2010/11. The number of young people accessing services for

primary use of Class A drugs such as heroin and cocaine has fallen year-on-year to fewer than 800 nationally by 2011/12. The proportion of young people dropping out before completing a course of therapy has continued to fall, from 29% in 2005/06 to 16% last year and 13% 2011/12[11].

Locally the TellUs school survey had included questions on drug use. Since the government discontinued this survey a local version has been run. It found:

In answer to the question: ***Have you ever taken drugs (this does not include medicine or alcohol, but does include solvents, glue and gas)?***

- 9% said that they have taken drugs.

This is lower to the lifetime use identified in the national survey where 17% of 11-15 year olds stated that they had taken drugs at some time. It should be noted that differences in methodology may affect the validity of direct comparison.

In answer to the question: ***Why did you try the drugs, the first time? The main reasons stated given were:***

- I wanted to get high or feel good
- I wanted to see what it was like
- Because my friends were doing it
- I had nothing better to do

In answer to the question: ***In the last 4 weeks, how often have you taken any of the following drugs? (Don't worry if you don't know exactly, just give us a rough idea).***

- Cannabis or Skunk was taken the most in 'the last four weeks'
    - 13 had taken once
    - 8 had taken twice and
    - 31 had taken 3 or more times

Respondents were also asked a number of questions designed to test their knowledge and understanding about drugs. The responses show a good level of knowledge of the dangers of drugs amongst Halton young people. A quarter did not feel that injecting drugs can lead to HIV. However, research does show that sharing needles increases risk of contracting blood borne virus's such as hepatitis and HIV (see section 2.6).

- **Cannabis is more dangerous than Heroin** : 35% said TRUE
- **Injecting drugs can lead to HIV:** 26% said FALSE
- **Ecstasy always makes you feel great with no side effects** : 17% said TRUE

2.5.2. Drug misuse among young adults (16 – 24 years)

Data from the Health & Social Care Information Centre[12] shows that in England and Wales, in 2011/12,an estimated 37.7% young adults have ever taken an illicit drug, 19.3% had done so in the last year and 11.1% in the last month.

Based on a 2013 population estimate of 13,793 16 to 24 year olds living in Halton, this would mean that **5,200** young adults have ever taken an illicit drug, with **2,662** having done so in the last year and **1,531** in the last month.

Last year use of any illicit drug fell from 29.7% to 19.3% between 1996 and 2011/12. This was due in large part to notable declines in cannabis (26.0% to 15.7%) and amphetamine use (from 11.8% to 2.0%).

Last year Class A drug use among 16 to 24 year olds has fallen in the long term from 9.2% in 1996 to 6.3% in 2011/12. (This would be equivalent to **869** young people in Halton).

2.5.3. Drug misuse among adults (16 - 59 years)

In England and Wales, in 2011/12[13], an estimated one in three adults (36.5%) have ever taken an illicit drug in their lifetime (around 12 million people), 8.9% of adults have used an illicit drug in the last year (nearly three million people) and 5.2% of adults have used an illicit drug in the last month (an estimated 1.7 million people).

Between 1996 and 2011/12 the last year use of any illicit drug fell from 11.1% to 8.9%. Any last year drug use remains around the lowest level since measurement began.

For Halton (based on 2013 population estimate of 72,827 people aged 16 to 59 years), this would mean approximately **26,582** people will have ever taken an illicit drug in their lifetime, **6,482** adults will have used an illicit drug in the last year and **3,787** adults will have used an illicit drug in the last month.

Nationally, in 2011/12 around 15.6% of adults have ever taken a Class A drug in their lifetime (around 5 million people), 3.0% have done so in the last year and 1.5% in the last month. The long term trend in Class A drug use in the last year shows no statistically significant difference between 1996 (2.7%) and 2011/12 (3.0%).

For Halton, this would indicate that the local usage figures would be 11,361 adults having ever taken a Class A drug in their lifetime, with 2,2185 having done so in the last year and 1,092 in the last month.

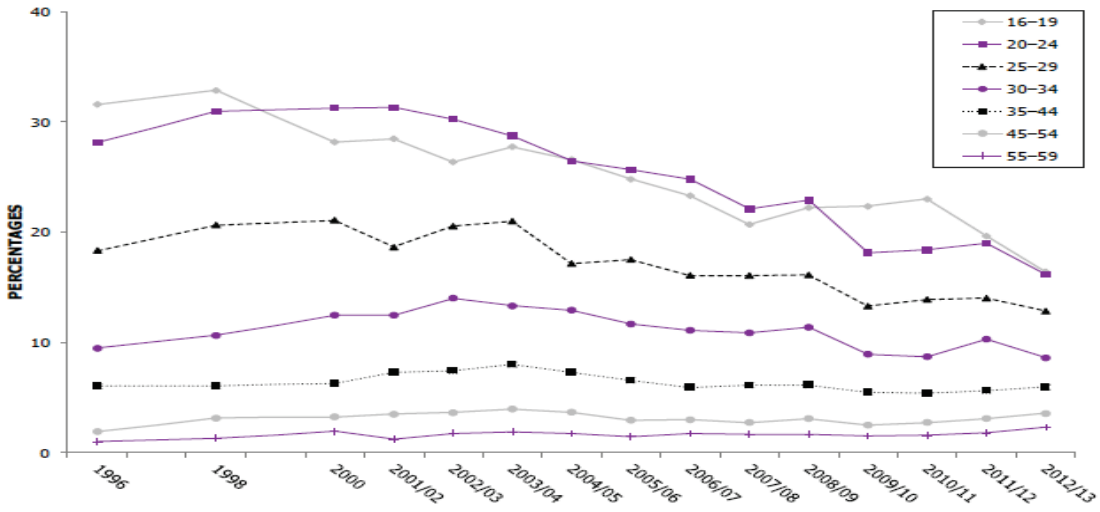
As in previous years cannabis was the most commonly used type of drug in the last year, in 2011/12 6.9% of 16-59 years (equivalent to 5,025 Halton residents) had used cannabis in the last year followed by powder cocaine (2.2% or 1,602 Halton residents) and ecstasy (1.4% or 1,020 Halton residents).

In 20010/11 it was estimated that there were **818** opiate and/or crack users in Halton. This corresponds to a rate of 10.33 per thousand of the population aged 15-64, a lower rate than in the North West (10.83 per 1,000 population aged 15-64) but statistically significantly higher than that across England as a whole (8.67 per 1,000 population aged 15-64)[14].

2.5.4. Drug use and age

Section 2.5.3 showed the estimated levels of drug use amongst the total 16 to 59 year old population. Within this group there is significant variation as the results of the latest Crime Survey for England & Wales shows[15].

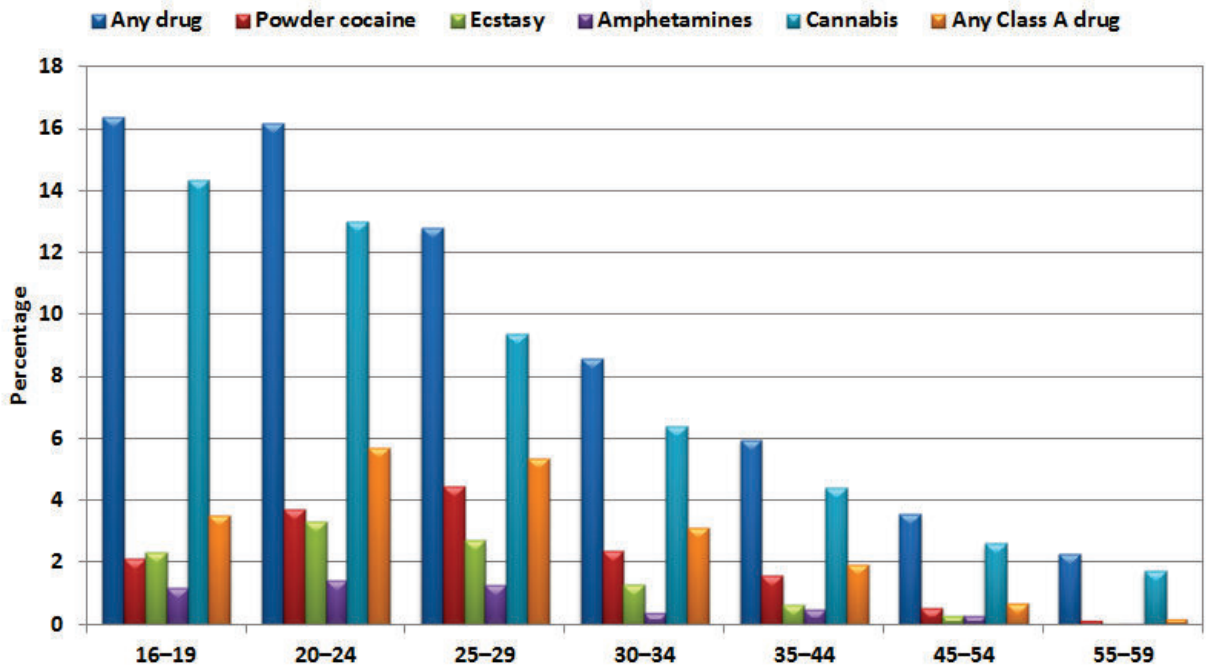
Figure 7: Proportion of 16 to 59 year olds reporting use of any drug in the last year by age group, 1996 to 2012/13 Crime Survey for England and Wales



Source: Home Office 2013

The pattern is similar when looking at different types of drugs, although whilst the peak for cannabis is 16-19 year olds - most adult drug users report they started using cannabis at age 13-15[16] - the peak age for ecstasy is 20-24 and for powder cocaine is 25-29.

Figure 8: Proportion of 16 to 59 year olds reporting use of powder cocaine, ecstasy and cannabis in the last year by age group, 2012/13 Crime Survey for England and Wales



Source: Home Office, 2013

If this pattern were repeated across Halton the following number of drug users would be seen:

Figure 9: Estimated number of adults in Halton who have used drugs in the last years, by age band

	Halton population	Any drug	Powder cocaine	Ecstasy	Amphetamines	Cannabis	Any Class A drug
16–19	6090	999	128	140	73	871	213
20–24	7703	1248	285	254	108	1001	439
25–29	8358	1070	368	226	109	786	451
30–34	8094	696	194	105	32	518	251
35–44	16250	959	260	98	81	715	309
45–54	18104	634	91	54	54	471	127
55–59	8228	189	8	0	0	140	16
16-59	72827	5795	1334	877	457	4502	1806

Source: Home Office, 2013

The overall figure of 5,795 is lower than that calculated using the Health & Social Care Information Centre findings, which put the figure at 6,482. As these reports analyse the data differently, it is more appropriate to put the estimated number as a range of **5,795 – 6,482**, rather than choosing one figure over the other.

2.5.5. Drug use by gender

Levels of use of any illicit drug and any Class A drug during the last year were higher among men than women in 2012/13, a pattern that has been seen every year since 1996. This pattern can also be seen for individual drugs, for example, according to the 2012/13 survey, men were twice as likely to report use of cannabis in the last year as women (8.6% and 4.1% respectively).

2.5.6. Drug use amongst vulnerable groups

Drug use is higher amongst some of the vulnerable groups identified in section 2.4. In 2003, 24% of vulnerable young people reported using illicit drugs frequently during the preceding 12 months, compared with 5% of their less vulnerable peers. There were significantly higher levels of drug use among those who belonged to more than one vulnerable group. Becker and Roe (2005)[17] define five groups of vulnerable young people: 'those who have ever been in care (22.7% had taken drugs), those who have ever been homeless (22.7% had taken drugs), truants (43.1% had taken drugs), those excluded from school (31.6% had taken drugs) and serious or frequent offenders (35.7%)'. The following are crude estimates, based on best available data. Given that substance misuse has been falling these may be overestimates. However, the 2003 crime survey is the last time this issue was explored and so provides the most up-to-date national prevalence data available.

Table 5: Estimated number of vulnerable young people in Halton who have taken drugs

Number of vulnerable young people in Halton	Estimated number who have taken drugs
145 children in care (2013)	33
192 Unauthorised school absences (2011/12)	83
790 fixed-term schol exclusions (2011/12)	250
10 permanent school exclusions (2011/12)	3
74 young offenders (2012)	26

2.5.7. Drug use amongst people with mental health problems

Research shows that substance use, intoxication, harmful use, withdrawal and dependence may lead to or exacerbate psychiatric or psychological symptoms or syndromes. Conversely, psychological morbidity and psychiatric disorder may lead to substance use, harmful use and dependence (addiction). The most common associations for substance misuse are with depression, anxiety and schizophrenia, post-traumatic stress, attention deficit, hyperactivity and memory disorders also occur[18].

For young people, emotional and behavioural disorders are associated with an increased risk of experimentation, misuse and dependence[19]. Recent research showed that pupils with a wellbeing score less than 10 (considered to be relatively low level of wellbeing) were more likely than pupils whose wellbeing scores were higher to have taken drugs in the last year (odds ratio=1.55)[20].

Research suggests 21.4% of people in contact with community mental health services also have a problem with drugs[21]. Other studies suggest the prevalence of dual diagnosis is between 30% and 50% of psychiatric caseloads, with some mental health conditions being more often associated with substance misuse than others e.g. Schizophrenia, Psychosis, Severe Depression: and Personality Disorder[22]. Indeed, a study using data from the Scottish Drug Misuse Database, April 2001 and March 2002, revealed that over 40% of individuals who sought treatment for problem drug use (3,236 out of a total of 10,798 individuals) reported that their mental health was one of the issues which led them to seek treatment[23].

With an estimated 2277 young people under age 16 (Table 3), 1066 young adults aged 16-19 years (Table 4), 12,583 adults aged 18-64 years estimated to have common mental health disorders and 5,606 two or more psychiatric disorders in Halton a significant proportion of these are also likely to have substance misuse issues. Even applying the lowest estimated prevalence rate of 21.4% identified in the research to the number of adults estimated to have common mental health problems and two or more psychiatric disorders would suggest **3,813** people in Halton with mental health problems also use drugs.

Table 6: People aged 18-64 predicted to have a mental health problem, projected to 2020

	2012	2013	2014	2015	2016	2018	2020
Common Mental Disorder	12,608	12,583	12,499	12,442	12,365	12,269	12,172
Borderline Personality Disorder	353	353	350	349	347	344	341
Antisocial Personality Disorder	270	268	267	265	263	261	259
Psychotic Disorder	313	313	311	309	307	305	303
Two or more Psychiatric Disorders	5,620	5,606	5,570	5,542	5,506	5,463	5,420

Source: PANSI, 2013

2.6 Health Impacts of substance misuse

Substance misuse is associated with significant health risks including anxiety, memory or cognitive loss, accidental injury, hepatitis, HIV infection, coma and death. It may also lead to an increased risk of sexually transmitted infections.

Table 7: Health impacts of different types of drugs

Drug	Effects on health
Cannabis	Linked to mental health problems such as schizophrenia, and, when smoked, to lung diseases including asthma. It affects how the brain works, so regular use can make concentration and learning very difficult. Can have a negative effect fertility. It is also dangerous to drive after taking cannabis. Mixing it with tobacco is likely to increase the risk of heart disease and lung cancer.
Cocaine	• Overdose from over stimulating the heart and nervous system, which can lead to a heart attack. • Depression, insomnia, extreme paranoia • Weight loss and malnutrition • If pregnant, it can harm the baby e.g. low birth weight and birth defectsand miscarriage. • Increased the chance of serious mental health problems returning. • Impotence in men • Damage to nasal passages • Injecting increases the risk of overdosing is higher and veins and body tissues can be seriously damaged. • Sharing needles this puts users at risk of catching HIV or viral hepatitis.
Mephedrone (meow meow, miaowmiaow,	Mephedrone can overstimulate the heart and nervous system. It can cause periods of insomnia, and its use can lead to fits and to agitated and hallucinatory states. It has been

meph)	identified as the cause of a number of deaths.
Ecstasy	• Anxiety, panic, confusion and difficulty in calming down. • Long-term use has been linked with memory problems, depression and anxiety. • Ecstasy use affects the body's temperature control and can lead to dangerous overheating and dehydration. This can cause dehydration, coma or even death. But a balance is important as drinking too much fluid can also be very dangerous for the brain, particularly because ecstasy tends to stop the body producing enough urine, so the body retains the fluid.
Speed (amphetamine)	Can cause high blood pressure and heart attacks. It can be more risky if mixed with alcohol, or if used by people with blood pressure or heart problems. Injecting speed is particularly dangerous, as death can occur from overdose. Speed is usually very impure and injecting it can cause damage to veins and tissues, which can also lead to serious infections in the body and bloodstream. Any sharing of injecting equipment adds the risk of catching hepatitis C and HIV.
Tranquillizers	• Severe headache • Nausea • Anxiety and confusion • If crushed up can cause veins to collapse, leading to infection and in extreme cases gangrene
Heroin	• Chemicals used to bulk out pure heroin can cause allergic or toxic reactions • Can cause heart failure. • Risk of choking on own vomit if sick whilst unconscious • Sharing needles increases risk of catching hepatitis C and HIV. • Long-term use can damage veins and lead to serious infections such as abscesses and severe constipation.
Source: NHS choices http://www.nhs.uk/Livewell/drugs/Pages/Drugsoverview.aspx and NHSInform http://www.nhsinform.co.uk/health-library/articles/d/drug-misuse/risks	

Wider impacts on families and society

Substance misuse is also a key factor in a significant number of child protection cases and domestic violence. Users can lose their families, homes and jobs. Users can also find themselves resorting to crime to pay for their drugs. Some of these are looked at in Part 7.

Part Three – Treatment and Care

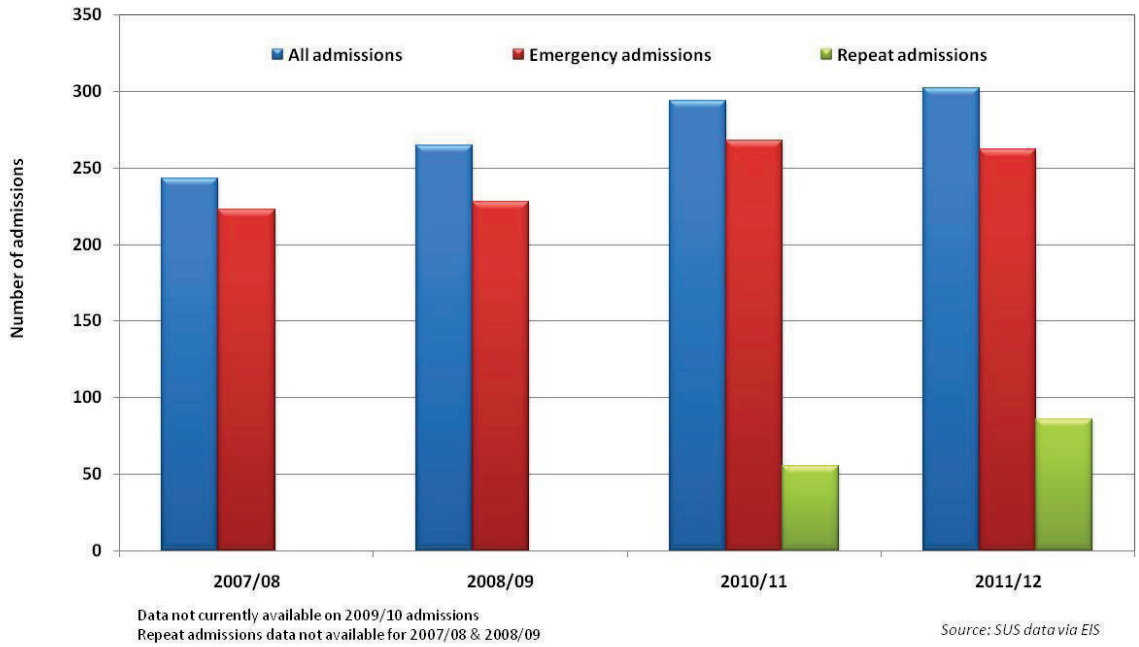
3.1. Hospital Admissions

3.1.1. Drug related admissions

Drug related admissions include any hospital admission where there is a drug diagnosis in any part of the record, although the primary reason for admission could be different.

There has been an upward trend in drug related hospital admissions and repeat admissions. In 2007/08 there were 243 admissions, rising to 302 in 2011/12. Repeat admissions stood at 55 in 2010/11 and 86 in 2011/12.

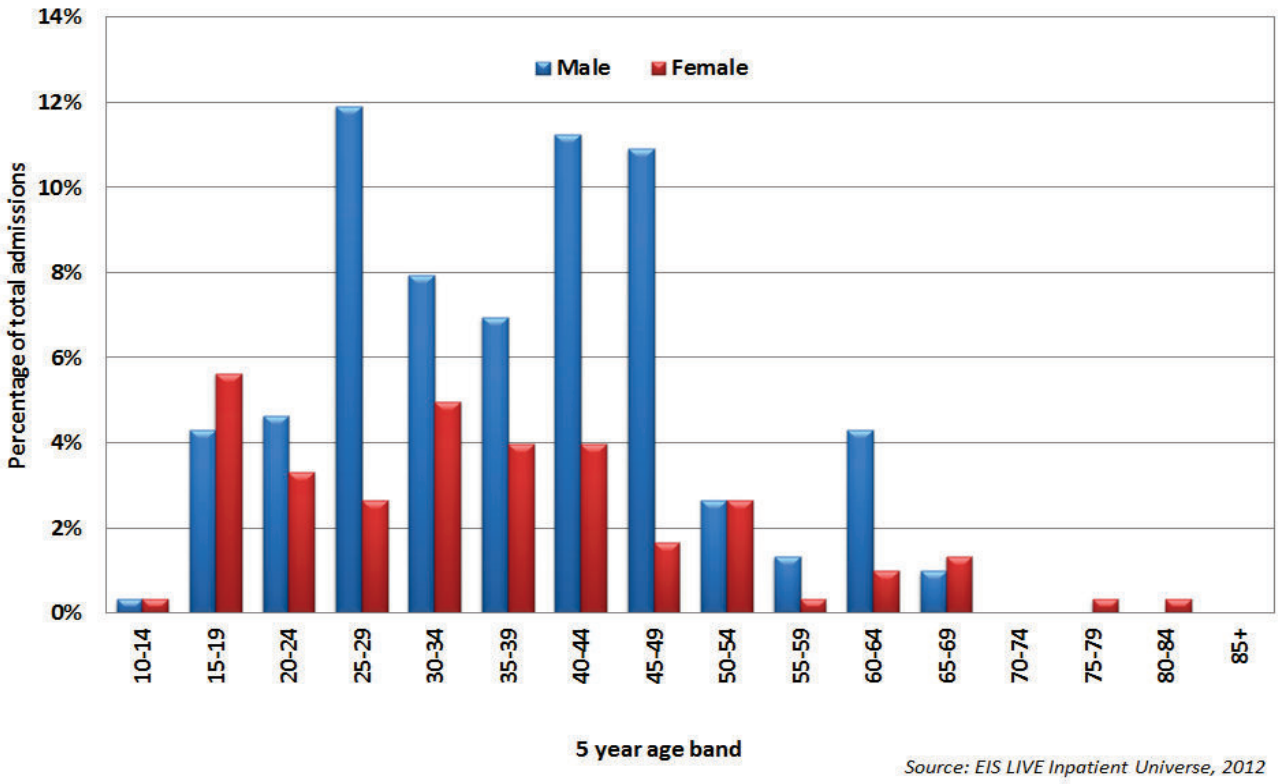
Figure 10: Trend in drug related hospital admissions in Halton



Age and sex

The percentage of the cohort that was male is also rising, with 68% of the admissions being male in 2011/12, compared to 53% in 2008/09. In terms of age, most admissions occur in the 40 to 44 age bracket, followed by those aged 25 to 29. However the pattern is different for males and females; for males, most occur aged 25 to 29, followed by ages 40 to 49, whereas for females, most occur aged 15 to 19, followed by ages 30 to 34.

