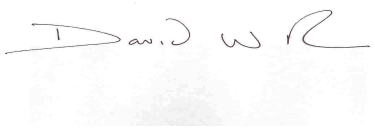
Public Document Pack

Health and Wellbeing Board

Wednesday, 13 November 2013 2.00 p.m.
Karalius Suite, Stobart Stadium, Widnes



Chief Executive

Please contact Gill Ferguson on 0151 511 8059 or e-mail gill.ferguson@halton.gov.uk for further information.
The next meeting of the Committee is on Wednesday, 15 January 2014

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

Part I

HEALTH AND WELLBEING BOARD

At a meeting of the Health and Wellbeing Board on Wednesday, 18 September 2013 at Karalius Suite, Stobart Stadium, Widnes

Present: Councillors Polhill (Chairman) Morley and Wright and S. Banks, P. Cook, J. Cooper, M. Creed, M. Grady, D. Hebden, T. Holyhead, D. Lyon, E. O'Meara, C. Myring, D Nolan, M. Pickup, C. Samosa, N. Sharpe, I. Stewardson, C. Richards, N. Rowe, P. McWade, A. Williamson and S. Yeoman.

Apologies for Absence: Councillors Philbin and S. Boycott, D. Johnson, A. McIntyre, D. Parr, D. Sweeney and J. Wilson.

Absence declared on Council business: None

Also in Attendance: One Member of the public.

ITEM DEALT WITH UNDER DUTIES EXERCISABLE BY THE BOARD

Action

HWB23 MINUTES OF LAST MEETING

The minutes of the meeting held on 17th July 2013 were taken as read and signed as a correct record.

HWB24 NHS A CALL TO ACTION - PRESENTATION

The Board received a presentation from Simon Banks, Chief Officer, NHS Halton Clinical Commissioning Group, on the publication of the *NHS belongs to the people: a call to action*, which called for the public, NHS staff and politicians to engage in an open and honest debate about the future shape of the NHS in order to meet rising demand, introduce new technology and meet the expectations of patients. This was set against a backdrop of flat funding which, if services continued to be delivered in the same way as now, would result in a national funding gap which could be £30bn between 2013/14 and 2020/21.

The NHS belongs to the people: a call to action set out the challenges facing the NHS, including more people living longer with more complex conditions, increasing costs whilst funding remained flat and rising expectations of the quality of care. The document stated that the NHS must

change to meet these demands and make the most of new medicines and technology and that it should not contemplate reducing or charging for core services.

It was noted that NHS Halton CCG had already facilitated an event on 26th June 2013 at which themes similar to those raised by *The NHS belongs to the people: a call to action* were discussed with Halton Borough Council and NHS England colleagues. NHS Halton CCG, working with NHS England and Halton Borough Council, proposed to utilise the outcomes of this event, which was to be discussed later on the agenda, to continue a dialogue with local people about the future shape of the NHS.

RESOLVED: That.

(1) the report and the publication of *The NHS belongs to the people: a call to action* be noted;

(2) the work already facilitated by NHS Halton CCG in partnership with Halton Borough Council to commence a public narrative about the future of health in Halton be noted; and

(3) the continuation of this public narrative with local people, NHS staff and politicians be supported.

HWB25 NHS ENGLAND - MERSEYSIDE UPDATE - PRESENTATION

The Board received a presentation from Michelle Creed, Deputy Director of Nursing – Patient Experience, on behalf of NHS England (Merseyside), which provided:

- an update on the revised structures of the NHS and their relationships;
- an outline of the different NHS organisations within the Merseyside area;
- the financial allocations for each CCG within Merseyside for 2013/14; and
- details of each Directorate within NHS England (Merseyside) including key ambitions.

RESOLVED: That the presentation be received.

HWB26 FUTURE OF HEALTH IN HALTON - PRESENTATION

The Board received a presentation from Simon Banks, Chief Officer, NHS Halton Clinical Commissioning Group, which provided details on the Future of Health in

Halton Seminar which was held on 26th June 2013. The seminar discussed how health could look like in the future in Halton including:

- ageing population;
- improving but still low life expectancy;
- unhealthy lifestyles;
- high rates of hospitalisation, demands on unplanned/urgent care;
- scarce resources; and
- the need to do things differently;

It was noted that the following points were raised:

- demographic changes, their impact on all services for the local population, not just hospitals;
- do plans take account of the changes ahead? Do we need to be more ambitious and aim for a radical step change; and
- focus should be on frail, vulnerable people – not just older people.

The seminar also discussed the next steps which included, checking the five key themes, developing metrics, defining the key themes in an accessible manner, how to work with local people and using social marketing approaches.

RESOLVED: That the presentation be noted.

HWB27 JOINT PROTOCOL BETWEEN HALTON CHILDREN'S TRUST, HALTON SAFEGUARDING CHILDREN BOARD AND HALTON HEALTH & WELLBEING BOARD

The Board received a report of the Strategic Director, Children and Enterprise, which outlined the draft protocol/memorandum of understanding that had been developed to define the role of the Board and relationship with Halton Children's Trust and Halton Safeguarding Children Board.

It was proposed that the joint protocol would be updated in light of the new Working Together to Safeguard Children 2013 Guidance. The Guidance placed a duty on the Director of Public Health to ensure that the needs of vulnerable children were a key part of the Joint Strategic Needs Assessment that was being developed by the Board.

Members considered a copy of the revised protocol which set out the expectations of the relationship and

working arrangements between Halton Children's Trust, Halton Safeguarding Children Board and Halton Health and Wellbeing Board. It covered the respective roles and functions, membership of the boards, arrangements for challenge, oversight and scrutiny, and performance management. The arrangements set out in the Protocol would be subject to review annually as a minimum to reflect recent developments or immediately following legislative change.

RESOLVED: That

(1) the report be noted;

(2) the Board agrees to sign up to the Protocol (attached to the report); and — Chief Executive

(3) six monthly meetings of the Chief Executive of Halton Borough Council and respective Board Chairs as described in Paragraph 36 of the Protocol be approved.

HWB28 END OF LIFE SERVICES

The Board considered a report which provided an overview of current End of Life services available in Halton, which included an outline of future priorities. Members considered a current Model of Clinical Support at End of Life in Halton which consisted of a range of services and systems to ensure the requirements of the patient pathway were met along with the support networks within the community.

With regard to future priorities the following were proposed:

- a two year strategy had been put in place to deliver End of Life tools training to all care homes in Halton;
- by 2015 all care homes within Halton would have been part of the six steps training programme;
- key champions had been identified within Social Care teams and these would be integrated into the existing Key Champions' Network established across care homes;
- the implementation of an electronic palliative care co-ordination system as recommended "Dying Well at Home – The Case for Integrated Working" was a

priority for 2013/14;

- a key priority was to ensure that Liverpool Care Pathway was replaced with a care plan that was reflective of individual patient circumstances in the last few days of their life; and

- Halton Haven Hospice had been successful in securing funding to build a new Family Support Centre with men's shared facility incorporated in 2013.

RESOLVED: That the report be noted.

HWB29 JSNA REFRESH

The Board considered an update report on the Joint Strategic Needs Assessment (JSNA). Since the transfer of the public health responsibility and team to the local authority, a public health page had been set up on the Halton Borough Council website and all JSNA chapters, data updates and other products were now located there.

Members considered a summary document which presented a number of in-depth health needs assessments that had been completed February 2012 to March 2013. It was noted that during 2013-14 major refresh elements of the JSNA were proposed as follows:

- Children: Following discussions with the Children's Trust Executive and Commissioning partnerships, a refresh of all elements of the children's JSNA using a life course approach had begun. This also included vulnerable children and young people such as Looked After Children and those with disabilities.

- Disabilities: Following requests for information to support the annual Self-Assessment Framework submission, Liverpool Public Health Observatory were commissioned to undertake a detailed needs assessment for Learning Disabilities and Autism. This covered children and adults;

- Environmental Health: Work would start on developing this during quarter 2;

- An in-depth needs assessment had been jointly commissioned from Liverpool Public Health Observatory on the health needs of homeless people. This would be led by Liverpool Public Health with

input from Halton staff;

- Halton was also participating in a research project on the impacts of fixed point gambling terminals. This was scheduled to report April 2014.

The Board was advised that despite the continuing challenges that the Borough faced, many of the health indicators showed year on year improvements. Therefore, whilst the Borough continued to be generally worse, in certain areas, than the England average, these improvements showed that the Borough was moving in the right direction, people were able to engage with services, making the most of them to bring about positive changes for themselves, their families their communities. The report detailed areas of improvements within the health indicators and also areas which had remained difficult to improve since the previous reporting period.

RESOLVED: That the report be noted.

HWB30 NHS HEALTH CHECKS

The Board considered a report of the Director of Public Health, on the NHS Health Check Programme and which sought to make recommendations on how health checks should be implemented in Halton.

From 1st April 2013 local authorities took over responsibility for the NHS Health Check Programme (The Programme). The Programme was a Public Health Programme for people aged 40 – 74 and aimed to keep people well for longer. It also aimed to reduce levels of alcohol related harm and raise awareness of the signs of dementia.

The Board was advised that commissioning of the risk assessment element of the programme was a mandatory public health function, to be funded from the public health budget. Details of the arrangements which local authorities must make were provided in the report. In addition, the report also contained information on the risk assessment tests and measures which were to be carried out.

At present, the Council had an agreement with GP practices to deliver Health Checks Plus to local residents as a local enhanced service. Health Checks Plus included most of the minimum requirements of the NHS Health Checks, in addition to some locally developed questions around

housing and fuel poverty and some medical questions. Following feedback from GP practices, it was reported that the Health Checks Plus assessment took on average around 45 minutes per patient, far longer than the 20 minutes expected. It was therefore proposed that Health Checks would be streamlined so that they included only the required information to carry out the mandatory risk assessments and included the new areas of alcohol screening and dementia awareness for patients aged 65 to 74.

It was also proposed that Health Checks would continue to be delivered by GP practices under existing contractual arrangements and a community-based provision would be identified that was also cost effective. A copy of the new Service Legal Agreement which had been drafted for GP practices setting out the requirements of the revised NHS Health Checks was circulated to Members.

RESOLVED: That

(1) the report be noted; and

(2) the proposals for delivery NHS Health Checks in Halton be noted.

HWB31 TROUBLED FAMILIES / INSPIRING FAMILIES UPDATE

The Board considered a report of the Strategic Director, Children and Enterprise, which gave members an update on the development of Inspiring Families Programme.

It was noted that in the first year 145 families were identified and details of their status in relation to Payment by Results (PBR) claims in January 2013 and those estimated for January 2014, with the percentage of those families achieving targets was outlined in the report. It was anticipated that approximately 70% (102 out of 145) of all families from year 1 were likely to achieve targets and a claim made for PBR to the Department for Communities Local Government by the end of July 2013.

It was also noted that from the 29 families where PBR had been claimed:

- 12 adults were on the work programme;
- there was a 75% reduction in calls to the police;
- 139 less service calls over a 6 month period; and
- 11 young people had successfully completed their Youth Offending Team order and had not reoffended

over a 6 month period.

In addition, it was noted whilst the development of the Inspiring Families cost savings tool continued, work was taking place collating local costs incurred in relation to staffing the process.

With regard to year 2/3 allocation, following a review in April 2013, practitioners and lead managers raised concerns at the number of families allocated at one time. They suggested that instead, the Inspiring Families Team should "drip feed" families on a smaller scale. This would enable teams to manage the workload/demands more effectively. At present, 109 out of 195 families had been allocated with the remaining families to follow during October and November.

RESOLVED: That

(1) the Inspiring Families approach in Halton be supported; — Strategic Director Children and Young People

(2) where viable, partners adopt a "Think Family" approach in the planning and implementation of their service delivery;

(3) the development of family assessment that could be used across all organisations be progressed;

(4) partners consult with the Troubled Families Co-ordinator when commissioning services for children, young people and families; and

(5) the options of reinvesting cost savings to add investment to areas of agreed work be explored with partners.

HWB32 AUTISM SELF ASSESSMENT FRAMEWORK

The Board considered a report of the Strategic Director, Communities, which provided Members with an update on the Autism Self-Assessment Framework.

The Board was advised that in December 2010, statutory guidance was published, 'Fulfilling and Rewarding Lives'. As part of this the Department of Health issued a local self-assessment for adults with autism for Local Authorties and Clinical Commissioning Groups to aid commissioners to plan how they were going to respond to statutory guidance. The purpose of the self-assessment

framework was to:

- assist Local Authorities and their partners in assessing progress in implementing the 2010 Adult Autism Strategy;

- assess progress since the baseline survey, as at February 2012;

- provide evidence of examples of good progress made that can be shared and of remaining challenges.

It was noted that the Autism Self-Assessment Framework would be submitted on 30th September 2013 as part of the validation process. The submission would also be presented to the Autism Strategy Group on the 23rd September 2013 and the Learning Disability Partnership Board. A copy of the Autism Self-Assessment Framework which was jointly owned by both the Local Authority and the Clinical Commissioning Group had been previously circulated to Members of the Board.

RESOLVED: That the report be noted.

HWB33 SCHOOL NURSING

The Board considered a report of the Director of Public Health, which provided an update on the progress of the procurement of School Nursing Service for Halton. From April 2013, Local Authorities assumed the accountability for the commissioning of School Nursing Services. This had provided an opportunity to review the existing commissioning arrangements to shape and design future provision with input from stakeholder engagement, in line with on-going review of all public health contracts. It was noted that the contract for the existing School Nursing Service had been extended to March 2014, with the option to extend for a further one year period. Due to the financial value of the contract and in line with Council policy, the service would need to go through an open procurement process.

A new specification was being developed as part of a collaborative piece of work with commissioners across the Cheshire and Merseyside footprint and the core elements of the proposed service were detailed in the report.

In order to ensure that all stakeholders could inform and influence the development of the service, it was intended a period of engagement would begin in September

for two months. During this time, head teachers, school staff, School Nurses, youth workers and other partners would be encouraged to provide their opinions on how the service could be improved to better meet the needs of children, young people and their families. In addition, children and young people would also be encouraged to feedback on the service and identify ways in which it could be improved. Further, Elected Members, The Children's Trust, Health and Wellbeing Board and the Local Healthwatch and other interested partners would also inform the final specification before it was subjected to procurement.

It was intended that the procurement process would commence in early 2014 with a view to ensuring that the successful provider was appointed no later than September 2014, in line with the beginning of the new school year.

RESOLVED: That

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

(2) any comments be fed back to the Director of Public Health; and — Director of Public Health

(3) the recommendation to commence with consultation on the procurement of a service to be in place no later than September 2014 be supported.

HWB34 NATIONAL ENERGY ACTION (NEA) PUBLIC HEALTH WORK PROGRAMME

The Board considered a report which sought approval in principle of an application for free assistance from National Energy Action (NEA) to support the achievement of fuel poverty public health outcomes. NEA was a national charity which aimed to eradicate fuel poverty and campaigned for greater investment in energy efficiency for vulnerable people.

Members were advised that the support offered would take up 12 days of officer time for development activities in 8 localities across England, which must be utilised by the 14th March 2014. Applications for assistance must be submitted by Friday 20th September 2013 by either a Director of Public Health or the Chair of the Health and Wellbeing Board. A copy of the completed draft application to be submitted to NEA was circulated to Members of the Board.

RESOLVED: That the Board support in principle the application for free NEA support.

HWB35 ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST - PROPOSED 5 YEAR CLINICAL AND FINANCIAL PLAN

The Board considered a report of the Strategic Director, Communities, which provided an initial assessment of St. Helens and Knowsley (STH&K) Teaching Hospitals NHS Trust proposed 5 year Clinical and Financial Plan and outlined areas that required close scrutiny.

On 2nd August 2013, Ann Marr, Chief Executive of STH&K Teaching Hospitals NHS Trust wrote to the Chief Officers of Halton, Knowsley and St. Helens Clinical Commissioning Groups (CCGs) outlining details of the Trust's draft 5 year Clinical and Financial Plan. The bulk of the Trust's income came from contracts with English CCGs, NHS England and Local Authorities. A table was detailed in the report outlining the breakdown of this funding.

Following a review of the Plan, a number of points were highlighted in the following areas:-

- Support to the whole of the Urgent Care Pathway;
- Accident and Emergency Department Attendances and Non-Elective Admissions;
- Social and Intermediate Care Activity and 7/7 working ;
- Estate Costs;
- Nurse Staffing Levels; and
- Medium Term Growth.

Members of the Board were advised that it had recently been announced that Accident and Emergency Units would benefit from an additional £500m over the next two years to ensure they were fully prepared for Winter. However, it was anticipated that the new funding would go to areas that were identified as being the most under pressure which may exclude both STH&K and Warrrington and Halton Hospital FoundationTrust (WHHFT) who both achieved their 4 hour A&E targets.

It was noted that when the announcement for winter pressure funding was made, reference was also made to the £3.8b pooled health and social care funding for integration to be held by Local Authorities. There would be an expectation that this fund was also used to support pressures across the

urgent care system.

Arising from the discussion, the Board referred to STH&K proposal that contracted levels for non-elective activity should be rebased, releasing 70% tariff for investment with the Trust to maintain safety, patient experience and levels of performance. It was acknowledged that should this funding be released then the funding should also be released to WHHFT and they should be given an opportunity to submit a proposal. It was recognised that STH&K funding proposal needed to be considered as a whole, which included WHHFT; and Halton CCG would meet in October to consider the five year plan and to make a response.

RESOLVED: That the contents of the report and associated appendixes be noted.

Meeting ended at 3.50 p.m.

REPORT TO: Health and Wellbeing Board

DATE: 13th November 2013

REPORTING OFFICER: North West Ambulance Service

PORTFOLIO: Health and Wellbeing; Children, Young People & Families

SUBJECT: North West Ambulance Service - Presentation

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 The North West Ambulance Service will be giving a presentation to the Board. The presentation will provide an overview and key priorities for the organisation.

2.0 RECOMMENDATION: That the Board note the contents of the presentation.

REPORT TO: Health & Wellbeing Board

DATE: 13th November 2013

REPORTING OFFICER: Lisa Birtles-Smith Clinical Lead Learning Disabilities (Halton CCG) and Lead Nurse Halton Learning Disability Nursing Team
Damian Nolan Divisional Manager Urgent Care

PORTFOLIO: Health & Wellbeing

SUBJECT: Halton Model of Care for People with a Learning Disability

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To present to the Committee Halton Model of Care for Adults with Learning Disabilities which sets out the range of local community based and acute sector support for adults with learning disabilities and their family carers.

2.0 RECOMMENDATION: That the Board

1. note the report; and

2. endorse the Halton Model of Care for Adults with Learning Disabilities

3.0 SUPPORTING INFORMATION

3.1 In recent years in response to national strategy and good practice guidance, community based health and social care services in Halton have undergone significant change and development to offer person centred support to adults with learning disabilities enabling them to remain in their home and reduce the need for admission to in-patient hospital beds or residential care. This model brings together and underpins the approach in the borough to further developing services and monitoring and evaluating the outcomes of health and social care provision.

3.2 The model has been developed by the LD Quality and Performance Board chaired by the Council's Operational Director Prevention and Assessment with representation from CCG Commissioners, CCG Clinical Lead/Lead Nurse, HBC Care Management and Commissioning, Bridgewater Community Healthcare NHS Trust and 5 Boroughs Partnership NHS Foundation Trust.

3.3 The model is based on the values enshrined in Valuing People and Healthcare for All and takes on board the recommendations of the Winterbourne View Final Report. It outlines the range of local community based and acute sector support for adults with learning disabilities and their family carers.

3.4 A stepped care approach has been adopted where an individual will initially access mainstream health and community services with more intensive specialist support available as appropriate. The most effective intervention is offered with the aim of supporting the person in their own home and not being overly restrictive or intrusive.

3.5 The model is intended to facilitate reduction in the numbers of individuals requiring admission to hospital or being sent out of area by offering local community based services that are consistent with best practice.

3.6 Included within the model is a performance framework of both quantitative and qualitative measures and outcomes to monitor progress and ensure that what is envisaged is being delivered. This framework has been mapped to the domains in the 2013/14 NHS, Adult Social Care and Public Health Outcomes Frameworks.

3.7 In addition, a Quality Check Template (Appendix 1 to the Model) and guidance (Appendix 2) is being tested and amended by practitioners as a prompt “to open their eyes wider” when visiting individuals in supported living or residential services to identify both best practice and any areas for concern. Use of this template offers an on-going perspective to supplement the Council’s inspection regime for these services. This enables identified good practice to be shared across the provider network and earlier identification of concerns and intervention to avoid issues escalating to a formal safeguarding referral.

3.8 The Model has been taken to the Adult Learning Disabilities Partnership Board and shared with self-advocates and family carers. Overview of the model will be through the LD Quality and Performance Board with quarterly reports into the ALD Partnership Board. (Appendix 3 to the model).

4.0 POLICY IMPLICATIONS

4.1 None identified.

5.0 FINANCIAL IMPLICATIONS

5.1 None identified.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

The model supports transition arrangements for young people with a learning disability into adult services.

6.2 Employment, Learning & Skills in Halton

Performance is the borough in relation to employment of adults with learning disabilities is evaluated as a key outcome.

6.3 A Healthy Halton

The model encourages people to manage their own health via mainstream services and where necessary provide timely approaches, via specialist services, which are person centred to meet the individual's needs.

6.4 A Safer Halton

None identified.

6.5 Halton's Urban Renewal

None identified.

7.0 RISK ANALYSIS

7.1 The model of care frames the existing service provision into a coherent pathway and therefore does not require a formal risk assessment.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 The model seeks to ensure that adults with learning disabilities have timely and appropriate access to all health and social care services and community provision and thus promotes social inclusion.

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

None identified.