Figure 11: Percentage of drug related admissions by sex and age band, 2011/12



Source: EIS LIVE Inpatient Universe, 2012

Reason for admission

There is also a changing picture with regards to reasons for admissions. The International Classification of Diseases, ICD 10, is a system that standardises codes for diseases, signs and symptoms. The table below shows over the four years between 2009/10 and 2011/12, the ICD 10 codes for drug related hospital admissions show:

- A decrease with regards to:
  - 'Mental and behavioural disorders due to use of opioids' from 81 to 58. Opioids include heroin, morphine, methadone and codeine.
- An increase in:
  - Mental and behavioural disorders due to use cannabinoids from 27 to 49
- Similar numbers for:
  - Mental and behavioural disorders due to cocaine.

- Mental and behavioural disorders due to use of other psychoactive substances
- Poisoning by benzodiazepines
- 'Intentional self-poisoning and exposure to narcotics and hallucinogens'.

The most common diagnoses in 2011/12 were mental and behavioural disorders due to use of opioids (19%) and Intentional self-poisoning by and exposure to narcotics and hallucinogens.

Table 8: Number of drug related admissions by ICD 10 sub-chapters, Halton 2008/09 to 2011/12

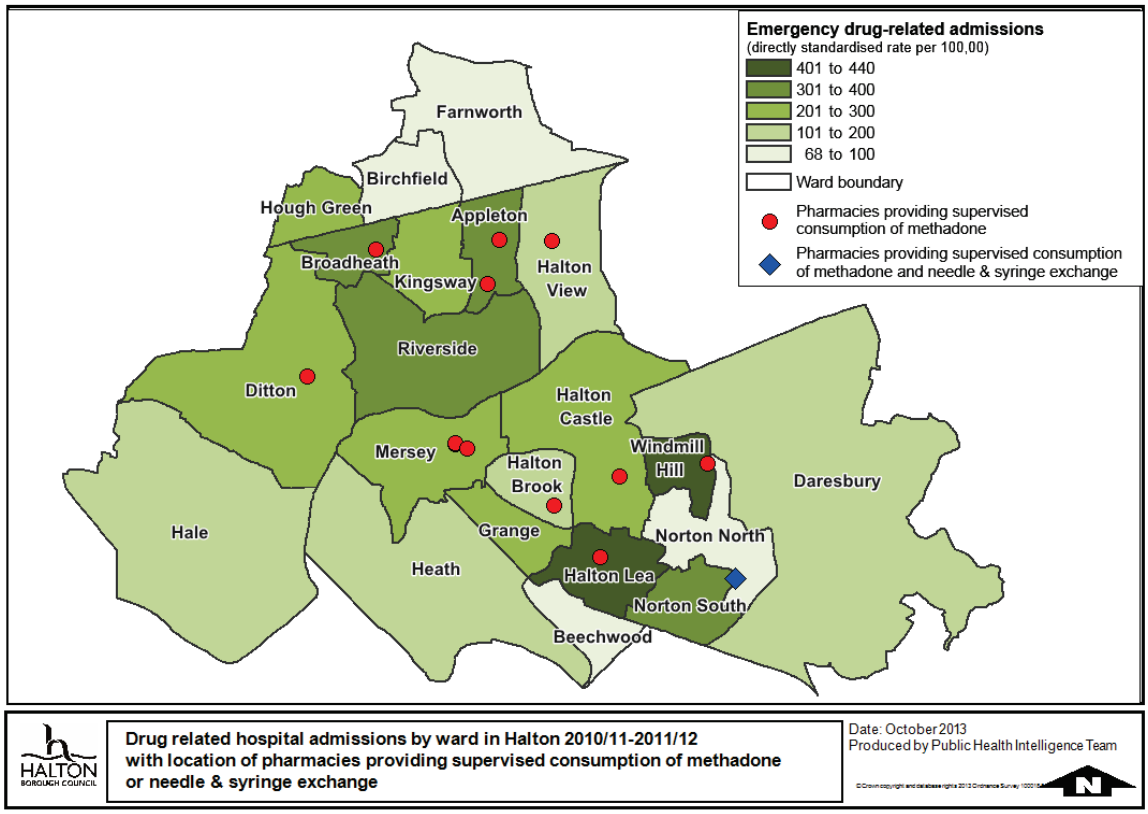
ICD 10 code	ICD Description	No. of admissions 2008/09	No. of admissions 2010/11	No. of admissions 2011/12
F11	Mental and behavioural disorders due to use of opioids	81	72	58
F12	Mental and behavioural disorders due to use of cannabinoids	27	20	49
F13	Mental and behavioural disorders due to use of sedative or hypnotics	3	5	3
F14	Mental and behavioural disorders due to use of cocaine	17	13	19
F15	Mental and behavioural disorders due to use of other stimulants, including caffeine	0	8	7
F16	Mental and behavioural disorders due to use of hallucinogens	0	1	1
F19	Mental and behavioural disorders due to use of other psychoactive substances	30	43	38
T38.7	Poisoning by androgens and anabolic congeners	0	0	1
T40	Poisoning by narcotics and psychodysleptics	8	27	27
T41.2	Poisoning by anaesthetics	1	1	1
T42.4	Poisoning by benzodiazepines	21	27	22
T43.6	Poisoning by psychotropic drugs: psycho stimulants with abuse potential	6	10	11
T59.8	Toxic effect of other gases, fumes and vapours	3	3	3
X42	Accidental poisoning by and exposure to narcotics and hallucinogens	13	1	0
X62	Intentional self-poisoning by and exposure to narcotics and hallucinogens	55	62	61
Z503	Drug rehabilitation	0	1	1
Total		**265**	**294**	**302**

Admissions by residence of patient

The map below shows the distribution of drug related admissions by ward of residence of patient over two years. Halton Lea ward has the highest rate of 440 per 100,000 population (55 admissions) and Beechwood

the lowest with 68 per 100,000 (5 admissions). There are pharmacies which provide supervised consumption of methadone in or within close proximity to the wards with the highest rates of admission.

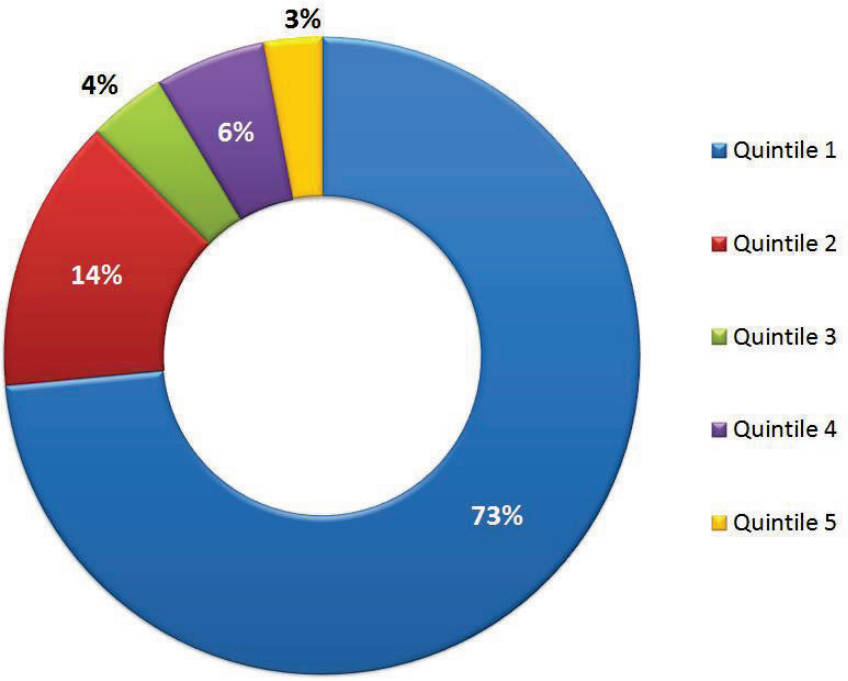
Figure 12: Drug-related hospital admissions (directly standardised rate per 100,000 population) by ward in Halton 2010/11 - 2011/12, with location of pharmacies providing supervised consumption of methadone or needle and syringe exchange.



Admissions and deprivation

The chart below shows that for admissions in 2011/12, 73% lived in the most deprived quintile (20%) nationally. Analysing admissions over the two years from 2010/11 to 2011/12, there is a strong relationship between rate of admission by ward and level of deprivation (r=0.87).

Figure 13: Percentage of drug related admissions by 2010 national deprivation quintile (IMD 2010), Halton, 2011/12 (Quintile 1 = most deprived, Quintile 5 = least deprived)



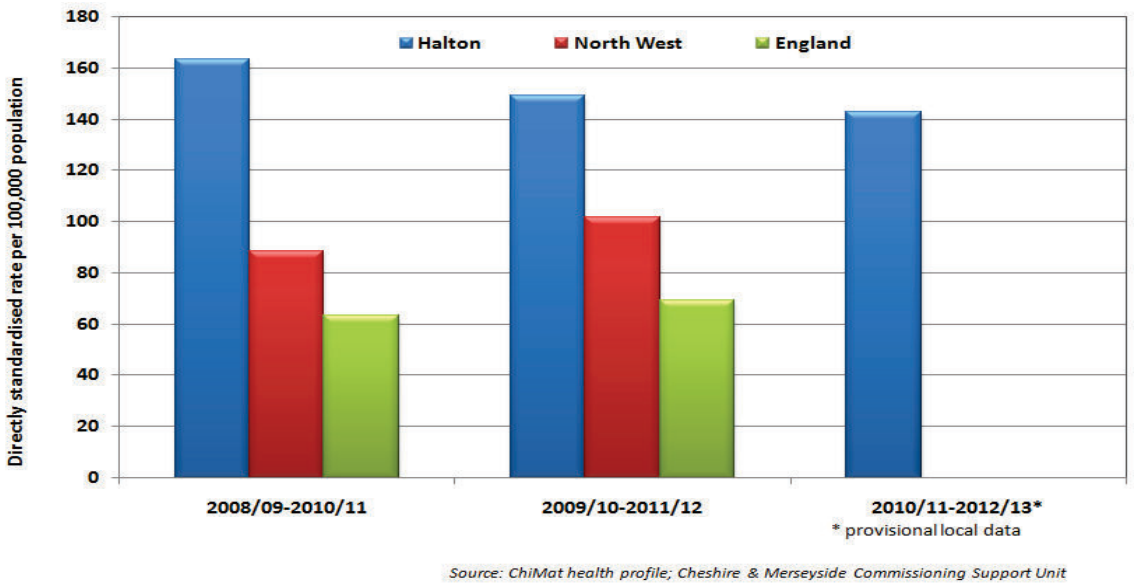
3.1.2. Substance misuse

Whereas drug related admissions could include activity not directly caused by drugs (but where the patient has a drug diagnosis on their admission record), substance misuse hospital admissions focus on those due directly to the harmful use of substances (physically or psychologically).

Children and young people

Data is collected nationally on substance misuse hospital admissions for 15-24 year olds. The chart below shows the trend since 2008/09 and the latest information for Halton, using local data. Due to the relatively small numbers involved, published data is based on a 3 year directly standardised rate per 100,000 population. Halton's rate has decreased since 2008/09-2010/11 but was significantly higher than the England average for both years' that comparator data is available; in 2008/09-2010/11 Halton had the highest rate of any Local Authority in England.

Figure 14: Trend in hospital admissions due to substance misuse (ages 15-24), 2008/09 to 2012/13



Source: ChiMat health profile; Cheshire & Merseyside Commissioning Support Unit

In terms of actual numbers, between 2010/11 and 2012/13, there were 69 admissions for substance misuse in those aged 15-24, an average of 23 per year.

Using local data over the last 4 years (2009/10 to 2012/13) for those aged 15-24:

- All were emergency admissions
- The majority were admitted via Accident and Emergency (92%)
- The most common types of substances diagnosed were:
  - Codeine/morphine (49%)
  - Multiple or unknown substances (13%)
  - Cocaine (10%)
  - Psychostimulants with abuse potential (excl cocaine) (10%)

All ages

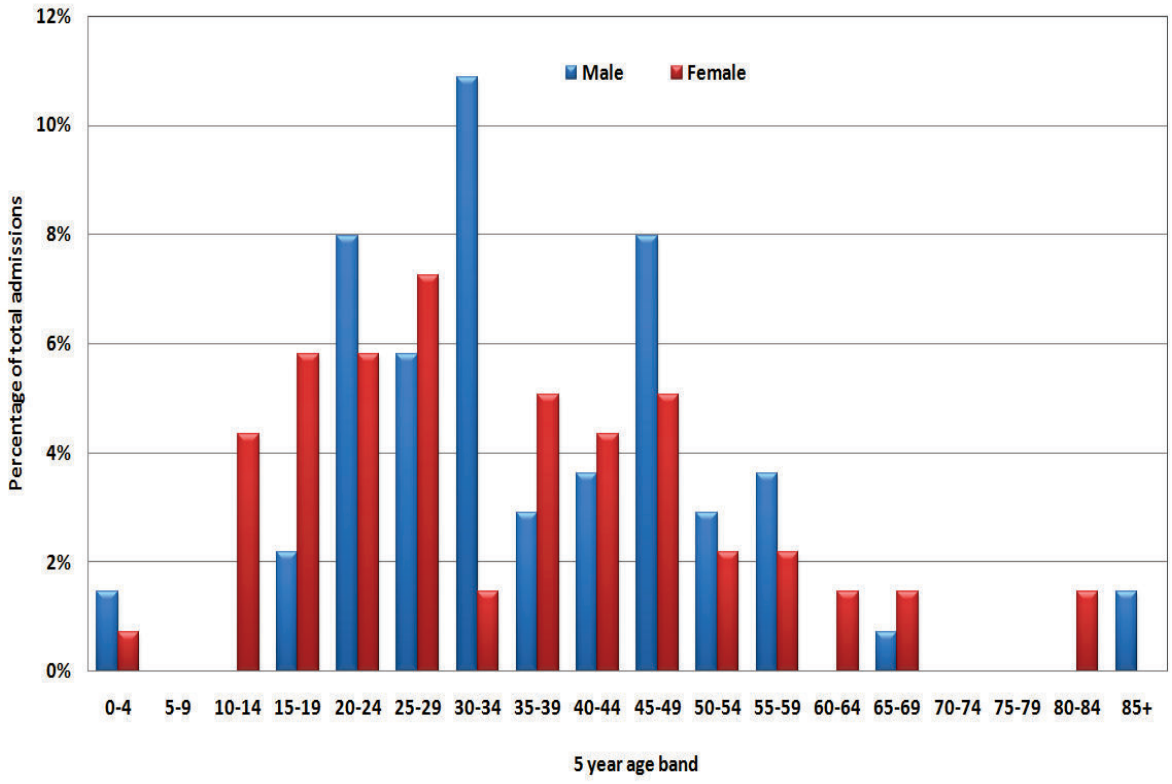
Data relating to substance misuse hospital admissions is not published nationally for all ages, but local data shows that the number has increased to 138 in 2012/13.

Table 9: Number of admissions due to substance misuse in Halton, 2009/10 to 2012/13

Year	No. of admissions
2009/10	84
2010/11	80
2011/12	76
2012/13	138

In 2012/13 there were approximately the same numbers of admissions in males and females. The chart below shows the age and sex breakdown in detail.

Figure 15: Percentage of substance misuse hospital admissions by sex and age band, 2012/13



Source: Cheshire & Merseyside Commissioning Support Unit, 2013

Overall, most admissions occurred in those aged 20 to 24; however females saw the highest number in those aged 25 to 29, whereas for males the most common age bracket was 30 to 34.

3.2 Accessing Treatment Services

The national standard regarding waiting times for treatment is that individuals should not wait longer than 3 weeks. Halton has no waiting time for treatment, offering a 'same day' service.

The largest group of people accessing services has been through self-referral. In seeking to reduce drug related crime, services have also been delivered at different points throughout the criminal justice system – custody suites, prison, courts. Between 2010 and 2012 the numbers entering treatment via the criminal justice system was low. 2012/13 has seen a significant increase in referrals via this route. However referrals from partner agencies where it would be anticipated that individuals with drug misuse problems would also appear, such as hospitals, social care and Job Centre Plus, remain low.

3.2.1. Treatment Services - Drugs used by individuals accessing treatment.

Data provided by Halton treatment service to the National Drug Treatment Monitoring System (NDTMS) identifies the patterns of drug use of people in treatment services. Heroin overwhelmingly remains the main drug of use. Cannabis and cocaine are the second and third main drugs of use. However, when examined in further detail, 2012/13 data indicates rises in cannabis and cocaine as primary drugs of use and increases in numbers of people using in combination alcohol and cocaine or cannabis and cocaine. In terms of secondary use, crack cocaine is the largest group, followed by alcohol, methadone and cannabis.

Table 8 shows that the percentage of people, in Halton, using heroin as the primary drug during 2012/13 is lower than the England and North West percentages. Due to this, the percentage of people using cocaine and cannabis as their primary drug in Halton is higher than England and the North West.
(See table below for percentages).

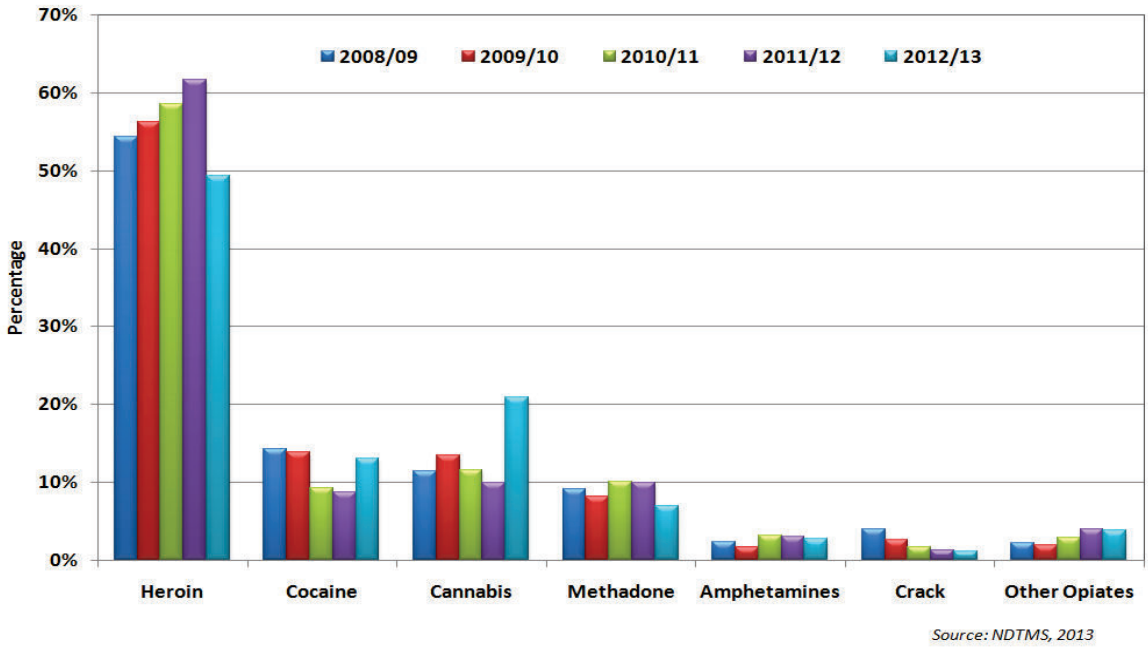
Table 10: Primary drug used

	Halton										North West	England
	2008/09		2009/10		2010/11		2011/12		2012/13		2012/13	2012/13
Main drug	***Number***	***Percent***	***Number***	***Percent***	***Number***	***Percent***	***Number***	***Percent***	***Number***	***Percent***	***Percent***	***Percent***
Heroin	376	54.3%	388	56.3%	370	58.6%	325	61.7%	323	49.3%	65.3%	67.3%
Methadone	63	9.1%	56	8.1%	64	10.1%	52	9.9%	46	7.0%	5.8%	4.2%
Other Opiates	15	2.2%	13	1.9%	18	2.9%	21	4.0%	25	3.8%	3.6%	4.6%
Benzodiazepines	*	*	*	*	*	*	0	0.0%	*	*	0.9%	0.9%
Amphetamines	16	2.3%	12	1.7%	20	3.2%	16	3.0%	18	2.7%	2.5%	2.4%
Cocaine	99	14.3%	95	13.8%	58	9.2%	46	8.7%	85	13.0%	7.6%	5.5%
Crack	28	4.0%	18	2.6%	11	1.7%	7	1.3%	7	1.1%	2.0%	3.7%
Hallucinogens	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0.1%	0.3%
Ecstasy	*	*	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0.1%	0.1%
Cannabis	79	11.4%	93	13.5%	73	11.6%	52	9.9%	137	20.9%	10.0%	9.3%
Solvents	*	*	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0.0%	0.1%
Barbiturates	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0.0%	0.0%
Major Tranquilisers	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0.0%	0.0%
Anti-depressants	*	*	*	*	*	*	0	0.0%	0	0.0%	0.0%	0.0%
Other Drugs	*	*	*	*	*	*	0	0.0%	*	*	0.4%	0.5%
Poly Drug	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0.0%	0.0%
Prescription Drugs	6	0.9%	9	1.3%	10	1.6%	8	1.5%	7	1.1%	1.9%	1.1%
Total	**692**	**100.0%**	**689**	**100.0%**	**631**	**100.0%**	**527**	**100.0%**	**655**	**100.0%**	**100.0%**	**100.0%**

*indicates numbers of 5 or less

As can be seen from the graph below, the percentage using heroin as main drug in Haltonhas increased year on year up to 2012/13 which saw a drop. Actual numbers presenting with Heroin as primary drug have fallen since 2009/10.

Figure 16: Primary drug used by people receiving treatment in Halton, 2008/09 to 2012/13



Crack is the most frequently cited secondary drug for Halton, North West and England. The percentage has decreased since 2010/11 in Halton, however, the percentage of people citing alcohol and cannabis has increased.