HALTON BOROUGH COUNCIL

Halton Clinical Commissioning Group

Halton Learning Disability Partnership Board
Working in partnership

Halton Model of Care for Adults with Learning Disabilities

Contents

1. Introduction

In recent years in response to national strategy and good practice guidance, community based health and social care services in Halton have undergone significant change and development to offer person centred support to adults with learning disabilities enabling them to remain in their home and reduce the need for admission to in-patient hospital beds or residential care. The number of assessment and treatment beds commissioned with the 5 Boroughs Foundation NHS Trust has been reduced as a result of this shift to community based service delivery.

2. Context

2.1 National Context

The 2001 DH White Paper Valuing People[1]provides the vision for people with learning disabilities and their families based on four principles of rights, independence, choice and inclusion. Valuing People Now published in 2009 reaffirmed these principles and whilst acknowledging the considerable progress achieved it highlighted that more needed to be done in a number of areas with the key priorities being:

Access to and improvements in healthcare,
Housing and a reduction in the number of residential placements
Employment[2] – increased numbers of people with learning disabilities in paid work by 2025

In December 2012, following its investigation of the failings, the Government published its full response to the criminal abuse uncovered at Winterbourne Hospital and practices observed in other settings: **Transforming Care: A national response to Winterbourne View Hospital (DH)**. The review exposed concerns regarded as:

- Inappropriate placements
- Inappropriate care models
- Poor care standards

A programme of action with stretching timescales is proposed across the whole health and social care system to improve care for people with challenging behaviour. The report sets out a revised model based on the work of Mansell[3] along with roles and responsibilities across the health and social care system including regulatory bodies.

National policy over recent years has stressed the importance of personalisation and prevention. The findings from Winterbourne reiterate this as well as stressing the importance of commissioners ensuring that services are

[1] Valuing People: Anew Strategy for Learning Disability for the 21st Century (DH 2001)
[2] Valuing Employment Now: real jobs for people with learning disabilities (DH 2009)
[3] Services for people with learning disabilities and challenging behaviour or mental health needs and challenging behaviour: The 'Mansell Report' (revised edition DH, 2007)

available locally that can deliver a high level of support and care to people with complex needs or challenging behaviour.

The 2012 White Paper **Caring for Our Future: reforming care and support** sets out the vision for a reformed care and support system that is more personalised, more preventative and more focused on delivering the best outcomes for those needing support. The aims are to:

- focus on people's wellbeing and support them to stay independent for as long as possible
- introduce greater national consistency in access to care and support
- provide better information to help people make choices about their care
- give people more control over their care
- improve support for carers
- improve the quality of care and support
- improve integration of different services

The White Paper is supported by the draft **Care and Reform Bill (2012)** it places a duty on local authorities to publish information on the care and support market, how providers might meet future demand and also ensures sustainability and continuous improvement in service quality.

In response to the Mencap report "Death by Indifference" which described the circumstances surrounding the deaths of six people with learning disabilities, **Healthcare for All**[4] identified actions needed to ensure adults and children with learning disabilities receive appropriate medical treatment in the NHS. Ten recommendations were made to improve access to health care and ensure equal rights imparted by the Disability Discrimination Act and Mental Capacity Act was being respected across the NHS.

Outcomes Frameworks 2013/14

The government has set out the areas it wishes to see improve across Public Health, Social Care and the NHS in three individual frameworks. The Department of Health has more closely aligned the frameworks so local partners across the health and care systems can identify challenges for their population and better inform local priorities for joint action. The overlay is illustrated in Section 4.

2.2 Local context

Within Halton Borough Council the Communities Directorate has responsibility to support, care for and protect its most vulnerable residents. It also offers information and signposting to enable its residents to make informed choices to help them maintain their independence, health and wellbeing.

The recent re-configuration of Prevention and Assessment Services within the Council provides an opportunity to revisit the range of locally available community support services and pathways, particularly in relation to complex

[4] Healthcare for All: Report of the independent inquiry into access to healthcare for people with learning disabilities (2008)

needs and challenging behaviour. Halton's Model of Care aims to emulate published good practice and highlight any areas for further development.

Halton's Model of Care takes a whole systems approach to supporting Adults with Learning Disabilities and is built on strong Partnership Working across agencies. Halton Clinical Commissioning Group and Halton Borough Council have entered into a Section 75 Partnership Agreement which establishes a framework for integrated commissioning to achieve better outcomes for local people.

2.2.1 Learning Disability Population

In March 2012 there were 431 adults with learning disabilities known to social care. Of these 37 were aged 65+. Less than 1.5% of those known to services belong to a minority ethnic group.

GP registers indicate 718 adults with learning disabilities are eligible for health checks though this number is rising as Reed codes are revised.

These numbers are lower than projections produced by Public Health England for all age groups which show:

- Numbers of people with learning disabilities probably known to services 543
- Likely true number of people with learning disabilities 2,369

2.2.2 Autism

Approximately 1% of the population have autism[5] and it is estimated that half of these people also have a learning disability. In Halton, this translates as 1,258 people on the autistic spectrum across all ages and 629 will have an accompanying learning disability.

Local estimates suggest 98 people on the autistic spectrum are known to services though there may be an element of double counting in this. A more accurate census will be conducted for both children and adults and this analysis will inform the Joint Strategic Needs Assessment for autism to be developed in 2013.

2.2.3 Health of people with Learning Disabilities

There is much evidence[6] to suggest that people with learning disabilities die younger and have poorer health than the general population. Whilst these inequalities are due to both the social determinants of health (e.g. poverty, social exclusion) and syndromes associated with learning disabilities which are associated with specific health risks the cause of death is often avoidable.

Common health problems among people with learning disabilities can be found at:
www.improvinghalthandlives.org.uk/publications/978/HealthInequalitiesandPeoplewithLearningDisabilitesintheUK:2011

[5] Fulfilling and Rewarding Lives (DH, 2011)
[6] Improving the Health and Wellbeing of People with Learning Disabilities: An evidence-based commissioning guide for Emerging Clinical Commissioning Groups (IHAL, 2012)

Mersey Public Health will be conducting a Health Needs Assessment across the region and at local level. This analysis should be available mid-2013.

2.2.4 Strategies Supporting Learning Disability Services

Learning Disability Commissioning Strategy

Learning Disability Housing and Support Strategy

Transition Strategy

Carers Strategy

Prevention and Early Intervention Strategy

Dementia Strategy

Complex Care Business Model

3. The Model of Care

3.1 Who is the Model of Care for?

This model will support all Halton adults with learning disabilities and their family carers, plus young people with learning disabilities in transition to adult services and their family carers, including those with complex needs arising from an autistic spectrum condition:

- Who are "ordinary resident" in Halton including those in distant placements or
- Who are registered with a Halton GP
- When reach-down is needed from age 16+ for a young person that will be transitioning to adult services.

3.2 Principles and Aims

The model of care presented below is founded on the principles enshrined in Valuing People[7] and re-affirmed in Valuing People Now[8] that embraces 'Rights, Independent Living, Control and Inclusion', with services delivered in a person-centred way with access to mainstream services, including mainstream health services, wherever possible.

The model is founded on a person centred approach with a focus on people having fulfilling lives with opportunities for education, employment, leisure and social activities. Where additional support is needed it should be flexible, accessible, community based, close to home and consistent with identified best practice.

This approach will also facilitate reduction in the numbers of individuals requiring admission to hospital and of out of area placements (Winterbourne Review Interim and Final Reports 2012):

Where additional support is needed people's experience of care and support will be improved by adopting these principles and aims:

[7] Valuing People: A New Strategy for Learning Disability for the 21st Century (DH, 2001)
[8] Valuing People Now a new three year strategy for people with Learning Disabilities (DH, 2009)

- Services for all, including those individuals presenting the greatest level of challenge
- High quality services for people with learning disabilities including those with behaviour which challenges
- Services which work around the individual – no one size fits all
- Services follow a life-course approach i.e. planning and intervening early, starting from early adulthood and incorporating crisis planning
- Services are provided locally
- Services offer timely responses
- Services focus on individual dignity and human rights
- Services are integrated/co-ordinated with good access to physical and mental health services as well as social care
- Where in-patient services are needed, planning to move back to community services starts from day one of admission.
- Services provide good value for money

3.3 The Range of Care Approach

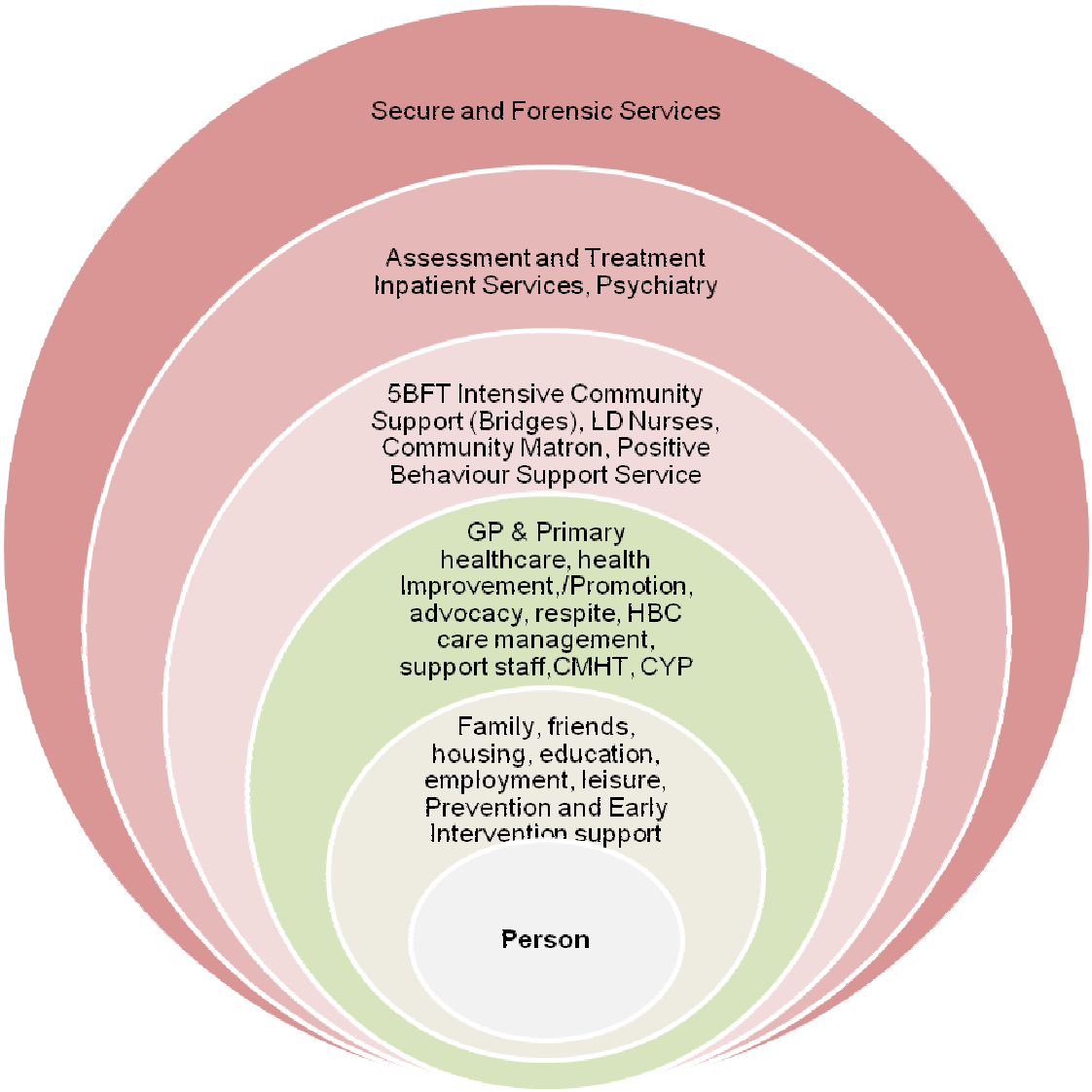
The model adopts a stepped care rather than progressive approach offering a range of care (Diagram 1) based on the premise that people with learning disabilities, including people with complex and challenging behaviour can lead fulfilling lives in the community. Stepped care recognises the range of levels of need from those less severe who manage and thrive with support of family, friends and mainstream health and community services to those requiring intensive specialist support. Stepped Care offers the most effective intervention which supports the person in their home without being overly restrictive or intrusive.

It is crucial that support is person centred with a focus on maintaining the individual living in the community, available from a range of sources, both formal and informal and responsive to specific needs at any given time. Implementation of the Halton Prevention and Early Intervention Strategy is fundamental to this approach particularly for the learning disabled population not known to social care (see 2.2.1).

In responding to changing need, crisis or circumstances the model must offer a speedy response with the ability to “step” up, down or across the range of support. Key elements of a safe and effective model are specialist crisis support, outreach and assessment and treatment, including in-patient care if appropriate, supported by cross-sector multi-agency working and care pathways.

Where a person needs more specialist support, including that arising from complex and challenging behaviour, they will have access to skilled support staff and where necessary the support of specialist professionals including behaviour analysts to assist assessment and help plan more effective individualised support.

Diagram1: The range of stepped care and support in Halton



Access into services comes through primary, social and secondary care referral routes.

4. Performance Framework

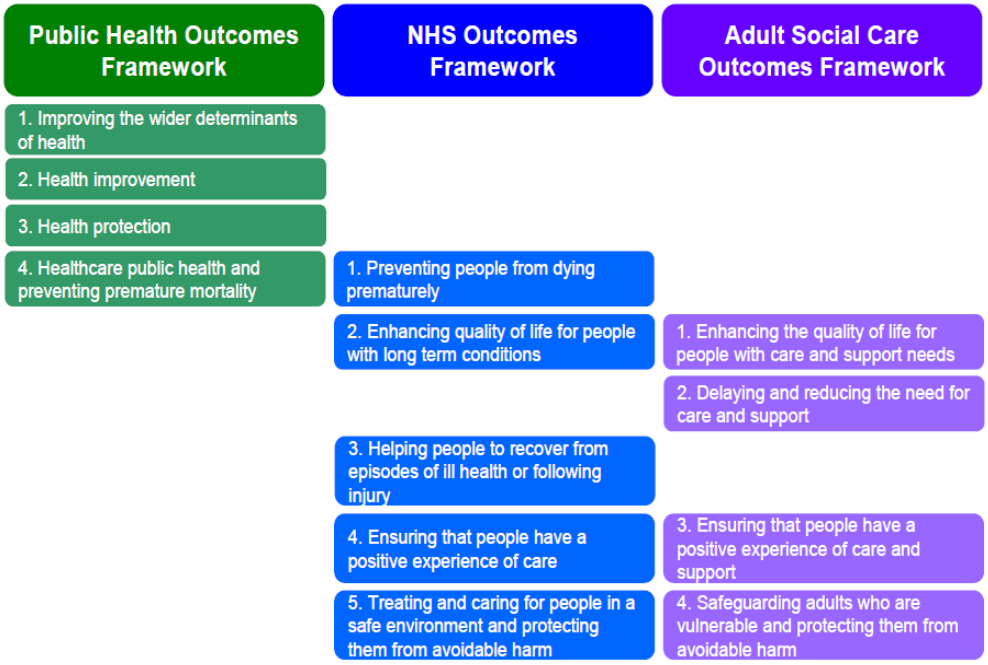
It is imperative that the partners responsible for delivering the model of care can keep track of progress and be confident that the model envisaged is the one being achieved. The performance framework set out below constitutes both qualitative and quantitative measures to monitor the range of activities across the whole model of care.

Some of the suggested indicators are collected nationally and these are referenced whilst others enable performance at the local level to be more closely monitored to trigger alerts to potential problems, offer analysis of the root cause from multiple perspectives and thus optimise performance of the whole system. All of the indicators contribute to delivering the national outcomes for the NHS, Public Health and Adult Social Care and have been linked to the relevant domains.

4.1 National Outcomes Framework 2013/14 overlay

Some indicators are the same across Adult Social Care the NHS and/or Public Health reflecting the shared role in progressing. Those that are not shared are complementary to similar indicators relating to the same issue in the NHS and Public Health frameworks.

Diagram 3



4.2 Reporting Structure

The measures will be reported regularly to the Learning Disability Quality and Performance Board and on a quarterly basis to the Learning Disability Partnership Board. The frequency of reporting a particular indicator will vary according to its relevance.

In addition to the identified indicators set out in the table below a Quality Framework Template and guidance (Appendix 1) has been developed to encourage practitioners to open their eyes wider when visiting individuals in supported living accommodation or residential/nursing accommodation. The template will give valued and on-going

feedback on service quality to supplement the more formal provider monitoring undertaken by the Council's Quality Assurance Team and the Care Quality Commission. It will highlight areas of best practice to be shared across services as well as identify any areas of concern to be addressed before they escalate. Practitioners will share their findings through the Operational Managers Group – see governance arrangements set out in Appendix 3

Adult Learning Disability Model of Care Performance Framework

Frequency of reporting will vary according to relevance of measure

Outcome Framework Domain	National data set indicator number	Data Collection Lead	Outcome Measure	Definition	2012/13 Outturn where available	2013/14 Target
ASC 1 NHS 2	ASCOF1A NHSOF2	HBC	People are able to maintain their quality of life	Social Care related quality of life-feedback via social care provider surveys and forums		
ASC 1 NHS 2 PH 3	ASCOF1D NHSOF2.4	HBC	Carers can balance their caring role and maintain their desired quality of life	Carer reported quality of life feedback via social care provider surveys and forums		
ASC 1 PH 1 PH 2 NHS 2	ASCOF1E PHOF1.8 NHSOF2.2	HBC	People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation	Proportion of adults with a learning disability in paid employment		
ASC 1 ASC 2 PH 1 PH 2 NHS 2	ASCOF1G PHOF1.6 ASCOF2A	HBC/CCG	When people develop care needs, the support they receive takes place in the most appropriate setting and enables them to regain their independence	• Proportion of adults with a learning disability who live in their own home or with their family • Permanent adults with a learning disability admissions to residential and nursing care homes per 1,000 population • Number of LD admissions to generic acute services		
ASC 1 ASC 3 ASC 4		HBC/CCG	People listed on the LD SAF registers in NHS care or placed out of area will have their needs reviewed annually	Number of people on LD register receiving a review as a percentage of those on the		

NHS 2 NHS 4 NHS 5				register		
NHS 2 NHS 3 NHS 4 ASC 1 ASC 2 ASC 3		Community Matron and Multi-disciplinary team	Helping people to recover from episodes of ill health/manage their health Enhancing quality of life for people with long term conditions	• Number of referrals to service • Number of on-going patients • Number of visits • Number/case studies of potential admissions avoided		
NHS 3 NHS 4 NHS 5 ASC 3 ASC 4		5BPFT	Assessment and Treatment	• Number of admissions to inpatient beds • Average length of stay as an inpatient		
NHS 3 NHS 4 NHS 5 ASC 1 ASC 3 ASC 4		5BPFT Care Management LD Nurses PBSS CCG	Timeliness of responses	• Average length of time from referral to allocation • Average length of time following 1st contact to completion of assessment • Number of individual case conferences/MDT meetings per month • Waiting times from referral to treatment for generic health services.		
PH 1 PH 2 PH 4 NHS 1	Partnership Board SAF	CCG Health Improvement Team	Health	• Numbers eligible for GP health check • Number of health checks		

NHS 2		Clinical Lead		completed by GP's as a percentage of those eligible
				• Numbers accessing screening services:
				  ○ Diabetes
				  ○ Dementia
				  ○ Cancer screening
				  ○ Eye health checks
				• Number of health action plans completed
				• Uptake of vaccinations
				• Numbers accessing advice on friendships and relationships		

ASC 1 ASC 2 NHS 2 ASC 3 NHS 4		HBC/CCG	Out of area placements	• Numbers of out of area placements • Number of people wishing to return to Halton as a percentage of all OOA placements		
ASC 4 NHS 5		HBC/5BFT	Safeguarding and incident reporting	• Number of complaints relating to LD services • Number of crisis placements and Length of stay		

Quality Framework for Practitioners

	Areas to consider	In this area, think about:
1	**Care and welfare of people who use services** People experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.	Is there evidence that clients views, desires and wishes taken into account in planning their care Activities – are they person centered Does the client have social contacts outside of the environment or attend activities with established groups? How is the outcome of activities recorded? Are care plans individual to that person? Does the client have a keyworker? Is the role of the keyworker defined?
	Areas to consider	**In this area, think about:**
2	**Assessing and monitoring the quality of service provision** People benefit from safe, quality care because effective decisions are made and because of the management of risks to people's health, welfare and safety.	Are risk assessments in place that include: • Health • Welfare • Safety Have internal and external reviews taken place? Is there evidence the client views have been taken into account with the risk assessments?
	Areas to consider	**In this area, think about:**
3	**Safeguarding people who use services**	Are staff aware of whistleblowing policy of the organisation

	from abuse People are safeguarded from abuse, or the risk of abuse, and their human rights are respected and upheld.	Have staff received training on signs and symptoms of abuse? Are staff aware of how to raise safeguarding concerns?
	Areas to consider	**In this area, think about:**
4	**Cleanliness and infection control** People experience care in a clean environment, and are protected from acquiring infections.	Does the client take part in the cleaning of their environment? Is the environment clean? Are there cleaning schedules (where appropriate) Have staff been trained in Infection Control? Do staff know procedures to follow re infection control?
	Areas to consider	**In this area, think about:**
5	**Management of medicines** People have their medicines when they need them, and in a safe way. People are given information about their medicines. Outcome 9, Regulation 13 – CQC	Are the views of clients taken into account regarding their medication regimes? (including PRN) Does the client know about their medication? Are PRN protocols/guidelines in place? Is PRN administration monitored and recorded? Are medicines stored safely? Are medication sheets available to view and match the medication administered? Is there a medication administration policy available? Do staff know the medication administration policy?
	Areas to consider	**In this area, think about:**
6	**Meeting nutritional needs**	How are food and drink choices evidenced?

	People are encouraged and supported to have sufficient food and drink that is nutritional and balanced, and a choice of food and drink to meet their different needs.	Is there evidence of menu planning? Does the client prepare their food and drink? Has a skills assessment taken place re preparation of food and drink? Are views, desires and wishes of the client paramount when planning meals?
	Areas to consider	**In this area, think about:**
7	**Safety and suitability of premises** People receive care in, work in or visit safe surroundings that promote their wellbeing.	Health and safety risk assessments Observations of the environment: • State of the environment • Smells • Social areas/gardens • Private space • Personalized bedroom
	Areas to consider	**In this area, think about:**
8	**Safety, availability and suitability of equipment** Where equipment is used, it is safe, available, comfortable and suitable for people's needs.	Has an assessment of the clients needs taken place? Is the equipment provided suitable for the clients needs? Is the equipment fit for purpose and there is evidence it is inspected regularly?
	Areas to consider	**In this area, think about:**
9	**Respecting and involving people who use services** People understand the care and treatment	How are the views/desires and wishes of clients ascertained and acted upon? Meetings, individual discussions Is the client's room personalized with their own property?

	choices available to them. They can express their views and are involved in making decisions about their care. They have their privacy, dignity and independence respected, and have their views and experiences taken into account in the way in which the service is delivered.	What evidence of regular social contacts is there? How are new experiences and learning opportunities evidenced? What evidence of friendships & relationships, old and new is available?
	Areas to consider	**In this area, think about:**
10	**Consent to care and treatment** People give consent to their care and treatment, and understand and know how to change decisions about things that have been agreed previously.	How does the client make decisions and consent about their care and treatment? What is the consent policy? Evidence that the MCA & B.I processes are in place
	Areas to consider	**In this area, think about:**
11	**Complaints** People and those acting on their behalf have their comments and complaints listened to and acted on effectively, and know that they will not be discriminated against for making a complaint.	How are clients or their family made aware of their right to complain? What is complaints the procedure? How many complaints have been received? What was the outcome of the complaints?
	Areas to consider	**In this area, think about:**

12	**Records** People's personal records are accurate, fit for purpose, held securely and remain confidential. The same applies to other records that are needed to protect their safety and wellbeing.	Are the daily records accurate, legible and complete? Are they signed and dated? Do records give information about happenings during the day? Is learning about the individual enabled by the recordings? Do they demonstrate equality and diversity and dignity? How does the client gain access to their records?
	Areas to consider	**In this area, think about:**
13	**Requirements relating to workers** People are kept safe, and their health and welfare needs are met, by staff who are fit for the job and have the right qualifications, skills and experience.	Safer Recruitment questions, CRB
	Areas to consider	**In this area, think about:**
14	**Staffing** People are kept safe, and their health and welfare needs are met, because there are sufficient numbers of the right staff.	Do clients attend health appointments, both routine and unplanned? Is there evidence of pro-active screening? Is there a Health Action Plan and Health Passport available?
	Areas to consider	**In this area, think about:**
15	**Supporting workers**	What are the agreed staffing numbers?

	People are kept safe, and their health and welfare needs are met, because staff are competent to carry out their work and are properly trained, supervised and appraised.	Have staff received the necessary training to do their job? Are staff trained in de-escalation and redirection techniques? Do staff receive regular supervision? Where are supervision notes and training records kept? Is there evidence of team/staff meetings? Do staff have annual appraisals? Are processes in place for observation by senior staff? Are senior staff trained and experienced?
	Areas to consider	**In this area, think about:**
16	**Cooperating with other providers** People receive safe and coordinated care when they move between providers or receive care from more than one provider.	The MDT member's feedback to others about their involvement and expectations? If more than one provider is involved, how is the care/supported coordinated and communicated? Has a review of the client's needs taken place in the last 12 months?

APPENDIX 2

Framework Guidance

Following the national response to the criminal abuse at Winterbourne View, a regional action plan has been developed, to give assurance that action is being taken to avoid repetition of the issues which could give rise to similar mal-practice in future. This framework for practitioners is a local framework devised by Halton, to give reassurances that consideration and action is taking place to prevent issues evidenced at Winterbourne view, from happening locally.

The framework is split into areas:

- Care and welfare of people who use services
- Assessing and monitoring the quality or service provision
- Safeguarding people who use services from abuse
- Cleanliness and infection control
- Management of medicines
- Meeting nutritional needs
- Safety and suitability of premises
- Safety, availability and suitability of equipment
- Respecting and involving people who use services
- Consent to care and treatment
- Complaints
- Records
- Requirements relating to workers
- Staffing
- Supporting workers
- Co-operating with providers

Each area has statements/questions to think about, which should act as an aide memoire or prompt to practitioners.

How could this framework be used?

Practitioners could use the areas to consider and things to think about when they visit individuals either in their own tenancy, where staff provide support or in residential/care homes. Some areas may not be appropriate to all settings. An example of this could be the area 'safety, availability and suitability of equipment' where individuals living in their own tenancy do not require equipment such as hoists.

It is expected that practitioners using the framework, **must** raise any concerns with the appropriate person/area as soon as possible.

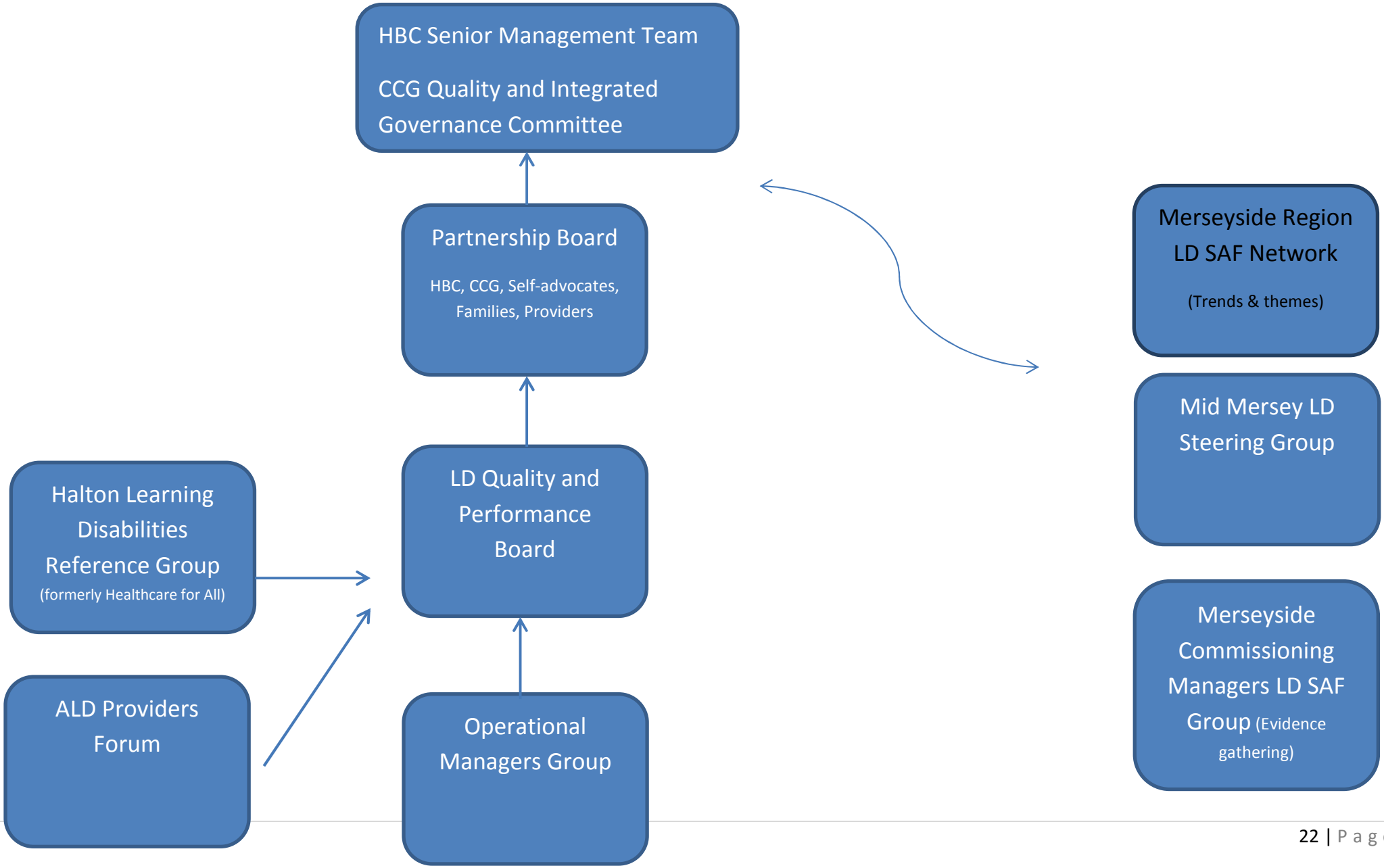
This could be one or a combination of the following:

- Halton's Quality Assurance Team
- The practitioners manager
- The manager of relevant Halton Care Management Team
- Halton's Integrated Safeguarding Unit

For further information or guidance, please contact Lisa Birtles-Smith on lisa.birtles-smith@halton.gov.uk or 0151 511 7765

Mapping of LD Model of Care Overview

APPENDIX 3



REPORT TO: Health & Wellbeing Board

DATE: 13 November 2013

REPORTING OFFICER: Strategic Director, Children & Enterprise

PORTFOLIO: Children, Young People and Families

SUBJECT: CQC Children Looked After and Safeguarding Reviews

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To inform the Board of the programme of Children Looked After and Safeguarding Reviews being undertaken by the CQC.

2.0 **RECOMMENDATION: That the Board notes the contents of the report**.

3.0 **SUPPORTING INFORMATION**

3.1 Following deferment of the planned multi-agency inspections of child protection arrangements, the CQC announced its intentions to undertake reviews of how health services keep children safe and promote the health and wellbeing of looked after children. The CQC implemented its programme of Children Looked After and Safeguarding Reviews on 30th September 2013, which will run until April 2015.

3.2 The reviews will evaluate the quality and impact of local health arrangements for safeguarding children and improving healthcare for looked after children and care leavers. As with Ofsted's single inspection framework, there will be a focus upon the experiences of looked after children and children and families who receive safeguarding services.

The lines of enquiry have been identified as:

- The experiences and views of children and their families.
- The quality and effectiveness of safeguarding arrangements in health.
- The quality of health services and outcomes for children who are looked after.
- Health leadership and assurance of local safeguarding and looked after children arrangements.

3.3 The inspections will take place in areas where the CQC believes there is the greatest risk within health services, and where they identify that there are deficiencies in the effectiveness of safeguarding arrangements and services for looked after children in the NHS. Reviews will cover all aspects of the provision of healthcare and the function of NHS England.

3.4 There will be two working days' notice of the review prior to a five day site visit by CQC children's services inspectors. As with Ofsted's single inspection framework, the CQC reviews will include case tracking of individual children to explore the effectiveness of health services. The review will take place within a local authority area, with a report published for each local area. There will also be a national report to bring together findings from across the country.

3.5 Further detail can be accessed via the CQC website; http://www.cqc.org.uk/node/755951

4.0 POLICY IMPLICATIONS

4.1 NHS Trusts have a duty under Section 11 of the Children Act 2004 to safeguard and promote the welfare of children. Further guidance is contained within *Working Together to Safeguard Children* 2013. Therefore NHS Trusts should already be compliant in terms of their safeguarding duties.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 There will be resource implications in terms of officer time within the NHS provider and commissioner organisations to support CQC reviews. Should any NHS organisation need to make improvements following a review, there would be further resource implications. Dependent upon the outcome of a CQC review, this could trigger an Ofsted inspection of the local authority area.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
The Health & Wellbeing Board, LSCB and Children's Trust have a formal protocol in place that sets out the accountability arrangements between the three. The LSCB should be formally consulted on the Joint Strategic Needs Assessment to ensure that safeguarding is embedded throughout.

6.2 **Employment, Learning & Skills in Halton**
NHS organisations should have suitable arrangements in place for training, supervision and safer recruitment to support a skilled, competent and confident workforce working with children & young people, families and adults who may be parents/carers.

6.3 **A Healthy Halton**
The safeguarding of children is fundamental to their health and well-being. The Joint Strategic Needs Assessment should ensure it takes into account safeguarding children priorities.

6.4 **A Safer Halton**
The effectiveness of Safeguarding Children arrangements is fundamental to making Halton a safe place of residence for children and young people.

6.5 **Halton's Urban Renewal**
None identified.

7.0 **RISK ANALYSIS**

7.1 The main risk is that NHS organisations are not sufficiently prepared for a CQC review. Halton CCG is working with NHS providers to ensure systems are in place. In addition there is a risk that a CQC review could trigger an Ofsted inspection under the single inspection framework in the local area. Any NHS organisation involved in a CQC review will be required to report the outcome to the LSCB and other strategic partnerships as appropriate.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 There are no equality and diversity issues

REPORT TO: **Health and Wellbeing Board**

DATE: **13 November 2013**

REPORTING OFFICER: **Operational Director – Children and Enterprise**

PORTFOLIO: **Children, Young People and Families**

SUBJECT: **Disabled Children's Charter**

WARDS: **Borough wide**

1.0 PURPOSE OF THE REPORT

1.1 Consider the request from Every Disabled Child Matters and the Children's Trust, Tadworth to support the Disabled Children's Charter.

2.0 RECOMMENDATION: That the Board

1) **sign the Disabled Children's Charter for Health and Wellbeing Boards; and**

2) **request an update report on progress in six months.**

3.0 SUPPORTING INFORMATION

3.1 Every Disabled Child Matters (EDCM) and The Children's Trust, Tadworth have developed a Disabled Children's Charter for Health and Wellbeing Boards. The Charter has been developed to support Health and Wellbeing Boards to meet their responsibilities towards disabled children, young people and their families.

3.2 It contains a vision statement and specific commitments attached as Appendix 1. Health and Wellbeing Boards who sign the Charter must agree to each of the seven commitments within a year of signing. Health and Wellbeing Boards will be asked to provide evidence of how they have met the commitments and this information will be published on the EDCM website.

3.3 The seven commitments the Health and Wellbeing Board are asked to make are as follows:

- We have detailed and accurate information on the disabled children and young people living in our area, and provide public information on how we plan to meet their needs.

- We engage directly with disabled children and young people and their participation is embedded in the work of our Health and Wellbeing Board.

- We engage directly with parent carers of disabled children and young people and their participation is embedded in the work of our Health and Wellbeing Board

- We set clear strategic outcomes for our partners to meet in relation to disabled children, young people and their families, monitor progress towards achieving them and hold each other to account.

- We promote early intervention and support for smooth transitions between children and adult services for disabled children and young people.

- We work with key partners to strengthen integration between health, social care and education services, and with services provided by wider partners.

- We provide cohesive governance and leadership across the disabled children and young people's agenda by linking effectively with key partners.

3.4 EDCM are asking all Health and Wellbeing Boards to sign up to the charter as they recognise the Boards potential to improve the services families with disabled children rely on. They ask for this support as they say:

> " Families with disabled children report that there is widespread dissatisfaction with health services. In Parliamentary Hearings on services for Disabled Children (2006) 48% of parents and 35% of professionals described health services for children as poor. EDCM's Disabled Children and Health Reform (2011) reports provided further evidence of parents' dissatisfaction caused by a lack of access to universal and specialist health services, and a failure to coordinate services around families with disabled children."

3.5 EDCM also believes that the failure to meet the needs of families with disabled children often causes disputes around who should commission and fund services, along with issues around transition between children and adult services. Health and Wellbeing Boards can encourage commissioners from children's and adult social care, health and other agencies to work together more effectively.

3.6 There is currently a Strategic Group addressing the changes required in the Children and Families Bill in terms of children and young people with health and special educational needs. It is suggested that this group be asked to ensure each of the seven commitments are addressed and provide an update report to the Board in six months.

4.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

4.1 Children and Young People in Halton

The Charter seeks to raise the profile and encourage a more joined up approach to the commissioning of services for disabled children and young people.

4.2 Employment, Learning and Skills in Halton

N/A

4.3 A Healthy Halton

The Charter seeks to encourage a more integrated approach to meeting the needs of Disabled Children.

4.4 A Safer Halton

N/A

5.0 RISK ANALYSIS

5.1 By signing the Charter the Health and Wellbeing Board are agreeing to meet the seven commitments within 12 months. Work is already being undertaken in the Borough to meet the requirements of the Children and Families Bill it is therefore suggested that these two areas of work are combined.

6.0 EQUALITY AND DIVERSITY ISSUES

6.1 The aim of the Charter is to improve provision for Disabled Children.

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

Document	Place of Inspection	Contact Officer
Every Disabled Child Matters Disabled Children's Charter For Health and Wellbeing Boards	www.edcm.org.uk	Ann McIntyre Operational Director Children and Enterprise

Appendix 1: The Charter commitments

1. We have detailed and accurate information on the disabled children and young people living in our area, and provide public information on how we plan to meet their needs

One of the primary tools Health and Wellbeing Boards have to drive strategic commissioning in their area is the Joint Strategic Needs Assessment (JSNA). The JSNA can only be an effective tool for evidence-based decision making if it is based on accurate and meaningful data. However, data on disabled children is notoriously poor and improving the quality and scope of information on disabled children and young people should be a priority.

2. We engage directly with disabled children and young people and their participation is embedded in the work of our Health and Wellbeing Board

Health and Wellbeing Boards should ensure that the voice of disabled children and young people is always heard when decisions are being made that affect them. The benefits of embedding participation of disabled children and young people are huge and well evidenced. All disabled children and young people communicate and have a right to have their views heard.

3. We engage directly with parent carers of disabled children and young people and their participation is embedded in the work of our Health and Wellbeing Board

The purpose of parent participation is to ensure that parents can influence service planning and decision making so that services meet the needs of families with disabled children. The benefits of effective parent participation are well established and Health and Wellbeing Boards should ensure that parent carers are involved in decisions that affect them at a strategic and service level.

4. We set clear strategic outcomes for our partners to meet in relation to disabled children, young people and their families, monitor progress towards achieving them and hold each other to account

The Joint Health and Wellbeing Strategy (JHWS) should address how the needs of disabled children, young people and their families should be met and make recommendations on cost-effective approaches to reducing the health inequalities they experience. However, if this group is not identified as a priority in the JHWS, the Health and Wellbeing Board should demonstrate how it is providing strategic direction for partners to meet the needs of disabled children and young people.

5. We promote early intervention and support for smooth transitions between children and adult services for disabled children and young people

The importance of early intervention and transitions to life-long outcomes has been repeatedly emphasized. This is particularly significant for disabled children, young people and their families, who often struggle to obtain a diagnosis and access appropriate support at an early age and when transitioning to adult services.

6. We work with key partners to strengthen integration between health, social care and education services, and with services provided by wider partners

Disabled children and young people frequently access services across multiple agencies and the failure to effectively coordinate services around them often leads to considerable distress and poor health outcomes. Health and Wellbeing Boards must work with partners, including education providers, to meet the needs of disabled children and young people and ensure seamless integration between the services they access.

7. We provide cohesive governance and leadership across the disabled children and young people's agenda by linking effectively with key partners

The role of the Health and Wellbeing Board must be understood in relation to new and existing partnerships, including: local children's trust arrangements; local safeguarding children's boards; learning disability partnership boards; and others. A clear local framework on how these partnerships interact needs to be established to avoid the duplication of effortor even competing for resources.
Health and Wellbeing Boards must also prepare for its new responsibilities which will be introduced by the Children and Families Bill.

REPORT TO:	Health and Wellbeing Board
DATE:	13th November 2013
REPORTING OFFICER:	Director of Public Health/Operational Director, Children's Organisation and Provision
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Better Health Outcomes for children and young people: Our Pledge
WARDS:	Borough wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to inform the Health and Wellbeing Board of the government's pledge to improve health outcomes for children and young people.

RECOMMENDATION: That the Board

1) **note the contents of the report; and**

2) **agree to sign up to the pledge (attached as Appendix 1 to this report)**

3.0 SUPPORTING INFORMATION

3.1 On 20th July 2013, the Children's Health Minister, Dr. Dan Poulter wrote to lead members for children's services and Chairs of Health and Wellbeing Boards to invite them to sign up to the Government's pledge: *Better Health Outcomes for Children and Young People*. The pledge is part of the February 2013 system wide response to the Children and Young People's Health Outcomes Forum Report (2012).

3.2 The introduction to the pledge emphasises that whilst children and young people growing up in England today are generally healthier than they have ever been, international comparisons and worrying long- term trends demonstrate there is room for improvement, with poor health outcomes for too many children and young people compared with other countries. The document also states that vulnerable groups such as looked after children suffer much poorer outcomes.

3.3 It goes on to say that system-wide change is required to achieve this and each part of the system, at each level has a contribution to make.
The shared ambitions set out within the pledge are:

- Children, young people and their families will be at the heart of decision-making, with the health outcomes that matter most to them taking priority.
- Services, from pregnancy through to adolescence and beyond, will be high quality, evidence based and safe, delivered at the right time, in the right place, by a properly planned, educated and trained workforce.
- Good mental and physical health and early interventions, including for children and young people with long term conditions, will be of equal importance to caring for those who become acutely unwell.
- Services will be integrated and care will be co-ordinated around the individual, with an optimal experience of transition to adult services for those young people who require ongoing health and care in adult life.
- There will be clear leadership, accountability and assurance and organisations will work in partnership for the benefit of children and young people.

3.4 Health and Wellbeing Boards are encouraged to ensure that there is a proper focus on children within its priorities, that there is a thorough assessment of their needs through the Joint Strategic Needs, as well as from engagement with children and young people themselves.