Table 11: secondary drug used

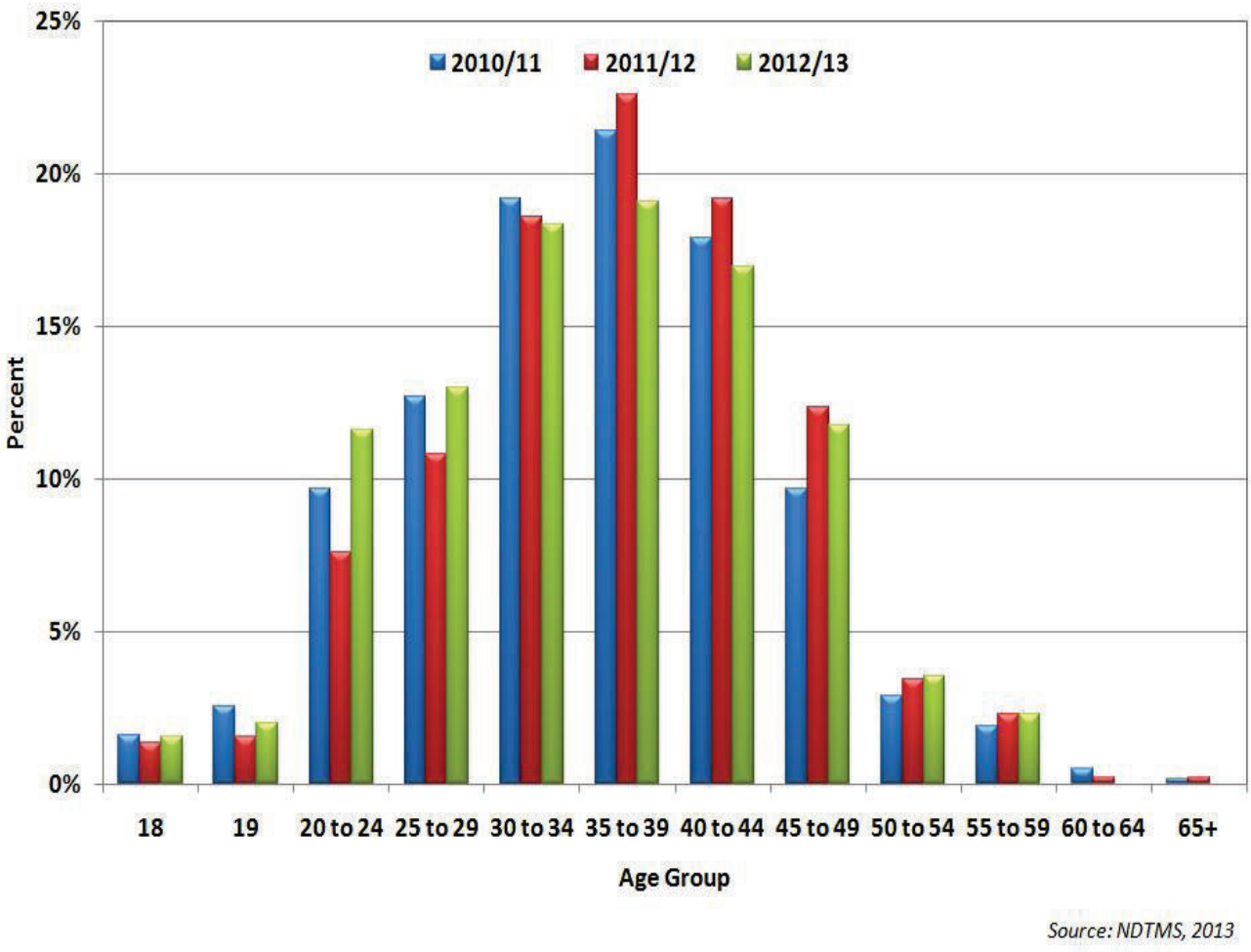
	Halton			North West	England
	2010/11	2011/12	2012/13	2012/13	2012/13
Crack	29.5%	27.5%	26.4%	19.9%	22.3%
Alcohol	10.8%	9.1%	12.5%	10.2%	11.5%
Methadone	6.8%	8.0%	5.3%	6.3%	4.3%
Cannabis	4.3%	3.2%	5.3%	6.2%	8.1%
Cocaine	4.4%	3.8%	3.5%	2.8%	3.1%
Amphetamines	0.8%	0.8%	2.3%	2.6%	2.5%
Heroin	2.9%	2.7%	1.5%	3.3%	3.2%
Other Opiates	0.6%	0.8%	1.4%	1.1%	1.6%
Benzodiazepines	1.4%	2.1%	0.8%	4.8%	4.5%
No other drugs used	37.2%	41.7%	39.7%	41.7%	37.3%

3.2.2. Age and Gender Profile

The balance of males and females has remained constant for a number of years in Halton. Of the total population of people in treatment during 2012/13, 26% were female and 74% male. This is very similar to the national (27% female and 73% male) and North West (28% female and 72% male) picture.

'Age group at mid-point' data over the past 3 years shows that the vast majority of people receiving treatment are aged between 20 and 49 years. The percentage of 20 to 29 year olds decreased during 2011/12, however the total number of people receiving treatment during this year (527) was lower than in 2010/11 (631) and 2012/13 (655).

Figure 17: Percentage of people receiving drug treatment by age group (at the mid point of the year), 2010/11, 2011/12 and 2012/13



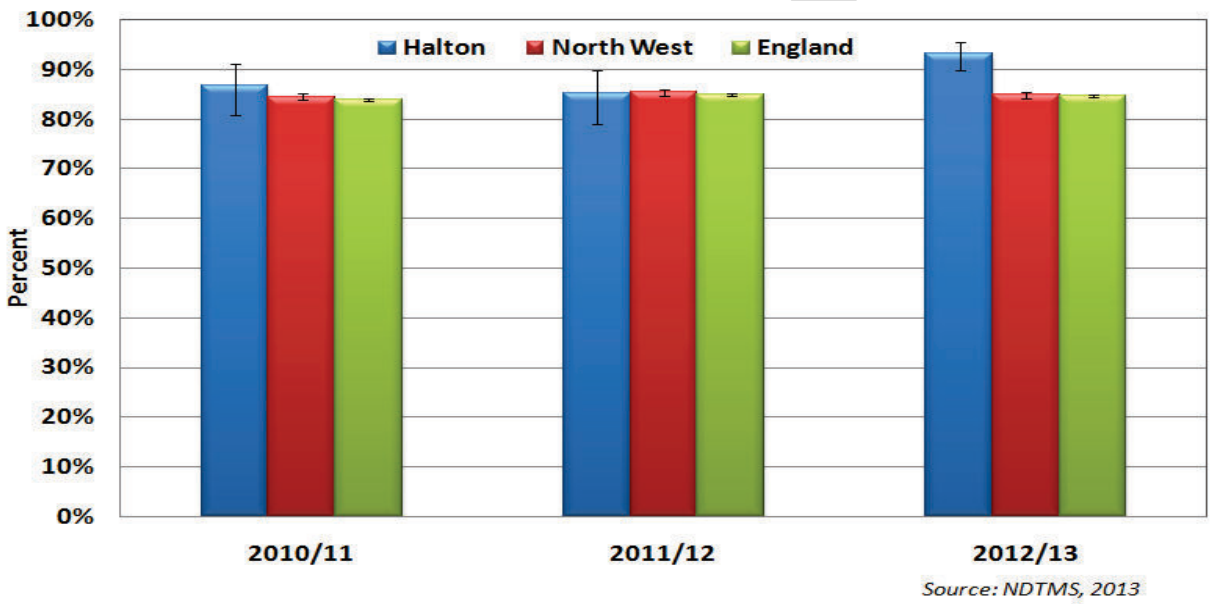
Source: NDTMS, 2013

3.2.3. Treatment Success

Research has shown that for drug treatment to be effective, individuals need to remain in service beyond 12 weeks. This data in the chart below relates to new treatment journeys within each year, and includes the number of people retained for 12 weeks or more and the number of completed (planned) exits.

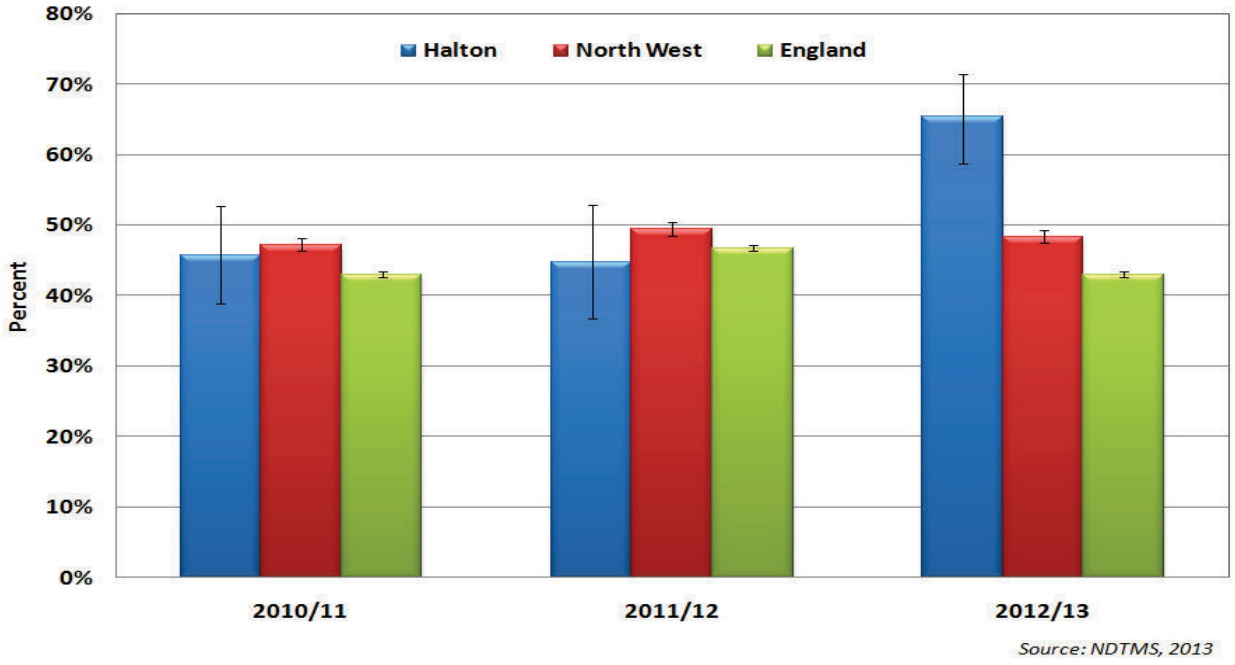
In Halton during 2012/13, 93% of people were 'successfully retained in effective treatment' compared with 87% in 2010/11. This means that the Halton 2012/13 percentage was significantly higher compared to the North West and England.

Figure 18: Percentage of people 'successfully retained in effective treatment' (new journeys), 2010/11 to 2012/13



In Halton, the percentage of people successfully leaving treatment is also continuing to improve – 65% in 2012/13 compared with 45% in 2011/12. During 2010/11 and 2011/12 the Halton percentage was similar to the England and North West percentages, however, in 2012/13 the Halton value was significantly higher. This data relates to the number of people whose exits from the treatment system were planned. This includes: 'Treatment completed – drug free' and 'Treatment completed – occasional user'.

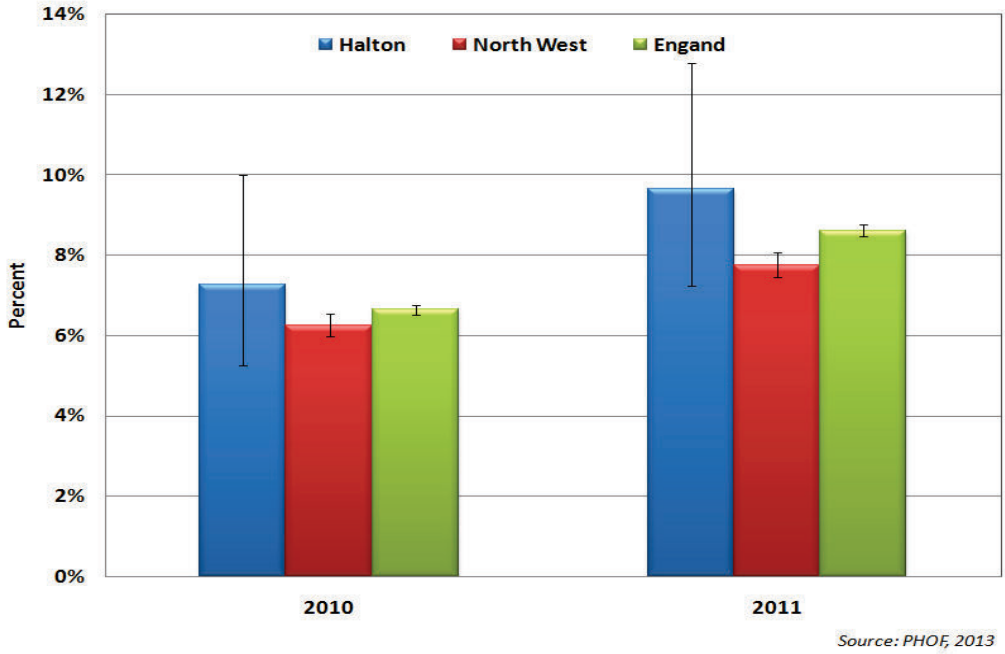
Figure 19: Percentage of exits which are completed (planned) during each year, 2010/11 to 2012/13



In Halton, the percentage of opiate users aged 18 to 75 years, who have successfully completed drug treatment, is higher than the North West and England figures, but not significantly so.

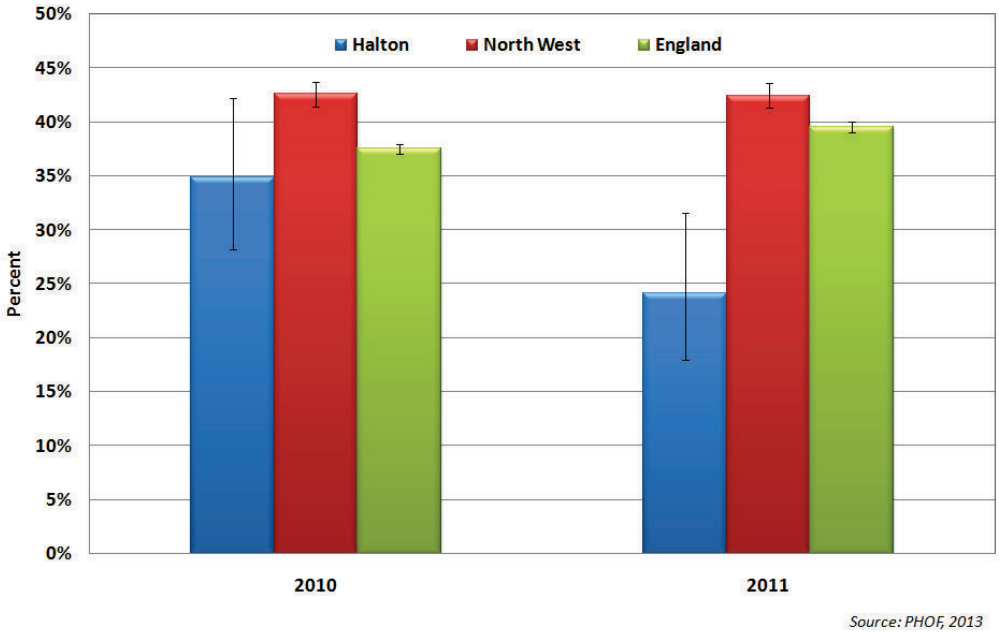
This data relates to people who have successfully left drug treatment and do not re-present to treatment within 6 months.

Figure 20: Successful completion of drug treatment,- opiate users, aged 18 to 75 years, 2010 and 2011



For non-opiate users, the percentage of people who do not re-present within 6 months is higher than opiate users. The chart below shows that the Halton percentage was similar to the England average in 2010, but decreased by over 10% in 2011. Due to this, the 2011 Halton value was significantly lower than the England and North West percentages.

Figure 21: Figure 17: Successful completion of drug treatment, non- opiate users, aged 18 to 75 years, 2010 and 2011



The Treatment Outcome Profile (TOP) is a measure that focuses on the four treatment domains as defined by the National Treatment Agency: substance use, injecting risk behaviour, crime and health and social functioning, measuring the progress an individual makes in drug treatment.

In 2011/12, TOP data shows that 42 exits from drug treatment were 'planned'. The majority of those leaving treatment at this time reported either abstinence or reduced drug use at exit. Individuals also reported that they were no longer committing crime, the number of people reporting being in paid work had increased, and health, psychological health and quality of life had also significantly improved.

3.3. Harm Reduction and Health Improvement

Chronic Hepatitis B and C are the leading cause of liver disease worldwide and the second most common cause of liver disease in the UK, after alcohol. The hepatitis B virus is transmitted perinatally from mother to child and through contact with infected blood. 95% of people who people with new chronic hepatitis B in the UK are migrants, most of whom acquired the infection in early childhood in the country of their. The remaining 5% of people with chronic hepatitis B acquired the infection in the UK, either through vertical transmission from mother to child or through exposure between adults. Hepatitis C is a blood-borne viral

infection transmitted through contact with infected blood. In the UK, hepatitis C is primarily acquired through injecting drug use. Approximately 70–75% of people with acute hepatitis C develop a chronic condition that can result in liver failure and liver cancer[24].

Preventing the spread of hepatitis, also known as a blood-borne viruses (BBVs), is a key public health issue, and a key outcome in the 2010 Drug Strategy[25]. Ensuring people who use drugs do not contract BBVs is one way of keeping them and their communities' safe before and during their recovery journeys.

Preventing BBV transmission also has benefits for wider society, both in terms of reducing health harms, and reduced treatment costs. Effective local action to prevent BBVs will include a range of services and interventions such as; needle and syringe exchange services; offers of testing and vaccination; providing harm reduction advice and information; promoting programmes that encourage a change of behaviour from injecting to some other form of administration.

Individuals that inject drugs are also at risk of HIV, skin and soft tissue infections, respiratory infections, wound botulism and tetanus. Over the past few years there have been a number of cases, both in the UK and main land Europe, of individuals contracting anthrax as a result of injecting contaminated drugs. There are currently 3 sites in Halton where a needle exchange scheme is provided. The largest is established at Ashley House, the other two are in Pharmacies within the community.

Of those individuals that began drug treatment in the past 3 years, over 90% have been offered a course of Hepatitis B vaccinations. However, of these, only 21% had a vaccination, comparing poorly to the regional figure of a third, and the national figure of 40%. With regards to Hepatitis C, nearly all people new to treatment who had a history of injecting were offered a Hepatitis C test, and this offer was taken up by over two thirds of individuals.

Anabolic Steroids

In 2010 the Advisory Council on the Misuse of Drugs (ACMD), a body that provides expert advice to Government, published its report into Anabolic Steroids[26]. In addition to the risks of contracting and/or transmitting BBVs, it reported a range of potential harms associated with their use including acne, cardiovascular symptoms, aggression and liver dysfunction. It also reported that their use by young people could potentially disrupt their normal pattern of growth and behavioural maturation.

The issue of substandard and counterfeit anabolic steroids was also raised. To address these issues the ACMD advised that steroid users should have access to sterile injecting equipment and that there was also a need for widespread, credible, information and advice to counteract mis-information provided by various web sites that actively promote anabolic steroid use.

A total of 507 individuals were reported as accessing the specialist agency needle and syringe programme in Halton in 2011/12. Of these, 403 were reported as steroid users (1 female, 402 male). Over 70% of steroid injectors were aged between 18 and 34. Of those individuals that were not injecting steroids, the age cohorts are evenly spread, although there is a small rise in the 30 to 34 age band.

Healthy Lifestyles Advice to people in treatment services

Many of the individuals presenting to treatment services also experience poor physical and mental well-being as a result of their lifestyles. In particular this can be poor respiratory health as a result of smoking, and poor mental wellbeing such as anxiety and depression. As a first step individuals are able to access a Health Checks Plus assessment. Over the first 6 months of 2012/13, 58 individuals were assessed there were also 77 referrals of people back to their GP for further assessment.

The Bridgewater Community NHS Trust also provides staff to work in Ashley House from their Health Improvement Team. This service aims to support people back into healthier lifestyles through accessing community facilities. Over the first 6 months of 2012/13 there were 37 referrals to the Health Improvement Team.

3.4 Dual Diagnosis

Dual diagnosis is the term used to describe people with mental illness and problematic drug and/or alcohol use. Historically the term has been used for those with “severe and enduring mental illnesses” such as psychotic/ mood disorders. More recently there has been an acceptance that personality disorder may also co-exist with psychiatric illness and/or substance misuse. The relationship between both conditions is complex. Concurrent mental health problems and substance misuse increases potential risks to the individual and is associated with; increased likelihood of suicide; more severe mental health problems; increased risk of violence; increased risk of victimisation; more contact with the criminal justice system; family problems; more likely to slip through services; less likely to adhere to medication or engage with other services; and more likely to lose accommodation and be at risk of homelessness.

With regards to prevalence; about half of patients in drug and alcohol services have a mental health problem, most commonly depression or personality disorder; about a third to a half of those with severe mental health problems will also have substance misuse problems; and alcohol misuse is the most common type of substance misuse and, where drug misuse occurs, it tends also to coexist with alcohol misuse.

In Halton, adult mental health services are delivered by the 5 Boroughs Partnership NHS Foundation Trust and the Council's mental health social care team. Following a recent configuration, the social care team are co-located with the Trust's Recovery Team. A recent audit of individuals in these mental health services identified 51% (n=198) individuals as having previous or current substance misuse. The main substances of use were alcohol, cannabis, amphetamine, benzodiazepines and cocaine. Only 1.5% (n= 6) identified methadone and heroin misuse.

In 2012, NHS Mersey led on a review of the response to Dual Diagnosis involving substance misuse in Liverpool, St Helens, Knowsley, Sefton and Halton. Two of the aims of the review were to 'highlight opportunities for change which could benefit all areas, and to identify gaps in provision'. The key issues that arose from the review and discussions with key stakeholders were;

- Transitions between services are problematic and are the points at which some individuals drop out of treatment.
- Clarification of the roles and responsibilities of the service and staff working within them in relation to dual diagnosis.
- Creating a network between the medical professionals working in substance misuse, mainstream mental health services and primary care.
- Both substance misuse and mental health services are increasingly 'recovery driven' and subject to 'payment by results', presenting opportunities for shared learning and development between the two sectors.
- Service users and their carers need to be involved at every stage in service improvement and development.

3.5 Carers

NICE Guidance identifies the need for services to discuss with families and Carers the impact of drug misuse on themselves and other family members, including children; offer an assessment of their personal social and mental health needs; and give advice and written information on the impact of drug misuse.

Since 2009, drug treatment services in Halton have been allocated a budget by the Carers Strategy Group to provide breaks to those individuals who have been assessed and are caring for someone with a drug and/or alcohol problem. There is currently 2 Carers support groups running at Ashley House. The assessment of carers needs, and the provision of information and advice has been mainstreamed into service delivery.

Between January 2009 and May 2012, 200 assessments were undertaken of Carers attending Ashley House. Age at assessment date ranged between 19 and 85 years with an average age of 47 years (n=73). 158 out of 200 (79%) carers were female. 79 Carers were caring for their son or daughter and 61 caring for their spouse/ partner. The largest cohort with regards to 'caring hours per week' was the 50+ hour's group, the majority of which were aged over 40.

3.6 Drug Related Deaths

The thirteenth annual report from the national programme on Substance Abuse Deaths (np-SAD) at St George's University of London presents information on drug-related deaths that occurred during 2011 and for which Coroner inquests and similar formal investigations have been completed. The Programme's principal function is to provide high-quality and consistent surveillance and to detect and identify emerging trends and issues in respect of this phenomenon. In this way, it contributes to the reduction and prevention of drug-related deaths in the UK due to the misuse of both licit and illicit drugs.

The main changes noted nationally in 2011 are a further overall fall in the proportion of deaths involving heroin/morphine but an increase in the contribution played by methadone. Whilst opiates and opioids continue to dominate, towards the end of 2009 there was a noticeable decline in the number and proportion of cases involving stimulants. To some extent these changes appear to have been reversed slightly for amphetamines, cocaine and ecstasy-type drugs.

The principal demographic characteristics of the decedents have remained consistent with previous reports. The majority of cases were males (72%), under the age of 45 years (66%), and White (97%). Most deaths (78%) occurred at a private residential address.