The Halton Picture

3.5 At a local level the Health and Wellbeing Board has already made an excellent start in considering the Health and Wellbeing needs of Children and Young People.
Some examples that demonstrate this commitment are outlined below:

- Child development is identified as a key priority in Halton's Joint Health and Wellbeing Strategy.
- A separate JSNA Children and Young Peoples Working Group has been set up to ensure that the needs of children and young people are adequately reflected across the JSNA. This work will be closely linked to the development of the new Children and Young People's Plan which will be developed later in the year.
- The Joint Health and Wellbeing Strategy has been developed using a Life Course approach to ensure that wherever possible, actions against the Health and Wellbeing Strategy priorities are considered across all age groups
- Key issues/ developments for Children and Young People are presented to the Health and Wellbeing Board on a regular basis
- A Commissioning Sub Group has been established underneath the Health and Wellbeing Board to look at joint commissioning across health and wellbeing priorities. This group includes representatives from Children and Young People's commissioning to ensure a joined up approach across partnerships.
- A Memorandum of Understanding is currently being developed between Halton Children's Trust, Halton Safeguarding Children Board and Halton Health and Wellbeing Board. This will clarify respective

roles and functions, membership of the boards, arrangements for challenge, oversight and scrutiny, and performance management.

4.0 POLICY IMPLICATIONS

4.1 The Health and Wellbeing Needs of Children and Young People are already a key consideration for Halton's Health and Wellbeing Board.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 None identified at this time.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

All of the considerations outlined within this report directly contribute to improving outcomes for Children and Young People.

6.2 Employment, Learning and Skills in Halton

Improving health outcomes for children and young people will contribute towards improving educational attainment, skills and maximising employment opportunities.

6.3 A Healthy Halton

All of the areas outlined within this report focus on improving the health and wellbeing of Children and Young People.

6.4 A Safer Halton

Reducing the incidence of crime, improving Community Safety and reducing the fear of crime has an impact on health outcomes particularly on mental health. There are also close links between partnerships on areas such as alcohol and domestic violence. It therefore remains a key consideration for the Health and Wellbeing Board.

6.5 Halton's Urban Renewal

The environment in which we live and the physical infrastructure of our communities has a direct impact on our health and wellbeing. It should therefore be a key consideration when developing strategies to address health and wellbeing.

7.0 RISK ANALYSIS

Halton Borough Council may be at risk of not meeting national targets if recommendations outlined in the report are not met. There are no financial risks. The recommendations are not so significant they require a full risk assessment.

8.0 EQUALITY AND DIVERSITY ISSUES

This is in line with all equality and diversity issues in Halton.

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

None within the meaning of the Act.

Better health outcomes for children and young people

Our pledge

> "The foundations for virtually every aspect of human development – physical, intellectual, and emotional – are laid in early childhood."
>
> **(Marmot)**

Children and young people growing up in England today are healthier than they ever have been before. Health care and social changes have had dramatic impacts. Previously common killer diseases are now rare. More children with serious illnesses and disabilities are surviving into adulthood and the infant mortality rate has fallen to less than a quarter of what it was at the beginning of the 1960s.

But international comparisons and worrying long-term trends demonstrate there is room for improvement, with poor health outcomes for too many children and young people compared with other countries. A smaller group of more vulnerable children – such as looked after children – suffer much worse outcomes. The variation in outcomes and quality of healthcare for children and young people is unacceptable. The clear evidence that pregnancy and the earliest years are critical to the future health and wellbeing of children and adults and that evidence-based early interventions can have significant positive impacts does not always inform how services are commissioned.

The need for improvement is not new; numerous reports have highlighted the issues. Individual initiatives have led to improvements in specific areas, but have not resulted in the system wide changes required to improve outcomes. What is new is the opportunity to ensure the focus on outcomes in the new health and care system includes children and young people clearly and explicitly, from conception through to adulthood.

We are committed to improving the health outcomes of our children and young people so that they become amongst the best in the world.

System-wide change is required to achieve this and each part of the system, at each level, has a vital contribution to make. To this end we pledge to work in partnership, both locally and nationally, with children, young people and their families.

Our shared ambitions are that:

1. Children, young people and their families will be at the heart of decision-making, with the health outcomes that matter most to them taking priority.
2. Services, from pregnancy through to adolescence and beyond, will be high quality, evidence based and safe, delivered at the right time, in the right place, by a properly planned, educated and trained workforce.
3. Good mental and physical health and early interventions, including for children and young people with long term conditions, will be of equal importance to caring for those who become acutely unwell.
4. Services will be integrated and care will be coordinated around the individual, with an optimal experience of transition to adult services for those young people who require ongoing health and care in adult life.
5. There will be clear leadership, accountability and assurance and organisations will work in partnership for the benefit of children and young people.

We all have a part to play in promoting the importance of the health of our children and young people.

Through our joint commitment and efforts we are determined to:

- **reduce child deaths** through evidence based public health measures and by providing the right care at the right time;
- **prevent ill health for children and young people and improve their opportunities for better long-term health** by supporting families to look after their children, when they need it, and helping children and young people and their families to prioritise healthy behaviour;
- **improve the mental health of our children and young people** by promoting resilience and mental wellbeing and providing early and effective evidence based treatment for those who need it;
- **support and protect the most vulnerable** by focusing on the social determinants of health and providing better support to the groups that have the worst health **outcomes**;
- **provide better care for children and young people with long term conditions and disability** and increase life expectancy of those with life limiting conditions.

Because

- **the all-cause mortality rate for children aged 0 – 14 years has moved from the average to amongst the worst in Europe**[1]
- **26% of children's deaths showed 'identifiable failure in the child's direct care'**[2]
- **more than 8 out of 10 adults who have ever smoked regularly started before 19**[3]
- **more than 30% of 2 to 15 year olds are overweight or obese**[4]
- **half of life time mental illness starts by the age of 14**[5]
- **nearly half of looked after children have a mental health disorder and two thirds have at least one physical health complaint**[6]
- **about 75% of hospital admissions of children with asthma could have been prevented in primary care**[7]

Building momentum

At national level a new **Children and Young People's Health Outcomes Board**, led by the Chief Medical Officer, will bring together key system leaders in child health to provide a sustained focus and scrutiny on improving outcomes across the whole child health system.

A new **Children and Young People's Health Outcomes Forum** will provide both ongoing expertise in child health and offer constructive challenge to the next phase of this work. The Forum will hold an annual summit involving the CMO to monitor progress on child health outcomes and make recommendations for their improvement.

The Children and Young People's Health Outcomes Forum report and system response can be found at **http://www.dh.gov.uk/health/2012/07/cyp-report/**

For the very first time, everyone across the health and care system is determined to play their part in improving health outcomes for children and young people.

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1 Wolfe I, Cass H,Thompson MJ et al. Improving child health services in the UK: insights from Europe and their implications for the NHS reforms. BMJ 2011; 342:d1277
2 CEMACH report 2008
3 Healthy Lives, Healthy People – our strategy for public health in England. Department of Health (2010)
4 Health Survey for England 2010
5 Kessler R, Angermeyer M, Anthony J et al. Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative. World Psychiatry 2007 Oct; 6(3):168-76
6 DfE Outcomes for children looked after as at 31 March 2012
7 Asthma UK. Wish you were here – England (2008).

REPORT TO: Health & Wellbeing Board

DATE: 13th 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

It is RECOMMENDED that Members of the Health & Wellbeing Board note the contents of the report.

3.0 SUPPORTING INFORMATION

3.1 The benchmarking framework:

3.1.1 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.

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.

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 Council 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.
- The Board 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 IMPLICATIONS

5.1 There are no financial implications arising from this report.

6.1 Children & Young People in Halton

None identified.

6.2 Employment, Learning & Skills in Halton

None identified.

6.3 A Healthy Halton

The activity will highlight successes and areas for development in adult social care across the North West.

6.4 A Safer Halton

The risk based approach to the process of sector-led improvement, will identify where an authority is deemed to require significant external input to ensure that its adult social care services are of a quality to ensure appropriate support to vulnerable people.

6.5 Halton's Urban Renewal

None identified.

7.0 RISK ANALYSIS

7.1 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.

8.0 EQUALITY AND DIVERSITY ISSUES

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

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

None within the meaning of the Act.

REPORT TO: Health & Wellbeing Board

DATE: 13th 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 & Wellbeing Board:**

1. **note the contents of the report; and**
2. **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.

3.3 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.

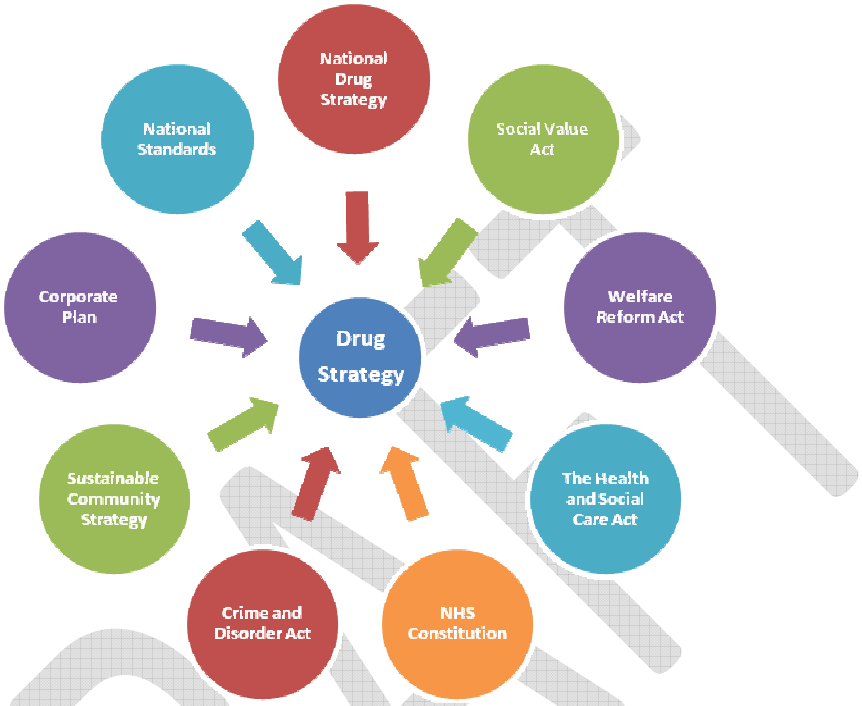
To help achieve the vision, we have adopted the objectives above with each containing a set of priorities as detailed below. The Strategy goes on to explain why each of the priorities has been selected, what we hope to achieve and how we plan to achieve it.

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.

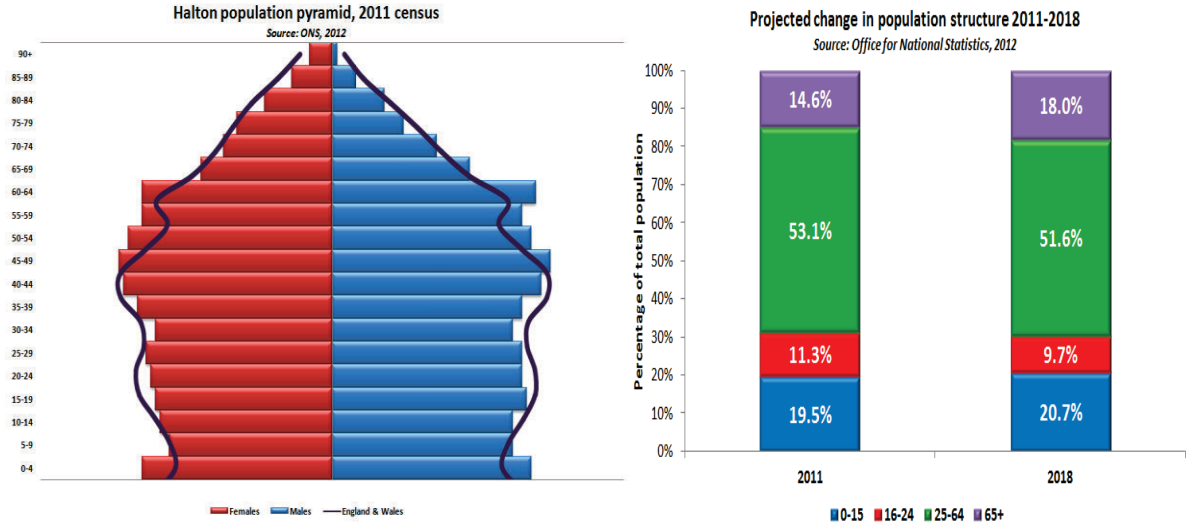
The quality standard requires that services should be commissioned from and coordinated across all relevant agencies encompassing the whole drug use disorder care pathway. An integrated approach to provision of services is fundamental to the delivery of high quality care to adults with drug use disorders.

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:

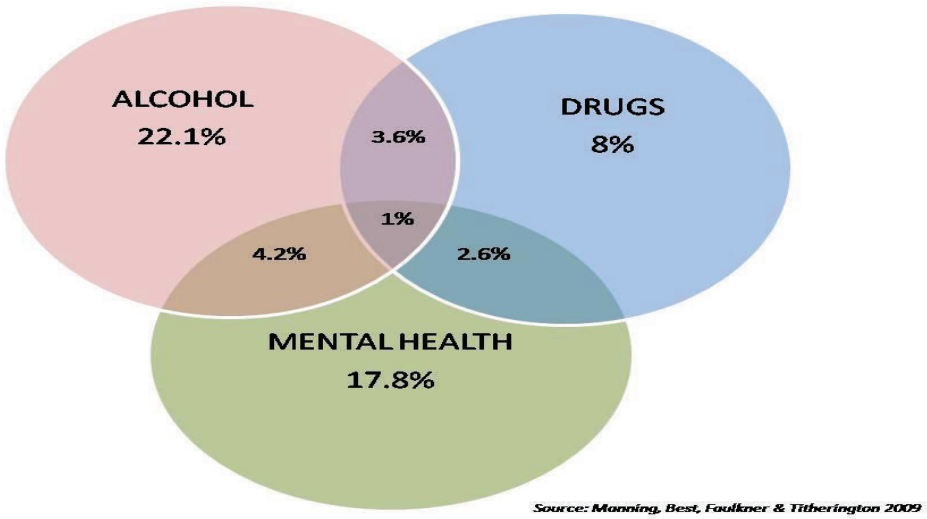
- increasing introspection and social isolation, with friendship difficulties (e.g. the young person is
- unlikely to visit or invite friends to their own home), anxiety or depression (for which psychoactive
- medication may be prescribed); attempts to escape their family home (e.g. by leaving home at 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

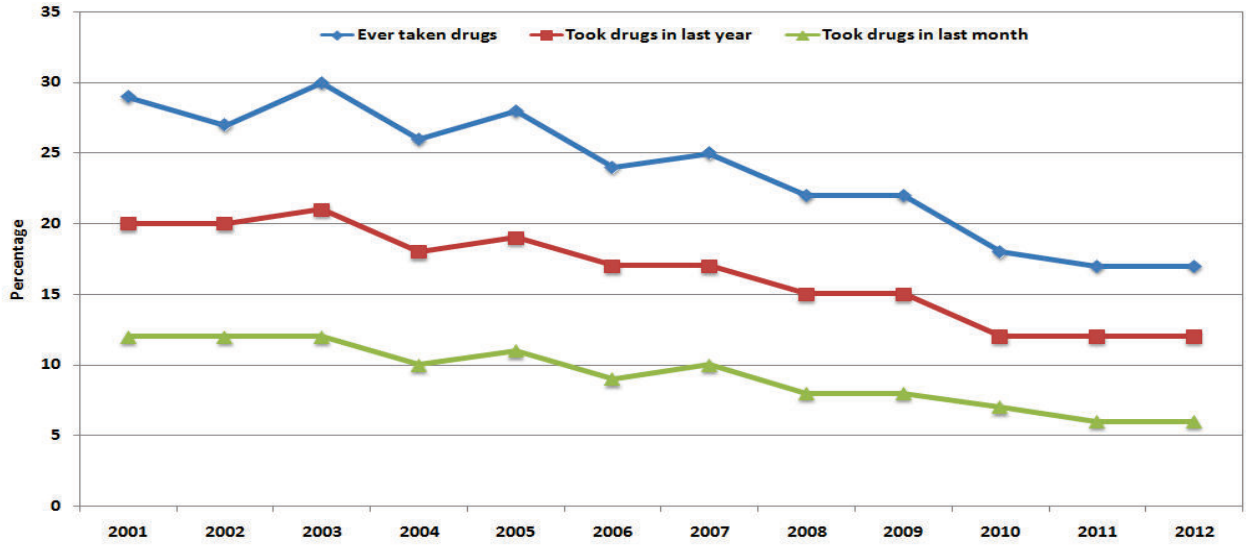
2.5. Estimated Prevalence of substance misuse in Halton

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.

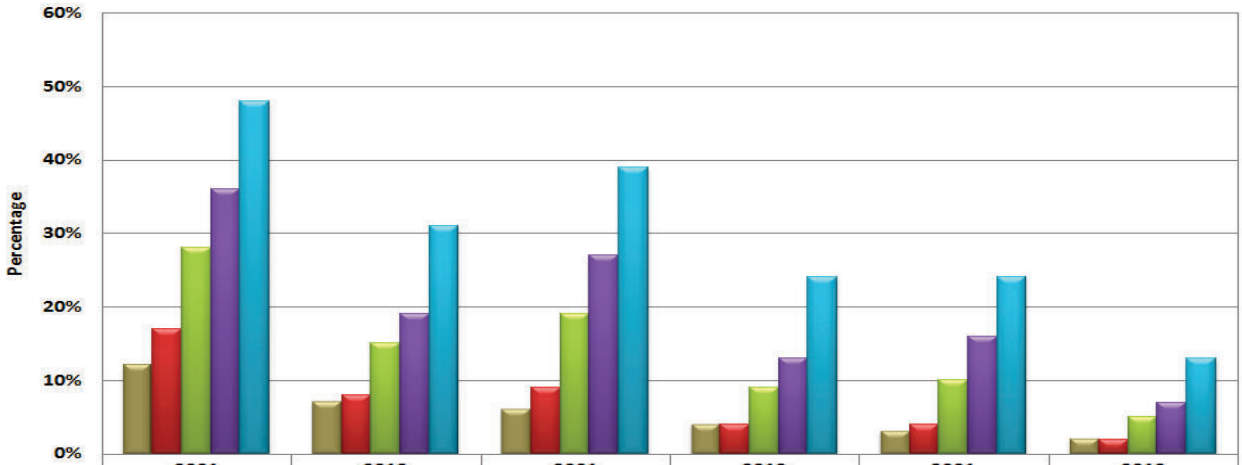
Figure 3: National trend in drug use amongst 11-15 year olds, 2001 to 2012



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

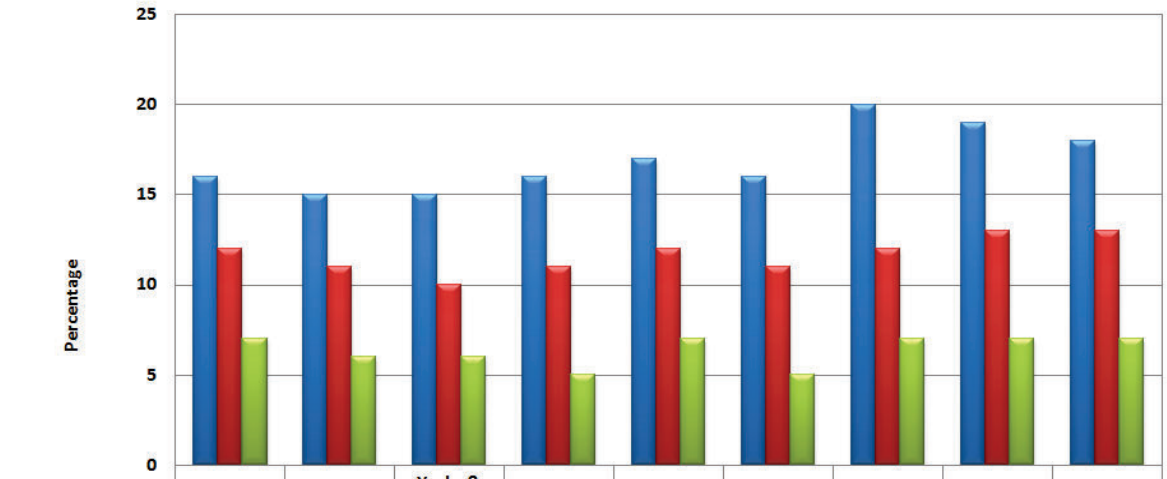


	2001	2012	2001	2012	2001	2012
	ever taken drugs		taken in last year		taken in last month	
11 years	12%	7%	6%	4%	3%	2%
12 years	17%	8%	9%	4%	4%	2%
13 years	28%	15%	19%	9%	10%	5%
14 years	36%	19%	27%	13%	16%	7%
15 years	48%	31%	39%	24%	24%	13%

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.

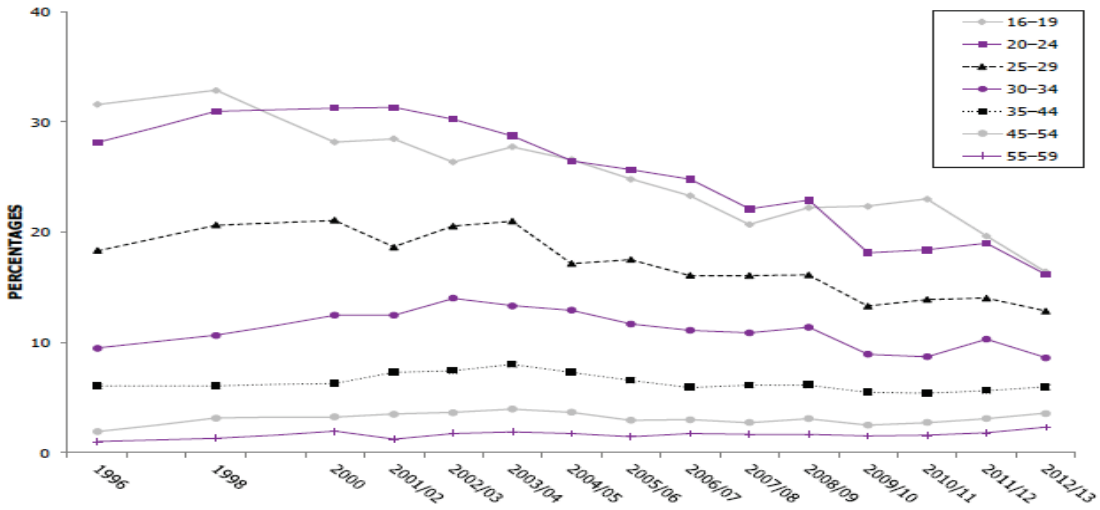
As in previous years cannabis was the most commonly used type of drug in the last year, in 2011/12 6.9% of 16-59 years (equivalent to 5,025 Halton residents) had used cannabis in the last year followed by powder cocaine (2.2% or 1,602 Halton residents) and ecstasy (1.4% or 1,020 Halton residents).

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].

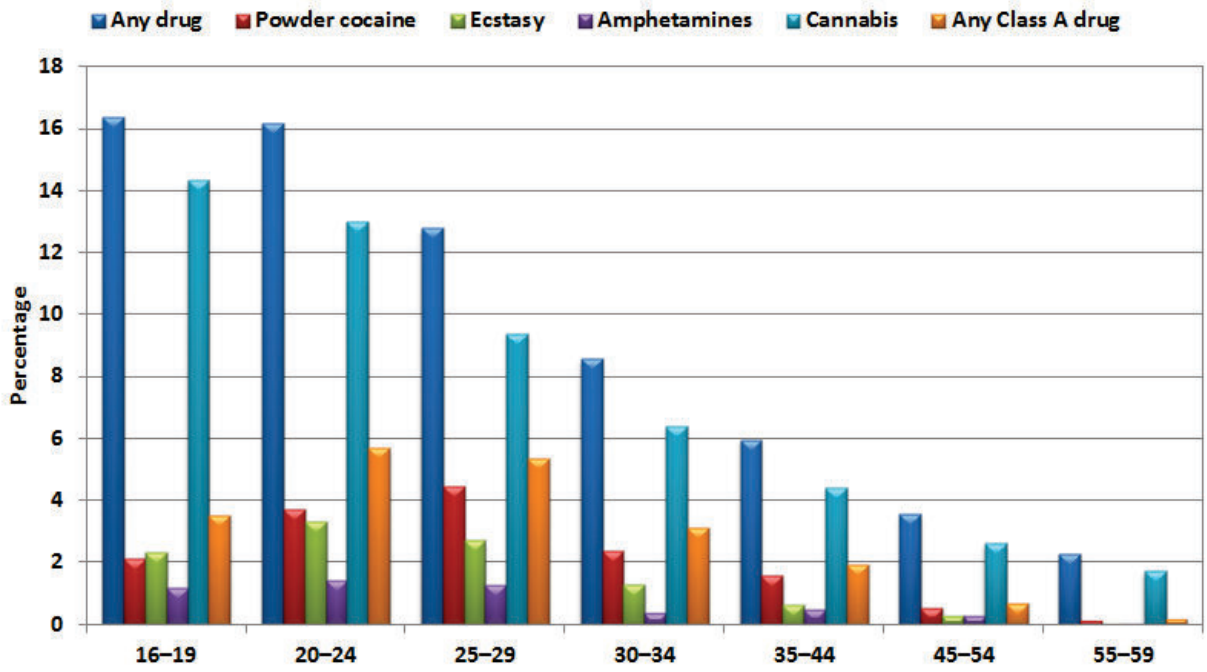
Figure 7: Proportion of 16 to 59 year olds reporting use of any drug in the last year by age group, 1996 to 2012/13 Crime Survey for England and Wales



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

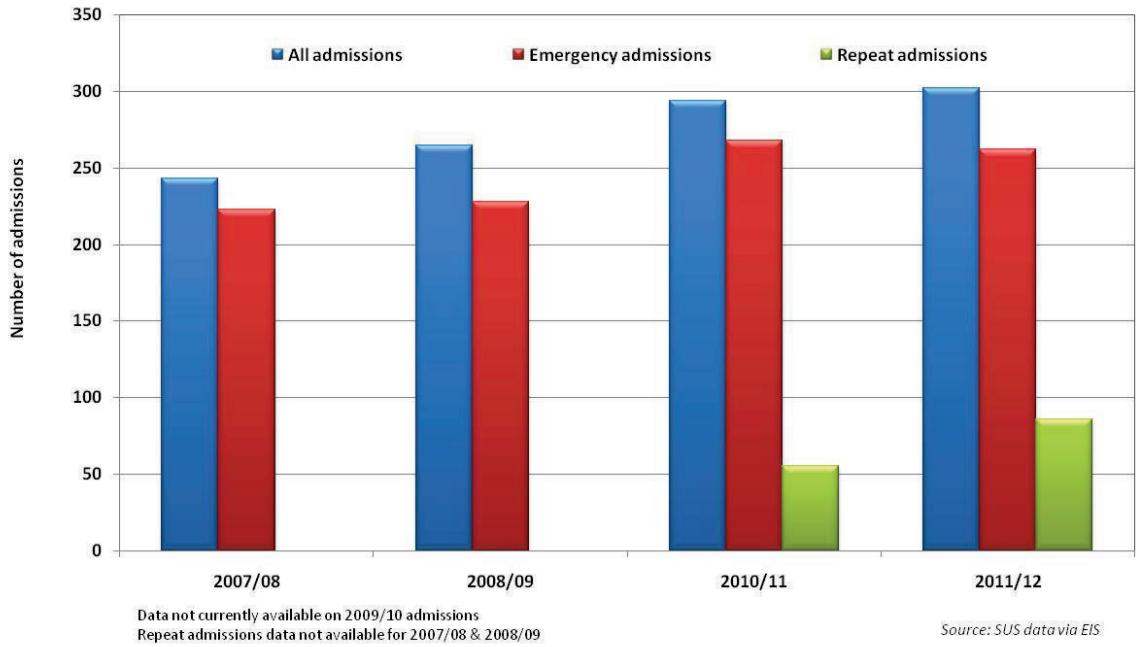
3.1. Hospital Admissions

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.

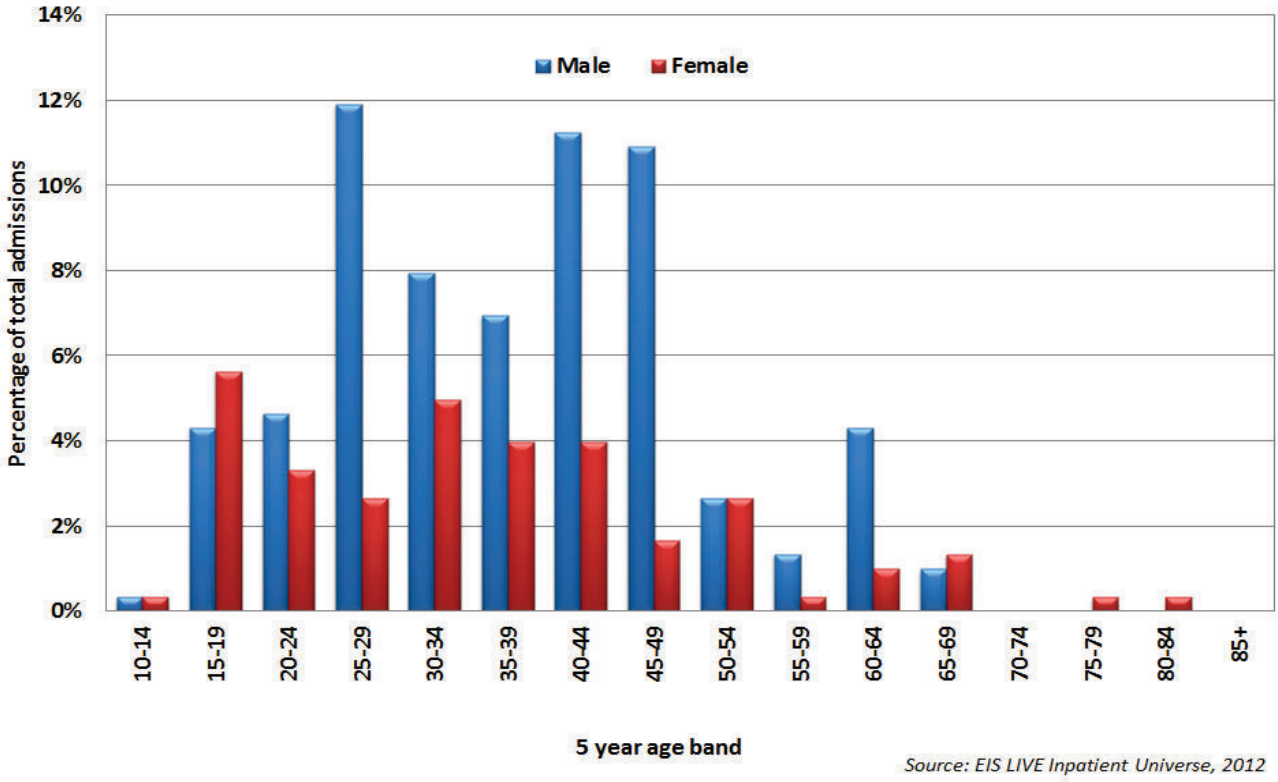
Figure 10: Trend in drug related hospital admissions in Halton



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

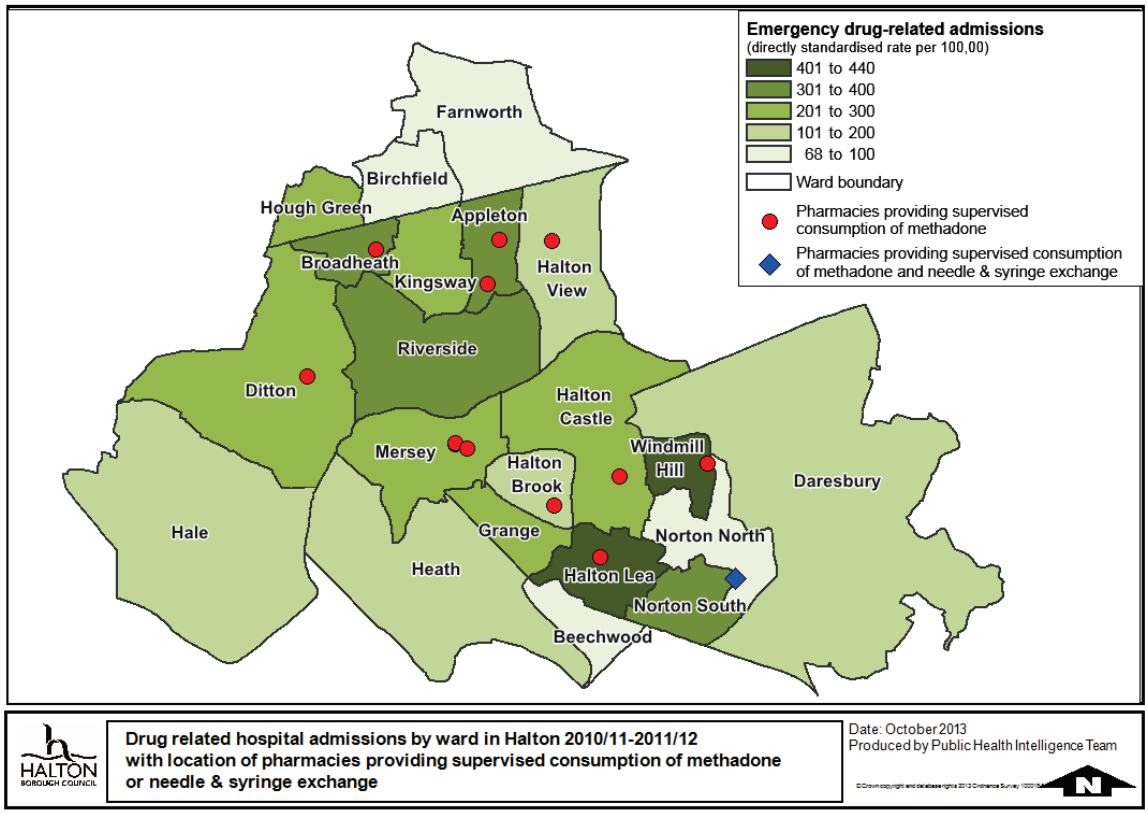
ICD 10 code	ICD Description	No. of admissions 2008/09	No. of admissions 2010/11	No. of admissions 2011/12
F11	Mental and behavioural disorders due to use of opioids	81	72	58
F12	Mental and behavioural disorders due to use of cannabinoids	27	20	49
F13	Mental and behavioural disorders due to use of sedative 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.

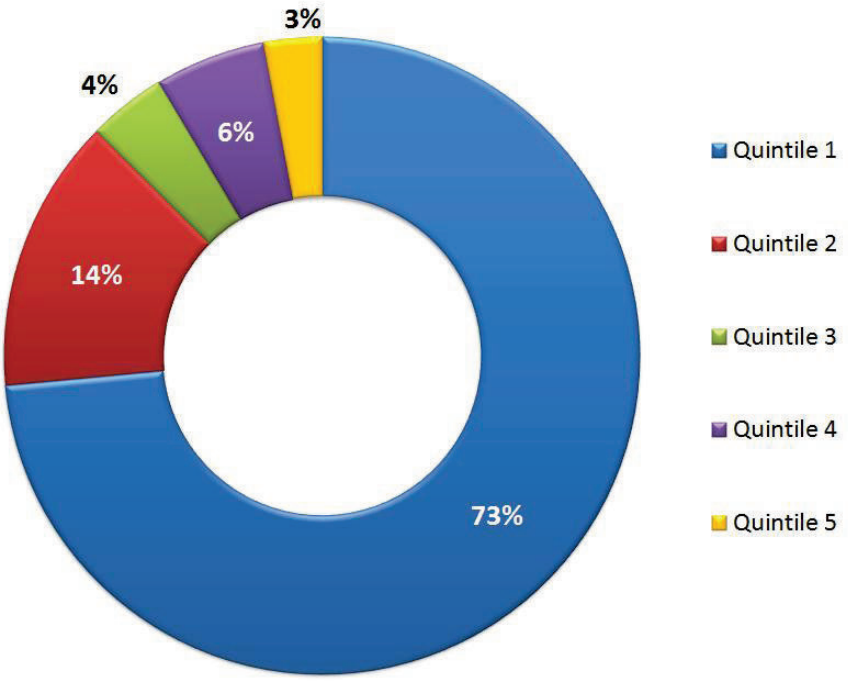
Figure 12: Drug-related hospital admissions (directly standardised rate per 100,000 population) by ward in Halton 2010/11 - 2011/12, with location of pharmacies providing supervised consumption of methadone or needle and syringe exchange.



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)



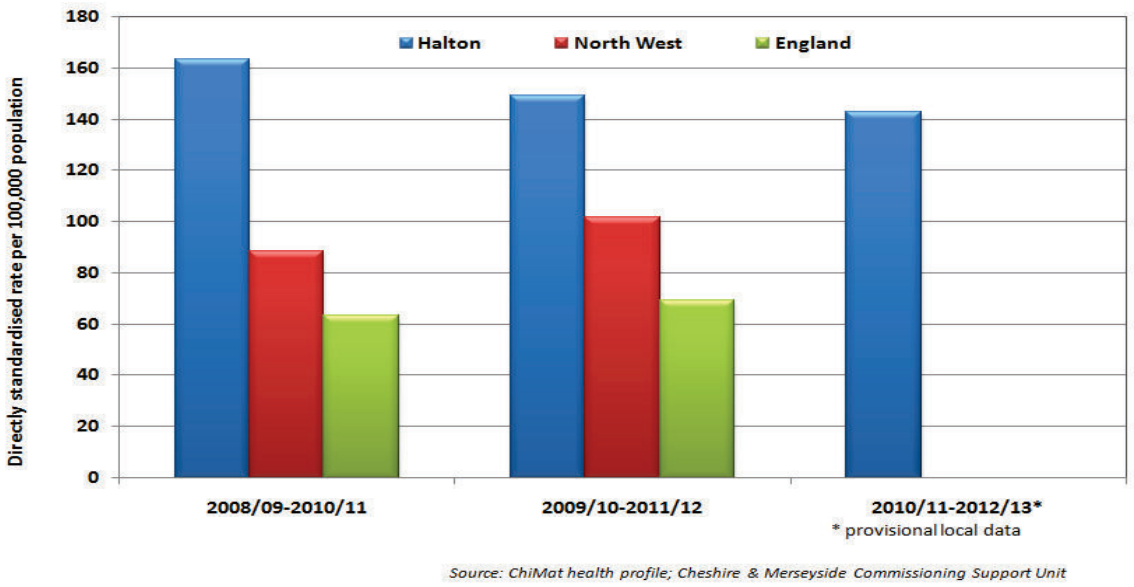
3.1.2. Substance misuse

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

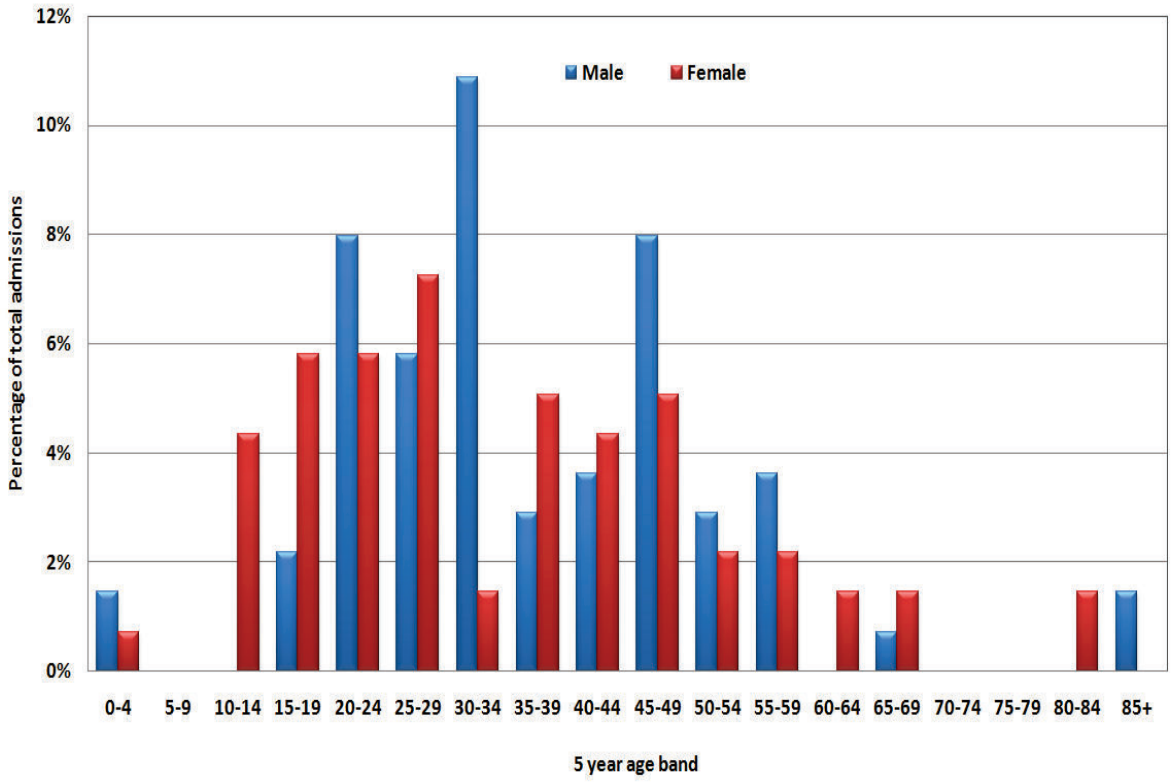
Data relating to substance misuse hospital admissions is not published nationally for all ages, but local data shows that the number has increased to 138 in 2012/13.

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).