Substances which at the time of the 2009 report were 'legal highs' but became controlled drugs; continue to be present in post-mortem toxicology reports. Towards the end of 2009 new 'legal highs' such as mephedrone started to appear in reports to np-SAD. These increased during 2010 and 2011. The speed with which these and other new substances are continuing to replace established recreational drugs means it is important that surveillance and monitoring of the situation continues. The most commonly prescribed medications implicated in death were anti-depressants followed by hypnotics/sedatives (mainly the benzodiazepines diazepam and temazepam).

The report identifies 2 Substance Abuse Deaths (np-SAD, Table C) in 2011 of individuals whose usual area of residence is Halton. The illicit drugs implicated were cocaine, amphetamine and ecstasy. In Warrington in the same period there were 11 deaths and in Cheshire, 14

Part Four – Wider Impacts of Drug Use

4.1. Drugs and Crime

In 2010/11, 222 people were arrested in Halton for drug's offences. Not all of these individuals were residents of Halton. Of the 222 arrests, 27 were female and 195 male. 57 people were under the age of 20. The number of arrests for drugs supply were only a little under the number of arrests for drugs possession. Cannabis was the drug for which the highest number of individuals was arrested, either for supply or possession. Cocaine was the second highest drug. Arrests for supply or possession of either heroin or crack cocaine was exceptionally low. There were also 37 arrests for cannabis cultivation.

The Drug Intervention Programme (DIP) is the national criminal justice initiative aimed at engaging substance misusing offenders in drug treatment. Individuals are identified at the various points of the criminal justice system, such as arrest, in prison or in court, and encouraged into treatment services thereby addressing the causes of their offending. For 2010/11 and 2011/12 the number of people entering treatment via this route in Halton was 16 and 17 respectively. However, since the arrival of the new treatment provider in February 2012, the number of people being both assessed and starting treatment via this route has increased significantly with 47 people entering treatment via DIP between April and November 2012. There have also been changes in the 'presenting drug' of individuals seen in the DIP. The numbers presenting using cannabis and cocaine have increased whilst those using heroin have decreased. Of the heroin using cohort only 1 individual is currently injecting.

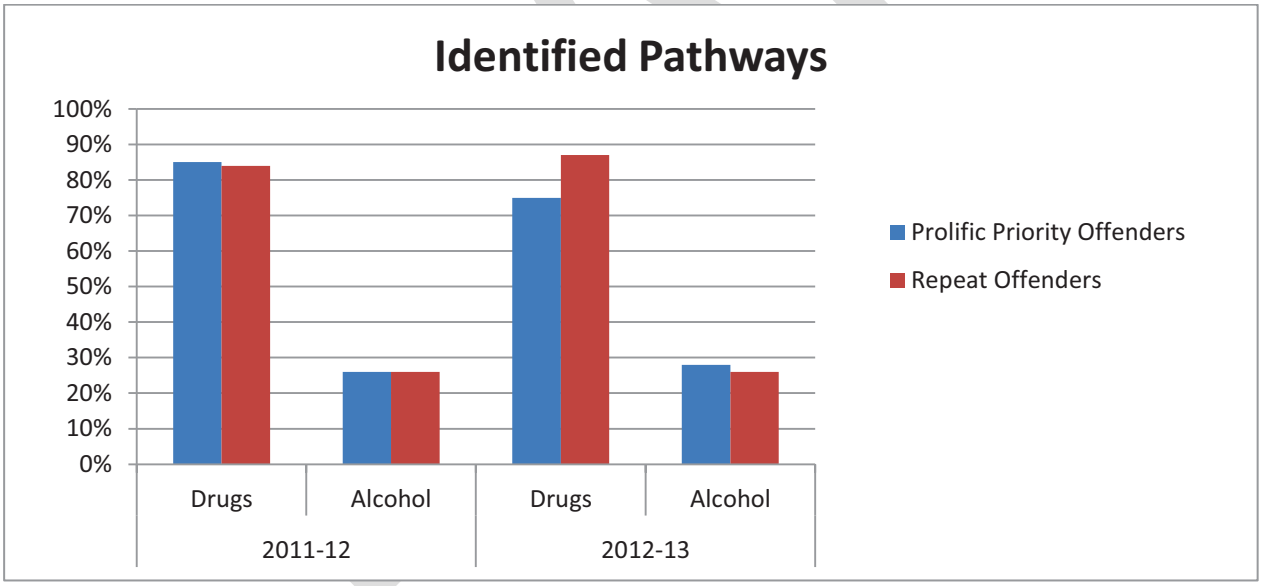
The National Probation Service for England and Wales is a statutory Criminal Justice Service, mainly responsible for the supervision of offenders in the community and the provision of reports to the criminal courts to assist them in their sentencing duties. Information extracted from the Strategic Needs Analysis of the Cheshire Probation caseload published in July 2011, based on all Initial Sentence Plan Assessments showed that over two thirds of Halton offenders had experienced some level of substance misuse, with nearly one third of those individuals still using. Substance misuse was linked to offending behaviour in over half of the Halton cohort analysed.

In a sample of 120 Halton offenders, 63% were using cannabis. For 49% of this cohort, cannabis was their sole drug of use. There were also correlations between age, gender and drug use. Cannabis use was much higher for the under 25 age range, whilst heroin and crack use was more prevalent amongst those aged over 40. Nearly a half, 46% of offenders aged between 18 and 20 were 'currently using' compared to 35% in the 21 to 40 age range and 17% for those aged over 40. Women offenders were also slightly more likely to

be 'currently using' than male offenders, and a higher proportion were using Class A drugs (heroin, crack cocaine & cocaine). Women were also more likely to have previously injected compared to men.

A Drug Rehabilitation Requirement (DRR) is one of a range of community sentences available to the courts. It provides access to drug treatment programmes with a goal of reducing drug related offending. Once a DRR is imposed by the courts the individual must agree to a treatment plan with probation and the treatment service. This plan then sets out the level of treatment and testing required throughout the order. In 2010/11 10 DRRs were started, of which 7 were completed.

The Integrated Offender Management Team, based at Ashley House, is composed of staff from the police, probation service, youth offending service, and substance misuse team. Their remit is to target the individuals in the Borough whose criminality has been identified as causing significant harm to the community, and working assertively with that person to address the causes of their offending and reduce their offending. Where there is little change in an individual's offending they are brought swiftly before the courts. In 2012/13, 75% of Prolific Offenders and 87% of Repeat Offenders had 'drugs' as an identified area for improvement.



4.2 Parental Impact of Drug Misuse

National figures show that a third of the adult drug treatment population has childcare responsibilities (NTA, 2010). For some parents this will encourage them to enter treatment, stabilise their lives and seek support. For others, their children may be at risk of neglect, taking on inappropriate caring roles and, in some cases, serious harm. Having a parent in drug treatment is a protective factor for children. The Munro Review of front line social work highlighted that children are too often 'invisible' to services, including substance misuse services, which tend to focus on the adult in front of them. For several years in Halton, the Commissioners and treatment providers have taken a safeguarding approach to protecting children who may be adversely affected by their parent's drug misuse. This is a wider, more preventative approach to meet the needs of children and involves the treatment services working with a range of agencies to prevent problems before they reach crisis point or formal proceedings need to be taken.

Halton's approach has been to; ensure representation and participation in the Safeguarding Children Board and its sub groups; ensure effective working relationships between treatment services and Children's services; identify, assess and if necessary refer parents misusing drugs; identify, assess and if necessary refer children who need to be safeguarded; and develop staff competencies and training.

A snapshot of treatment service data in February 2013 has shown that just under half of the 700 adults in drug and alcohol treatment services were parents. A similar proportion can also be seen in the 'new treatment journey' data. Between April and September 2012, Ashley House made 59 referrals to the service that provides early help and support to families, Children's Social Care's Integrated Working Support Team (IWST).

A training needs assessment carried out by Halton Adult and Safeguarding Children Boards identified that for the treatment service provider, the priority for training was those staff identified as belonging to Groups 5 and 6. 'Workers considered Professional Advisors, named and designated lead professionals' and 'Operational managers at all levels'. For Adult Safeguarding this means completing the Adult Referrers course or employer equivalent and for Safeguarding Children it means the completion of Effective Supervision or an employer equivalent.

Substance use problems are commonly identified for families which are the subject of Serious Case Reviews in Children's Services. Building on the learning from serious case reviews: A two-year analysis of child protection database notifications 2007-2009, which analysed 268 such reviews, parental drug use was mentioned in 22% of cases, and 22% also noted parental alcohol use. Research evidence suggests that around half of all survivors of domestic violence use substances problematically (Humphreys et al, 2005), with survivors who have experienced more than one sexual assault being 3.5 times more likely to begin or increase substance use (McFarlane et al, 2005).

Part Five –Delivering effective services

Substance misuse can be defined as intoxication by – or regular excessive consumption of and / or dependence on – psychoactive substances, leading to social, psychological, physical or legal problems. It includes problematic use of both legal and illegal drugs (including alcohol when used in combination with other substances)[2].

Early use of drugs increases a person's chances of more serious drug abuse and addiction so it is clear that preventing early use of drugs or alcohol may reduce the risk of progressing to later abuse and addiction. If we can prevent drug abuse, we can prevent drug addiction.

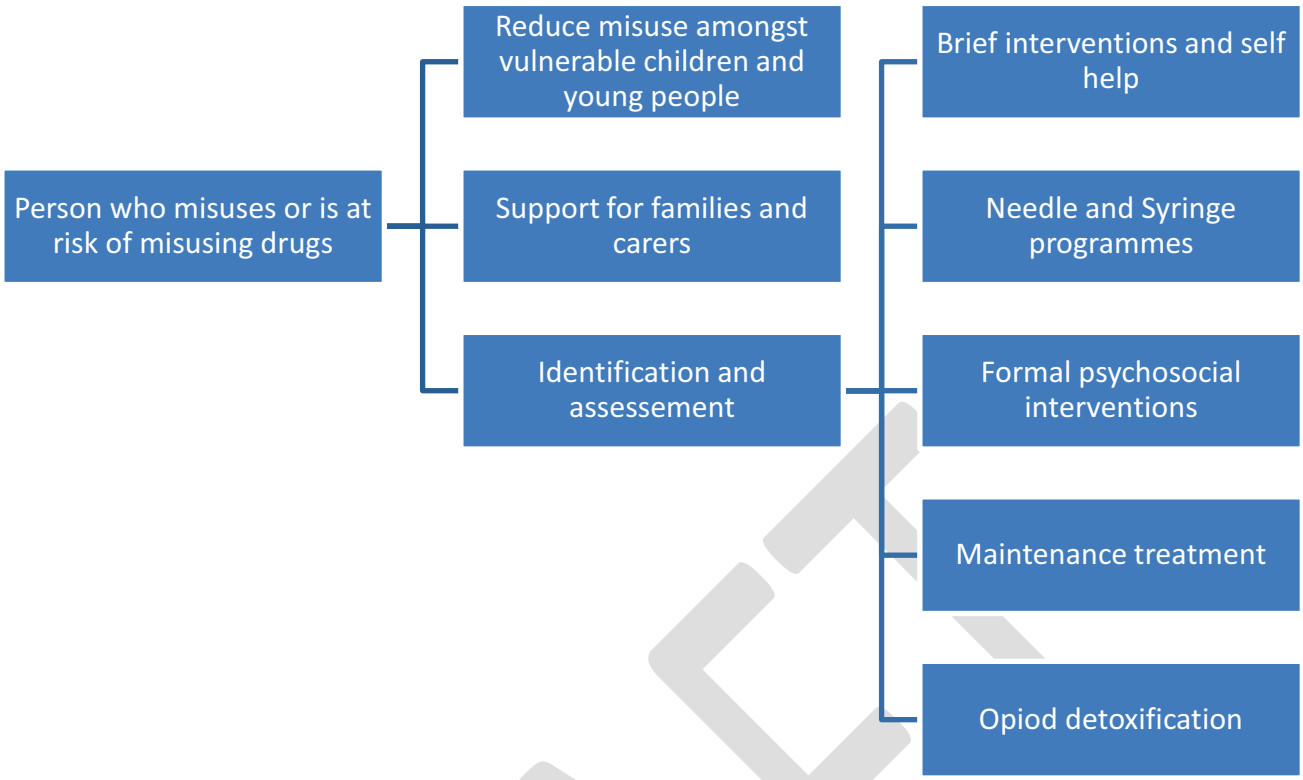
In early adolescence, children are often exposed to legal and illegal substances such as cigarettes and alcohol for the first time. When they enter secondary school, teens may encounter greater availability of drugs and social activities where drugs are used. At the same time, many behaviours that are a normal aspect of their development, such as the desire to do something new or risky, may increase teen tendencies to experiment with drugs. Others may think that taking drugs (such as steroids) will improve their appearance or their athletic performance or that abusing substances such as alcohol or ecstasy (MDMA) will ease their anxiety in social situations.

Drug misuse amongst young people is different from adults. Few young people use heroin or crack and very few are addicted. The most common illicit drug for which young people seek support is cannabis.

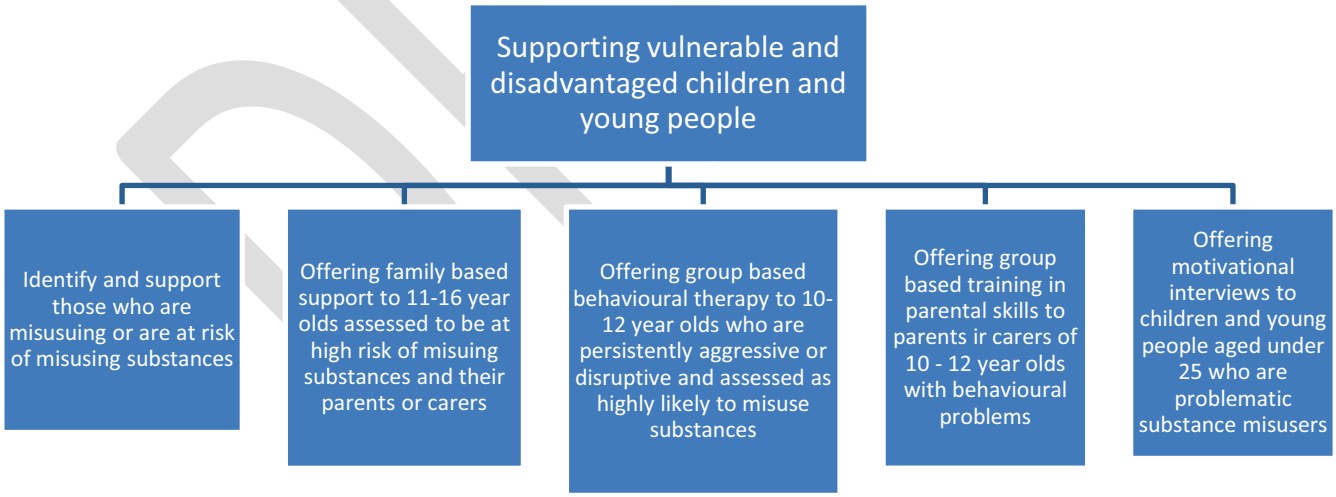
Family support plays a central part, including very early intervention with vulnerable families (particularly parents using drugs themselves). Drug Education and prevention work is delivered through schools and nationally through the FRANK campaign although review is needed to determine how to support schools to improve the quality of all PSHE teaching. NICE proposes that a number of pathways should be in place to support the effective delivery of local services to prevent and reduce the impact of substance misuse[3], particularly amongst vulnerable and disadvantaged children and young people.[4]

The NICE pathway suggests that Local Authorities and their partners should have a strategy and system in place to effectively **identify and support and treat those who misuse or are at risk of misusing drugs**.

[2] http://www.drugabuse.gov/publications/science-addiction
[3] http://pathways.nice.org.uk/pathways/drug-misuse
[4] http://pathways.nice.org.uk/pathways/reducing-substance-misuse-among-vulnerable-children-and-young-people/working-with-vulnerable-and-disadvantaged-children-and-young-people



In addition, NICE suggests that the following pathway should be in place for practitioners and others who work with **vulnerable and disadvantaged children and young people aged under 25.**



Substance Misuse Prevention

Drug use prevention approaches tend to fall into two categories – universal and targeted:

- Universal approaches are designed to reach everyone within a particular population regardless of their risk of substance misuse
- Targeted approaches focus on high-risk sub-groups of individuals or those already engaged in problematic behaviour. In the drugs field the main (but not sole) focus for the primary prevention of drug use has been adolescents in schools.

It has been predicted that roughly 10% of drug users become problem users, and from a public health point of view, it has been argued that greater attention and resources should be paid to those 'at risk' of becoming problem drug users and also those with problematic drug use in order to reduce the associated harm. Others identified as 'at risk' within the current drugs strategy include school excludes/truants, those leaving care, sex workers, young offenders and homeless people.

Research[5] has indicated that there is an association between licit and illicit drug and while both might be considered together as there are similarities in the intervention approaches used to reduce licit and illicit drug use, behaviour varies from drug to drug. Whilst one intervention may be effective in reducing licit drug use, it does not necessarily follow that it will be effective with illicit drugs. Whilst there are clearly advantages to sharing the learning across all substances it has been argued that drug prevention approaches should be drug specific.

Studies have also shown that drug use is strongly associated with early drinking, smoking and sexual activity, indicating that it is part of a repertoire of 'risk-taking' behaviours in young people. The concept of risk has a number of dimensions and, for some, riskiness is itself attractive or for others certain levels of risk can be accepted and rationalised. Whilst drug use is found across all social groups, there is a common assumption that the more damaging forms are to be found particularly among those who are relatively disadvantaged as there appears to be a direct link between drugs and deprivation.

Drug prevention approaches have encompassed a number of different positions - the information dissemination approach aims to increase public' knowledge about the health aspects of drug use, while affective education approaches adopt a broader stance that focus on increasing self-understanding and awareness and enhancing personal development and self-esteem. These approaches to health promotion have tended to assume that as rational individuals, people will make sensible choices about their health if they are given sufficient information.

Until recently, drug misuse was treated largely in isolation from other social and environmental factors and this strategy advocates a multi-agency approach to tackling drug misuse and there is a widely recognised need for public health measures to deal with the issue of illicit drugs and to support people to recognise the need to make a full positive contribution to their communities and make informed decisions about their lifestyle and future choices.

[5] http://www.nice.org.uk/niceMedia/documents/drug_use_prevention.pdf

Towards recovery

The effective commissioning and oversight of drug and alcohol treatment services is a core part of the work of the Director of Public Health. Directors play a key local leadership role around delivering public health outcomes and work with local partnerships – including Police and Crime Commissioners (PCCs), employment and housing services, and prison and probation services – to increase the ambition for recovery. The Health and Wellbeing Board looks to the Director of Public Health, along with local partners, to ensure that the drug treatment and recovery services, and those for the more severely alcohol dependent, are delivered in line with best practice and are aligned and locally led, competitively tendered and rewarded and transparent about performance.

Key to successful delivery in a recovery orientated system is that all services are commissioned with the following best practice outcomes in mind:

- *Prevention of children, young people and adults using drugs*
- *Freedom from dependence on drugs or alcohol;*
- *Prevention of drug related deaths and blood borne viruses;*
- *A reduction in crime and re-offending;*
- *Sustained employment;*
- *The ability to access and sustain suitable accommodation;*
- *Improvement in mental and physical health and wellbeing;*
- *Improved relationships with family members, partners and friends; and*
- *The capacity to be an effective and caring parent.*

Recovery can only be delivered through working with education, training, employment, housing, family support services, wider health services and, where relevant, prison, probation and youth justice services to address the needs of the whole person.

Halton is committed to ensuring that it can offer every opportunity to those people who face up to the problems caused by their dependence on drugs, and wish to take steps to address them. We now need to become much more ambitious for individuals to leave treatment free of their drug dependence so they can recover fully. We will strive to create a recovery system that focuses not only on getting people into treatment but also in getting them into full recovery and off drugs for good. It is only through this permanent change that individuals will stop harming themselves and their communities, cease offending and successfully contribute to society.

Recovery involves three overarching principles– wellbeing, citizenship, and freedom from dependence. it is an individual, person-centred journey, as opposed to an end state, and one that will mean different things to different people. We must therefore, put the individual at the heart of any recovery system and commission a range of services to provide tailored packages of care and support. This means that local services must take account of the diverse needs of the community when delivering services.

Substitute prescribing continues to have a role to play in the treatment of heroin dependence, both in stabilising drug use and supporting detoxification. However, for too many people currently on a substitute prescription, what should be the first step on the journey to recovery risks ending there. Recovery is not just about tackling the symptoms and causes of dependence, but about enabling people to successfully reintegrate into their communities. It is also about ensuring that they have somewhere to live, something to do and the ability to form positive relationships. Those already on the

recovery journey are often best placed to help, and we will support the active promotion and support of local mutual aid networks such as narcotics anonymous.

Evidence also shows that treatment is more likely to be effective, and recovery to be sustained, where families, partners and carers are closely involved. We will encourage local services to promote a whole family approach to the delivery of recovery services, and to consider the provision of support services for families and carers in their own right.

It is estimated that a third of the treatment population has child care responsibilities and for some parents, this will encourage them to enter treatment, stabilise their lives and seek support. Halton is committed to supporting those working with children and families affected by substance misuse to undertake appropriate training so they can intervene early to protect children from harm. Playing a more positive role in their child's upbringing is often a motivating factor for individuals in making a full recovery.

Evidence also suggests that housing and employment, along with appropriate support, can contribute to improved outcomes for drug users in a number of areas, such as increasing engagement and retention in drug treatment, improving health and social well-being, improving employment outcomes and reducing re-offending, and we will ensure that support is in place to work with individuals to maximise their life chances.

The following NICE quality standards and clinical guidelines are also available to support local implementation of both prevention and treatment activities.

- **QS23 Drug use disorders: quality standard (web format)**
- **Interventions to reduce substance misuse among vulnerable young people**. NICE public health guidance 4 (2007).
- **NICE clinical guideline: CG113 Anxiety**
- **NICE clinical guideline: CG91 Depression with a chronic physical health problem**
- **NICE clinical guideline: CG90 Depression in adults (update)**
- **NICE public health guidance: PH18 Needle and syringe programmes**
- **NICE clinical guideline: CG52 Drug misuse - opioid detoxification**
- **NICE clinical guideline: CG51 Drug misuse - psychosocial interventions**
- **NICE clinical guideline: CG113 Anxiety**
- **NICE clinical guideline: CG91 Depression with a chronic physical health problem**
- **NICE clinical guideline: CG90 Depression in adults (update)**
- **Drug misuse and dependence: UK guidelines on clinical management - Department of Health (England) and the devolved administrations (2007)**
- Drug misuse: opioid detoxification. NICE clinical guideline 52 (2007).
- Drug misuse: psychosocial interventions. NICE clinical guideline 51 (2007).
- Behaviour change. NICE public health guidance 6. (2007).
- Drug misuse - naltrexone. NICE technology appraisal 115 (2007).
- Drug misuse - methadone and buprenorphine. NICE technology appraisal 114 (2007).
- Brief interventions and referral for smoking cessation. NICE public health intervention guidance 1 (2006).
- **Service user experience in adult mental health**. NICE clinical guideline 136 (2011)
- **Self-harm: longer-term management**. NICE clinical guideline 133 (2011)
- **Psychosis with coexisting substance misuse**. NICE clinical guideline 120 (2011)
- **Alcohol use disorders**. NICE clinical guideline 115 (2011)

- **Anxiety**. NICE clinical guideline 113 (2011)
- **Depression in adults**. NICE clinical guideline 90 (2009)
- **Obsessive-compulsive disorder**. NICE clinical guideline 31 (2005)
- **Post-traumatic stress disorder (PTSD)**. NICE clinical guideline 26 (2005)
- **Self-harm**. NICE clinical guideline 16 (2004)
- **Eating disorders**. NICE clinical guideline 9 (2004)

Systems, processes and pathways must be put in place to best meet the national guidance and ensure that the best possible services are available on a local level to provide cost effective, efficient and timely services to those who need them.