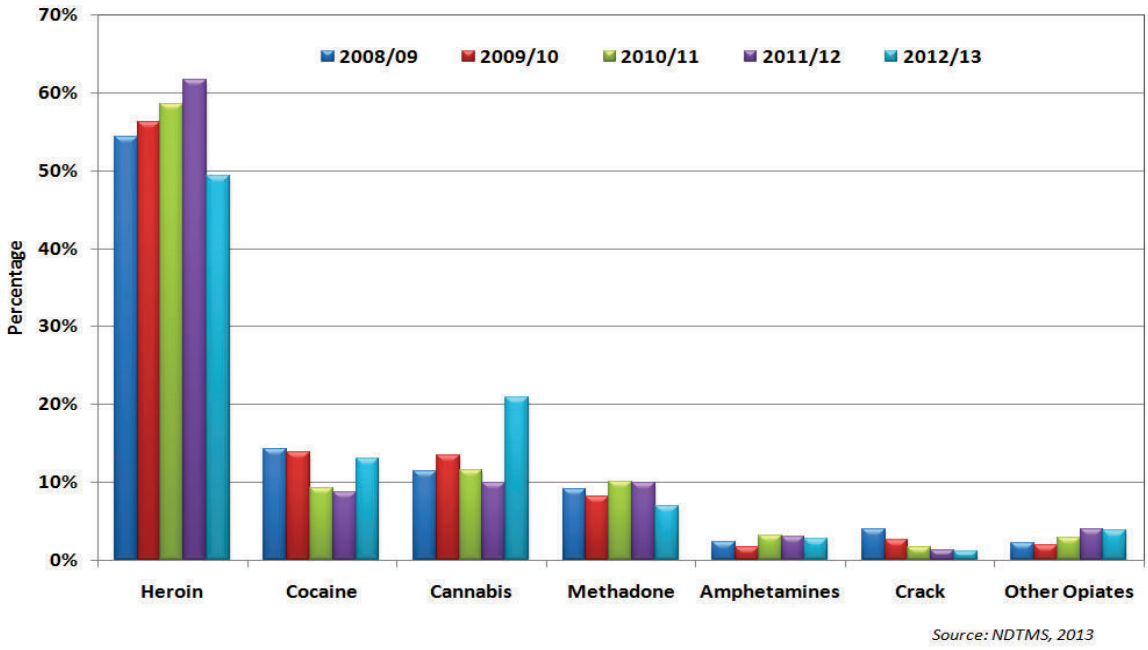
Table 10: Primary drug used

	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

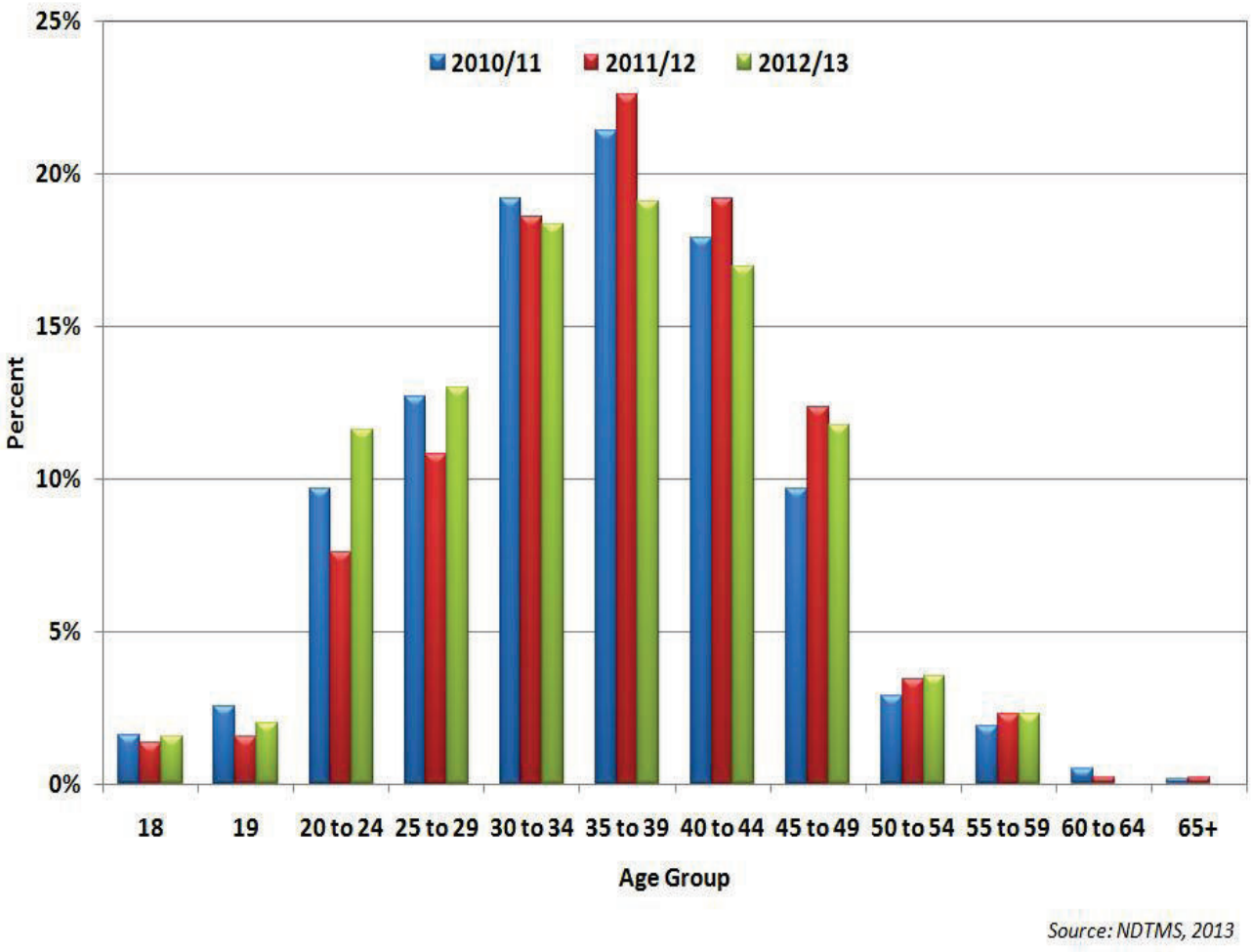
	Halton			North West	England
	2010/11	2011/12	2012/13	2012/13	2012/13
Crack	29.5%	27.5%	26.4%	19.9%	22.3%
Alcohol	10.8%	9.1%	12.5%	10.2%	11.5%
Methadone	6.8%	8.0%	5.3%	6.3%	4.3%
Cannabis	4.3%	3.2%	5.3%	6.2%	8.1%
Cocaine	4.4%	3.8%	3.5%	2.8%	3.1%
Amphetamines	0.8%	0.8%	2.3%	2.6%	2.5%
Heroin	2.9%	2.7%	1.5%	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



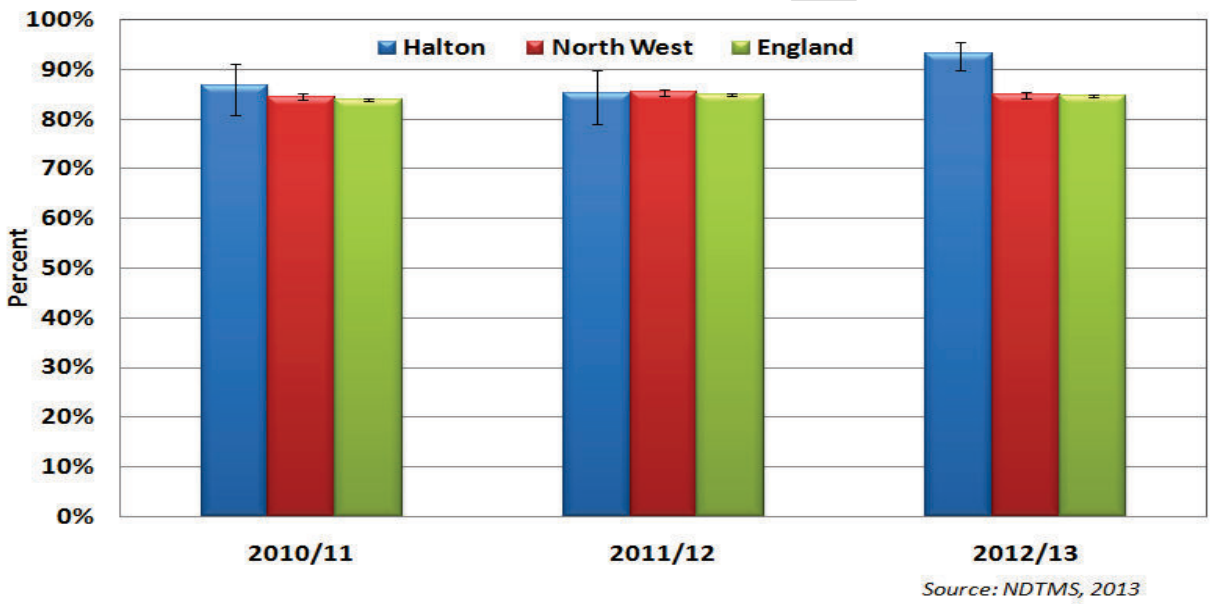
Source: NDTMS, 2013

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.

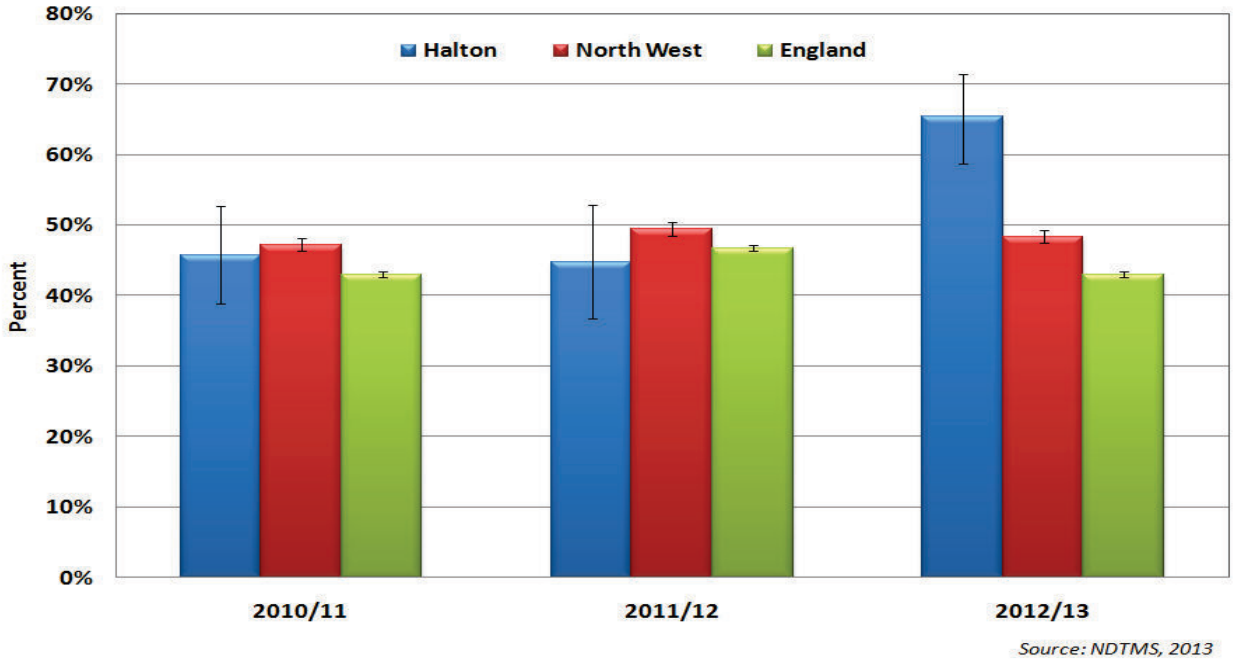
In Halton during 2012/13, 93% of people were 'successfully retained in effective treatment' compared with 87% in 2010/11. This means that the Halton 2012/13 percentage was significantly higher compared to the North West and England.

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'.

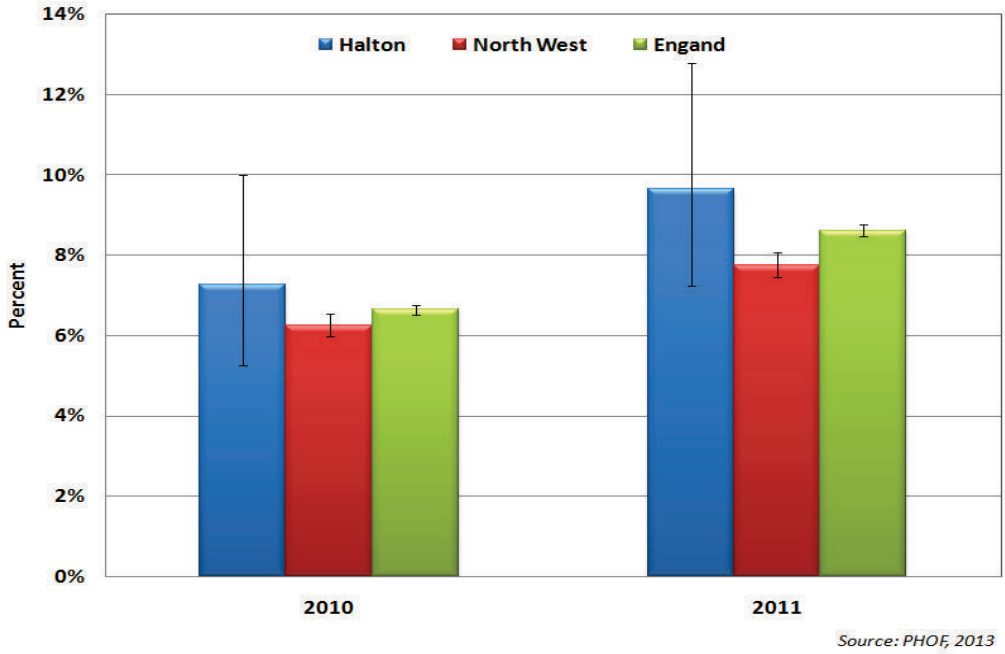
Figure 19: Percentage of exits which are completed (planned) during each year, 2010/11 to 2012/13



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.

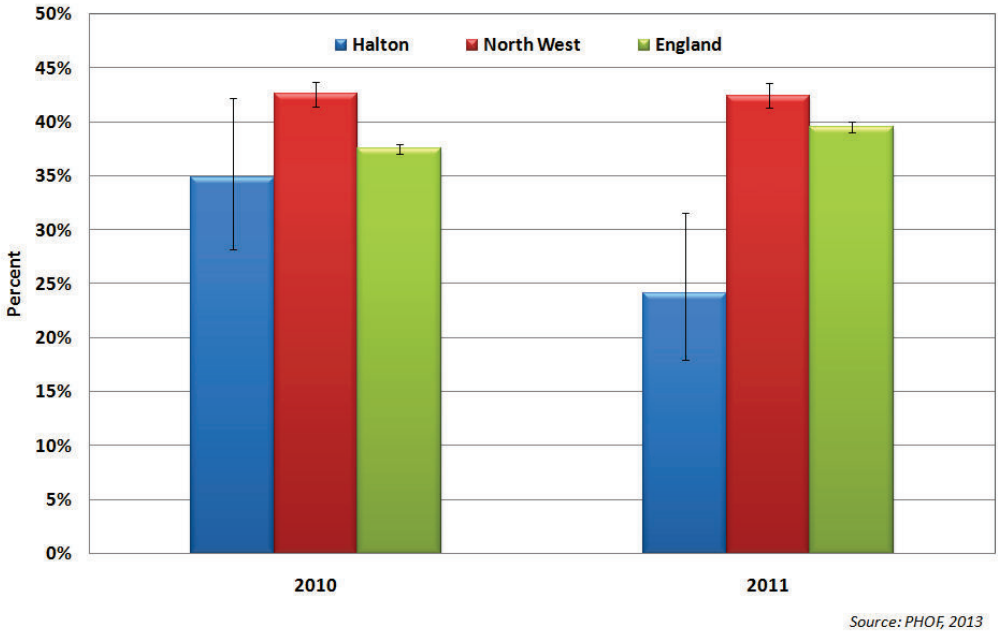
This data relates to people who have successfully left drug treatment and do not re-present to treatment within 6 months.

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.

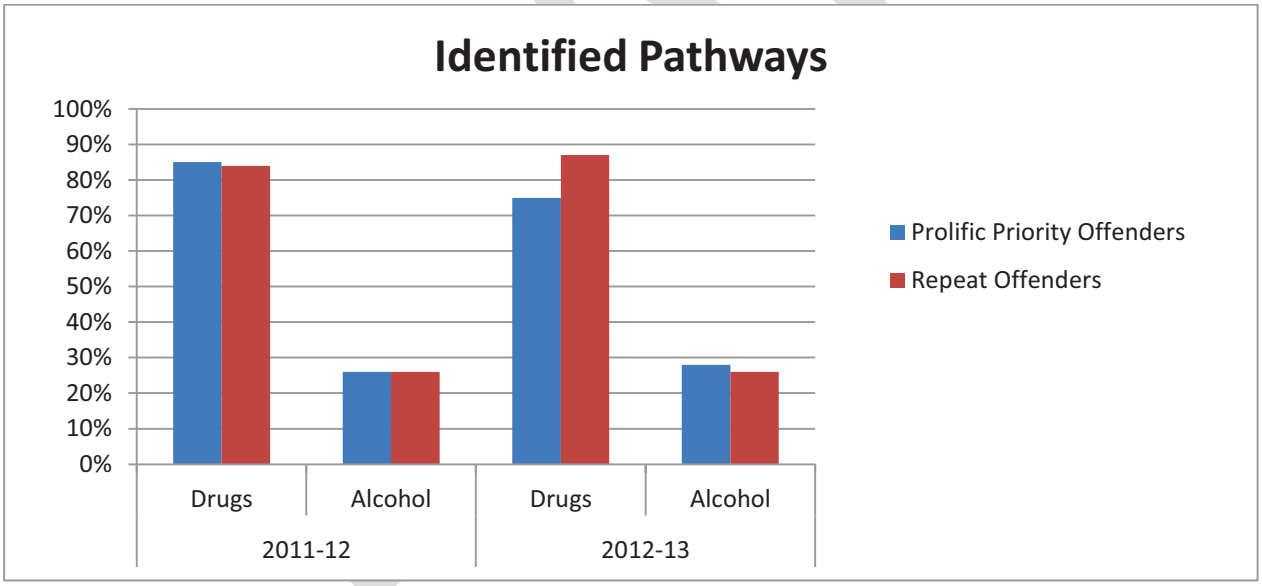
The National Probation Service for England and Wales is a statutory Criminal Justice Service, mainly responsible for the supervision of offenders in the community and the provision of reports to the criminal courts to assist them in their sentencing duties. Information extracted from the Strategic Needs 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.

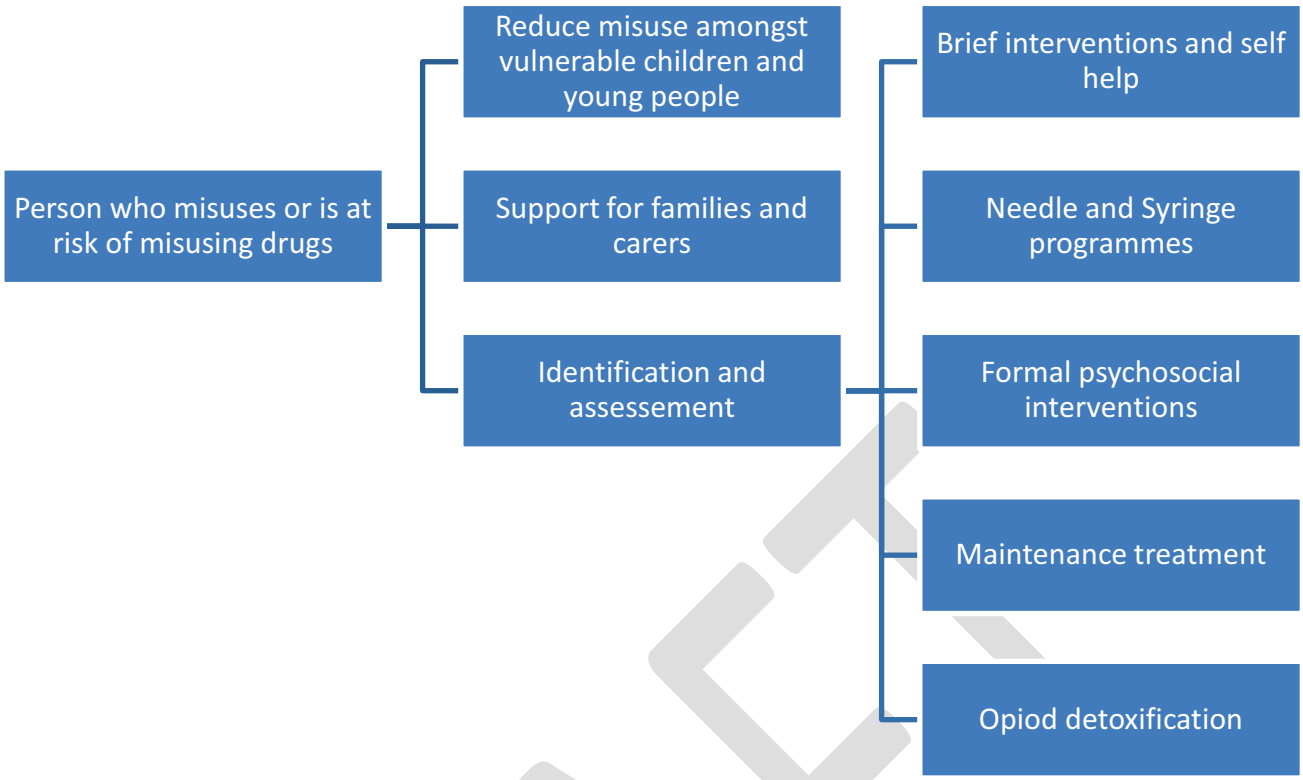
In early adolescence, children are often exposed to legal and illegal substances such as cigarettes and alcohol for the first time. When they enter secondary school, teens may encounter greater availability of drugs and social activities where drugs are used. At the same time, many behaviours that are 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.