Part Six –Service User & Carer Involvement and Patient Opinion

Empowering people to shape their own lives and the services they receive through policies such as*;* Putting People First, the Localism Bill, and Liberating the NHS*,* has been a central feature of public sector delivery for a number of years. A more personalised approach to health and social care based on giving service users and carers a more direct say over service quality and improvement underpins the regulatory functions performed by the Care Quality Commission. In addition, commissioning guidance in general states the importance of not only incorporating service user and carer views in the shaping of delivery, but also in the monitoring of provider performance.

In Halton, this issue is being addressed through a variety of means. Earning the trust and respect of service users and carers is central to successful engagement and listening to local people requires time, energy and effort to create and cultivate trusting relationships that are based on respect and understanding. By doing so, people are more likely to be motivated and inspired to give insight from some of their most personal experiences.

Unsuccessful relationships between users and providers are often when service users feel that the service provided is being done **'to'** rather than **'with'** them. Service users are central to their own treatment plans so that individual needs are considered and more integration and coordination with other institutions is possible. Each service provider is challenged to provide robust evidence of active engagement with service users, their carer's and families and demonstrate how the voice of the service user has informed and influenced service design and delivery. Services are monitored on any comments, compliments or complaints that are provided directly and, in the case of the Substance Misuse contract, an organisation known as Patient Opinion, which is an independent, not for profit organisation that works across the NHS has been commissioned to provide a point of communication for service users.

The work of Patient Opinion has been exampled in several Government publications, most notably a House of Commons Health Committee report that said, ' the Committee sees great value in providers constantly viewing the comments left about them on websites such as Patient Opinion and NHS Choices. Or the Cabinet Office report 'Making Open Data Real' that said 'by creating structured public conversations about recent experiences of a local health service, Patient Opinion aims to both stimulate improvement and show transparently whether services are listening to those they serve' and that 'feedback posted by patients and carers can be directed not just to the providers of care, but also to commissioners, regulators, civil society organisations and others'. One of the examples quoted in the report was where feedback from a Halton service user resulted in a change of

prescribing practice by the drug treatment service with a subsequent reduction in risks of re-offending and health.

Part Seven –Workforce

The development of skills, knowledge and expertise with regards to substance misuse has focused on two areas; ensuring staff employed within the substance misuse service are appropriately skilled and qualified to deliver effective drug treatment; and improving the awareness and knowledge of front line professionals in order to recognise, and where appropriate, either intervene through a brief intervention, or signpost individuals to more specialist support.

Since taking up the contract to deliver drug and alcohol treatment in February 2012, Crime Reduction Initiative (CRI) has instigated a comprehensive training programme with their staff. In addition to learning around key drug treatment skills such as the International Treatment Effectiveness Programme and Motivational Interviewing, colleagues have also received training in key areas such as Safeguarding Adults, Safeguarding Children and Equality and Diversity

Delivering learning to non-drug treatment staff has taken a two pronged approach; through the provision of e-learning and a wide variety of one day courses covering key areas.97 individuals across a wide range of organisations completed the 'awareness of alcohol and substance misuse' e-learning course. In terms of course evaluation, 96% of respondents would recommend the course to colleagues; 86% rated the course highly in terms of giving confidence to deal with these issues and in terms of content.

In 2012/13, 10 courses were available to individuals looking to acquire a more in depth knowledge of substance misuse. The courses; key concepts for Understanding Drug Use, Keep off the Grass – People and cannabis, Alcohol awareness – Identification and Brief Advice, Cocaine – Whose Line is it Anyway, and Drug Trends and Legal Highs. In 2012/13 a total of 127 people attended these courses. 74 were from within the Council, and 53 from external agencies. In the year previously 38 people attended these types of courses. The reason for the considerable increase in attendance was that following the termination of a contract with a Liverpool based specialist drugs training company, the resource was re-invested in providing more appropriate training delivered in Borough.

Over the past 2 years, 4 courses on parental substance misuse have been delivered by the treatment providers on behalf of Halton's Safeguarding Children Board. 30 individuals attended in 2012/13 and 33 individuals in 2011/12.

Part Eight- Funding

8.1. Introduction

As the Government's policy of deficit reduction continues, the impact on the public sector is significant and with the public sector having to make unprecedented decisions about the services that it continues to deliver, this ultimately has an impact on service delivery and residents expectations. The current position with regards to financing substance misuse service will be discussed within this part of the document.

Figure 22: Funding for Substance Misuse Service 2013/14

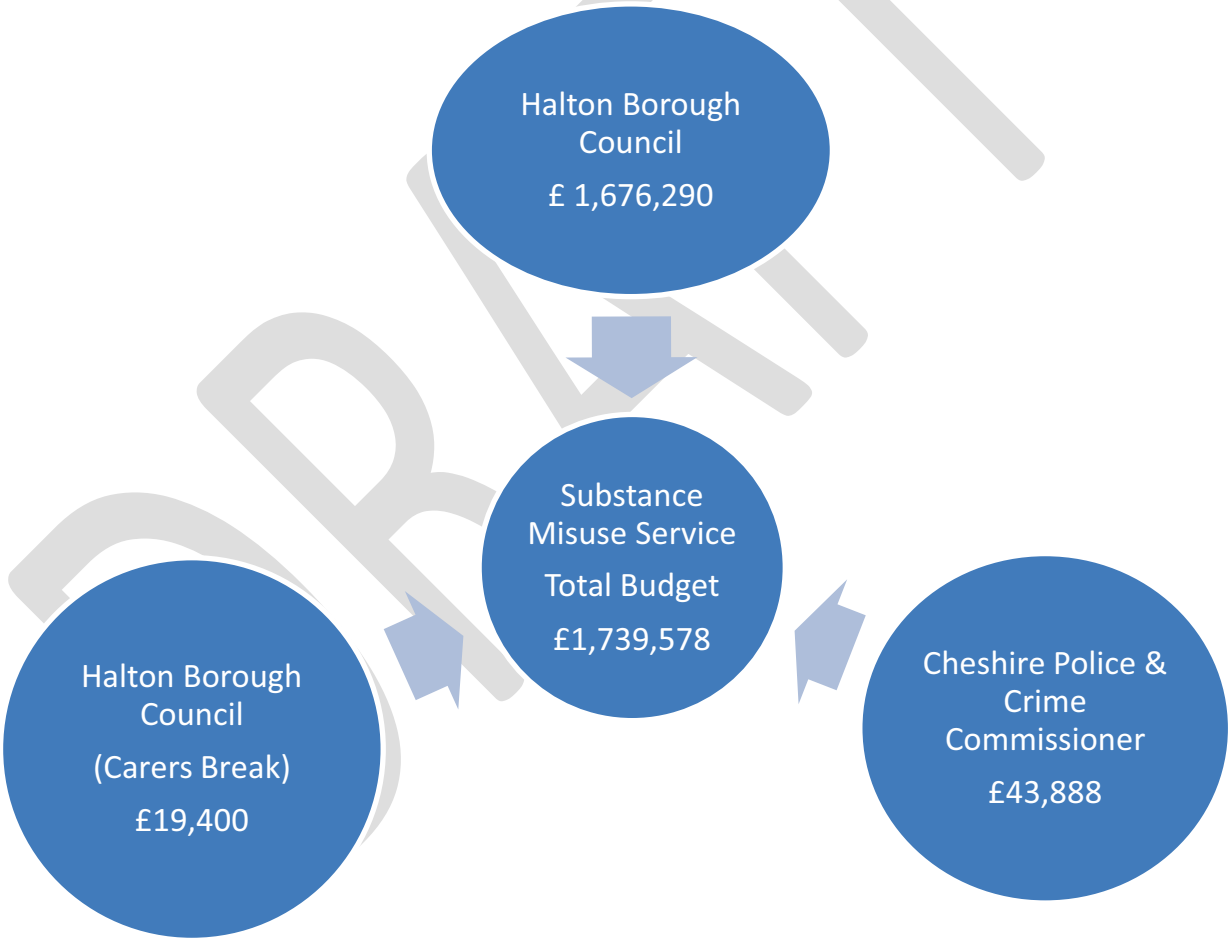


Table 12: Budget received for 2012/13 for substance misuse service (including drugs and alcohol)

Halton Borough Council	£1,676,290
Cheshire Police and Crime Commissioner	£43,888
Halton Borough Council (Carers Breaks Funding)	£19,400
Total	**£1,739,578**

From April 2013, all of the funding streams changed now all Government funding for Drugs is via Public Health (England) with the exception of the Home Office DIP funding, which transferred to the Police and Crime Commissioner. In-patient and Community treatment budgets for alcohol, used to contract provision from Mersey Care NHS Trust and Crime Reduction Initiatives (CRI) respectively also transferred into the Public Health allocation.

8.2 Pooled Treatment Budget (PTB) Allocation Funding Formula

The formula used by the National Treatment Agency to allocate Pooled Treatment Budgets in 2012/13 for each individual area was comprised of 3 parts:

- Complexity of partnership; 24% of the allocation is based on the 'York formula' which reflects deprivation, health and socio-economic conditions
- Activity; 56% is based on the number of adult drug users in treatment for 12 weeks or more, or if left treatment before 12 weeks, did so 'successfully'. This data is also segmented to identify heroin/crack users and other drug users, with the former attracting twice the tariff of the latter. A Department of Health 'Market Forces Factor' is also applied.
- Reward; 20% is allocated on the basis of activity in relation to the number of successful completions that did not re-present for treatment anywhere in England for at least 6 months

The Advisory Committee on Resource Allocation has recommended that this formula should continue beyond April 2013. This is in effect a 'payment by results' approach.

8.3 Payment by Results

The 2010 national drug strategy committed to introduce pilots to test how payment by results could work for drug services. The intention was based of the outcomes expected to be seen; free from drug(s) of dependence, reductions in offending and improvements in health and wellbeing, providers are freed up to innovate rather than follow target-driven processes, and are encouraged to support more people to full recovery. At present there are a number of areas around the country that are piloting this approach to commissioning drug treatment. A similar exercise is taking place with alcohol treatment. A formal evaluation over 3 years is currently being undertaken by the National Drug Evidence Centre (NDEC) at the University of Manchester, regular updates can be found on the Department of Health website.

8.4 Value for Money

During 2010, the National Treatment Agency (NTA) worked closely with economists in the Department of Health and the Home Office to develop a Value for Money (VFM) model of drug treatment which models the costs, cost savings and natural benefits of providing effective drug treatment. For 2010/11 the VFM Tool identifies £5.3 million of crime savings and £4.5 million of health savings as a result of providing drug treatment in the Borough. For the period of 2005/06 to 2010/11 the tool also identifies that for every pound spent on drug treatment £5.47 was gained in total benefits. This compares favourably to the national figure presented by the National Treatment Agency of £1 spent generating £2.50 of benefits.

8.5 Financial Constraints

There are a number of financial pressures anticipated in delivering this drug strategy

- A significant proportion of the Pooled Treatment budget is allocated on activity with regards to individuals who use heroin and/or crack cocaine. Current evidence is highlighting that there are very few individuals remaining in the community with this issue, and therefore activity with regards to this cohort will be fairly static this follows a national trend of reduced numbers of heroin and crack use. The area of increasing activity is with people using other types of drugs. They however only attract half the tariff. Therefore income for this funding stream may continue to reduce, despite good performance.

- To date there has been little pressure on the community care budget to fund residential rehabilitation. Were there has, this been around alcohol using adults. However, as the patterns of drug use change and work extends into what have previously been 'hidden' populations such as older people, people addicted to prescribed medications, women with children etc this may change. Management of demand for this form of intervention will rely heavily on the front line professionals in the treatment service and their integrated working with partners such as the Local Authority and Primary Care.

Part Nine–Current Service Provision

9.1 Introduction

Drug users have to take responsibility for their actions, and also their recovery. Services are there to support them by providing appropriate information, support and advice to enable individuals to make informed choices. In order to support an individual to recover from drug use or dependency it is essential to have services available at the time a drug user chooses to ask for help, any delay in the initial contact may miss the opportunity to support an individual to change their drug habits, dependency or behaviours. Those that use drugs will do so for a range of reasons and the interventions required will vary from person to person. The services available in Halton have been designed to meet a diverse range of needs with partner agencies working together.

The service model in Halton is one of prevention and recovery with the service user as the focal point and agencies working together to maximise resources and to promote individual growth, reducing the risk of dependency, and the impact on family members and the community (see diagram on pg. 43).

The services offered in Halton are themed:

- Reducing Crime
- Improving Health
- Reducing parental impact of drug use
- Promoting recovery for individuals

Table 13: How the budget was allocated 2013/14 for

Workforce Development:	£14,000
User Involvement	£5000
Carer Involvement	£31,250
Harm reduction	£165,000
Re-Integration	£113,000
Open Access Drug Treatment	£127,750
Structured Community Based Treatment	£360,110
In-patient rehab/detox	£170,120
Drug Intervention Programme	£107,750
Children's Service (Specialist Provision)	£79,000
Commissioning System	£25,380
Operational	£179,218
Alcohol Services	£362,000

9.2. Ashley House (Substance Misuse Service)

Halton's Integrated Support Service based at Ashley House, Widnes is a 24 hour 'One-Stop Shop' for substance misuse services, offering support in Halton. The services at Ashley House include advice, treatment and information for anyone to get help and support for drug and alcohol related issues.

Ashley House has a team of supportive staff, who are always on hand to offer advice and support and work towards helping people get their lives back on track and drug free. Some individuals are unable to be drug free but substitute illegal drugs for prescribed medication e.g. methadone; their journey through drug treatment programmes takes many years but the absence from illegal drugs reduces the risk and impact on the individual, family members and communities.

9.3. Children and Young People's Services

The Early Intervention / Targeted Outreach provision is delivered through the VRMZ outreach bus and street based teams. It identifies and targets those young people who are vulnerable to substance misuse.

Through Halton Youth Provision, we continue to support young people to recognise the need to make a full and positive contribution to their communities and make informed decisions about their lifestyle and future choices.

Halton Youth Provision actively engages with and works alongside other agencies to meet the needs of young people at risk of substance misuse, including Youth Offending Service, Health Improvement Team, School Health, Social Care, Community Safety and the Voluntary and Community Sector.

School based interventions are provided through the "Healthitude" programme, which aims to provide information, advice and guidance on a number of key health areas, including substance misuse, and to build the resilience of young people against risk taking behaviour.

Halton Early intervention and targeted Youth Provision also provides a range of one-to-one or group-based activities, for example:

- Reducing anti-social behaviour and substance misuse
- Support for young people affected by parental substance misuse, through the Skills for Change and Amy Winehouse Foundation.
- Debate with young people and communities issues related to ASB and substance misuse
- Cognitive restructuring interventions
- Interventions on positive substance misuse and sexual health
- Motivational strategies
- Positive Activities for Young People programmes which aim to engage young people in productive activities during school or college, holiday periods;

Figure 23: Service User focused approach to recovery

The choices individuals make can have a significant impact on their future health and well-being, the earlier individuals make informed choices about their drug use and the problems this can cause to their health and well-being, the earlier they can either stop using drugs or ask for help to reduce the dependency.

In order to enable individuals to make informed choices they need to have valid information and advice to understand the implications that their actions and choices have. Investing time and resources to address the broader determinants of health and wellbeing has been shown to not only lead to the prevention of disease in the longer term, but have a positive outcome beyond disease prevention, such as improved physical health, more social cohesion and engagement, better educational attainment, improved recovery from illness, stronger relationships and improved quality of life.

9.4. Peer mentoring (Recovery Champions)

Peer mentoring and support are invaluable when an individual asks for help; a person that has travelled the same journey and is in recovery holds a significant influence on those new to treatment. As services develop and information campaigns are designed it is key to success to have former and current users, family members, parents and carers involved in the design of information campaigns and sharing the news.

The Recovery Champion Programme at Ashley House provides training to individuals that have successfully recovered from drug use/dependency to enable them to provide a consistent approach when supporting other recovering drug users.

9.5. Carers and Families

Carers and family members of drug misusers are a diverse group and the stresses or problems that they may experience will be influenced by a number of factors which may include for example their own coping skills and mechanisms, culture and other stresses that they may be experiencing at that time in their life. Ashley House has a dedicated carers group that supports new and existing members in a range of ways to relieve the stress and pressure of the informal caring role; carers are also signposted to the Halton's Carers Centre for information, advice and support. The role of the carer is essential in the journey of recovery for the person dependent on drugs.

9.6 Narcotic Anonymous

Each week at Ashley House there is a Narcotic Anonymous meeting, the key to this meeting is those attending build a trusting relationship with services and others recovering from drug dependency, but the key theme is that drug misuse and dependency didn't happen overnight, so recovery will also take time and is designed to promote resilience and empower individuals to recover from drug dependency.

9.7. Community Pharmacies (Needle Exchange)

The community pharmacies have a key role to play in enabling a person to recover from their drug dependency. The knowledge and skills of pharmacists enable them to offer advice and signpost individuals to other more specialist resources for on-going support. In particular the needle exchange that is offered within two of Halton's Pharmacies and Ashley House reduces the risk of cross contamination of Blood Bourne Viruses, through the provision of free sterile needles. The pharmacists also work with the Substance Misuse Service at Ashley House in relation to supervised consumption of recovery drugs, the relationship is key in this partnership as drug users miss a pick up the Pharmacist will alert Ashley House staff who contact the individual, the benefit of this procedure is that the person in recovery stands a greater chance of maintaining their recovery.

9.8 Health and Wellbeing

An individual's health and well-being can be affected in numerous ways; this may be poor physical and mental health, housing related problems or homelessness, unemployment or financial hardship all of which can have a direct impact on the individuals drug use.

Primary health services have a role to play in the promotion and improvement of individual's health and wellbeing, this may be advice and guidance at the early stages of drug misuse, or advice for family and carers who are concerned about their family members. Under the NHS reorganisation, the responsibility of commissioning primary care to deliver drug treatment services transfers from the Primary Care Trusts to the Local Authority. Currently there are 3 GP practices delivering this service in Halton.

Health improvement initiatives are essential tools for ensuring drug users have the appropriate support and care they need:

- Health Checks
- Blood Bourne Virus Screening (HIV, Hepatitis C and B)
- Smoking Cessation programmes
- Sexual Health programmes
- Access to early detection and prevention of cancer.
- Screening and treatment associated with Chronic Pulmonary Obstructive Disease (COPD)

There is a growing trend of dependency on prescription medication, over the counter medication, steroids and human enhancing drugs such as weight loss, anti-ageing, and sexual enhancing drugs, the long term health implications are not known but research continues both nationally and internationally. Services need to work together, to ensure that drug users are appropriately supported, at the time of asking for help.

When a drug user comes into contact with services (Health Care, Social Care, Housing providers, criminal justice services or education) it may be the opportunity for them to turn their lives around, at that point referral pathways between services are essential alongside awareness training for front line practitioners of the local specialist drug services available.

Recovery can maximise the health and wellbeing of the individual, this then has a positive impact on the wider communities. The hardest part and the first step of recovery is for the drug user to acknowledge they have a drug problem. Individual wellbeing is about how people experience their own quality of life, and includes family relationships, financial situation, work, community and friends, health, personal freedoms and personal values. Individuals and communities are resilient and are able to cope with change, challenge and adversity.

Recovery embraces inclusion, or a re-entry into society and the improved self-identity that comes with a productive and meaningful role. For many people this is likely to include being able to participate fully in family life and be able to undertake work in a paid or voluntary capacity.

9.9. Public Health

Public health is "The science and art of promoting and protecting health and wellbeing, preventing ill-health and prolonging life through the organised efforts of society" UK Faculty of Public Health (2010)

As a function of the Local Authority, Public Health is concerned with the health of the entire population, requiring a collective multi-disciplinary effort. Public Health has a responsibility for:

- commissioning health services
- monitoring health status and investigating health problems
- health protection
- informing, educating and empowering people
- creating and supporting community partnerships
- developing policies and plans
- linking people to needed services
- conducting evaluations and research

One of the main concerns of public health is to reduce inequalities in health; in Halton compared to other areas in England and also within various communities across Widnes and Runcorn. Health in Halton is generally improving, with life expectancy increasing each year and rates of people dying from heart disease

and most forms of cancer are decreasing. However, this is not the case for all people in Halton and as a result the health of the population in Halton is below average compared to England as a whole. We can improve this, and we aim to encourage people to lead a healthy lifestyle to help improve health and tackle inequalities in health. Leading a healthy lifestyle means eating healthily, drinking sensible amounts of alcohol, taking exercise, quitting smoking and leading a healthy and safe sex life.

9.10 Public information campaigns, communications and community engagement

Information and advice are key to the prevention of drug use, ensuring young people, parents and adults are provided with factual, accessible information about the risks involved in taking drugs. Parents and schools also require information and advice to enable them to identify when young people may be taking drugs.

There is an increase in the use of social media, and also internet available advice and support via a variety of media, in order to meet the changing needs of young people and adults information needs to be available using a range of formats linking to self-assessment and self-help tools so individuals take responsibility for their health and lifestyle.

The overall aim of information and advice is to prevent drug use or to enable an individual to access information to prevent the drug use becoming an issue or dependency. As drug use takes many forms from illegal drugs to over the counter or prescription medication; information and advice will cover all forms of drug use and the associated risks.

Public information campaigns are an essential tool in getting the information to the public, this can be achieved through national campaigns as well as television programmes that highlight the issues of drug use. Locally information and advice is provided to schools, homeless hostel accommodation, community centres and GP surgery's etc.

9.11 Halton Clinical Commissioning Group (CCG)

Halton Clinical Commissioning Group is made up of representatives from each of the 17 practices across Runcorn and Widnes. The CCG is responsible for planning NHS services across the borough, and work with other clinicians and healthcare providers to ensure they meet the needs of local people.

Creation of CCGs forms part of the government's wider desire to create a clinically-driven commissioning system that is better aligned to the needs of patients.

The CCG works with patients and healthcare professionals, as well as in partnership with local communities and Halton Borough Council to make sure that health and social care is linked together for people whenever possible. In addition to GPs, our governing body will have at least one registered nurse and a doctor who is a secondary care specialist.

9.12 Cheshire Constabulary

The police sit at the heart of local enforcement. Good neighbourhood policing will gather intelligence on local drug dealers, provide reassurance and be visible to the public and deter individuals who seek to threaten and intimidate neighbourhoods. The supply, dealing and possession of drugs continues to be a priority for neighbourhood policing, thus providing reassurance to communities that anti-social or illegal behaviour will not be tolerated within Halton.

Cheshire Constabulary will continue to invest in key individuals dedicated to the role of drug experts. These individuals will act as a source of expertise and advice for officers and will be an effective conduit for updated information regarding the changing drug landscape and legislation.

It is essential that appropriate information sharing across agencies is maintained to ensure that a co-ordinated strategic approach to tackling drug supply is achieved; this is supported by national information sharing protocols with other police forces and the National Crime Agency.