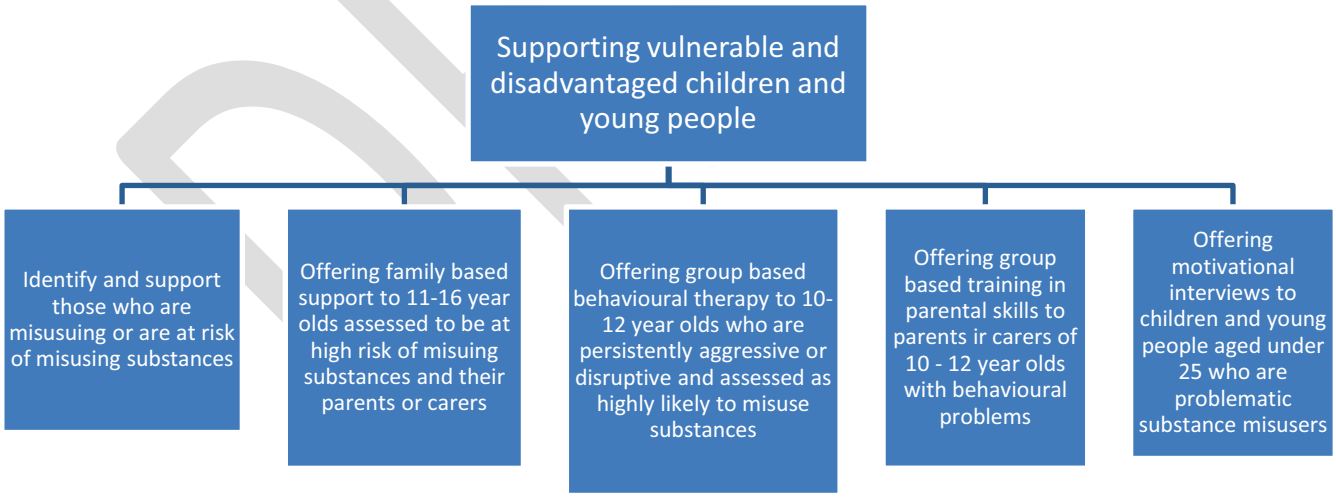
Family support plays a central part, including very early intervention with vulnerable families (particularly parents using drugs themselves). Drug Education and prevention work is delivered through schools and nationally through the FRANK campaign although review is needed to determine how to support 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

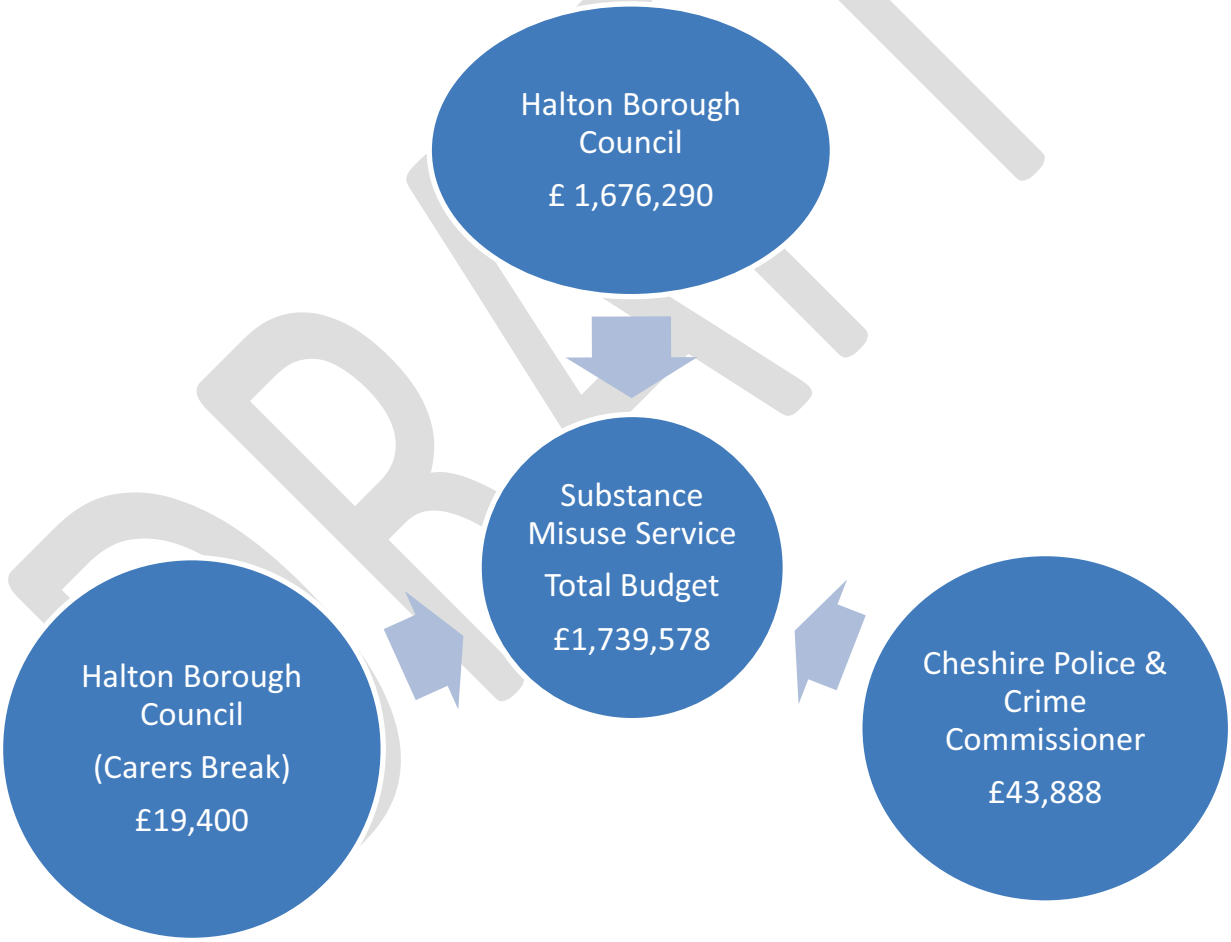


Table 12: Budget received for 2012/13 for substance misuse service (including drugs and alcohol)

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 and Wellbeing Board

DATE: 13th November 2013

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health and Wellbeing

SUBJECT: Progress with the Health and Social Care Settlement 2015/16

WARD(S) Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To update the Board with progress on the Health and Social Care Settlement 2015/16.

2.0 **RECOMMENDATION: That the Board**

1. note the content of the report; and

2. agree the proposals set out in 3.5

3.0 **SUPPORTING INFORMATION**

3.1 Members of the Board will recall that at their meeting on 17th July 2013, the Strategic Director, Communities tabled a report which outlined the Department of Health approach to integrating health and adult social care services. At the meeting it was agreed that the Strategic Director would establish a task and finish group to paper a draft "plan" for the Board's consideration. Since, then Halton Borough Council and the NHS Halton Clinical Commissioning Group have been awaiting communication from NHS England and the Local Government Association in terms of further guidance on the "Plan" required for the Integrated Transformation Fund (ITF).

3.2 On 10th October a letter was published from NHS England (Sir David Nicholson) on "Planning for a sustainable NHS: responding to the 'call to action'" (Appendix 1). This was followed by a letter on 17th October from NHS England and the Local Government Association (Bill McCarthy and Carolyn Downs) on "the next steps on implementing the Integrated Transformation Fund" (Appendix 2), along with a spread sheet template for the "Plan" (Appendix 3). The "Plan" has to be completed and signed off by the NHS HCCG, the Borough Council and the Health and Wellbeing Board by 15th February 2014.

3.3 Meetings have taken place to discuss the requirements of the guidance that has now been issued and the process of the development of the plan has begun.

3.4 The spread sheet template for the "Plan" is split into the following sections:

- Plan Details
- Vision and Schemes
- National Conditions
- Outcomes and Metrics
- Finance
- Risks

3.5 A small working group has begun populating each of the sections detailed above. Under "Plan Details" engagement with service providers and patients, service users and the public must be undertaken. The proposal is to link into the People's Forum for the patients, service users and public engagement and to use this Forum as the basis for the development of the plan and for consultation.

3.6 It is proposed that NHS providers on the Board, as well as Health & Wellbeing Board Members, be consulted on the plan by arranging a facilitated event in January 2014.

4.0 POLICY IMPLICATIONS

4.1 Nationally, the Public Health White Paper and the Health and Social Care Act both emphasise more preventative services that are focussed on delivering the best outcomes for local people. Locally, the Integrated Commissioning Framework sets out formally the joint arrangements for Commissioning. The joint Health and Wellbeing Strategy includes shared priorities based on the Joint Strategic Needs Assessment and local consultation.

5.0 FINANCIAL IMPLICATIONS

5.1 Undertaking the recommendations within this report will ensure that the new pooled budget funding is accessible so that outcomes for people living within Halton can be improved further.

5.2 The Department of Health have announced significant funding to be made available to implement the plan. However, at this stage it is not clear about the levels of finance and this will be determined at a later date.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
Effective arrangements for children's transition services will need to be in place.

6.2 **Employment, Learning & Skills in Halton**
Any long-term integration arrangements will need to focus upon staffing issues.

6.3 **A Healthy Halton**
Developing integration further between Halton Borough Council and the NHS Halton Clinical Commissioning Group will have a direct impact on improving the health of people living in Halton. The plan that is developed will be linked to the priorities identified in the Integrated Commissioning Framework.

6.4 **A Safer Halton**
None identified.

6.5 **Halton's Urban Renewal**
None identified.

7.0 **RISK ANALYSIS**

7.1 Halton Borough Council and the NHS Halton Clinical Commissioning Group may be at risk of losing funding if certain criteria/conditions described in this report are not met. To avoid this, it is vital that we work together to produce the "Plan" in line with the guidance that has been issued.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 This is in line with all equality and diversity issues in Halton.

Publications Gateway Reference No: 00542

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To: NHS Commissioners: CCG leaders and NHS England Area Directors

CC: Chief Executives of NHS providers
Chief Executives of upper tier Local Authorities
Chair and Chief Executive of LGA
ALB Chief Executives
Permanent Secretary, Department of Health
NHS England National and Regional Directors

10 October 2013

Dear Colleague

Planning for a sustainable NHS: responding to the 'call to action'

Earlier this year, we published a landmark document: *The NHS belongs to the people – a call to action.* This document sets out the challenges facing the NHS and makes the case for developing bold and ambitious plans for the future. Commissioners have embraced the *call to action* and are leading discussions locally about how the NHS needs to change. Commissioners now face the task of crystallising the conclusions of these discussions into comprehensive plans.

We heard from the NHS Commissioning Assembly last month about the importance of giving early advice to commissioners, so I am writing to set out my assessment of the challenges facing us as commissioners and the key actions that need to be taken. We will be issuing planning guidance later in the year, but I thought it would be helpful to highlight ten key points at this stage:

1. **Improving outcomes** - commissioners need to place improving outcomes for patients at the heart of their work. For that reason, commissioners should prioritise an approach to planning which combines transparency with detailed patient and public participation**.** We need to construct, from the bottom up, quantifiable ambitions for each domain of the NHS Outcomes Framework. We will, therefore, be asking CCGs and NHS England Area Teams to work together to determine local levels of ambition, based on evidence of local patient and public benefit, against a common set of indicators that place our duty to tackle health inequalities front and centre stage. This will ensure that we can clearly articulate the improvements we are aiming to deliver for patients across seven key areas:

- Reducing the number of years of life lost by the people of England from treatable conditions (e.g. including cancer, stroke, heart disease, respiratory disease, liver disease);
- Improving the health related quality of life of the 15 million+ people with one or more long-term conditions;
- Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital;
- Increasing the proportion of older people living independently at home following discharge from hospital;
- Reducing the proportion of people reporting a very poor experience of inpatient care;
- Reducing the proportion of people reporting a very poor experience of primary care;
- Making significant progress towards eliminating avoidable deaths in our hospitals.

2. **Strategic and operational plans** – given the scale of the challenges we are facing, we are asking commissioners (CCGs and NHS England commissioners) to develop ambitious plans that look forward to the next five years, with the first two years mapped out in the form of detailed operating plans. Taking a five year perspective is crucial, as commissioners need to develop bold and ambitious plans rather than edging forward on an incremental basis one year at a time. It will be essential for commissioners to work closely with providers and social care partners as they develop these plans, and we are in dialogue with the relevant national bodies to define fully aligned planning processes to facilitate this.

3. **Allocations for CCGs**– we want to provide certainty to commissioners. To this end, we intend to notify CCGs of their financial allocations for both 14/15 and 15/16 to help them plan more effectively. We are currently working with a subgroup of the Commissioning Assembly to finalise proposals for future allocation formulae for CCGs and direct commissioning, but stability is a key consideration and the pace of change is likely to be slow, given that we are operating with very limited financial growth overall.

4. **The tariff** – we recognise the importance of stability of tariff as well as its accuracy and responsiveness to the needs of patients. Together with Monitor, we intend to minimise changes to the structure of the tariff for 14/15. By December we plan to jointly publish our priorities for tariff in 15/16, giving commissioners and providers the maximum amount of time to assess any impact on the financial position of their services and respond systematically to tariff signals.

5. **The integration transformation fund** – the financial settlement for 15/16 includes the creation of an integration transformation fund (ITF). This will see the establishment of a pooled budget of £3.8bn, which will be committed at local level with the agreement of Health & Wellbeing Boards. (Locally, CCGs can decide to place additional resources into the ITF if they wish). The ITF is a 'game changer': it creates a substantial ring-fenced budget for investment in out-of-hospital care. However, it will also require us to make savings of over £2bn in existing spending on acute care. This implies an extra productivity gain of 2-3% across the NHS as a whole in 15/16. We will work with Monitor

to determine how this is reflected in the expectations placed on commissioners (in the form of QIPP savings from demand management, pathway change, etc) and providers (in the form of the efficiency deflator incorporated in tariff). We are currently exploring the feasibility of bringing forward an element of the 15/16 saving requirement into 14/15 to avoid a financial 'cliff edge' in 15/16.

6. **Developing integration plans** – the NHS will only be sustainable in 15/16 if we put the ITF to the best possible use and reduce significantly the demand for hospital services. It is my view that investment should be targeted at a range of initiatives to develop out of hospital care, including early intervention, admission avoidance and early hospital discharge - taking advantage, for example, of new collaborative technologies to give patients more control of their care and transform the cost effectiveness of local services. This will require investment in social care and other Local Authority services, primary care services and community health services. We are currently exploring how an accountable clinician can be identified to coordinate the out-of-hospital care of vulnerable older people and the ITF might be used to accelerate this initiative. We will write to you over the next few days (jointly with the Local Government Association) with more details on the process for developing integration plans.

7. **Working together** – a critical ingredient of success for the transformation fund will be the quality of partnership working at local level. Health & Wellbeing Boards will need to have strong governance arrangements for making transparent and evidence-based decisions about the use of the ITF. The Chief Executive of NHS England will remain the accounting officer for the ITF, accountable to parliament for its use, and in that context I am asking NHS England Area Directors to take a close interest in the effectiveness of local arrangements for governance and implementation.

8. **Competition** – there has been considerable discussion about the impact of competition rules on commissioners over recent months. The key requirement for commissioners is to determine how to improve services for patients including how to use integrated care, competition and choice. Commissioners should adopt transparent decision making processes which use competition as a tool for improving quality, rather than as an end in itself. NHS England and Monitor will support commissioners who adopt this approach to competition.

9. **Local innovation** – while we will set a national framework for planning we want to encourage local innovation and don't want to be overly prescriptive. Within the scope of the new tariff rules for 14/15 agreed with Monitor, we will welcome innovative local approaches that enable change to happen on the ground. For example, commissioners could add additional resources to the transformation fund or they could agree local variations to the national tariff in line with the recently published 14/15 national tariff system rules, where they can demonstrate that it is in the interests of patients to do so. Commissioners could explore new contracting models, such as giving acute providers responsibility for patients 30-100 days following discharge from hospital and introducing prime contractor arrangements for integrated care.

10. **Immediate actions** – I would encourage commissioners to focus on three immediate tasks. First, you should progress the development of five year plans and engage local people in this work. Second, you should strengthen your local partnership arrangements so that you are well placed to make decisions about the use of the ITF. Third, you should identify the things that will make the greatest difference to patients locally and maintain a relentless focus on putting them into action at pace.

Over the coming months we will be publishing further material to help commissioners navigate their way through the planning process. This will include detailed planning guidance, financial allocations and 'commissioning for value' packs for CCGs which will help each CCG to identify where there is the greatest opportunity.

We are committed to working in partnership with CCGs, and I would encourage feedback from CCGs via the Commissioning Assembly planning and finance working group chaired by Paul Baumann, NHS England's Chief Financial Officer. More immediately, however, I advise you to press ahead with development of your plans, and I hope the points I have highlighted in this letter will help you make early progress. The challenges facing both commissioners and providers are significant, and it is essential we start to address them without delay.

Yours faithfully

Sir David Nicholson
Chief Executive

17 October 2013

To: CCG Clinical Leads
Health and Wellbeing Board Chairs
Chief Executives of upper tier Local Authorities
Directors of Adult Social Services

cc: CCG Accountable Officers
NHS England Regional and Area Directors

Dear Colleagues

Next Steps on implementing the Integration Transformation Fund

We wrote to you on 8 August 2013 setting out the opportunities presented by the integration transformation fund (ITF) announced in the spending review at the end of June. While a number of policy decisions are still being finalised with ministers, we know that you want early advice on the next steps. This letter therefore gives the best information available at this stage as you plan for the next two years.

Why the fund really matters

Residents and patients need Councils and Clinical Commissioning Groups (CCGs) to deliver on the aims and requirements of the ITF. It is a genuine catalyst to improve services and value for money .The alternative would be indefensible reductions in service volume and quality.

There is a real opportunity to create a shared plan for the totality of health and social care activity and expenditure that will have benefits way beyond the effective use of the mandated pooled fund. We encourage Health and Wellbeing Boards to extend the scope of the plan and pooled budgets.

Changing services and spending patterns will take time. The plan for 2015/16 needs to start in 2014 and form part of a five year strategy for health and care. Accordingly the NHS planning framework will invite CCGs to agree five year strategies, including a two year operational plan that covers the ITF through their Health and Wellbeing Board.

A fully integrated service calls for a step change in our current arrangements to share information, share staff, share money and share risk. There is excellent practice in some areas that needs to be replicated everywhere. The ingredients are the same across England; the recipe for success differs locality by locality.

Integrated Care Pioneers, to be announced shortly, will be valuable in accelerating development of successful approaches. We are collaborating with all the national partners to support accelerated adoption of integrated approaches, and will be launching support programmes and tools later in 2013.

Where does the money come from?

The fund does not in itself address the financial pressures faced by local authorities and CCGs in 2015/16, which remain very challenging. The £3.8bn pool brings together NHS and Local Government resources that are already committed to existing core activity. (The requirements of the fund are likely to significantly exceed existing pooled budget arrangements). Councils and CCGs will, therefore, have to redirect funds from these activities to shared programmes that deliver better outcomes for individuals. This calls for a new shared approach to delivering services and setting priorities, and presents Councils and CCGs, working together through their Health and Wellbeing Board, with an unprecedented opportunity to shape sustainable health and care for the foreseeable future.

Working with providers

It will be essential for CCGs and Local Authorities to engage from the outset with all providers, both NHS and social care, likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity requirements across the system. CCGs and Local Authorities should also work with providers to help manage the transition to new patterns of provision including, for example, the use of non-recurrent funding to support disinvestment from services. It is also essential that the implications for local providers are set out clearly for Health and Wellbeing Boards and that their agreement for the deployment of the fund includes agreement to the service change consequences.

Supporting localities to deliver

We are acutely aware that time is pressing, and that Councils and CCGs need as much certainty as possible about how the detail of the fund will be implemented. Some elements of the ITF are matters of Government policy on which Ministers will make decisions. These will be communicated by Government in the normal way. The Local Government Association and NHS England are working closely together, and collaborating with government officials, to arrive at arrangements that support all localities to make the best possible use of the fund, for the benefit of their residents and patients. In that spirit we have set out in the attached annex our best advice on how the Fund will work and how Councils and CCGs should prepare for it.

The Government has made clear that part of the fund will be linked to performance. We know that there is a lot of interest amongst CCGs and Local Authorities in how this “pay-for-performance” element will work. Ministers have yet to make decisions on this. The types of performance metrics we can use (at least initially) are likely to be largely determined by data that is already available. However, it is important that local discussions are not constrained by what we can measure. The emphasis should be on using the fund as a catalyst for agreeing a joint vision of how integrated

care will improve outcomes for local people and using it to build commitment among local partners for accelerated change.

Joint local decision making and planning will be crucial to the delivery of integrated care for people and a more joined up use of resources locally. The ITF is intended to support and encourage delivery of integrated care at scale and pace whilst respecting the autonomy of locally accountable organisations.

This annex to this letter sets out further information on:

- How the pooled fund will be distributed;
- How councils and CCGs will set goals and be rewarded for achieving them;
- Possible changes in the statutory framework to underpin the fund;
- The format of the plans for integrated care and a template to assist localities with drawing up plans that meet the criteria agreed for the fund;
- Definitions of the national conditions that have to be met in order to draw on the polled fund in any locality; and
- Further information on how local authorities, CCGs, NHS England and government departments will be assured on the effective delivery of integrated care using the pooled fund.

Leads from the NHS and Local Government will be identified to assist us to work with Councils and CCGs to support implementation. More details on this can be found in the annex. We will issue a monthly bulletin to Councils and CCGs with updates on the Integration Transformation Fund.

Yours faithfully

Carolyn Downs
Chief Executive
Local Government Association

Bill McCarthy
National Director: Policy
NHS England

NHS England Publications Gateway Ref. No.00535

Annex

Advice on the Integration Transformation Fund

What is included in the ITF and what does it cover?

Details of the ITF Fund

The June 2013 SR set out the following:	
2014/15	2015/16
An additional £200m transfer from the NHS to social care, in addition to the £900m transfer already planned	£3.8bn pooled budget to be deployed locally on health and social care through pooled budget arrangements

In 2015/16 the ITF will be created from the following:
£1.9bn NHS funding
£1.9bn based on existing funding in 2014/15 that is allocated across the health and wider care system. Composed of:
• £130m Carers' Breaks funding
• £300m CCG reablement funding
• £354m capital funding (including c.£220m of Disabled Facilities Grant)
• £1.1bn existing transfer from health to social care

1. The Integration Transformation Fund will be £3.8 billion worth of funding in 2015/16 to be spent locally on health and care to drive closer integration and improve outcomes for patients and service users. In 2014/15 an additional £200m transfer from the NHS to social care in addition to the £900m transfer already planned will enable localities to prepare for the full ITF in 2015/16.

2. In 2014/15 use of pooled budgets remains consistent with the guidance[1] from the Department of Health to NHS England on 19 December 2012 on the funding transfer from NHS to social care in 2013/14. In line with this:

3. *"The funding must be used to support adult social care services in each local authority, which also has a health benefit. However, beyond this broad condition we want to provide flexibility for local areas to determine how this investment in social care services is best used.*

4. *A condition of the transfer is that the local authority agrees with its local health partners how the funding is best used within social care, and the outcomes expected from this investment. Health and wellbeing boards will be the natural place for*

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

discussions between the Board, clinical commissioning groups and local authorities on how the funding should be spent, as part of their wider discussions on the use of their total health and care resources.