9.13 Cheshire Probation Service

The National Probation Service for England and Wales is a statutory Criminal Justice Service, mainly responsible for the supervision of offenders in the community and the provision of reports to the criminal courts to assist them in their sentencing duties. Information extracted from the Strategic Needs Analysis of the Cheshire Probation caseload published in July 2011, based on all Initial Sentence Plan Assessments showed that over two thirds of Halton offenders had experienced some level of substance misuse, with nearly one third of those individuals still using. Substance misuse was linked to offending behaviour in over half of the Halton cohort analysed.

9.14 Integrated Offender Management Programme

The Integrated Offender Management (IOM) Programme is a joint scheme by Cheshire Probation Service, Cheshire Police and Halton Borough Council and is co-located with other services at Ashley House. The IOM service focuses on the most Prolific and Priority Offenders (PPO). Under the programme, once an individual

has been identified as a PPO they have two options: either to work with the PPO officers and team at Ashley House, or choose 'not' to accept any help. If they choose to work with the PPO Officer and team to change their behaviours and lifestyle they are supported to overcome their drug and/or alcohol addiction and find suitable accommodation. By choosing not to work with the PPO Team the individual opens themselves up to robust and proactive targeting by all agencies involved in the programme; this will include close supervision and several unplanned visits per day by the joint agencies to manage both the offending behaviour and their behaviour in the community, with any evidence of criminal activity being dealt with as a priority by the court. Cheshire Police are using the Restorative Justice process to support some individuals found in possession of cannabis directly into treatment rather than being subject to criminal procedures. The ultimate aim is to reduce crime and ensure individuals take responsibility for their actions.

9.15 Social Care (Children and Adults)

"Social workers are ideally placed to offer a holistic approach to understanding the relationship between the person's substance use and their family, home and community." (Galvani and Forrester, 2010)

9.15.1. Children's Social Care

National figures show that a third of the adult drug treatment population has childcare responsibilities (NTA, 2010). For some parents this will encourage them to enter treatment, stabilise their lives and seek support. For others, their children may be at risk of neglect, taking on inappropriate caring roles and, in some cases, serious harm. Having a parent in drug treatment is a protective factor for children. The Munro Review of front line social work highlighted that children are too often 'invisible' to services, including substance misuse services, which tend to focus on the adult in front of them. For several years in Halton, the Commissioners and treatment providers have taken a safeguarding approach to protecting children who may be adversely affected by their parent's drug misuse. This is a wider, more preventative approach to meet the needs of children and involves the treatment services working with a range of agencies to prevent problems before they reach crisis point or formal proceedings need to be taken.

A snapshot of treatment service data in February 2013 has shown that just under half of the 700 adults in drug and alcohol treatment services were parents. A similar figure proportion can also be seen in the 'new treatment journey' data. Between April and September 2012, Ashley House made 59 referrals to the service that provides early help and support to families, Children's Social Care's Integrated Working Support Team (IWST).

9.15.2. Adult Social Care

Individuals that misuse drugs can suffer from a range of physical health and mental health problems. Yet the complex nature of health and social care issues alongside a dependency on substances can make it difficult to support an individual. Halton Borough Council Social Care teams and a Mental Health Recovery Team provide assessments of individual needs and offer appropriate advice and support, utilising a person centred approach to promote independence. It is the co-ordinated approach of care management that enables professionals to work together to achieve outcomes for the service user. The link between services is evolving social care and the substance misuse service co-ordinate case management for individuals.

9.16 Housing Solutions Team

The Housing solutions team work with individuals who are threatened with homelessness or who are homeless, the team's aim is to prevent homelessness where possible. The Housing solutions team offer advice and guidance to individuals and families. The team work closely with the Welfare Rights, Citizens Advice Bureaux (CAB), Register Social Landlords, and private landlords, and providers of temporary accommodation within the borough as well as statutory services to ensure that appropriate advice and support is provided to the individual and/or family.

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REPORT TO: Health Policy and Performance Board

DATE: 6 November 2013

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health and Wellbeing

SUBJECT: Housing Adaptation Policy (Major & Minor Procedures and Practice Manual)

WARD(S): Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To consult with members of the Health Policy and Performance Board on the proposed amended section of the Housing Adaptations Policy relating to **Ramps**

2.0 RECOMMENDATION: That the Board:

i) Note the contents of the report; and
ii) Provide comment on the proposed amendments.

3.0 SUPPORTING INFORMATION

3.1 This policy was originally introduced in 2010 to:

- To ensure a fair and consistent response when considering the provision of adaptations to a person's home; and
- To assist Occupational Therapists, Community Care Workers and technical staff in recommending adaptations that are necessary, appropriate, reasonable, practical and cost effective.

3.2 In addition to the policy being reviewed in early 2013, a further review of the ramps section of the policy has taken place during August 2013. This was in response to an increase in ramp requests raised with the Contact Centre, by residents who have independently purchased mobility scooters, where an Initial Assessment Team assessment of access to the residential property had not been undertaken.

3.3 Eligibility for a ramp is primarily based around being a wheelchair user. The Wheel Chair Assessment Team do not currently assess for scooters. Scooters can be purchased outright or via lease agreements buy individuals who have had no assessment of mobility or assessment of access to their property.

3.4 The revised ramp section of the policy has clarified the criteria for ramp installation to make it easier for initial decisions made by Contact Centre staff to be made equitably.

Amendments to the Ramp section of the Housing Adaptations Policy

3.5 Generally the principals behind assessment of access to a property and suitability of ramp installation remain unchanged. However, the following proposed change to the policy guidelines was approved, in principal, by Communities SMT in August 2013:

'A ramp will not be provided for a person who has privately purchased a mobility scooter, unless that person has been assessed by the Wheelchair Service as being in need of an outdoor wheelchair and the person has chosen to use a scooter as a means of outdoor mobility instead.'

3.6 The policy references that where enquiries are about an individual who is palliative consideration must be given to their current mobility and access needs. Alternatives to permanent ramps could be considered (i.e. grab rails, portable ramps).

3.7 The review takes into account that where eligibility for ramp installation is not met, individuals who have already independently purchased mobility scooters may benefit from signposting and information should they wish to make their own arrangements for ramp installations and/or storage of the scooter.

3.8 It is clear in the policy that by providing this information it is not an acceptance by Halton Borough Council that the use of a mobility scooter is warranted and that ramp access is required. It serves simply to provide information on options available to the individual should they wish to purchase ramp or storage equipment themselves. Providing signposting to information may enhance the customer experience when contacting the Council

3.9 Signposting will primarily be done via the Independent Living Centre (ILC). Information will be provided on ramps and outdoor scooter storage equipment.

3.10 The policy emphasises the public liability consequences for ramp installation and usage. The responsibility for appropriate use of a ramp lies with the individual, not the Council, i.e. where a ramp is installed for wheelchair use (a lesser specification ramp) and is then used for a mobility scooter, the liability for injury or damage as a result lies with the individual. The Council's Legal department have confirmed that there is no recourse under Public Liability, for the Council, for condoning the use of a privately purchased scooter by approving or installing a ramp or providing information on such.

3.11 The policy emphasises that the individual must satisfy themselves that any ramp or storage equipment they purchase independently is fit for purpose.

3.12 The Ramp revised section of the Housing Adaptations Policy can be found in ***Appendix 1***

Consultation

3.13 In addition to this consultation with members of the Health PPB, the proposed amendments to the policy will be consulted on through the Halton Disability

Partnership. Consultation via a group brought together specifically to look at this policy amendment will take place in November 2013.

3.14 Feedback from the consultations shall be considered and, if requested, the finished policy can be presented to Health PPB in January 2014.

4.0 POLICY IMPLICATIONS

4.1 The reviewed ramp section of the policy supports the delivery of a responsive, appropriate, practicable and cost effective adaptations service in Halton in line with statutory responsibilities and recognised good practice.

4.2 The procedures and practice guidance documents relating to ramps provides practical support to staff within the IAT and Complex Care Teams who are responsible for making complex decisions around service users' needs and the provision of appropriate and cost effective adaptations.

4.3 In 2010 the Department for Transport undertook a public consultation on proposed changes to the laws governing mobility scooters and powered wheelchairs. As a result of the consultation, the Minister, Norman Baker, provided a Written Statement which set out that the Department would:

- "review the unladen weight limit for powered wheelchairs"
- "consider the case for mandatory eyesight testing"
- "review matters relating to insurance and the use of specialist training providers"
- "work with transport operators and the industry to enable a disabled person to have more confidence that they can travel with a mobility scooter"

4.4 The Department of Transport, in considering the above, want policies to balance carefully the mobility needs of disabled people with the safety of pedestrians and road users.

4.5 It is not mandatory to have either insurance or training to use a mobility vehicle and the Department of Transport lacks reliable information on whether or not users voluntarily utilise products that are available. They similarly have limited information on how users purchase their vehicles.

4.6 The Age Action Alliance is assisting the Department of Transport try to obtain reliable information on these subjects through the use of its networks. A survey has been designed to be completed by users (or their relatives) and is currently being distributed.

4.7 The findings of this survey and subsequent policy recommendations will be considered in due course.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 It is possible that an increase in requests for assessments may be made should Health PPB ratify the proposed additional eligibility criteria relating to outdoor

wheel chair users. AS a result, demand for the Disables Facilities Grant (DFG) may increase.

5.2 Funding for ramp installation for Owner Occupiers is via the Council held DFG, and is means tested.

5.3 Fifty per cent of the funding for ramp installations for tenants of registered housing providers is met by Halton Borough Council, with the remainder being met by the Housing Provider.

5.4 On spend from the DFG budget, the Council completed 9 wheelchair access ramps via DFG last financial year (2012/13) with an estimated total cost of £32.3K. It's difficult to cost the ramp element specifically as the work is usually done in conjunction with other adaptation work (i.e. bathroom adaptations). In 6 cases, we also had to alter or replaced the external door, usually because the threshold needed to be lowered, or the door widened. And in 2 cases it was to provide ramp access to a new extension.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
None identified at this time

6.2 **Employment, Learning & Skills in Halton**
None identified at this time

6.3 **A Healthy Halton**
The Housing Adaptations Policy enables people with a disability to live as independently as possible and promote equality of opportunity for disabled people.

6.4 **A Safer Halton**
None identified at this time

6.5 **Halton's Urban Renewal**
None identified at this time

7.0 RISK ANALYSIS

7.1 There is a risk that if the guidance is not clear the needs of service users and their families and carers may not be met, thus compromising their health, wellbeing and independence

7.2 Changes to the eligibility criteria may have implications on the Council's ability to meet the demands of any increase in eligible applications for ramps.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 The policy aims to enable decisions about eligibility for housing adaptations in an equitable way and aims to support the independence of those with physical disability within their own homes.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF

THE LOCAL GOVERNMENT ACT 1972

9.1 None under the meaning of the Act

Appendix 1

Ramps Section of the Housing Adaptations Policy

1.3 Ramps

Description: This is a platform and sloped pathway, with handrails and up stands that provide access for wheelchairs from door to path / pavement level at the most appropriate entrance to the property.

Permanent ramps are usually made of concrete and will replace any existing access provision such as steps.

Semi-permanent ramps are usually made of metal, fibreglass or plastic. They are usually installed over the existing arrangement i.e. steps and are left in place until no longer required. They can be removed and reused. N.B be aware of the problems associated with placing metal ramps on grass. Provision of a wooden ramp is not appropriate, as there is no BS standard to check against.

Guidelines

The disabled person meets the Fair Access to Care eligibility criteria for adaptations AND the assessor has applied the stepped approach taking account of cost effectiveness issues.

An assessment of the disabled person's access to the property will be undertaken by the Initial Assessment Team Occupational Therapist

Ramps may only be constructed where it is possible to construct a ramp to the current building regulations and no steeper than 1:12

Ramps are provided for disabled people who are a permanent wheelchair user, and the wheelchair was prescribed by the Wheelchair Service, and meet at least one of the criteria below:

- The disabled person is reliant on wheel chair and they have stepped access to their home and are unable to manage steps safely or independently, as assessed by an Occupational Therapist, which is having a detrimental impact on their ability to be independent.

- A ramp will not be provided for a person who has privately purchased a mobility scooter, unless that person has been assessed by the Wheelchair Service as being in need of an outdoor wheelchair and the person has chosen to use a scooter as a means of outdoor mobility instead.

Considerations

- The disabled person with a mobility difficulty may find it easier to negotiate a couple of steps rather than walk on a sloping surface.

- Where the disabled person is able to walk short distances and negotiate steps with the assistance of helpers, a ramp may not be necessary. However frequency of use should be taken into account.
- An environmental home visit is required to check which is the most appropriate entrance to be ramped. Assess the width of door, the overall height of steps to door, which way the door opens, length of available space (allow an additional 1200 mm for a level platform outside the door). A joint visit or discussion with a technically competent person is recommended.
- Particular care needs to be taken concerning structure, design and location of the ramp to ensure its safe use, not only by the disabled person, but also by other members of the public. NB the platform and ramp cannot impinge on public pavements.
- Misuse of the ramp is at the individual's own risk, for example, using a ramp specified for wheelchair use by a mobility scooter. The Council would not be liable for any damage or injury sustained.
- In some circumstances provision of a ramp may be contraindicated e.g. where the gradient would be too steep. An individual risk assessment of the situation must be completed.
- Note the tenure of the property, as consent for the ramp to be constructed may be required from the landlord.
- Where the Council approves and installs a ramp it will be fit for purpose, If it is not suitable for a scooter (because it is designed to a lesser specification) the user should be informed and the ramp marked accordingly.
- A follow up visit must be completed when the ramp is in place to check that it is safe and suitable for the disabled person's needs.
- Where an individual is palliative consideration should be given as to the suitability/benefits of installing a ramp, dependant on the individual's mobility and access needs at the time of assessment. Alternatives to permanent ramp installations could be considered ie portable ramps or handrails.
- If a disabled person buys their own powered scooter to allow independent leisure activities, shopping etc. it will be expected that they make their own arrangements for access / storage of this equipment within, or outside, the property at the time they buy the scooter.
- Where an individual does not meet assessment or eligibility criteria for ramp installation then they should be signposted to the Independent Living Centre for information and advice and further sign posting, should the individual wish to make their own arrangements for ramp installation or purchase of scooter storage equipment. By signposting to the Independent Living Centre it is not an acceptance by Halton Borough Council that the use of a mobility a scooter is warranted and that ramp access is required, it serves simply to support the individual in making an informed decision about options available to them should they wish to purchase a ramp or storage equipment themselves.
- Where an individual purchases a ramp or storage equipment themselves, they responsibility lies with the individual to satisfy themselves that the equipment is fit for purpose.

Design Considerations

- Steps may need to be provided adjacent to the ramp for other users who are ambulant, and who do not find a ramp easy to climb. It is essential to

retain steps if the access is communal; this is in accordance with Part “M” of the building regulations.

- The provision of a ramp may necessitate looking at gate opening, direction of opening and threshold adaptations.
- Ramps should be constructed to The Building Regulations 2000 Part M (Access and facilities for Disabled People) or BS 8300: 2001 standard.
- A dropped kerb in the area may be needed, therefore refer to the Highways Department
- Fire regulations may need to be considered and fire exits and ramps being positioned appropriately e.g. in sheltered housing blocks.

REPORT TO: Health Policy and Performance Board

DATE: 6 November 2013

REPORTING OFFICER: Strategic Director Communities

PORTFOLIO: Health & Wellbeing

SUBJECT: Update on Sector Led Improvement

WARD: Borough Wide

1.0 **PURPOSE OF REPORT**

1.1 This report describes the benchmarking process that has been set up in the North West region to inform the process of Sector Led Improvement and highlights the performance in Adult Social Care in Halton over the last 12 months.

2.0 **RECOMMENDATION That: the Board note the contents of the report**

3.0 **SUPPORTING INFORMATION**

3.1 **The benchmarking framework:**

3.1.1 As Health Policy and Performance Board is aware, Sector Led Improvement (SLI) is the new framework for ensuring continuous improvement and development within adult social care services. Led nationally by the Towards Excellence in Adult Social Care Board, it is driven in this region by the North West Towards Excellence Board. A report on the background to SLI was presented to PPB on the 10th September 2013

3.1.2 The North West Performance Leads (NWPL) group for, has had in place a framework for lead performance officers to benchmark their performance against key national adult social care performance indicators.

3.1.3 This framework has now been developed and enhanced as a part of the SLI process in the North West; the first submission was in September 2012 but was backdated until the start of that financial year. The latest submission will therefore complete the first year of data collection in the new format.

3.1.4 Three tiers of information are now collected on a quarterly basis. These tiers consist of:

- Key Adult Social Care Outcomes Framework (ASCOF) data

- ADASS/AQuA whole system data, which is drawn down mainly from published health service data
- An additional suite of information which provides North West benchmarking.

These tiers combine into Towards Excellence in Adult Social Care (TEASC)

3.1.5 The TEASC overview analysis for 2012/13 has now been published. It contains 80 items and is divided under the following sections:

1 Access to Services – 9 items
2 Community Based Services – 14 items
3 Residential and Nursing – 8 items
4 Intensity of Home Care – 1 item
5 Services for Carers – 2 items
6 Quality of Life – 17 items
7 Self Directed Support – 13 items
8 Living Independently – 4 items
9 Assisting Discharge – 3 items
10 Views of Users and Carers – 9 items

TEASC provides comparators with:

a) The North West
b) Unitary Authorities
c) CIPFA comparators

3.1.6 The data is collected from each Authority and are therefore able to see how they perform against other areas, and particularly their nearest neighbours in terms of benchmarking. Additionally the indicators are reported in chart form, which allows each locality to see how it performs against other comparators, as shown in Appendix 1.

3.1.7 The submitted data will be used by the NW Towards Excellence Board as part of the SLI Risk Analysis. At this stage it is not clear whether particular indicators will carry more weight in terms of being seen to pose enough risks to trigger intervention. However it is likely that three areas will be of particular interest: self directed support, direct payments and adult safeguarding.

3.2 The data

3.2.1 Halton's data has now been submitted and shows exceptional performance and a sustained picture from previous years – this applies to at least 75% of submitted items.

3.2.2. The TEASC provides the Directorate with very positive outputs across

a number of domains.

- The numbers of people in residential and nursing care are significantly less than in comparator groups. However, the numbers of placements are showing a year on year increase and this is subject to further investigation currently due to the budgetary implications.
- The proportion of people who feel they have enough control over their daily lives again is significantly higher than comparators.
- The proportion of people receiving Self Directed Support has increased and is above the National target of 70%.
- There has been a significant increase in the numbers of people subject to an adult safeguarding referral. This is consistent with the introduction of the Safeguarding Unit and continued local and National publicity. In addition the "Priory" Hospital in Widnes generated significant numbers of referrals before closing in late 2012.
- PPB are aware of the key problems with admissions and re-admissions to hospital and extra resources and an urgent care strategy have all been agreed to address these problems.

4.0 POLICY IMPLICATIONS

4.1 There are no policy implications arising from this Report.

5.0 FINANCIAL/RESOURCE IMPLICATIONS

5.1 There are no financial implications arising from this Report.

6.0 RISK ANALYSIS

6.1 The collection and publication of benchmarking information is part of the public sector's commitment to openness and transparency, and shows local people how well the Authority is performing across a whole range of issues and compared with all other councils in the region. However, the process itself raises the risk that Halton will fall significantly outside – either very good or very bad – the regional average in its indicators. This would be likely to attract the attention of the North West Towards Excellence Board and therefore would run the risk of attracting a peer review. However having compared ourselves against the other Councils this is highly unlikely.

7.0 EQUALITY AND DIVERSITY ISSUES

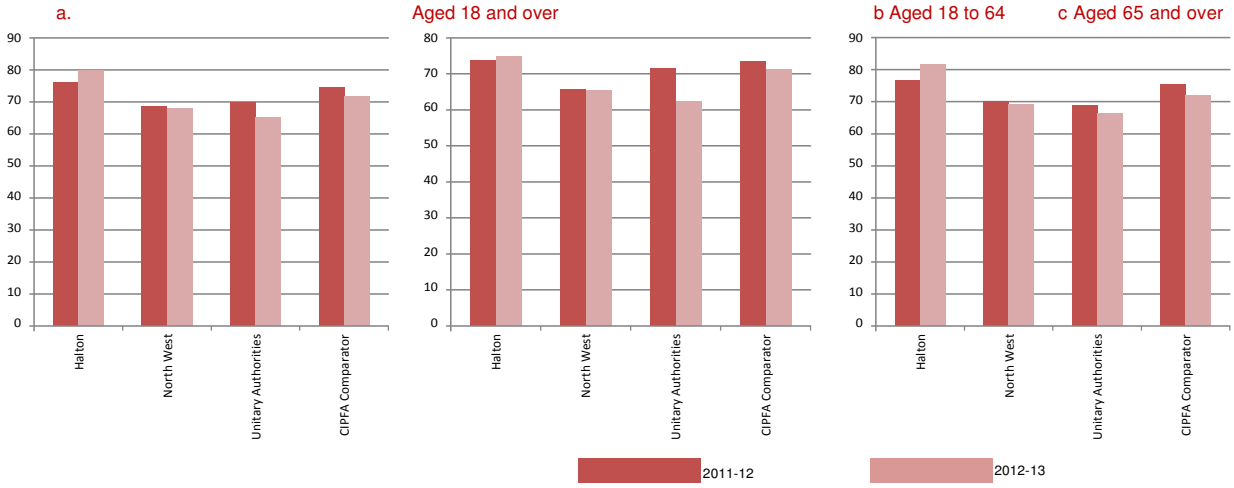
7.1 An Equality Impact Assessment is not required for this report.

8.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

8.1 None under the meaning of the Act

Appendix 1

Percentage of people in receipt of a service who received a review during the year



REPORT TO: Health Policy & Performance Board

DATE: 6 November 2013

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health & Wellbeing

SUBJECT: Francis Inquiry Update

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 This report provides an update to the Board in relation to the recommendations and actions from the Francis Inquiry. As the Board is aware this report was produced from the publicly held inquiry into the care provided by Mid Staffordshire NHS Hospitals Foundation Trust. The report provided 290 recommendations and was clear in its challenge to all of those involved (commissioners, regulators and other) that they had in many ways failed to protect the patients.

2.0 **RECOMMENDATION: That the Board:**

i) Note the progress being made in this area and the plans for on-going monitoring ; and

ii) Define if any further updates will be required by the Board and the frequency.

3.0 **SUPPORTING INFORMATION**

3.1 In the previous report the recommendations where outlined and in particular those which relate to the commissioners of care specifically the fundamental need for commissioners to commission safe and effective care through appropriate contract and performance monitoring, including setting and monitoring tightly quality standards and ensuring that processes are in place to identify any problems with local service quality at an early stage.

3.2 Since the publication of the inquiry the following actions have been completed with all local NHS providers

1. All providers locally agreed to delivery improvements in care via a Commissioning for Quality and Innovation (CQUIN)

2. All providers have presented for review and approval an internal assessment of their performance in relation to the Francis Inquiry recommendations. Within the assessment they were required to review Quality of care and

strategies, Nursing Strategies and staffing levels, training and competency of nursing staff, training and competency of Health Care Assistants, leadership, whistleblowing and duty of candour.

3. The initial assessments by providers have identified some good practice but also some areas of work to progress, to this end each provider will submit updates regularly through the contracting process on their performance.

4. The CCG has now in place excellent quality reporting across all providers and an Early Warning Dashboard (reviewed monthly) which includes patient complaints, incidents, safety issues, Health Care Acquired Infection rates, CQC reviews, performance on all national and local quality targets.

5. The local Quality Surveillance Group is now well established and this group has been effective in identifying issues with providers and enabling all Commissioners to work together with providers to improve their performance and keep patients and service users safe.

3.3 The CCG Quality Committee is reviewing quality across all providers and working closely with LA colleagues to enable us to be assured that quality is fundamental to service delivery in all areas.

3.4 It is clear that ensuring the people of Halton are safe and receive a quality services is a fundamental function for the CCG and the Local Authority we are responsible to the local people and we must be able to provide assurance to them. The process remains complex as there are many actions and processes which deliver quality but it is essential that this is delivered.

3.5 Currently the CCG is working to develop processes to ensure that we hear first-hand the views of patients bad are able to take action to improve as required. The CCG has developed an issues@haltonccg.nhs.uk email address which is currently available to GPs and all other clinicians to raise issues with service provision. The clinicians' are closest to patients and will receive early feedback of issues both negative and positive, we are encouraging them to provide this feedback to the CCG and sharing this with providers to understand issues early and find solutions. We will also use this process to identify key themes for providers. This process is not a replacement for formal complaints system which we advise continuous to be used as appropriate. To date the key themes reported through this process have related directly to discharge arrangements and to improve this across all providers as Safer Care Collaborative has been developed. This group will look to agree across all providers' good practice in communications, discharge and pathways of care.

3.6 The CCG at its recent Check point meeting with NHS England was able to evidence a good handle on provider performance in relation to quality, delivering on trajectory in most areas, one area which require further work locally is the Friends and Families Test (F&Ft) in acute care for which response rates have been low in some areas but this is true nationally. As this is a key strand of the listening to the patient voice, though not the most important, we are working closely to support providers to improve in this area. Maternity Services F&Ft commences in October 2013 and our local community and mantel health providers are pilot sites for the mental health and

community F&Ft programme.

3.7 As the Board will be aware since the publication of the Francis Review there has been the publication of the Kehoe Reviews and the Cavendish Inquiry both of which link directly to the issues identified in the Francis Inquiry and have major impacts on service providers and the quality of care. It is planned that a short overview of these reports will be presented at a later date if the Board would find this of interest.

4.0 POLICY IMPLICATIONS

4.1 Both the LA and CCG need to continue to work together to develop local safety and quality standards to ensure the safety of services to the people of Halton.

4.2 Failure to monitor, report and manage quality of services will have a major impact on the health of local people.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 Poor quality health care costs more, for service users they are sick for longer, the outcomes of their illness are poorer and they are more likely to be unable to be financially independent

5.2 For the NHS poor quality care means patient spend longer in hospital and need more intervention, all of which costs

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
Poor quality health care will affect detrimentally the wellbeing of local children and young people.

6.2 **Employment, Learning & Skills in Halton**
Healthy people are better able to develop skills and live an active and useful life.

6.3 **A Healthy Halton**
Poor quality care will affect the health of all people in Halton and prevent local people maintaining their health.

6.4 **A Safer Halton**
Safeguarding is an essential element and will be monitored via this process.

6.5 **Halton's Urban Renewal**
Local people who are not healthy cannot support Halton's urban renewal.

7.0 RISK ANALYSIS

7.1 The report outlines clearly some areas of risk for the LA and CGG.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None identified with this report.

9.0 **LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972**

9.1 None under the meaning of the Act

REPORT TO: Health Policy and Performance Board

DATE: 6 November 2013

REPORTING OFFICER: Strategic Director - Communities

PORTFOLIO: Health and Wellbeing

SUBJECT: Halton - A place without Loneliness

WARD(S): Borough-wide

1.0 PURPOSE OF REPORT

1.1 To present the Halton-A place without Loneliness Scoping Document and highlight future work required to further develop our strategic approach to the prevention of loneliness in Halton.

2.0 RECOMMENDATION

RECOMMENDED: That the Board

(1) Note the contents of the report; and

(2) Comment on the Scoping Document attached at Appendix 1.

3.0 SUPPORTING INFORMATION

3.1 The Campaign to End Loneliness was formed last year and is a coalition of organisations and individuals working together through research, policy, campaigning and innovation to combat loneliness and inspire individuals to keep connected in older age in the UK. They have worked in partnership with the Local Government association and Age UK Oxford to produce toolkits and action packs for Health and Wellbeing Boards, Professionals and older people around the subject of loneliness. The association was developed as research began to demonstrate that loneliness harms health and effects people's quality of life.

3.2 Halton Borough Council has, for many years, been at the forefront of initiatives to prevent and alleviate social isolation especially with their Sure Start to Later Life and Community Bridge Builders services. However, it is becoming clearer that a focus on social isolation alone may not combat the pain of loneliness felt by so many of our older citizens. All partners and individuals involved in the development and provision of prevention services for Older People, through the work of the Health and Well-Being Steering Group and the Older People's Board now recognise that we need to further develop the services and activities associated with tackling social isolation, which already exist in the borough, to turn their attention to also combating loneliness.

3.3 We will be one of the first Local authorities to adopt a strategic approach to combating loneliness and therefore the outcomes of the project will be of national importance both to practice and research in this field, and has been endorsed by the National lead for

the campaign to end loneliness:
"Your strategy is excellent…….I was particularly pleased that you've been consulting the older population in Halton….this is a solid plan. Would you be happy for us to use this as an example for other health and well-being boards…"

3.4 This Document, forms an initial scoping of the strategic approach required to address this issue in Halton, and will be further developed through the steering group, with input from all key partners including public Health, CCG, HBC and community and voluntary sectors to:

- Further develop a needs assessment
- Build on the evidence base to identify innovative solutions.
- Consider widening the strategy to include other socially isolated groups
- Further develop preventative strategies

4.0 POLICY IMPLICATIONS

4.1 *"A locally agreed approach, which informs the Sustainable Community Strategy, utilising all relevant community resources especially the voluntary sector so that prevention, early intervention and enablement become the norm. Supporting people to remain in their own homes for as long as possible. The alleviation of loneliness and isolation to be a major priority. Citizens live independently but are not independent; they are interdependent on family members, work colleagues, friends and social networks." Putting People First (December 2007).*

Putting People First is a concordat signed by six central Government departments, the NHS, local government, professional bodies, regulators, adult social care and health providers across all sectors. It is the underpinning policy document in the transformation of social care; the "strategic shift to prevention and early intervention is a central objective. In this context, the alleviation of loneliness and isolation is a major priority.

4.2 Much of the most influential work on the impact of isolation and loneliness was conducted by the Social Exclusion Unit in the Office of the Deputy Prime Minister during the 2004-06.

In its final report, *A Sure Start to Later Life: ending inequalities for older people* (January 2006), it asserted that:

"Ending poverty and improving the responsiveness of health services is not enough on its own to end exclusion. Isolation, loneliness and poor social relations are also major factors leading to the exclusion of older people. Social isolation affects about one million older people, and has a severe impact on people's quality of life in older age. Tackling social isolation and loneliness is not currently a priority for service providers, but is vital if we are to end social exclusion."

This is a message which appears to have been taken on board in all subsequent policy documents produced by the Government.

5.0 FINANCIAL IMPLICATIONS

5.1 The project aims to work within the existing financial budgets of the organisations

concerned. It is planned that the robust partnership working already in existence will be utilised in making the project a success. The Health Improvement Team has been reconfigured to now contain an older people's team who will be one of the main new contributors to the initiative.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

The strategy takes an intergenerational approach to the prevention of loneliness. Local schools will be twinned with care homes and local projects will involve students and older people working on intergenerational projects.

6.2 Employment, Learning & Skills in Halton

The strategy aims to spread intergenerational learning across the borough, hopefully adding to the work already taking place to try and reduce any intergenerational tension.

6.3 A Healthy Halton

Research demonstrates that loneliness has an effect on health equivalent to smoking 15 cigarettes per day. People who are lonely have an increased risk of depressive symptoms, higher blood pressure and admission to hospital and care homes. The strategy aims to tackle some of these health inequalities

6.4 A Safer Halton

The project should be a major factor in supporting very vulnerable people across the borough.

6.5 Halton's Urban Renewal

Part of the strategy aims to develop links between Community Development, Transport and Environment departments in order to create a joined up approach to community and environmental issues. For example some people are lonely because they cannot access transport, because they fear crime or because they have reduced mobility. It is only by using a partnership approach that issues can be addressed.

7.0 RISK ANALYSIS

7.1 Failure to fully implement this strategy could result in an increase in the numbers of Older People in the Borough who are lonely and isolated, increasing the risks of ill health and dependency on services.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 The project is an attempt to engage with the issue of loneliness which is a major factor in older people's quality of life.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

9.1 None under the meaning of the Act.

HALTON BOROUGH COUNCIL

NHS
Halton Clinical Commissioning Group

Halton - A Place without Loneliness

Scoping Document

myhalton
living life well

"The most terrible poverty is loneliness, and the feeling of being unloved." **Mother Teresa (1910 – 1997)**

1. Introduction

There is growing recognition that loneliness is a formidable problem which impacts on an individual's health and quality of life and even on community resilience with 10-13% of the population estimated to be acutely lonely. There is increasing evidence that people who are lonely are more likely to use health and social care services and a developing confirmation, through personal stories, of the emotional costs and misery that loneliness can cause.

Loneliness is a complex state which has been described as the discrepancy between desired and achieved levels in the quantity and quality of social relations. In simple terms, the mismatch between the quantity and quality of our relationships, and the expectations we have of what level of relationships would make us content and happy. Loneliness can thus be viewed as a subjective emotion. "If a person thinks they are lonely, then they are lonely" (Beaumont 2013).

Loneliness can be a passing emotion, be associated with certain situations or it can be persistent and long standing. For instance people can feel lonely when older children leave home, be lonely at family gatherings due to hearing loss, or suffer from deep rooted and ceaseless loneliness.

Loneliness and social isolation are often connected but there are important distinctions between the two concepts. Some people report feeling lonely despite having a good deal of contact with family friends while others feel content and even

glory in their solitude. A distinction is also sometimes made between lack of a close friend or partner (emotional loneliness) and lack of a social network of friends (social

loneliness). The good news is that many older people are willing and eager to do something about loneliness given the right support.

2. Loneliness and Health

Loneliness has a very negative impact on health. Some estimates put the health impact of loneliness as equivalent to smoking fifteen cigarettes each day, of greater severity than not exercising and twice as harmful as obesity (Holt-Lundstad 2010). The lonelier a person is, the more likely they are to experience increased depressive symptoms. Loneliness has been linked to hypertension and high blood pressure and in developing cardiovascular disease. Lonely individuals have double the risk of contracting Alzheimer's disease while having a dementia increases our chance of feeling lonely. Lonely people also have an increased chance of being admitted to care homes and hospitals. Experiencing loneliness can make it more difficult to manage smoking, alcohol consumption and eating habits (Campaign to End Loneliness 2013). With an increasing research base demonstrating the major health consequences of loneliness, it seems remarkable that more attention and resources have not been focused on the issue. This may well be because the very word "loneliness" has been avoided as it is associated with emotions that are not the state's concern. It may also be because we have concentrated more on the concept of social isolation which may well require a different type of intervention.

Public health interventions which address key health challenges for older people can also be targeted towards lonely people, especially as insensitivity to the issue is likely to limit the success of the interventions. These include increasing physical activity which creates opportunities to develop social networks, health screenings and community resilience events. Falls prevention programmes can be vital in helping older people retaining their social connectedness by maintaining their mobility.

3. Loneliness and Quality of Life

While the negative outcomes of loneliness on health are becoming clearer, the impact of loneliness on a person's quality of life is of equal importance. A number of studies have identified relationships as having a significant impact on living a long and healthy life. Quality of life measures identify good social relationships as the key dimension in bringing quality to most people's lives. One study with older people discovered that over 80% said that relationships brought quality to their lives by providing companionship, confidence and generally making life bearable. Many others described how poor social relationships reduced their quality of life. And it is these stories of the personal and emotional costs of loneliness which should be the main drivers of our response. "At a profounder personal level loneliness means the loss of hope, energy and contribution from so many daily lives spent in quiet desperation" (Cann 2012).

4. The National Context

Age UK have been critical of the lack of national initiatives around the loneliness agenda. “The leaders of our health, housing, environment and social care systems need to place social isolation alongside the standard menu of public health challenges, as urgent and in need of action. This requires strategy, programmes and targets, not lip-service in speeches or policy documents.” (Paul Cann, Chief Executive, Age UK Oxfordshire).

The Office of National Statistics has recently produced a series of short articles examining the well-being of older people, one of which gives a national picture of loneliness. The key points include:

- 9 per cent of respondents said they felt lonely often.
- A higher percentage of those aged 80 and over reported feeling lonely some of the time or often when compared to other age groups (46 per cent of those aged 80 and over compared to the average of 34 per cent for all aged 52 and over).
- Those who report feeling lonely sometimes or often are much more likely to report a lower level of satisfaction with their lives overall.
- People who had been widowed, separated or divorced or those who were in poor health were more likely to report feeling lonely.
- There is a strong association between reported feelings of loneliness and reported limitations in performing daily activities.
- Limitations in daily activities together with other changes in circumstances such as loss of partner or losing touch with friends as age increases are likely to contribute to the increase in reported feelings of loneliness in the oldest age groups.
- In all age groups a higher percentage of women than men reported feeling lonely some of the time or often, the differences were larger in the older age groups.

Some other national statistics about loneliness:

- **6 - 13% of older people say they feel very or always lonely**
- **6% of older people leave their house once a week or less**
- **17% of older people are in contact with family, friends and neighbours less than once a week, and 11% are in contact less than once a month**
- **Over half (51%) of all people aged 75 and over live alone**
- **Almost 5 million older people say that the television is their main form of company**
- **ELSA estimates 1 in 6 adults aged over 50 are socially isolated (Campaign to End Loneliness)**

5. Causes of loneliness

The causes of loneliness can give us indications of how to identify and locate people who are lonely. Causes include:

- Poor health
- Sensory loss
- Loss of mobility
- Moving into care or moving house
- Reduced/low income
- Bereavement
- Retirement
- Becoming a carer/ceasing to care/ change of role
- Other change, e.g. giving up driving

Feelings of loneliness can also be caused by wider societal issues such as poor access to transport, poor physical environment and housing, high crime rates and issues associated with new technology. These causes also indicate the importance of partnership working in overcoming the phenomenon.

6. Neighbourhood and individual responses.

Action at neighbourhood level is vital to the success of any loneliness initiative. Communities can play an important part in both combating and aggravating loneliness. Research demonstrates that supporting communities to develop resilience to loneliness can be effective in tackling the issue and lead to age friendly neighbourhoods. Successful interventions have included improved public seating and public meeting places, upgraded pavements and street lighting, developing intergenerational contact and improving local transport. Community Development Officers will thus play a crucial role in the effectiveness of any campaign by harnessing the strengths of older people. Workshops have been piloted with older people in Halton asking the basic question "What would it take to make this place a better place to grow older in?" The actions from these workshops should form the basis of our local area response to loneliness.

Interventions on an individual level will require inventive solutions. The nature of loneliness can mean that there are challenges around identifying and approaching people who are lonely. Knowledge of the risk factors associated with loneliness will be important in targeting the initiative as will strong partnership arrangements to ensure vital joint working.

7. What we already have

The Borough already provides a number of initiatives which can help alleviate loneliness as part of the Health and Wellbeing Service. These include Community Bridge Builders, Sure Start to Later Life, Health Improvement Team, Adult Placement Service, Wellbeing Enterprises, Age UK, Red Cross, Community Development and Sports Development. There are well established referral pathways between these agencies established through relationships made through PIP (Partnerships in Prevention) and the Health and Wellbeing Board and steering groups. The general feeling within PIP and the Health and Wellbeing Steering Group is that some good work is being done around social isolation but we have little focus or data on loneliness per se.

- Sure Start to Later Life has a small befriending service supported by volunteers.
- Community Bridge Builders can provide support to older people to engage in community activities.
- There are intergenerational initiatives being developed around the loneliness agenda within the Borough.
- There is an initiative being developed with care homes to twin them with local schools.

- A small Visbuzz project is being developed. Visbuzz is a simple Skype type tablet which enables older people to keep in touch with family, friends and carers.
- Some of the social groups facilitated by the Health Improvement Team swap telephone numbers and become telefriends to each other. There are existing social groups for older people but plenty of scope for the development of new groups, initially facilitated by the Health and Wellbeing Service with an eye to the groups becoming independent of agencies as quickly as possible.
- Many of the local third sector agencies provide activities which alleviate loneliness. For example, Wellbeing Enterprises run eight week life skills courses designed to equip people to cope with, among other things, depression and loneliness, while Age UK and The Red Cross have numerous activities to combat loneliness
- Currently there is a mapping exercise being undertaken to identify community assets including activity groups which is being facilitated by Community Development who also arrange many local events.

8. What actions/ interventions we will develop to combat loneliness

The flowchart below is a visual representation of appropriate interventions that will be developed by the project Steering Group.

The existing Sure Start to Later Life volunteer/befriending service currently has 12 active volunteers. This service will be expanded by incorporating some of the volunteers from the Health and Wellbeing Service and by advertising within existing agencies such as Halton borough Council. The strong relationship with Halton and St. Helens Voluntary and Community action will be utilised to further expand the service. It is hoped that the number of volunteers will at least double to 24 in the first year. Relationships developed through the Partnerships in Prevention Group (PIP), for example Age UK, The Red Cross, Community Transport and the Health and Wellbeing Service will strengthen this arm of the project.

It is sometimes assumed that older people in care homes will have plenty of company. This is sometimes not the case. The project will thus also include a theme of “twinning” care homes with local schools. It is hoped that schools will adopt a local care home and initially establish visits and events. There are many possible creative outcomes of this work including alleviating loneliness, facilitating residents to develop relationships in the community and encouraging intergenerational contacts.

A Visbuzz scheme will be piloted with up to 100 local older people. The scheme will enable lonely older people to keep in contact with family, friends and carers.

Existing telefriending services in the borough will be examined and reviewed to identify how effective such interventions are and if it is worthwhile further developing such services.

Current research on loneliness identifies social groups as the most effective intervention, especially where older people themselves are choosing the activities to be undertaken by the group. Staff from the Health and Wellbeing Service will facilitate the development of existing social groups, where appropriate, and support the establishment of new groups.

The project will take an intergenerational approach wherever possible. The Community Warden and Reablement service are currently identifying older people who have expressed feelings of loneliness and who are agreeable to visiting a local school to take part in a "Halton-Past and Present" venture. In this scheme older people will be positively viewed as holders of important memories rather than being judged on the more negative concept of loneliness. The Grange area has been identified for an initial scheme and the Grange Comprehensive School has commenced preparation briefings for some of their students.

Many of the above projects will require vital input from volunteers building on already robust work within the Health Improvement Team, Sure Start to Later Life, Age UK and Halton and St.Helens VCA. There will be a particular focus on lonely older people becoming volunteers.

Loneliness awareness training will be delivered to staff and the general public across the borough. In this context the Making Every Contact Count (MECC) developments will be crucial to the success of the project.

9. What success will look like

The outcomes of the project will be an improvement in the quality of life of older people in the borough and cost savings by preventing the need for more acute services. The following case study demonstrates savings but also illustrates the transformational potential of combating loneliness.

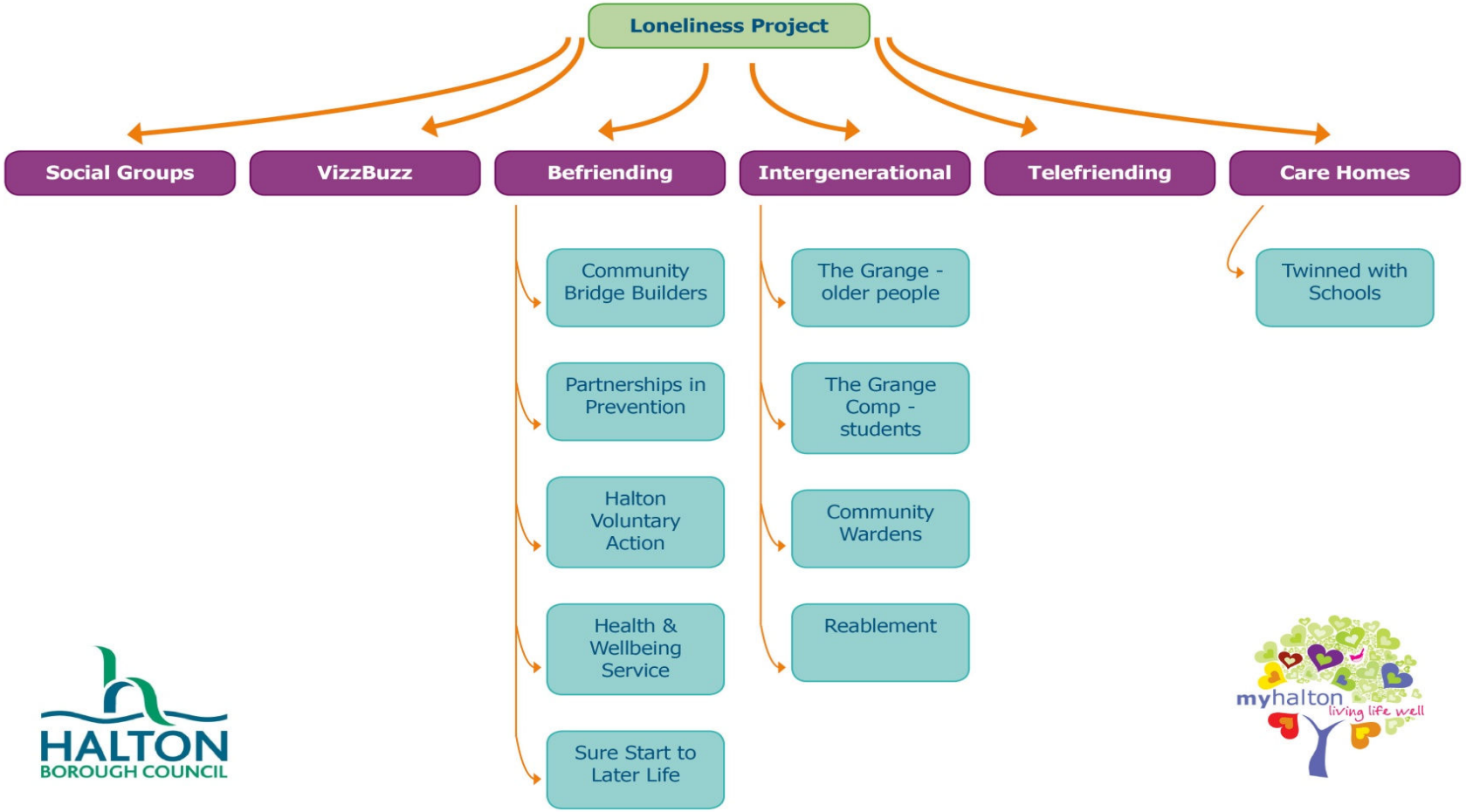
V described himself as being "lost" after losing his wife four years ago after 52 years of marriage. His life consisted of "TV, looking at four walls, being miserable, and completely lonely." He had no friends locally. He became a volunteer befriender with Sure Start to Later Life. Through his volunteering V met Mrs.S who was also in her eighties; S described herself as unsteady on her feet and very lonely. V would accompany S on trips out shopping and support her when she was a bit unsteady on her feet. He made her laugh and they were good company

for each other. Both describe their lives as changing from "miserable and lonely" to "glorious". "Loneliness is a disease but now I'm living again; our lives have turned upside down". Both report feeling "alive and well, physically and mentally. We are living again; it is so natural it is unbelievable. None of this would have happened if I hadn't volunteered for Sure Start to Later Life."

Not only has the intervention transformed the couple's lives but the potential savings to the health and social care economy are significant. Mrs. S was certainly heading for a permanent care home placement and possible falls related injuries. The couple now support each other rather than relying on support from health and social care agencies.

10.How will we measure our interventions?

There has been a lack research evidence of the effectiveness of measures of loneliness. There are thus a number of measures which the project will be testing out including the De Jong Loneliness scale and the SWEMWEBS tool for measuring wellbeing. Outcomes will also be tracked to examine the difference that the various interventions have made to people's lives using the outcome domains from the Care Quality Commission.


Loneliness Project
Social Groups
VizzBuzz
Befriending
Intergenerational
Telefriending
Care Homes
Community Bridge Builders
Partnerships in Prevention
Halton Voluntary Action
Health & Wellbeing Service
Sure Start to Later Life
The Grange - older people
The Grange Comp - students
Community Wardens
Reablement
Twinned with Schools

In the current financial climate efforts to combat loneliness need not be arduous. Much of the infrastructure to tackle the issue already exists in Halton. Better targeting of these resources and creative partnership working between statutory and voluntary will greatly increase the benefits to lonely people and provide cost effective solutions to the problem of loneliness.

11. References

The following documents have been useful in writing this strategy:

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Cacioppo, John; Patrick, William, *Loneliness: Human Nature and the Need for Social Connection*, New York : W.W. Norton & Co., 2008. ISBN 978-0-393-06170-3. Science of Loneliness.com

42Holt-Lunstad J conference presentation: http://www.campaigntoendloneliness.org.uk/loneliness-conference/ See also Holt-Lunstad J,Smith TB, Layton JB (2010) Social relationships and mortality risk: a meta-analytic review. PLoS Medicine 7(7). http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000316

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Phongsavin.P.et al. Journal of Ageing Health. August 14th 2013. Age, Gender, Social Contacts, and Psychological Distress. Findings from the 45 and Up Study.

Combating Loneliness. A guide for local authorities. Local Government Association and Campaign to End Loneliness

Loneliness Harms Action Pack. Campaign to End Loneliness supported by Calouste Gulbenkian Foundation

Loneliness-The State we're in. Campaign to End Loneliness and Oxfordshire Age UK

Measuring National Well-being – Older people and loneliness, 2013
Jen Beaumont. Office for National Statistics 11th April 2013

Preventing loneliness and social isolation: interventions and outcomes. SCIE Research Briefing. October 2011

Appendix 1

The following are statements from local stakeholders and older people on the topic of loneliness. As far as possible the actual words of the person have been used. The comments have informed the strategy.

What is the current reality about loneliness in the Borough? That is, what is working, what are we proud of?

1/ I think most isolated/ hard to reach older people feel lonely. They are then in this bubble where being alone is their comfort zone, so it is very difficult to break through this. i.e Daytime TV trap.

Services current at the moment are working hard to tackle this; however the individual has to want to change their lifestyle. I personally am very proud of our DayTrippers group now having over 240 members. With the help of Halton Community Transport we facilitate door to door transport for Day Trips and Meals Out to places which are just not accessible to those who don't have transport. People are meeting up with past friends, having lost touch and also making new ones, so it is very much having a positive effect on people in the Borough. It eases lonely people into mixing socially, as they travel on the bus with people and realise there is others in the same boat as they are. Friendships are flourishing, people looking out for each other creating natural support which is just fab!

2/ The Community Bridge Building Team use a person centred approach to enable a person to identify mainstream activities and social groups within their local community and provide initial support to the person to help them settle into the groups and make new friends and look at natural support.

We have a positive relationship with the Social Work Team and if a person is unable to sustain themselves in the community then we can liaise with the Social Worker for direct payments.

We have built up key allies within the community and there are new groups for older people/luncheon clubs setting up new groups.

There are improvements for people with early onset dementia and there are a couple of groups set up that they can attend offering respite for the person who cares for them and activities for the person in a supportive environment. The recent one is at Chapelfields on a Friday morning and they are also in the process of setting one up on a Wednesday morning.

There is more education and training available to support staff to have a basic knowledge of people with Dementia.

3/ I think there are several areas that impact greatly on loneliness in the Borough. The main being the overall landscape; estates are very fragmented and people become isolated easily if they don't have transport or the means to get from A to B. Money is a huge barrier for people to access and attend services that may be in place; if it's a choice between food and a class etc. then we know what people need more. Fear – many people lack confidence and once they get on the slippery slope of isolating themselves it's gets harder to get out. There are a lot of services for young, families and school age and then it jumps to elders. What happens when you are in your 40's, 50's?

Proud of trying to combat all of the above in the arts provision we offer – making classes as accessible as possible, trying to go to people and make relationships before expecting them to engage and also bringing in people and product that is appealing to a wide section of the communities we work within.

4/ I suggest the initiative of the joint wellbeing strategy and programme with CCG is proving successful and is spreading to GP Practices and Community Centres. One of its main features is that it is FREE at the point of access and I suggest this feature should remain. (lonely people might have the money, but to pay involves some commitment, which such people find difficult to make).

5/ Recharge programme

Community Bridge Builders

Telephone support

Befriending

Wellbeing project –Mark Swift

House bound services?

Local care support workers –social service providers

Chair based exercise groups

6/ Live life well website has a section on older people socialising section

Participation groups

Stay Safe service

People's Register of Traders

Helping Hands Halton Open Money Advice Service

Products and services

Information services

7/ SAQ/ Carer's Assessments can identify if someone is lonely or has little opportunity to meet people.

Community Bridge Building Team is available to increase opportunities for employment and education, activities and social groups, through which individuals can meet other people and form friendships.

Carers Centre to support carers and prevent isolation.

Development of Children's Centres and Community Centres with groups and activities for all age ranges.

Adult Placement service – allows those cared for and carers to socialise with others.

Day Services.

8/ Sure Start and Bridge Builders, local community initiatives i.e. Sheltered Housing Schemes, Age UK.

9/ Development of services –SS2LL / Bridgebuilding and Day Services.

Adult family placement is an expanding and effective service that reduces loneliness.

The work the Visual Impairment team does to ensure people have access to equipment and support that keeps them in touch with the world around them.

10/ Hard to identify for people not involved with services but the long term impact on this group can be significant leading them to require contact with services due to mental health and physical health problems.

11/ When we do identify people in the Borough that require some lower level support to reduce loneliness this can take some time to access possibly due to waiting lists/high demand for current pool of volunteers. This is particularly true of people with additional needs (mobility and personal care needs especially) as many services cannot provide the additional support needed within existing Day Services.

12/ Within our groups lots of the clients have made good friendships and now do things together outside their groups.

Clients actively promote our services and encourage their friends to join who may be lonely.

We have lots of programmes that promote health and wellbeing, and people who are lonely may be suffering from health issues that may be related to their loneliness, so this will benefit them.

The pilot of a tele friending service.

13/ I think there are people in our communities who don't necessarily come into contact with any service area and are disconnected to their local community and local services.

I think community centres make a vital contribution to tackling social isolation and building a sense of belonging to the local community, in particular where there are community café's which enables drop in and social contact.

What are the issues and concerns about loneliness in the Borough?

1/ Transport is still a massive issue for people, along with mobility & health problems. Also lack of instant support for people can result in them losing interest or motivation to do something other than sit around, as it can be a while before the support is available. More immediate support needs to be available for people with Dementia and other mental health issues, as they sometimes need more specialist help which may be too much to ask of a volunteer at times.

2/ Families do not live locally and therefore unable to identify when their relative is lonely.

People live busy lifestyles.

The person does not know how to ask for help or access services.

People lack motivation and become happy within the boundaries of their own home

3/ That they are tackled in short bursts and there isn't a consistent approach to the problem. The communities we work in see Council Officers as not in the 'real' world and it's tricky to break through this barrier. There has to be a grass roots method (CDW methods).

4/ There are still hard to reach lonely people and barriers to their participation need to be tackled such as transport and accompanying service.

How do we contact those who do not use services - not on Housing Lists, Benefit Lists etc. but all would be on a GP practice list. Could we use their information to make contact?

There is a big shyness issue and a sensitive approach is needed - fear of official connections is wide spread - a befriending service may work.

Although some of the lonely people may be accessing groups/activities already many of them are not and sometimes those that are accessing services are still lonely.

Lonely people mostly want someone to talk to and listen to them and often teams are restricted to the amount of time available to offer this service.

5/ Transport/travel to and from available groups

Engagement with the housebound

Transport

6/ Poverty – this may restrict the opportunities individuals have to meet new people.

Care Leavers – can become lonely when moving on to own accommodation, this can lead not wanting the tenancy and mismanagement of the tenancy or sometimes eviction if the person is unhappy with their situation and

Adults - moving on to their own accommodation as above.

Older people living alone – may have little opportunity to socialise, particularly if they are not accessing the community.

Young Carers – may become isolated as a result of their caring role – young carers support, CAF.

7/ Main difficulty I perceive is transport and support required as people's needs increase in the group setting, also home visits.

8/ I would stress that loneliness is not only in OPs, but the young and isolated are often lonely but find it difficult to admit to - there is no shame in it , but some feel this way and we must remove that somehow - cross generational work could help.

9/ A lot of loneliness is due to family relationship breakdown-I'm minded of one case where the lady in question had not seen her son for several years as his late father (her husband) had fallen out with the son's wife. He only lived a mile away! It was sad for her despite the protestations of managing all right. Variations on this seem to be a common theme and no amount of social participation can heal the wounds. I'd like to see some sort of conciliation service offered to estranged families, where disputes don't seem too serious.

10/ From my service area there is an increasing demand from individuals who simply need to talk and pass the time of day with someone, this is particularly noticeable in community centres where on occasion they have approached members of staff for assistance with paperwork regarding benefits, utilities, etc. For some people, they don't have any family or network around them to do this.

What opportunities exist in the Borough that we could utilise?

1/ We need to work together as providers to identify those who may be lonely, and speak to them offering options and alternatives. This really needs to be based on personal preference, as I think a lot of people assume because someone is lonely that they need to change things. This is quite often the case where people are happy in their lives and decline change, but family or professionals make referrals as they think they know what is best for that person. It just causes frustration and confusion for them and results in barriers going up. I think it would be great if there is a way we can inform people about things going on, without following the assessment process, that way those who are put off by service intervention can choose to access things independently.

2/ There are many groups available to offer information, advise and support.

Local churches offer groups and luncheon clubs

Community Centres offer activities and social groups

3/ Building on the peer-peer tele-friending service we are piloting in our groups
Targeting the venues where lonely people will frequent, such as GPs
Pharmacy delivery teams could be skilled up to recognise lonely people they may be delivering medicines to

4/ Existing older peoples groups and organisations

Time banks

Church based visiting schemes

GP Contacts

5/ If you have a look at the activities in Churchill Hall, that is a good example of what some over 50's need.
The reason being most of the activities are during the day time,

The Brindley have some great evening shows that finish around 10pm/10.30pm but transport is difficult. That could be area we could look at.

6/ Local centres with staff trained in giving personal care, and knowledge of working with people who have dementia. Increase in befriending service

7/ We have a Relationship Centre in Halton

8/ Knowledge of the above groups so that support can be identified and appropriate social groups could be organised

9/ Targeted support could be available in community venues.

What would be your vision/dream for loneliness in the Borough?

1/ Recruit more volunteers to offer support to people in need. Actual lonely people would benefit from doing this – Kill two birds with one stone in effect. They would be providing a very worthwhile opportunity to others whilst combating their own loneliness. I would love this to develop into a network of lonely people, who could be matched together to form friendships. Sort of like a friendship agency (and possibly dating too!). It could link in with the Vis Buzz project.

2/ That every older person has contact/access to another person every day and in times of need (Visbuzz idea).

3/ That individuals have as many opportunities to be active within the community and to socialise at a level they are comfortable with.

4/ Local services available to people who may not fit traditional concepts of being in need of support but are feeling lonely.

5/ Services responsive and able to signpost and provide support aimed at reducing the long term impact of loneliness on people.

6/ To live in a Borough where loneliness did not exist and to have robust services in place that prevent this from happening.

7/ To make lonely people realise there are others like them and everyone can have a friend/buddy available to contact anytime (rather like AA) - a massive voluntary force harnessed to provide this individual contact for all those who need it. Especially those who live alone.

8/ That we can alleviate this feeling for some; buddy people up with those who are engaged and gradually have a community that's one.

9/ Utopia would be a strong sense of community spirit where local communities look out for each other and it doesn't require any intervention from service providers, strong resilient and caring communities in Halton.

What actions do you think need to be taken to address loneliness in the Borough? (Think "outside the box" as well as inside it!)

1/ Funding to support new innovative ideas. Positive staff to develop new projects. Funding to support volunteer recruitment drive.

2/ Integrate the tele-friending service in all groups that older people frequent.

Set up a befriending service that is not only phone calls but also a home visiting service not just for signposting but to have a conversation with and about the client.

Have a robust training programme for both carers of older people and also older people themselves so that they have awareness of how loneliness impacts on health and wellbeing and how they can access services to combat loneliness
Utilise every opportunity to find the lonely people in the Borough, i.e. Pharmacies, GPs, Hospital outpatients, care homes, taxi drivers & HCT etc.
Consultation with lonely clients to find out what they think will work

3/ Telephone link for all older people advertised on local radio/TV

Information booklet given to all over 50's of support groups/help lines

More locally organised groups in neighbourhoods where there are lots of older people

Intergenerational work – links between schools/colleges

Bring your grandparents/older neighbours to school/uniform group

Bring your children to older peoples community activities

4/ 5 GREAT Ways workshops/personal confidence building

Men in sheds

Befriending an elderly neighbour – giving information packs/Signposting

Ensure that all assessments discuss the issue appropriately with those we work with and that other agencies identify if they are concerned that someone is lonely and support them as far as possible.

Check what is available in the Borough for individuals. Workers to be emailed opportunities in the Borough.

5/ Skype, organised activities/interest groups, more trained volunteers, Rota of home visits for lonely people, increase of responsibility of local religious groups, Community bobbies doing regular checks on the more vulnerable.

Could existing services be expanded further to ensure that demand is met more quickly?

6/ Typical lonely/depressed/suicidal type mental health campaigns are aimed at people who have already been lonely for an extended period of time and for whom it has already affected their mental health. Could we establish support through places like third sector groups/Community Centres/Libraries/Parks and Gardens and Leisure Centres for example aimed at pulling people into groups and support networks aimed at reducing loneliness at a much earlier stage (likely to be well before they reach health/mental health and social services?)

7/ Could there be a poster and local media campaign highlighting current and existing groups across 3rd sector, Parks and Leisure Services as well as looking for new groups to be developed aimed at this group of people)

8/ Are men one of the groups that needs to be targeted most e.g. single men middle aged and up??

9/ How do we contact those who do not use services - not on Housing Lists, Benefit Lists etc. but all would be on a GP Practice List. Could we use their information to make contact?

There is a big shyness issue and a sensitive approach is needed - fear of official connections is wide spread - a befriending service may work

10/ Get out and amongst the communities more! Not with 'Council' boards and badges but be seen to care and be consistently 'present' at ground level. Bring the estates together and stop this feeling and fear of difference. Equality is a huge issue and although there is a lack of diversity when there is its very visible and this can escalate problems and insight a feeling of loneliness. We need to tackle all of this from a young age and get to those who are really alone through whatever means possible.

11/ The Library bus goes out to local areas and people's homes maybe they could identify older people who are housebound or socially isolated and make referrals to appropriate services, or staff from these services spending time on the bus and chatting to the staff and home owners.

12/ We need to support residents being connected, that might be to a neighbour, a service area, an activity, I guess this is sure start to later life territory. We need to provide a positive safe environment where people feel comfortable coming out their front doors and participating or indeed inviting people into theirs. Befriending arrangements and buddy support seems to work well but only happens in some areas of service. One point of contact who can address all concerns for residents would help, not sending people from pillar to post so they end up feeling exasperated, a model whereby people feel valued and want to contribute something back, identify their skills and strengths, timebanks maybe?

Appendix 2: Key Research Messages

- As people age they become more likely to have reduced contacts with family and friends .They are also more likely to be less mobile and have reduced income. These factors and others such as increased likelihood of hearing and sight deterioration can cause older people to be vulnerable to loneliness.
- Loneliness and isolation pose severe risks to health and can lead to early death. The effect of loneliness on life expectancy exceeds the impact of factors such as physical inactivity and obesity, and has a similar effect to that of cigarette smoking and alcohol consumption. Older people who are lonely have a greatly increased risk of developing Alzheimer's disease and have an increased use of health and social care services.
- Information services, community navigation services and befriending schemes have been shown to be successful in reducing people's feelings of loneliness and to be cost effective. Older people want such 1-1 services to be flexible and fashioned in accordance with individual's needs and preferences. Users of such services report finding them useful in maintaining and often increasing their engagement with community activities. Befriending schemes can be effective in reducing depression. "We need to invest in proven projects". (SCIE).
- The outcomes from mentoring services are less clear; one study reported improvements in mental and physical health, another that no difference was found.
- Older people who are part of a social group are likely to live longer than those who are not.
- There is some evidence that young adults experience similar levels of loneliness to much older people.
- There is some evidence to suggest that ethnic minority elders are among the loneliest as are people over 80 years of age. Gay men and lesbians are at greater risk of loneliness as they age as they are more likely to live alone and have less contact with relatives.
- Robust partnership working needs to be in place if services designed to reduce loneliness are to be effective and sustainable.
- Supporting older people to create, maintain and sustain existing and new relationships can reduce feelings of loneliness. Research also suggests that supporting older people to plan to maintain relationships and activities would be a worthwhile assistive mechanism. This could be particularly effective in the form of pre-retirement courses.

- Technology can be useful in alleviating loneliness where it assists in maintaining relationships with family and friends and where it is available to housebound older people, older people living with HIV/AIDS and people who live in communal housing.
- The research around effective interventions is somewhat inconclusive but indicates that reliance on one method of intervention is likely to lead to an ineffective response as is concentrating on social isolation at the expense of loneliness. A multi-pronged approach to the problem seems to be more effective.
- Well targeted loneliness interventions can substantially decrease spending on health and social care services. SCIE give case studies of befriending schemes saving £300 per person per year and Community Bridge Builder / Sure Start to Later Life type services saved even more. Group activities in one study indicated savings of £800 on health care use compared to the control group.
- Interventions are more likely to be effective where older people have been involved in the planning, development, delivery and assessment of interventions.
- More research is necessary to investigate the effectiveness of services particularly with different genders and populations.
- Although specific interventions can be effective, it is important that general services and activities are geared up to meet the needs of lonely people.
- There is a consistent relationship between increased frequency in phone contacts, social visits, and social group contacts and reduced risk of psychological distress adjusted for demographic and health factors.

Appendix 3: Action Plan

Action No.	Action	Responsible person	Timescale	Progress
1	Create a Loneliness Project steering group. This should include older people who should be involved in the creation and development of the project.	Peter Ventre	September 2013	
2	Identify actions that are likely to be effective in developing a strategic action plan which demonstrates top to bottom commitment to combating loneliness.	Peter Ventre	Ongoing	Initial Action Plan proposed
3	Identify people within the Borough that are at risk of, or suffer from, loneliness. This task could be facilitated through the Health and Wellbeing Steering Board and involve close consultation and the participation of older people. This will help define the local loneliness issue and involve many local agencies in shaping the agenda.	Sue Wallace-Bonner/Steering Group	December 2013	
4	Regularly measure loneliness and mapping need through JSNA and/or lifestyle surveys. Use this to monitor impact of interventions. There are currently no measures for loneliness included in	Sue Wallace-Bonner/Steering Group	January 2014	

	the JSNA.			
5	Include measures for reducing loneliness in any outcome-based commissioning (e.g. of voluntary sector groups and independent service providers) and in Council strategies for ageing - ensuring awareness of the subject in all areas of the Council's work.	Mark Holt/Steering Group	Ongoing	
6	Build on the asset based community approaches already being developed by the Council and its partners. Community Development will be a key partner in ensuring the project is developed locally.	Nicky Goodwin/ Steering Group	Ongoing	Community asset mapping exercise underway
7	Improve information and advice on existing services and activities that reduce loneliness and isolation. Community Bridge Builders, Sure Start to Later Life, Community Wellbeing Project, Health Improvement Team, Health and Wellbeing service and Adult Placement service are key existing services to facilitate this. Ensure these existing services and the many other services in the Borough focus on loneliness rather than just social isolation.	Peter Ventre/ Steering Group	Ongoing	Loneliness awareness training being developed as part of healthy ageing package of training. To be delivered to appropriate services first and then to widest possible audience
8	Support the voluntary and community sector to build referral partnerships with primary healthcare bodies (GPs, Community Nurses), Fire Services and Social Workers.			
9	Work with local transport providers to improve	Sue Wallace-Bonner/	Ongoing	

	accessibility for Older People	Steering Group		
10	Evaluate and improve physical environment E.g. are there plenty of benches available for people to rest on whilst shopping?	Sue Wallace-Bonner/ Steering Group	On going	
11	Identify what is going well. How could best practice be replicated across the Borough?	Peter Ventre/Steering Group	Ongoing	
12	Take an intergenerational approach to loneliness. There is some evidence to suggest that younger people experience loneliness as much as older people.	Peter Ventre/Steering Group		Initial intergenerational pilot being developed with Care Homes and schools- Wardens service and Grange Comprehensive School
13	Approach local businesses (particularly those with a significant proportion of older customers) and ask them to identify and make changes that can improve social networks/environment for older people in the community.	Peter Ventre/Steering Group		
14	Develop loneliness awareness/combating loneliness training for the general public and staff. This will support ensuring general services are geared up to meet the needs of lonely people.	Peter Ventre/ Steering Group	November 2013	Loneliness/falls awareness training being developed as part of healthy ageing package of training. Training to target widest possible audience e.g. refuse collectors, drivers, wardens and anyone else who may come in contact with lonely older people. The Making Every Contact Count(MECC) agenda will be an important reference

				point for this part of the project
15	Psychological support should be available, where necessary, to older people who experience extreme loneliness. This issue should be the focus of partnership working between health, the local authority and the voluntary sector.	Sue Wallace-Bonner/Steering group	Ongoing	
16	Develop pathways with GP's for "social prescriptions". That is, GP's referring to appropriate agencies those people who are lonely or at increased risk of being lonely, at risk of falling or who have fallen.	Mark Swift/Steering Group	November 2013	
17	Develop a loneliness pathway alongside the existing falls prevention pathway.	Peter Ventre	October 2013	
18	Test existing measures of loneliness and wellbeing for their effectiveness	Peter Ventre/Steering Group	Ongoing	
19	Make project part of Making Every Contact Count (MECC) agenda	Peter Ventre	November 2013	
20	Develop existing volunteer network for Health and Wellbeing Service	Peter Ventre/Steering Group	Ongoing	Volunteers from Health Improvement Team about to join loneliness project work stream.
21	Complete a review of the scoping strategy based on the data and evidence base developed	Peter Ventre/PH consultant	April 2014	