5. *In line with our responsibilities under the Health and Social Care Act, NHS England is also making it a condition of the transfer that local authorities and clinical commissioning groups have regard to the Joint Strategic Needs Assessment for their local population, and existing commissioning plans for both health and social care, in how the funding is used.*

6. *NHS England is also making it a condition of the transfer that local authorities demonstrate how the funding transfer will make a positive difference to social care services, and outcomes for service users, compared to service plans in the absence of the funding transfer"*

7. In 2015/16 The fund will be allocated to local areas, where it will be put into pooled budgets under joint governance between CCGs and local authorities. A condition on accessing the money in the fund is that CCGs and local authorities must jointly agree plans for how the money will be spent, and these plans must meet certain requirements.

How will the ITF be distributed?

8. Councils will receive their detailed funding allocation following the Autumn Statement in the normal way. When allocations are made and announced later this year, they will be two-year allocations for 2014/15 and 2015/16 to enable planning.

9. In 2014/15 the existing £900m s.256 transfer to Local Authorities for social care to benefit health, and the additional £200m will be distributed using the same formula as at present.

10. The formula for distribution of the full £3.8bn fund in 2015/16 will be subject to ministerial decisions in the coming weeks.

11. In total each Health and Wellbeing Board area will receive a notification of its share of the pooled fund for 2014/15 and 2015/6 based on the aggregate of these allocation mechanisms to be determined by ministers. The allocation letter will also specify the amount that is included in the pay-for-performance element, and is therefore contingent in part on planning and performance in 2014/5 and in part on achieving specified goals in 2015/6.

How will Councils and CCGs be rewarded for meeting goals?

12. The Spending Review agreed that £1bn of the £3.8bn would be linked to achieving outcomes.

13. In summary 50% of the pay-for-performance element will be paid at the beginning of 2015/16, contingent on the Health and Wellbeing Board adopting a plan that

meets the national conditions by April 2014, and on the basis of 2014/15 performance. The remaining 50% will be paid in the second half of the year and could be based on in-year performance. We are still agreeing the detail of how this will work, including for any locally agreed measures.

14. In practice there is a very limited choice of national measures that can be used in 2015/6 because it must be possible to baseline them in 2014/5 and therefore they need to be collected now with sufficient regularity and rigour. For simplicity we want to keep the number of measures small and, while the exact measures are still to be determined, the areas under consideration include:

    - Delayed transfers of care;
    - Emergency admissions;
    - Effectiveness of re-ablement;
    - Admissions to residential and nursing care;
    - Patient and service user experience.

15. In future we would hope to have better indicators that focus on outcomes for individuals and we are working with Government to develop such measures. These can be introduced after 2016/7 as the approach develops and subject to the usual consultation and testing.

16. When levels of ambition are set it will be clear how much money localities will receive for different levels of performance. In the event that the agreed levels of performance are not achieved, there will be a process of peer review, facilitated by NHS England and the LGA, to avoid large financial penalties which could impact on the quality of service provided to local people. The funding will remain allocated for the benefit of local patients and residents and the arrangements for commissioning services will be reconsidered.

Does the fund require a change in statutory framework?

17. The Department of Health is considering what legislation may be necessary to establish the Integrated Transformation Fund, including arrangements to create the pooled budgets and the payment for performance framework. Government officials are exploring options for laying any required legislation in the Care Bill. Further details will be made available in due course. The wider powers to use Health Act flexibilities to pool funds, share information and staff are unaffected and will be helpful in taking this work forward.

How should councils and CCGs develop and agree a joint plan for the fund?

18. Each upper tier Health and Wellbeing Board will sign off the plan for its constituent local authorities and CCGs. The specific priorities and performance goals are clearly a matter for each locality but it will be valuable to be able to:

    - Aggregate the ambitions set for the fund across all Health and Wellbeing Boards;

- Assure that the national conditions have been achieved; and

- Understand the performance goals and payment regimes have been agreed in each area.

19. To assist Health and Wellbeing Boards we have developed a draft template which we expect everyone to use in developing, agreeing and publishing their integration plan. This is attached as a separate Excel spread sheet.

20. The template sets out the key information and metrics that all Health and Wellbeing Boards will need to assure themselves that the plan addresses the conditions of the ITF. We strongly encourage Councils and CCGs to make immediate use of this template while awaiting further guidance on NHS planning and financial allocations.

21. Local areas will be asked to provide an agreed shared risk register, with agreed risk sharing and mitigation covering, as a minimum, steps that will be taken if activity volumes do not change as planned. For example if emergency admissions increase or nursing home admissions increase.

What are the National Conditions?

22. The Spending Review established six national conditions:

National Condition	Definition
Plans to be jointly agreed	The Integration Plan covering a minimum of the pooled fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Well Being Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and Local Authorities should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.
Protection for social care services (not spending)	Local areas must include an explanation of how local social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with the 2012 Department of Health guidance referred to in paragraphs 2 to 6,

National Condition	Definition
	above.
As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends	Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The forthcoming national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England will provide guidance on establishing effective 7-day services within existing resources.
Better data sharing between health and social care, based on the NHS number	The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care. Local areas will be asked to: • confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to; • confirm that they are pursuing open APIs (ie. systems that speak to each other); and • ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place. NHS England has already produced guidance that relates to both of these areas, and will make this available alongside the planning template. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by the Department of Health).

National Condition	Definition
Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Local areas will be asked to identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning.
Agreement on the consequential impact of changes in the acute sector	Local areas will be asked to identify, provider-by-provider, what the impact will be in their local area. Assurance will also be sought on public and patient engagement in this planning, as well as plans for political buy-in.

How will preparation and plans be assured?

23. Ministers will wish to be assured that the ITF is being used for the intended purpose, and that the local plans credibly set out how improved outcomes and wellbeing for people will be achieved, with effective protection of social care and integrated activity to reduce emergency and urgent health demand.

24. To maximise our collective capacity to achieve these outcomes and deliver sustainable services we will have a shared approach to supporting local areas and assuring plans. This process will be aligned as closely as possible to the existing NHS planning rounds, and CCGs can work with their Area Teams to develop their ITF plans alongside their other planning requirements.

25. We will establish in each region a lead local authority Chief Executive who will work with the Area and Regional Teams, Councils, ADASS branches, DPHs and other interested parties to identify how Health and Wellbeing Boards can support one another and work collaboratively to develop good local plans and delivery arrangements.

26. Where issues are identified, these will be shared locally for resolution and also nationally through the Health Transformation Task Group hosted by LGA, so that the national partners can broker advice, guidance and support to local Health and Well Being Boards, and link the ITF planning to other national programmes including the Health and Care Integration Pioneers and the Health and Well Being Board Peer Challenge programme. We will have a first review of readiness in early November 2013.

27. We will ask Health and Well Being Boards to return the completed planning template (draft attached) by 15 February 2014, so that we can aggregate them to provide a composite report, and identify any areas where it has proved challenging to agree plans for the ITF.

Integration Transformation Fund

Draft Plan Submission Template

Local Authority	<Name of Local Authority>
Clinical Commissioning Groups	<CCG Name/s> <CCG Name/s> <CCG Name/s> <CCG Name/s> <CCG Name/s>
Boundary Differences	<Identify any differences between LA and CCG boundaries and how these have been addressed in the plan>
Date agreed at Health and Well-Being Board:	<dd/mm/yyyy>
Date submitted:	<dd/mm/yyyy>
Minimum required value of ITF pooled budget: 2014/15	£0.00
2015/16	£0.00
Total agreed value of pooled budget: 2014/15	£0.00
2015/16	£0.00

Authorisation and Sign Off

Signed on behalf of the Clinical Commissioning Group	
By	<Name of ccg>
Position	<Name of Signatory>
date	<Job Title>
	<date>

Signed on behalf of the Clinical Commissioning Group	
By	<Name of Signatory>
Position	<Job Title>
date	<date>

<Insert extra rows for additional CCGs as required>

Signed on behalf of the Local Authority	
By	<Name of Signatory>
Position	<Job Title>
date	<date>

Signed on behalf of the Health & Wellbeing Board	
By Chair of the HWB:	<Name of Signatory>
Position	<Job Title>
date	<date>

Service provider engagement

Please describe how health and social care providers have been involved in the development of this pla, and the extent to which they are party to it

Patient, service user and public engagement

Please describe how patients, services users and the public have been involved in the development of this plan, and the extent to which they are party to it

Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition

Vision for Health and Care Services

Please describe the vision for health and social care services for this community for 2018/19.
- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Integration Aims & Objectives

Please describe your overall aims and objectives for integrated care and provide information on how the integration transformation fund will secure improved outcomes in health and care in your area. Suggested points to cover:
• What are the aims and objectives of your integrated system?
• How will you measure these aims and objectives?
• What measures of health gain will you apply to your population?

Description of Planned Changes

Please provide an overview of the scemes and changes covered by your joint work programme, including:
1. The key success factors including an outline of processes, end points and time frames for delivery
2. How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

Implications for the Acute Sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

National Conditions

1 Protecting social care services

Please outline your agreed local definition of protecting social care services.

Please explain how local social care services will be protected within your plans.

2 7-day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy)
Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

3 Data-sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Please confirm that you are commited to adopting systems that are based upon Open APIs and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Please confirm that you are commited to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements , professional clinical practise and in particular requirements set out in Caldicott2.

4 Joint-assessments and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional.

Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

Outcomes and metrics

Please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

Outcome measures- Examples only	Current Baseline (as at....)	14/15 Projected delivery (full year?)	15/16 Projected delivery (full year?)
Delayed transfers of care			
Emergency admissions			
Effectiveness of reablement			
Admissions to residential and nursing care			
Patient and service-user experience			
<Local measure>			
<Local measure>			
<Local measure>			

Finance

Please summarize the total health and care spend for each commissioner in your area. Please

Organisation	2013/14 spend	2013/14 benefits	2014/15 spend	2014/15 benefits	2015/16 spend	
Local Authority Social Services						
CCG						
Primary Care						
Specialised commissioning						
Local Authority Public Health						
Total						

Please summarize where your pooled budget will be spent. NB the total must be equal to or more than your total ITF allocation

ITF Investment	2014/15 spend	2014/15 benefits	2015/16 spend	2015/16 benefits
Scheme 1				
Scheme 2				
Scheme 3				
Scheme 4				
Scheme 5				
Total				

Approximately 25% of the ITF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

Contingency plan:		2015/16	Ongoing
Outcome 1	Planned savings (if targets fully		
	Maximum support needed for other		
Outcome 2	Planned savings (if targets fully		
	Maximum support needed for other		

Key Risks

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk Rating	Mitigating Actions
Risk 1		
Risk 2		
Risk 3		
Risk4		

REPORT TO: Health and Wellbeing Board

DATE: 13th November 2013

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health & Adults; Children, Young People & Families

SUBJECT: Marketing Guidelines for Health and Wellbeing branding

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To brief the Health and Wellbeing Board on progress with the development of branding guidelines for the use of the health and wellbeing brand and logo.

2.0 RECOMMENDATION:That the Board

1. note contents of the report;

2. endorse the proposed guidelines; and

3. agree and support the usage of the guidelines and logo within partner organisations.

3.0 SUPPORTING INFORMATION

3.1 Following extensive consultation with local residents and community groups a health and wellbeing brand was developed and endorsed by the Health and Wellbeing Board in July 2012.

3.2 The logo is intended to provide an umbrella image and strapline that signifies a partnership approach in delivering services around health and wellbeing. It is not intended to displace an organisations individual logo but rather complement and sit alongside this. (Full details on how this would operate in practice are set out within the guidelines).

Guidelines for usage

3.3 In order to ensure the appropriate use of the logo, the Council's Marketing and Communications Team has developed a set of guidelines. These can be found in Appendix 1 of this report.

3.4 It is however recognised that embedding the usage of the logo will need to be driven from a senior level in partner organisations.
Marketing and Communications teams will need to be made fully aware of the existence of the logo and the guidelines for usage. Help and support can be provided from within HBC Communications and Marketing if required.

4.0 Policy Implications

4.1 Implementation of the branding guidelines and use of the health and wellbeing logo will complement the implementation of the Health and Wellbeing Strategy and action plans which is the under-pinning strategy for the Health and Wellbeing Board.

5.0 Other/ Financial Implications

5.1 None

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children & Young People in Halton**
Improving the Health of Children and Young People is a key priority in Halton and will continue to be addressed by the Health and Wellbeing Board through the implementation of the Health and Wellbeing Strategy.

6.2 **Employment, Learning & Skills in Halton**
The above priority is a key determinant of health. Improving outcomes in this area will have an impact on improving the health of Halton residents.

6.3 **A Healthy Halton**
All issues outlined in this report focus directly on this priority.

6.4 **A Safer Halton**
Reducing the incidence of crime, improving Community Safety and reducing the fear of crime have an impact on health outcomes particularly on mental health. There are also close links between partnerships on areas such as alcohol and domestic violence, which will be included in the Health Areas.

6.5 **Halton's Urban Renewal**
The environment in which we live and the physical infrastructure of our communities has a direct impact on our health and wellbeing.

7.0 RISK ANALYSIS

7.1 The JSNA identifies that whilst Halton has made progress in a number of health and wellbeing areas, there is still much to do as the rate at which Halton has improved is still behind the national averages. By implementing a new, innovate way of engaging with the communities of Halton on Health and Wellbeing Issues and offering services to meet the specific needs of those communities it is anticipated that this will contribute further to the positive direction of health and wellbeing in Halton.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 This is in line with all equality and diversity issues in Halton.

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

None

Halton | **Health & Wellbeing**
Brand Guidelines

About the Health and Wellbeing Board

The Health and Wellbeing Board is a local partnership working to improve the 'health and wellbeing' of local residents. Our work is not just about providing health improvement services or access to GPs and hospitals - although these are important to us – it is also about improving quality of life by:

- improving access to employment and education
- improving the environment in which we live
- improving and creating safer and stronger communities

This brand is designed to reflect the diverse and far-reaching work being carried out by the individuals and organisations that make up the Health and Wellbeing Board.

It is our hope that over time, the brand will come to be recognised as a symbol of positive health and well-being in Halton. We anticipate it being used alongside existing organisation corporate identities as a clear demonstration of our partnership approach.

We hope the brand's value will be enhanced by the positive experiences of our service users and our community and by the progress we are making to improve the lives of ordinary people living in Halton.

These guidelines have been produced to help you understand our brand values and how to apply the identity correctly and consistently.

Developing the brand

We asked local people to talk to us about the things that are important to them, what makes them feel good, what they like about living in Halton and what changes they would like to see to help improve their own health and wellbeing. Through these discussions a number of themes emerged, they were:

- A sense of community
- A sense of belonging / wanting to belong
- Access (to services and public transport)
- History and pride
- Love of green spaces and openness

It is with these themes in mind that our brand was created. It incorporates a number of elements:

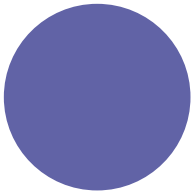
The 'tree' logo: a symbol of life and growth; reaching down to the ground and up to the sky (access); family tree; tree of knowledge. In addition, there's the obvious links to green and open spaces.

Leaves: the Board's work is focused on seven health locality areas, each represented by a coloured leaf. Together they embody the strong sense of community, so valued by our community. Leaves are also strong symbols, representing happiness, healing and friendship.

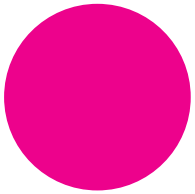
Strapline: My Halton, living life well: a positive statement that has close associations to health and being healthy without being too focused on purely health services

Colour palette

Colours (use images of leaves) with pantone references



PANTONE P 99-14



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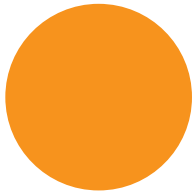

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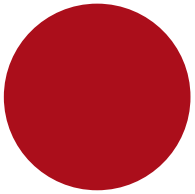
PANTONE P 48-8



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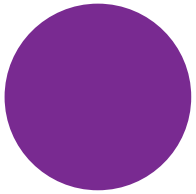
PANTONE P 4-8



PANTONE P 91-8

The logo

Full colour

Correctly proportioned full colour logo

Do not stretch the logo

Do not tilt the logo

Minimum Size 17 mm

Single colour

Correct use of single colour logo

Incorrect use of two colour logo

Imagery

Images are an important element of our visual brand. The images we use should reflect our community and wherever possible should be 'real' photographs of Halton people in local settings. A picture can tell a thousand words so we should spend time to find the right image to help us get our message across.








How the brand should be used

It is our hope that over time, our brand will come to be recognised as a symbol of positive health and well-being in Halton.

To achieve this, we would encourage all partners of the Health and Wellbeing Board to adopt the brand.

We recognise that our brand has to work in partnership with service delivery brands, including as Halton Borough Council, NHS Halton CCG and Voluntary organisations.

We want to avoid logo overload and ensure those seeking help do not become confused. Where we are co-branding, we should always ensure it is clear who is delivering a particular service and who a resident/professional should contact if they need help.

Therefore, how the logo is used will depend on the scenario, service or setting. The following examples, though not exhaustive, provide some general guidance:

Scenario 1: as the lead brand

Scenario 2: as a supporting brand

Scenario 3: where there is a partnership approach

Our tone of voice

Our words and the tone of voice we use when communicating, either in person, in print or online will help to reinforce our brand and enhance its value.

In many cases we will be speaking with people who are vulnerable, in distress, or are seeking our support to change something in their life.

While we will need to adapt our style to suit different audiences, we should always use language that is appropriate

Optimistic and hopeful

Our tone should reflect the positive work we are doing to improve the health and wellbeing. We know the services we provide make a difference, wherever appropriate we should talk about achievements and share our vision

Genuine and realistic

It is important that we talk honestly with our various audiences in terms that that they understand. Our words should appear realistic and our plans deliverable.

Personal and direct

We should always keep in mind the audience we are communicating with. Our words should build trust, be inclusive and never be patronising.

For further guidance, contact:
Lead Officer Communications,
Design and Marketing
Halton Borough Council
t: 0151 511 7723

REPORT TO: Health and Wellbeing Board

DATE: 13th November 2013

REPORTING OFFICER: Director of Public Health

PORTFOLIO: Health and Adults

SUBJECT: Seasonal Flu vaccinations

1.0 **PURPOSE OF REPORT**

1.1 To inform the Board of the details of the 2013/14 season flu vaccination campaign and local implementation

2.0 **RECOMMENDATION**

To acknowledge the content of the report and request that senior managers promote the benefits of the vaccine to all appropriate staff.

3.0 **SUPPORTING INFORMATION**

3.1 Influenza (often referred to as Flu) is an illness that occurs all year round but peaks in the winter time. It is a highly contagious viral infection that for most people is a self-limiting illness that will cause nasty symptoms for up to a week. However, older people, the very young, pregnant women and those with underlying disease, particularly chronic respiratory or cardiac disease, or those who are immunosuppressed, are at particular risk of severe illness if they catch flu. Flu is easily transmitted and even people with mild or no symptoms can still infect others.

3.2 To protect those at risk immunisation is recommended. It is particularly important that frontline staff that have direct contact with patients of all ages are offered immunisation against Influenza.

3.3 Vaccinating staff against flu is an important infection control measure as part of the annual winter planning process to ensure that health and social care are as resilient as possible.

3.4 The following key points have been communicated to all frontline staff across all community and social care services –

- As part of your duty of care to your patients or residents you should do everything in your power to protect them against infection. This includes getting vaccinated against flu.
- The impact of flu on frail and vulnerable patients, in communities, care homes and in hospitals, can be fatal.
- Getting vaccinated against flu can help protect you and your family.

- Even if you have no symptoms you can still pass flu to patients.
- Having the flu vaccination can be a powerful message to colleagues and patients.

3.5 HBC Staff have been offered free seasonal flu vaccinations on 29 and 31 October. Sessions were arranged at a location in Widnes and Runcorn and ran from 9.30 to 5pm to allow as many staff as possible the opportunity to attend. This is a healthy workplace initiative which has the potential benefit of maintaining staff capacity during the winter months due to improved resilience against flu.

3.6 Priority has been given to HBC Staff who fulfil the definition of being frontline staff, which are those who have direct patient contact; they have been given the opportunity to attend at the ASDA Pharmacy in Widnes or Runcorn up until the first week of December. The message has been given alongside the fact that that the sooner they go the sooner they are protected.

3.7 To improve vaccine coverage, research suggests that a multi-faceted approach will be most effective, within the context of a comprehensive infection control programme that is designed to protect both patients and staff. This should include:

• easy access to flu vaccination during staff working hours with protected time and on-site provision
• senior clinical flu vaccination champions
• clinicians vaccinating colleagues
• education and training
• visible Board and staff engagement with the local campaign.

3.8 The Public Health Team has coordinated arrangements for vaccination of all staff including those in the front line.

4.0 POLICY IMPLICATIONS

4.1 Immunisation against infectious disease (the Green Book)[1] states that immunisation should be provided to healthcare and social care workers in direct contact with patients/clients to protect them and to reduce the transmission of influenza within health and social care premises, to contribute to the protection of individuals who may have a suboptimal response to their own immunisations, and to avoid disruption to services that provide their care.

4.2 The updated Code of practice on the prevention and control of infections and related guidance reminds both NHS and social care bodies of their responsibilities. These are to ensure, so far as is reasonably practicable, that health and social care workers are free of, and are protected from exposure to infections that can be caught at

[1] For the Green Book see: https://www.gov.uk/government/organisations/public-health-england/series/immunisation-against-infectious-disease-the-green-book

work.[2]

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 The responsibility for funding the seasonal flu vaccine and its administration to staff (other than those that are in a clinical risk group) lies with employers.

6.0 RISK ANALYSIS

6.1 Making flu vaccination available to staff reduces the risk of them transmitting the illness to others who may be in a vulnerable at risk group, reduces staff absenteeism and increases winter resilience

7.0 EQUALITY & DIVERSITY ISSUES

7.1 Not likely to impact adversely on any of the nine groups

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[2] The Code can be found at: https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance)