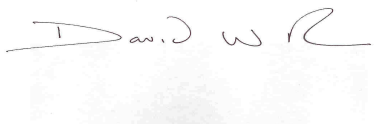
Public Document Pack

Safer Policy and Performance Board

Tuesday, 12 November 2013 at 6.30 p.m.
Council Chamber, Runcorn Town Hall



Chief Executive

BOARD MEMBERSHIP

Councillor Shaun Osborne (Chairman)	**Labour**
Councillor Norman Plumpton Walsh (Vice-Chairman)	**Labour**
Councillor Susan Edge	**Labour**
Councillor John Gerrard	**Labour**
Councillor Robert Gilligan	**Labour**
Councillor Valerie Hill	**Labour**
Councillor Miriam Hodge	**Liberal Democrat**
Councillor Darren Lea	**Labour**
Councillor Martha Lloyd Jones	**Labour**
Councillor Paul Nolan	**Labour**
Councillor Pauline Sinnott	**Labour**

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

The next meeting of the Board is on Tuesday, 14 January 2014

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

Part I

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

Agenda Item 3

REPORT TO: Safer Policy & Performance Board

DATE: 12 November 2013

REPORTING OFFICER: Strategic Director, Corporate and Resources

SUBJECT: Public Question Time

WARD(s): Borough-wide

1.0 PURPOSE OF REPORT

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

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

2.0 RECOMMENDED: That any questions received be dealt with.

3.0 SUPPORTING INFORMATION

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

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

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

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

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

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

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

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

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

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

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

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

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

4.0 POLICY IMPLICATIONS

None.

5.0 OTHER IMPLICATIONS

None.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

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

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

6.3 **A Healthy Halton** – none.

6.4 **A Safer Halton** – none.

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

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

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

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

REPORT TO: Safer Policy and Performance Board

DATE: 12 November 2013

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Community Safety

SUBJECT: Presentation – Police and Crime Commissioner (PCC)

WARDS: Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To receive a presentation from Mr John Dwyer, PCC updating the Members on current activities within Cheshire.

2.0 RECOMMENDATION: That

(1) Members receive the presentation; and

(2) Members ask any questions about the service as it operates in Halton.

3.0 SUPPORTING INFORMATION

3.1 The Policing & Social Responsibility Act 2011 contained legislation which shifts the decision-making on the strategic management of policing to elected Police and Crime Commissioners in England

3.2 The first elections of Police and Crime Commissioners took place on the 15 November 2012. The new PCC officially took office on the 22nd November 2012.

3.3 The conservative candidate John Dwyer was duly elected as the Police Crime Commissioner for Cheshire. He received a total of 48,591 votes. The turnout of voters in Cheshire was 14.08%, which equated to 111,335 papers counted.

4.0 POLICY IMPLICATIONS

4.1 The policy implications of the review relate primarily to the Safer Halton priority. However this is a cross cutting work area which has wider implications on other areas of council business

5.0 OTHER IMPLICATIONS

5.1 None.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton**

None

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

None.

6.3 **A Healthy Halton**

None

6.4 **A Safer Halton**

Fundamental to the overall long-term safety of people.

6.5 **Halton's Urban Renewal**

None.

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

7.1 None under the meaning of the Act.

REPORT TO: Safer Policy and Performance Board

DATE: 12 November 2013

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Community Safety

SUBJECT: Cheshire Fire & Rescue Service Annual Report

WARDS: Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To consider the report from Cheshire Fire and Rescue Service presenting the Annual report for Halton 2012-13, and to receive an update on the Integrated Risk Management Plan 2013-14 (IRMP).

2.0 RECOMMENDATION: That

(1) Members note the report; and

(2) Members ask any questions about the service as it operates in Halton.

3.0 SUPPORTING INFORMATION

3.1 The Board have a scrutiny function to review Cheshire Fire and Rescue Service on an annual basis. The Annual Report for Halton has been attached at Appendix 1 to the report for Members consideration.

4.0 POLICY IMPLICATIONS

4.1 The policy implications of the review relate primarily to the Safer Halton priority. However this is a cross cutting work area which has wider implications on other areas of council business.

5.0 OTHER IMPLICATIONS

5.1 None.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 **Children and Young People in Halton**

None

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

None.

6.3 **A Healthy Halton**

None

6.4 **A Safer Halton**

Fundamental to the overall long-term safety of people.

6.5 **Halton's Urban Renewal**

None.

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

7.1 None under the meaning of the Act.

CHESHIRE FIRE & RESCUE SERVICE

Fire Service of the Year 2011 Emergency Service Awards

EXCELLENT FIRE & RESCUE SERVICE EQUALITY FRAMEWORK

Halton

Annual REPORT 2012-13

For the latest news visit: **www.cheshirefire.gov.uk**

FIRES REACH ALL-TIME LOW

Fire Chiefs say they are delighted that the number of fires in Cheshire is now at the lowest level ever recorded but have vowed to continue campaigning for more safety improvements in the future.

Figures show that the total number of primary fires – those involving homes, businesses, cars, injuries and incidents where more than five fire engines were used – fell to 1,181 in 2012-13, a reduction of more than a third over the last five years.

For more performance information see page 6

There were four fire deaths during the year and 52 fire-related injuries, again a reduction on the previous year.

"We have a very clear focus on making Cheshire safer for everyone and these excellent results are largely due to the hard work of our staff in providing safety advice and help to those most at risk," said Fire Authority Chair Cllr. John Joyce.

"We have always believed strongly that prevention is better than cure and even though we face major cuts in our funding, we think it is more important than ever that we continue investing in our community safety work."

In 2012-13 the Service carried out nearly 23,000 visits to high risk households across Cheshire, giving out key safety advice and fitting free smoke alarms as part of its Home Safety Assessment (HSA) programme. Over the last 10 years firefighters and community safety advocates have completed over 357,000 HSAs throughout Cheshire.

"There is no doubt that our work has been a key factor in reducing fires to their lowest ever level in Cheshire but we can't be complacent," added Chief Fire Officer Paul Hancock.

"That's why our high profile campaigns for the fitting of sprinklers and smoke alarms to be compulsory are vital if we are to maintain these safety improvements going forward."

Investing in the future

Cheshire Fire Authority Member, Cllr Stef Nelson, hands over the keys to a new fire engine that will be based at Runcorn Fire Station. The vehicle is part of the Authority's continued investment in firefighting equipment.

Safety plea to public

Fire chiefs are reassuring communities that they will still be able to provide a fire and rescue service across Cheshire during any potential industrial action by the Fire Brigades Union (FBU).

Members of the FBU have voted in favour of industrial action as part of a dispute with the Government over plans to reform firefighter pensions.

But Cheshire's Chief Fire Officer Paul Hancock said: "We have put in place plans and procedures that will enable us to continue to protect the communities of Cheshire if strikes go ahead.

"Clearly, however, there will be fewer fire engines and firefighters available than normal and we would urge residents and businesses to take extra care by following our key safety messages."

Public safety campaigns are underway, while the Service's website – www.cheshirefire.gov.uk – will carry up to date information about the potential strikes. Residents are urged to follow the Service on Twitter @CheshireFire or visit it on Facebook at CheshireFRS.

New system to keep you Alert

A new system aimed at keeping local communities across Cheshire informed about incidents, emergencies and key safety campaigns is being launched by Cheshire Fire and Rescue Service.

The Fire Alert System is a free two-way community messaging system allowing people to receive important alerts from the Service not only by text message but also by email and phone.

"Incidents and emergencies can have a very real impact on the lives of residents and workers and it is important we continue to develop ways in which we can let people know what is going on," said Deputy Chief Fire Officer Mark Cashin.

Cheshire Fire ALERT

"This system offers us a fast and efficient way of providing basic updates and safety advice and I hope that as many Cheshire residents and business owners as possible take just a couple of minutes to register for this free service".

The secure countywide portal has been developed in partnership with Cheshire Police and means users can also register to receive updates from them and other partners.

Registration is via the Service's website and users can put in their home or work post code or that of a relative and choose what alerts they would like to receive. People without the internet can call 01606 868422.

Film honour for fire cadets

Cheshire Fire Cadets won a national road safety award, as part of a campaign to help save young lives co-ordinated by the road safety charity, Break.

The 2young2die awards encouraged young people to get creative and promote life-saving road safety messages to their peers and the wider community through powerful campaigns.

Fire Cadets from Congleton, Sandbach and Runcorn were thrilled to claim the award for their series of hard-hitting short films, which they created in a bid to educate young road users. The inspiration behind the project was their friend and fellow Fire Cadet, Hayley Bates, who was tragically killed in a road crash in September 2010.

Laura Wheelton, Fire Cadet Watch Manager at Congleton, said: "It was a good feeling when we were told that we'd won the 2young2die award. We're proud that we have been able to turn something that has affected us so deeply into something positive."

Rich Andrew, senior development officer at Brake, says "The Cheshire Fire and Rescue Service Cadets have shown great dedication to spreading road safety awareness and their powerful messages are reaching a large audience of young people."

The Cadets will be presented with their award, at Brake's annual reception at the Houses of Parliament in January 2014.

A 20 year success story

The Service marked a special milestone this year as it celebrated two decades of delivering The Prince's Trust Team Programme – an inspirational project that has helped thousands of young people.

The Team programme is a 12-week personal development scheme which helps unemployed 16 to 25-year-olds build the skills and confidence they need to get a job. The Service's involvement with the programme began back in 1993 when it recognised it as an opportunity to engage with and inspire Cheshire's younger generation.

Chief Fire Officer, Paul Hancock, said: ***"It is with a huge amount of pride that I am able to reflect on our involvement with the Prince's Trust. Over the past 20 years we have seen thousands of young people pass through our doors. I am delighted to say that for the vast majority of them their involvement with us and The Prince's Trust proves to be a positive turning point in their lives."***

To mark this special anniversary the Service held a gala dinner at Chester Racecourse, which was attended by a host of dignitaries, celebrities and people who had played a key role in the success of the programme over the years. In addition the event saw a number of past team members return to share their experience of how the course had helped transform their lives.

The event, which was hosted by Prince's Trust Ambassador and ITV weather presenter Claire Nasir and her husband BBC Radio 6 music presenter Chris Hawkins, featured a video message from His Royal Highness The Prince of Wales, which thanked the Service for the work it had done.

Other guests included the Fire Minister Brandon Lewis MP, Cheshire's Lord Lieutenant, David Briggs and rugby player James Roby.

There are many more Team programmes being planned and so if you or your company would like to get involved please contact a member the Service's Youth Engagement team on 01606 868700 or visit our website.

Cheshire wins prestigious award

The Service has won the Improvement and Efficiency (iESE) Fire and Rescue Project of the Year award, which focus on innovation and efficiency in public services.

Cheshire won the award for its ground breaking efforts in the field of fire prevention. It has over a number of years developed a first class range of interventions designed to reduce risk significantly and the need for emergency intervention.

This has seen a range of positive outcomes, not least a reduction of 70% of injuries in fires and a reduction of 41% in house fires.

Head of Community Fire Safety Evan Morris said: "I am delighted that our organisation has won this award and am especially thrilled it's been recognised as a leading Fire and Rescue Service for the work of its Community Safety Department. This is a significant achievement and reflects the hard work invested by all our staff and volunteers."

Investing in safety

As part of the Fire Authority's commitment to keeping firefighters safe, a series of projects have been completed to boost frontline training and equipment.

The investment of around £500,000 includes a new joint facility at Manchester Airport, which will enable crews to access backdraft and flashover training scenarios. The site next to the runway, offers an ideal open area where fuels can be burnt away from any commercial or residential areas. It involves a series of containers and observation points that will enable firefighters to train and observe how to deal with potentially deadly situations.

Investment has also been made in a number of other areas including the purchase of 'Tough Books', which will provide a robust device that can be used to obtain and transfer vital information during incidents.

In addition, flow meters are being fitted to fire engines to provide a digital reading of the litres of water per minute being applied to a fire. This will be invaluable at larger incidents when crews need to tell the Environment Agency how much water is being used. It will also be useful during chemical incidents when crews sometimes need to determine how much water is needed to dilute the substance involved.

The Service has also bought 16 'Eagle Attack' thermal imaging cameras. These vital pieces of equipment enable crews to locate fires and casualties even when there is poor visibility. The 'Eagle Attack' has been chosen because it is small, lightweight and suitable to be attached to crews' breathing apparatus.

Major drive on safety campaigns

Two campaigns which can make a major improvement to public safety are being given top priority by the Fire Authority.

The Service is continuing its campaign to see sprinkler systems fitted in all new buildings in England and it is also launching a drive to get housing landlords signed up to its smoke alarm campaign pledge.

As part of the sprinkler campaign the Fire Authority agreed to earmark £160,000 to work with local housing associations on retro-fitting systems into at least one block of flats in each of the four local council areas.

Fire Authority Chair Cllr. John Joyce said: "Sprinkler systems are proven to save lives and property as well as improving firefighter safety, reducing the amount of damage and limiting the impact on the environment.

"We have been urging landlords and businesses to install these for some time but now we are launching a real drive to ensure action is taken – including providing some part-funding to get them put into tower blocks across Cheshire."

The investment is enough to fund 50% of the costs of installing sprinklers in at least four high rise tower blocks with around 60 flats in each. Initial talks with some local landlords have indicated that they would be prepared to meet the other half of the costs.

"Cheshire Fire and Rescue Service has a national reputation for innovation and this programme is an exciting opportunity to kick start an investment in sprinkler systems which are now a cost effective way of dramatically improving people's safety," said Chief Fire Officer Paul Hancock.

Celebrating top employer award

The Service is celebrating after making it into Stonewall's annual guide to the UK's top 100 lesbian, gay, bisexual and transgender (LGBT) friendly employers.

Stonewall - the national body working to achieve equality for lesbians, gay men and bisexual people - also heralded the Service as the North West's Most Improved Employer after it climbed 101 places to claim the 45th slot in this year's Workplace Equality Index.

Fire Authority Deputy Chair Cllr Stef Nelson said: "This is something we are really proud of - we are totally committed to developing an inclusive working environment where staff feel valued regardless of their background or sexual orientation.

"Our aim is to deliver an excellent fire and rescue service and ensure the communities of Cheshire remain safe. I am certain that this is best achieved when our people feel supported and can be themselves at work."

Seasonal safety

With Summer over, the clocks going back and Bonfire Night coming up, the Service would like to remind residents of some key safety messages:

Clocks - check your smoke alarms are working as you put the clocks back on October 27

Keeping warm - Ensure electric blankets are working properly, any heaters are not obstructed, don't leave fires on overnight and get your chimney swept

Autumn driving - colder nights mean more chance of fog, so slow down if visibility is poor and allow extra time for journeys.

Bonfire night - go to an organised bonfire but if you must light your own, don't use flammable liquids and site away from buildings and trees. Store and use fireworks responsibly.

SCHEME TARGETS LANDLORDS

While the number of fire related deaths is at an all time low, there is evidence that an increasing proportion of fire deaths occur in those properties without a working smoke alarm. The latest figures show that 37% of deaths occur in the 14% of properties without a smoke alarm.

Data collected by some fire and rescue services also shows that a majority of those who are at risk live in rented properties.

That's why the Fire Authority is launching a scheme this autumn urging private and social landlords in Cheshire to ensure that their properties are fitted with working smoke alarms and their tenants understand the risks and receive safety advice.

The Fire Authority is promoting the 'Smoke Alarm Pledge' scheme in partnership with local and national agencies, such as the Chief Fire Officers' Association, local housing associations, the Cheshire Federation of Women's Institutes (WI) and the Fire Protection Association (FPA).

The Authority is also aiming to persuade the Government of the need to make it a legal requirement for landlords to fit smoke alarms when they renovate their properties. Similar legislation is in place in Scotland and the organisation will be meeting stakeholders and presenting evidence in this financial year to generate support.

Residents, businesses, partners and staff have all helped to shape ambitious plans by the Fire Authority to fundamentally change how its emergency response services will be delivered across Cheshire in the future.

Last year the organisation completed its most extensive consultation to date as it sought views on the options to build some new fire stations, keep virtually the same number of fire engines but make significant changes in how many of them are staffed.

The three month consultation was overseen by the Consultation Institute and Cheshire subsequently became the first fire and rescue service in the country to be successfully accredited through its Compliance Assessment scheme.

The outcomes from the consultation were used by the Authority in confirming which of the options it intended to pursue and the map alongside summarises the current plans. The programme is expected to take up to four years to complete and will be scrutinised through the organisation's annual risk management processes to ensure it still meets the Authority's objectives and the challenge of saving nearly £8 million by 2017-18.

Implementing the programme will clearly be the Service's main focus over the coming years, however, it is important that efforts are made to review and improve all aspects of the organisation.

The organisation's draft plan for 2014-15, therefore, also includes a number of new proposals for developing the organisation, protecting local communities and responding to emergencies. While these are not as far reaching as those set out in last year's plan, the Authority remains committed to ensuring residents, businesses, partners and staff have the opportunity to give their views.

Residents are urged to give their views on the projects below by visiting the Service's website – www.cheshirefire.gov.uk – where there is an online survey and details of community roadshow events being held across Cheshire. Alternatively, email consultation@cheshirefire.gov.uk or 'phone 01606 868408. The formal consultation runs until December 16.

Summary of proposals for 2014-15

Developing the organisation

- Review key service-wide systems such as those for finance and HR and evaluate options for future collaboration after the launch of the North West Fire Control
- Implement the outcomes from the Service's income generation working group.

Protecting local communities

- Develop new data sharing agreements with local health partners and take a lead role on negotiations over access to national data sources
- Set up a pilot project to provide a paid-for Home Safety Assessment programme for low risk households
- Establish the smoke alarm landlord pledge project and implement the first phase of the project to part fund the retro-fitting of sprinklers in some hi-rise flats
- Examine the feasibility of establishing Cheshire's own dedicated Safety Centre for young people
- Review options to further reduce the number of false alarms from automatic fire systems which the Service attends.

Responding to emergencies

- Continue to implement the Authority's emergency response programme including new crewing arrangements for the second fire engine at Runcorn, a new shift system at Macclesfield and new on-call recruitment at Alsager, Congleton, Knutsford, Northwich, Penketh, Stockton Heath and Winsford
- Review the impact of the Service having a presence at the former Redsands Children Centre in Willaston, Nantwich
- Review how the Service's fleet of fire engines should be bought, specified and maintained in the future.

Planning

This map highlights the emergency response proposals the Ser few financial years.

While the Service doesn't operate its fire stations purely on loc grouped by unitary areas for easy reference. Visit www.cheshir draft risk management plan for 2014-15.

Warrington

Proposals:

1. **Penketh** – build a new wholetime community fire station with two fire engines, one operated by on-call staff in 2015-16
2. **Warrington** – move the second fire engine to Penketh the same year
3. **Lymm** - build a new wholetime station near the M6/M56 motorway interchange and use it as a base for other specialist vehicles in 2015-16
4. **Stockton Heath** - change crewing to on-call and move the aerial appliance to Warrington the same year
5. **Birchwood** – no change.

Cheshire West and Chester

Proposals:

1. **M56/M53 motorway interchange –** open a new wholetime station near the M6/M56 motorway interchange and use it as a base for other specialist vehicl from 2016-17
2. **Chester** – move the second fire engine to the new motorway base the same y
3. **Neston** – continue to review the feasibility of creating a new on-call station wi one fire engine
4. **Ellesmere Port** – change the crewing of the second fire engine or move it to a new on-call station at Neston in 2016-17
5. **Winsford** and **Northwich** – change from day crewing to a nucleus crewing arrangement in 2015-16
6. **Frodsham**, **Malpas** and **Tarporley** – no change.

for a safer Cheshire

vice intends to implement over the next

al council boundaries, the proposals are
efire.gov.uk to see a full copy of the

Halton

Proposals:

1. **Runcorn** – change the crewing of the second fire engine to on-call from 2014-15
2. **Widnes** – stop crewing the second fire engine with support provided by the new station at Penketh from 2015-16

Key
- Wholetime
- Day crewed
- On-call
- Nucleus
- Proposed stations

Cheshire East

Proposals:

1. **Macclesfield** – introduce a new crewing system for the main fire engine during 2014-15
2. **Knutsford** – change to on-call from 2015-16
3. **Alsager** – open a new on-call station with one fire engine in 2015-16
4. **Congleton** – remove the second engine and change the station to a nucleus crewing arrangement in 2015-16
5. **Crewe** – crew the second fire engine by on-call staff from 2016-17
6. **Wilmslow** – no change.

Scan this code with a smart phone to go to our online consultation.

Operational excellence

Training its operational staff to the very highest possible standards has remained a top priority for the Service.

Thankfully major incidents are a rare occurrence, however, it remains vital that fire crews are exposed to realistic training scenarios to prepare them just in case something serious happens.

The Service's Command Training Group has overseen a number of training events both at Headquarters and out on location.

The events, which involved crews from across Cheshire as well as volunteers playing 'live casualties', all involved very realistic scenarios that were designed to test the crews' practical application of skills and the incident commander's decisions.

The training scenarios have included chemical leaks, fires in high rise buildings and incidents at major public events.

In addition to this sort of training the Service's state-of-the-art Incident Command Training Suite continues to use the very best in virtual technology to ensure that Cheshire has some of the best prepared crews in the country.

Safety Day triumph

The third annual Cheshire Fire and Rescue Service Safety day was another success as firefighters joined forces with staff from across the organisation to help spread some winter warmth.

The event, which was entitled, 'Get Set for Winter', focused on cold weather awareness as well as the standard fire safety advice. More that 850 residents, many of who were older more vulnerable people, were visited on the day as the Service aimed to create safer communities.

Chair of Cheshire Fire Authority, Cllr John Joyce, took part in delivering Home Safety Assessments on the day. He said: "The day was a fantastic success and one that saw us directly engaging with hundreds of older people in their homes."

Summary of accounts 2012-13

CHESHIRE FIRE AUTHORITY

Fire Authority

Cheshire Fire Authority is the public body which manages the fire and rescue service on behalf of local communities. It is made up of 23 elected Members, with eight appointed by Cheshire East Council, seven by Cheshire West and Chester, three by Halton Borough and five by Warrington Borough. The current political make up of the Authority is Labour (12), Conservative (9), Liberal Democrat (1) and Independent (1).

The Authority is a separate legal body and has the power to set council tax and agree its own policies and procedures without needing the approval of these local councils. Its meetings are open to the public and are usually held at the Service's Winsford headquarters full details are on the website – www.cheshirefire.gov.uk

Its key duties include setting the annual budget, agreeing the numbers of staff and levels of equipment necessary to provide an effective service and approving the organisation's key policies, plans and strategies.

It is also responsible for ensuring its business is conducted in accordance with the law and proper standards, that public money is properly accounted for and how it aims for continuous improvement. To demonstrate this it produces an Annual Governance Statement to accompany the Statement of Accounts, available via the Service's website.

From 2013-14 there is also a requirement under the new Fire and Rescue Service National Framework to publish an annual Assurance Statement. The first statement will be made available on the Service's website in December 2013.

Accounts

The Fire Authority's accounts show how it uses its resources to deliver a fire and rescue service across Cheshire. The summary accounts below provide an overview of where the funds come from, how they are used and the financial position as at March 31st 2013.

Summary Revenue Account

The 2012–13 Fire Authority budget was £44.7m, with total expenditure incurred of £44.5m resulting in an underspend of around £200,000.

The Authority has a General Reserve of £6.7m. This has been assessed as proportionate to the risks facing the organisation and balances the current public sector financial position with the need to ensure there are sufficient funds to deal with major incidents.

In line with the continuing financial pressure it faces, the Authority has developed a range of options to deliver future savings. Implementing some of these will take time, however, and it is recognised that the reserves will be needed to smooth the financial pressure over the next few years.

Summary Balance Sheet

The Summary Balance Sheet shows the 2012-13 end of year position and the most obvious point to note is the net liability of £358.9m. In other words, the Fire Authority has assets worth £50.9m, but has long term liabilities of £409.8m.

Most of the liabilities relate to all expected future pension costs – £405.9m, compared to £349.7m in 2011-12. All local authorities are required to recognise this liability in their balance sheet even though it is not an immediate call on their resources, but instead is paid out over the life of our existing and future pensioners.

At present, all deficits on the Firefighters' Pension Scheme are funded by Government through a specific top up grant.

Summary Revenue Account 2012-13	£'000	£'000
Community Fire Safety	4,607	
Firefighting and Rescue Operations	31,687	
Corporate And Democratic Core	695	
Non-Distributed Costs	67	
Net Cost of Service		**37,056**
Other income, expenditure and adjustments	7,476	
Amount to be met by Govt Grant and Local Taxation		**44,532**
Revenue Support Grant and Local Taxation	-19,664	
Council Tax	-25,064	
Net General Fund (Surplus)\Deficit		**-196**
Balance on General Fund brought forward	-6,545	
Balance on General Fund Carried Forward		**-6,741**

Summary Balance Sheet 2012-13	£'000	£'000
Long Term Assets	35,677	
Current Assets	19,858	
Long Term Liabilities	-409,766	
Current Liabilities	-4,634	
Total Assets less Total Liabilities		**-358,865**
Financed by:		
Unusable reserves	380,770	
Earmarked Reserves	-15,164	
General Reserve	-6,741	
TOTAL NET WORTH		**358,865**

A full copy of the Statement of Accounts is available on our website - **www.cheshirefire.gov.uk** or by telephoning 01606 868815.

Focus on Performance 2012-13

Cheshire Fire and Rescue Service closely monitors and manages its performance so it can improve the way it protects the safety of local communities. For 2012-13 a new scorecard approach to performance reporting was developed using segments to represent different aspects of the organisation and provides an overview of Key Performance Indicators (KPIs) across the Service's main activities. Each segment displays a small number of KPIs and shows performance against targets set for the year as well as performance compared with the previous year.

Community Outcomes

It is remarkable that the number of fires attended by the Service continues to be driven down. The number of primary fires during 2012-13 was 1,181 which is the lowest level ever recorded for Cheshire. Of these, just over a third were accidental dwelling fires (ADFs). Deliberate primary fires reduced by around a quarter compared with the previous year, as did non-domestic premises fires.

There were four fire deaths during the year, all occurring in house fires. While the number is very low, the details known about these tragic incidents highlight the importance of continually refining our targeting policy to ensure we maximise data sharing arrangements with other organisations to reach individuals at highest risk of fire. Our target every year will be zero deaths so performance against this indicator will show red until that ambition is achieved.

In addition to the fatalities, there were 52 fire-related injuries recorded. This is slightly lower than the previous year, although higher than the target that was set at the start of the year. Around a fifth of these injuries were classed as serious and these were mostly burns - the rest were recorded as slight injuries, the majority of which were due to smoke inhalation.

Deliberate secondary fires were at an all-time low during 2012-13 with a 36% decrease compared with the previous year. The wet weather during the year undoubtedly contributed to the low numbers in addition to the Service's continuous monitoring and analysis of arson which ensures very targeted intervention work in problem areas. Cheshire's arson conviction rate is much better than the national average which is testament to the proactive way that the Service tackles these issues and the close working relationship with the Police, including a detective paid for by the organisation.

COMMUNITY OUTCOMES KPIs

Indicator	Actual	Year End Target	Year on Year Change
Primary fires per 100,000 population	117.01	124.07	⇩
Fatalities in primary fires per 100,000 population	0.4	0	⇩
Injuries in primary fires per 100,000 population	5.06	4.56	⇩
Deliberate fires per 10,000 population	14.36	20.96	⇩
RTCs attended	364	327	⇧
Customer satisfaction with the Service	83%	85%	⇧

Key:

- Performance better than target by at least 10%
- Meeting target
- Within 10% of target
- Failing against target by at least 10%

Prevention and Protection

Delivery against planned prevention and protection activities has been successful on the whole. Strong performance management during the year has ensured that targets have been met, and in some cases significantly exceeded.

An exception relates to Age UK Contact Assessments for older people – the take-up rate hasn't been as good as desired so during 2013-14 there will be a concerted effort by crews and advocates to improve this.

A new policy was launched in July 2012-13 to reduce the number of times the Service attends false alarm calls caused by problems with automatic alarm systems. An accompanying target was set for 2012-13 to reduce the number by 10% and a reduction of 15% was actually achieved by the end of the year through the implementation of the policy.

COMMUNITY PROTECTION KPIs

Indicator	Actual	Year End Target	Year on Year Change
Thematic Inspections Completed	1,869	1,848	⇧
NDP fire safety audits completed	2,055	1,894	⇧
Arson conviction rate	13%	6-8%	⇧
Unwanted Fire Signals per 1,000 non-domestic premises	51.40	54.91	⇩
Hits to business safety internet pages	5,594	None*	New KPI

PREVENTION KPIs

Indicator	Actual	Year End Target	Year on Year Change
HSAs delivered to high risk dwellings	22,723	20,000	⇩
Contact assessments acceptance rate	33%	40%	⇧
Number of young people completing a youth programme	1,026	708	⇧
Number of people reached through road safety events	40,920	21,844	⇧

* New baselines being established during 2012-13

Response

The pass rate against the Cheshire Response Standards stood at 88% at the end of the year which was slightly below the target of 92%. For residential fires the Cheshire Standards were met on 98% of occasions.

The pass rate for road traffic collisions was somewhat lower at 73%. As published in IRMP 10, the Service has adopted a new 'blanket' 10 minute response time for life risk incidents from 2013-14.

A further reduction target was set for 2012-13 to continue to drive down the number of times the Service turns out in response to malicious calls.

Since 2007-08 there has been a 68% reduction in attendance at these incidents and this has been a result of rigorous call challenge and publicity regarding hoax calls.

EMERGENCY RESPONSE KPIs

Indicator	Actual	Year End Target	Year on Year Change
Cheshire Standards pass rate	88%	92%	⇧
Average On-Call availability	66%	None*	⇧
% Emergency calls handled within the standards	80%	85%	New KPI
% Malicious calls not attended	62%	60%	⇧

* New baselines being established during 2012-13

Resources

The resources KPIs focus on internal aspects of the organisation including a number relating to the Service's workforce. This segment shows healthy performance with all targets having been met.

'Working days lost to injury' is a Health and Safety measure. Overall, accidents and near misses in the workplace have reduced compared with 2011-12.

Any serious accidents must be reported to the Health and Safety Executive (HSE) under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

During 2012-13 the number of accidents reported to the HSE was eight, which is a continuation of the trend in recent years for low numbers of serious accidents.

RESOURCES KPIs

Indicator	Actual	Year End Target	Year on Year Change
Average days/shifts lost to sickness	5.43	5.5	⇩
ICT core service availability	100%	96%	New KPI
Working days lost to injury	106	150	⇩
Core skills training completed	100%	100%	New KPI
Overall staff satisfaction*	83%	65%	⇧
Website visitors	325,966	166,610	⇧

* Measured every two years: last recorded in 2011-12

Crews bring a major blaze under control

Firefighters rose to the challenge when a fire broke out at a Widnes recycling plant – a fire that was to burn for 32 days.

The incident, thought to be the longest incidents in the Service's history, took place on Johnson's Lane and involved thousands of tonnes of recycled plastics.

At the height of the blaze there were 15 fire engines at the scene battling to get the initial fire under control.

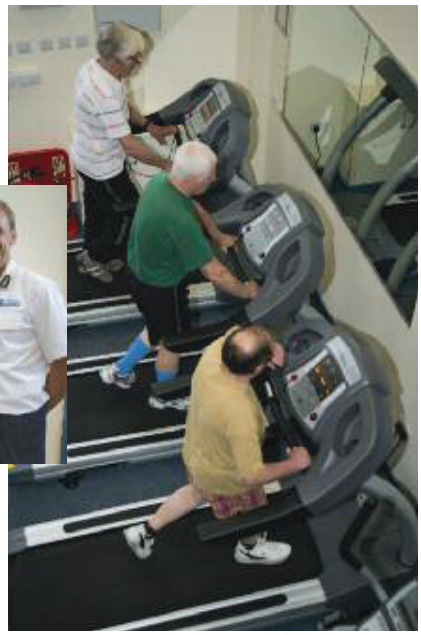
In the weeks that followed crews from Halton endured some challenging circumstances, as they ensured that the fire was dealt with in such a way that the damage to the surrounding environment was kept to a minimum.

Keeping hearts healthy

The Service has opened a new facility at its Runcorn Fire Station to assist those with cardiac-related illnesses.

The Healthy Hearts Runcorn Gym has been unveiled at the Heath Road site. It was inspired by firefighters at the Station, who worked closely with the NHS to create the gym for use by Halton Hospital's Cardiac Rehabilitation Team.

Runcorn Fire Station Manager Sean Henshaw, said: "For many years now Runcorn Fire Station has been at the heart of the local community, with facilities such as its community garden and climbing wall. The Healthy Hearts Gym is a great new development that will be used as an outreach facility for delivering fitness sessions to patients who are rehabilitating following heart surgery or heart attacks."



The old engine house has been completely refurbished to create a fully-equipped gym which has been designed in partnership with Warrington and Halton NHS Foundation Trust and is supported by the Local Area Forum.

Runcorn fire station staff will also be able to use the facility for training and fitness.

How clean is your grill?

Cheshire Fire and Rescue Service launched its latest campaign - 'Dirty Grills Kill' - at Runcorn Fire Station Open Day. The campaign encourages people to clean their cookers to prevent a build up of oil causing a fire to break out.

Terry McDermott, Head of Service Delivery said: "Cooking remains the biggest cause of house fires in Halton. A major cause of this type of fire is unfortunately dirty grills.

"The problem occurs when a build up of fat and oil is left in the grill pan and heats up – basically creating a mini chip pan in your cooker. One spark can lead to it igniting and causing the type of blaze that at best will destroy your kitchen or even your home but at worst it could cost you your life or that of a loved one.

"Therefore we are urging people to join our campaign by making sure they keep their grills and cookers clean. I am certain that together we can drive down the numbers of these potentially devastating fires."

Between 2009-10 and 2012-13 there have been 861 cooking related house fires in Cheshire with 16% of incidents involving an injury or fatality.

Terry added: "We have a clear vision in Cheshire of seeing the number of fire deaths drop to zero but we need people's help so please get behind this campaign and start scrubbing those grills!"

Halton
Unitary performance area profile

In the last three years, primary fires in Halton have reduced by 25%. These are fires that involve buildings and vehicles and include both accidental and deliberate incidents. In 2012-13 we saw the lowest number ever recorded. Although there was one fatality in a fire in Halton during 2012-13, this is the first since 2008-09. Injuries have reduced over the last three years and all of them in 2012-13 were categorised as 'slight' with no serious injuries.

Accidental dwelling fires are included in the primary fires category and these numbers are at an all-time low and have been relatively static over the last three years in Halton. Delivery of Home Safety Assessments continues to be focused on those households most at risk and this is backed up with publicity campaigns highlighting key safety messages, particularly around safety in the kitchen where around 50% of house fires start.

Deliberate fires are more of an issue in Halton than in the other areas covered by the Cheshire Fire Authority, however, there has been a dramatic reduction of 35% over the last three years. It is likely that the wet weather will have contributed to the reductions in 2012-13, however, there have been concerted efforts to tackle the problems in 'hotspot' areas in Halton, particularly focusing on small (secondary) deliberate fires associated with anti-social behaviour.

Key statistics	2010-11	11-12	12-13
Deliberate primary fires per 10,000 population	8.3	7.0	5.9
Deliberate secondary fires per 10,000	44.8	39.8	28.7
Primary fires per 100,000	169.5	166.8	127.3
Fatalities from primary fires per 100,000	0.0	0.0	0.8
Non-fatal casualties per 100,000	6.7	4.2	4.0

Key contacts

Alex Waller
Service Delivery Manager

Emma Coxon
Locality Safety Manager

Liz Thompson
Hub Administration Manager

Ian Kay
Station Manager - Community Fire Protection

Fire Authority Members

Stef Nelson

Rob Polhill

Phil Harris

■ Wholetime station

Your local station

For more information about your local fire station, its opening times and any upcoming open days or other events please visit our website www.cheshirefire.gov.uk

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REPORT TO: Safer Policy & Performance Board

DATE: 12th November 2013

REPORTING OFFICER: Strategic Director, Policy & Resources

PORTFOLIO: Community Safety

SUBJECT: Alley-gate proposal: Elkan Road, Widnes

WARD(S) Halton View

1.0 **PURPOSE OF THE REPORT**

1.1 To present details of an alley-gating scheme requested of Birchfield, Farnworth and Halton View Locality Area Forum.

2.0 RECOMMENDATION: That: Members of the Board note and comment upon the report.

3.0 **SUPPORTING INFORMATION**

3.1 The Locality Area Forum for Birchfield, Farnworth & Halton View received a request for the installation of an alley-gate from a resident of Elkan Road, Widnes, in January 2013.

The request was made for a gate to be installed between numbers 31 and 33 Elkan Road to reduce the incidence of anti-social behaviour on the pathway that runs between the two properties, through to Moorfield Road.

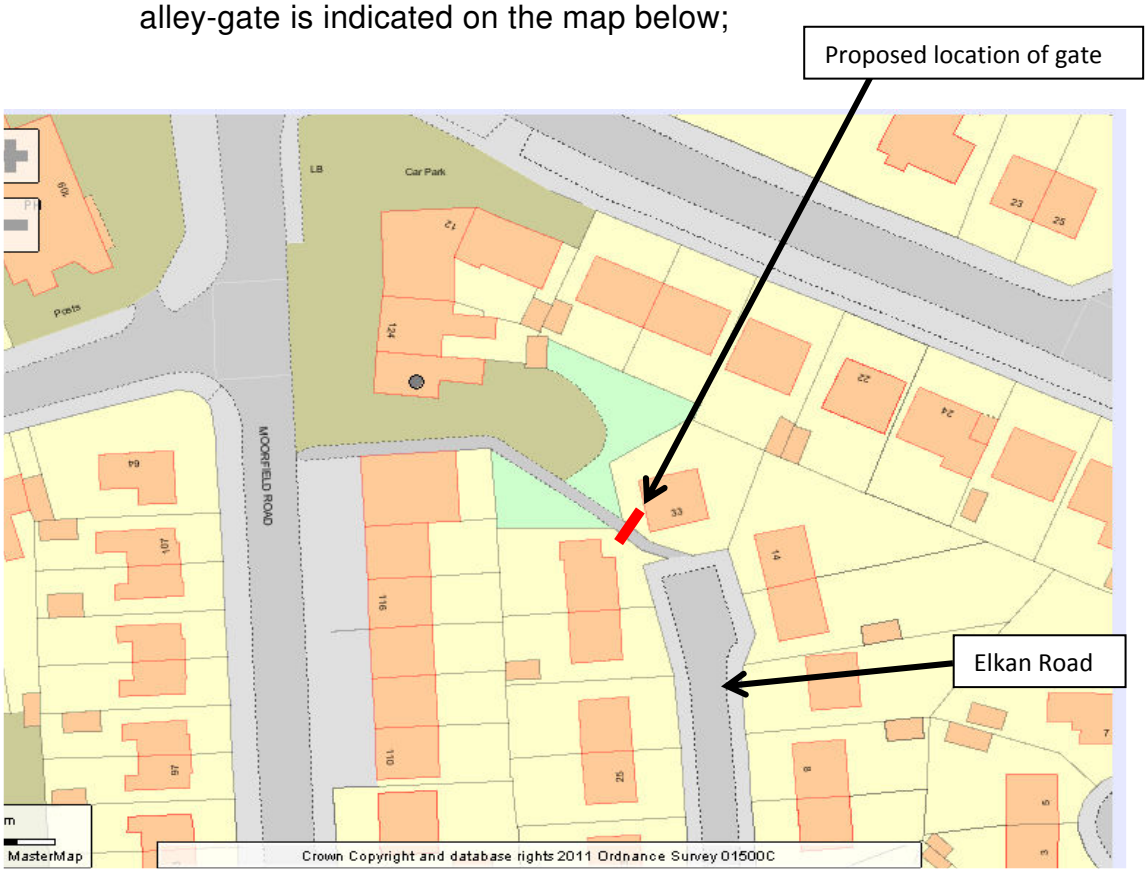
The request was made in light of a number of incidents of anti-social behavior, criminal activity, and an armed robbery that took place at retail premises on Moorfield Road in 2012, for which the pathway was used as an escape route.

The gate has been requested on the basis that it would hinder access to and from a grassed area adjacent to the pathway, and will therefore discourage the congregation of individuals in that area.

A request was also made that a gate be considered between the shops on Moorfield Road, to reduce access to the pathway from its other access point. It was decided that initially this aspect of the request would not be pursued, but could be revisited should issues remain following the installation of a gate between numbers 31 and 33 Elkan Road.

It was noted during discussion with Ward Councillors that residents in Elkan Road have been proactive and have set up an informal 'neighbourhood watch' scheme, but are seeking preventative measures.

The geography of the pathway and the desired location of the alley-gate is indicated on the map below;



3.2 Information provided to the Locality Area Forum by the Community Safety Team indicates that recorded criminal incidents are not notably high, there being 26 recorded incidents in the vicinity over a six month period.

Analysis of reported disorder within the vicinity indicates the presence of anti-social behavior, affecting individuals and groups of people, as well as the wider community.

Residents have cited that youths regularly congregate on the grassed area adjacent to the pathway and consume alcohol. On entering the pathway from Elkan Road, such congregations of people cannot immediately be seen.

Whilst the number of recorded incidents does not constitute persistent disorder, feedback from the resident requesting the alley-gate indicates that many instances go unreported.

The availability of unhindered access to an area in which those wishing to perpetrate anti-social behavior can do so is an influencing factor in heightening the perception of crime and disorder, contributing significantly to making residents feel vulnerable and unsafe.

As outlined above, it is noted that this location has been used as an escape route following a particularly violent armed robbery on Moorfield Road in 2012. This appears to have further heightened fear of crime in this location.

3.3 In discussions between the Community Safety Team and the Area Forum it was concurred that the geography of this location does lend itself to encouraging anti-social / criminal behavior, as there is no direct view of the land adjacent to the path from the Elkan Road end of the alley alleyway. This is demonstrated in the photograph at Fig.1 below.

Fig.1: View from Elkan Road

Conversely, during the course of bringing this matter forward, a concern was raised around the possibility of a person walking from Moorfield Road, between the shops, and into the open area that leads through to Elkan Road being in a potentially vulnerable situation. From that direction it is not possible to see the whole of the area behind the Moorfield Road properties. Should anyone be

followed or confronted within this area, their escape could be hindered by the installation of an alley-gate.

The Police Crime Reduction Advisor has surveyed the site with this in mind and has confirmed that the installation of a gate does not present any more risk than would be present in an ordinary cul-de-sac. The Community Safety Team has signaled support for the scheme that was consulted upon.

3.4 The pathway is an adopted footway with a right of access. Refer to map at Appendix 1.

The recorded statistics do not indicate that the existence of the highway facilitates the persistent commission of criminal offences or anti-social behavior. As such the pathway does not meet the requirements of S129(A) of the Highways Act 1980, so cannot be gated under that legislation.

In the absence of legislation permitting the installation of a gate, the Locality Area Forum agreed to consult local residents, using the Council's Procedures Applicable to Alleygating Applications.

In the event that a gate was installed at the proposed site, residents of neighbouring streets, who may currently use the pathway as a route to shops and amenities on Moorfield Road, would need to use an alternative route on Chorleys Lane, or Belmont Road, to reach Moorfield Road. Refer to map at Appendix 2.

All residents in Elkan Road and Elkan Close would be issued with keys.

3.5 Consultation with Local Residents took place in April 2013.

162 households were consulted by letter within a radius of properties determined by the Highways Department. There were 17 responses received.

The results can be summarised as;

- 12 respondents submitted a written response to lodge support of the scheme;
- 4 respondents submitted a written response to support the scheme conditionally (related to the provision of keys and the aesthetics of the scheme);
- 1 respondent submitted a written objection to the scheme on the basis of a 'blocking of the highway'.

The resident who submitted the one firm objection would be issued with a key as part of the scheme.

4.0 POLICY IMPLICATIONS

4.1 The Local Transport Plan states that the Council will promote cycling and walking and provide safe routes to school. Alongside the UDP it aims to provide sustainable access to employment and local amenities. The gating of safe routes to school and access to the cycle network is contrary to meeting those aims.

5.0 FINANCIAL IMPLICATIONS

5.1 The Council's Property Services Division has estimated the costs for the proposed scheme as £2,232.18, to include fees, keys and maintenance.

The Area Forum have agreed that this would be met from the Birchfield, Farnworth & Halton View Locality Area Forum budget.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

No significant implications. The consultation responses did not indicate the pathway to be a widely used walking route to schools in the area.

6.2 Employment, Learning & Skills in Halton

There is no indication that the pathway is used to access work and employment areas. The demographic of the immediate area is predominantly that of people over working age.

6.3 A Healthy Halton

Residents perception that they live in a safe environment aids general well-being.

Gating the pathway may discourage the use of the footpath network by people from surrounding streets, potentially reducing the benefit of walking, and promoting greater car use.

6.4 A Safer Halton

Previous studies have indicated that alleygates reduce burglaries, instances of littering and fly-tipping, and general anti-social behaviour.

Anti-social behavior can have a significant impact on quality of life.

6.5 **Halton's Urban Renewal**

By reducing fly-tipping and general litter problems, gates improve the overall appearance of the borough.

The provision of gates can be deemed visually intrusive by others, and present an image that the area is subject to anti-social behavior.

7.0 **RISK ANALYSIS**

7.1 Alleygates are designed to reduce the risk of crime and anti-social behavior within the borough.

There are no other risks linked to the proposed scheme.

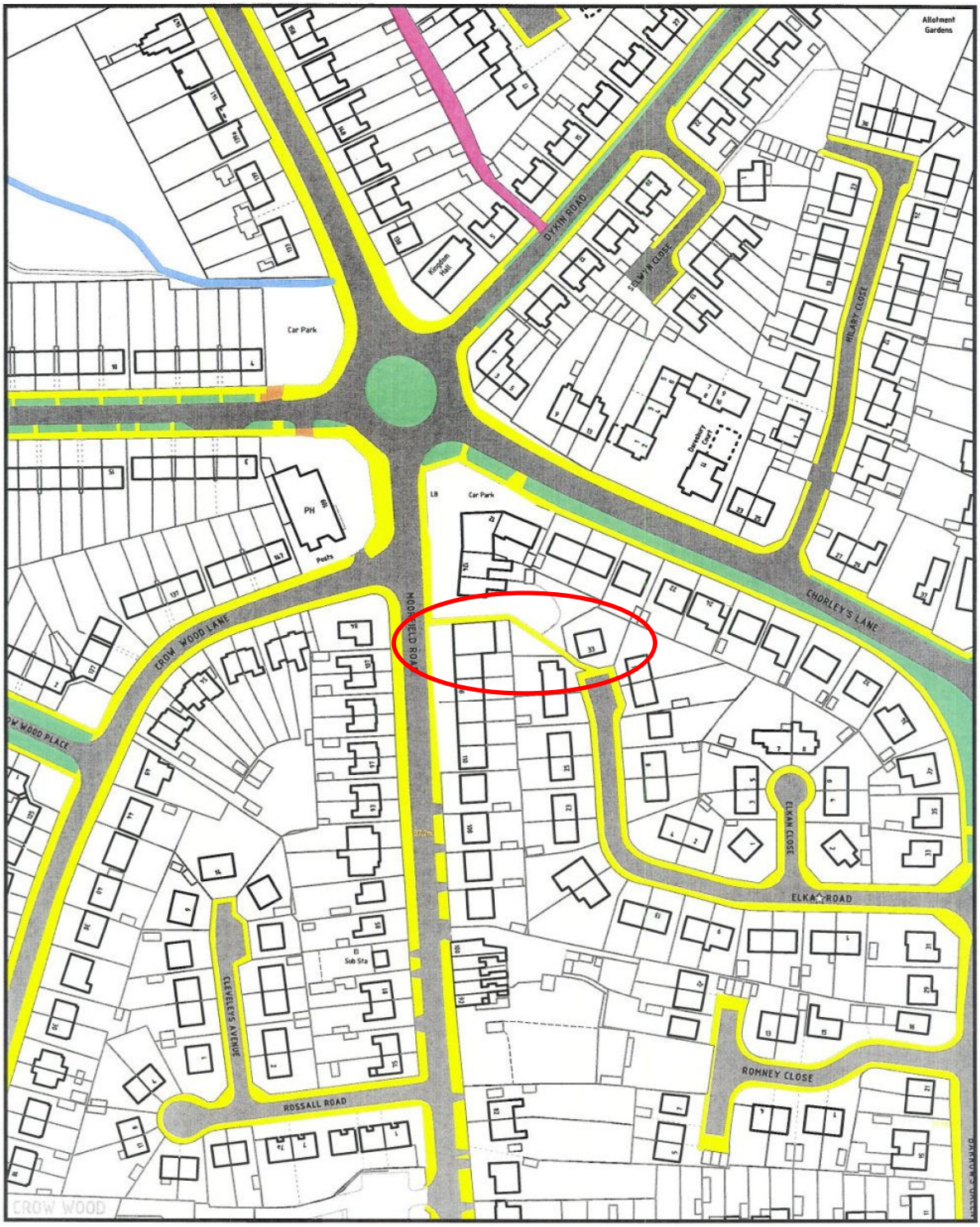
8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 There is a potential issue should elderly and disabled users use the pathway as a through route. These are likely to be residents of surrounding streets who would not be key-holders. There were no responses to the consultation highlighting this issue specifically.

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

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

APPENDIX 1



HALTON BOROUGH COUNCIL

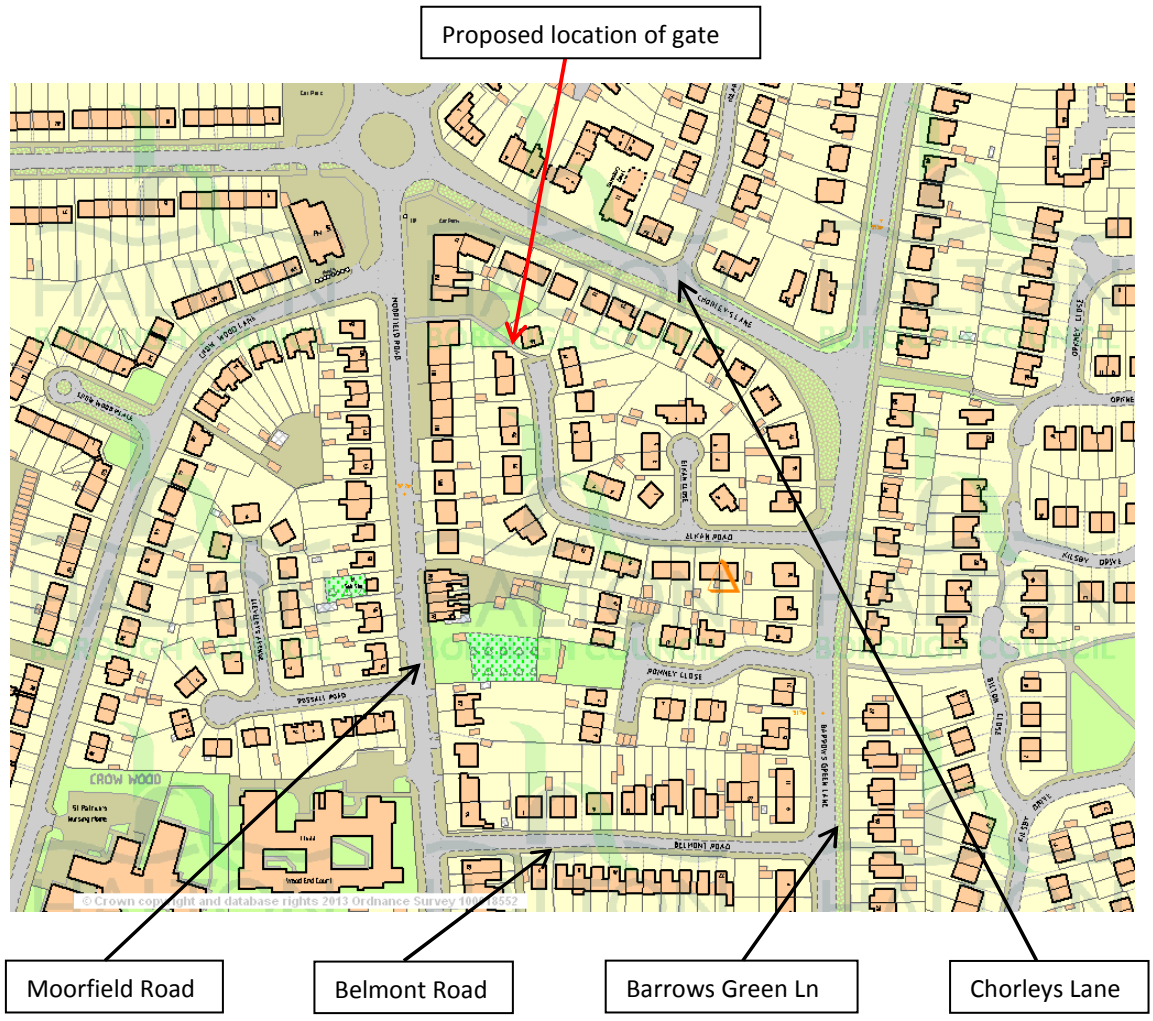
TITLE

Adopted carriageway
Adopted Verge
Adopted Footway
Adopted Alleyway
Public Right of Way (approximate line only)

Date :
Scale :

N

APPENDIX 2


Proposed location of gate
Moorfield Road
Belmont Road
Barrows Green Ln
Chorleys Lane

REPORT TO: Safer Policy and Performance Board

DATE: 12 November 2013

REPORTING OFFICER: Strategic Director Children & Enterprise

PORTFOLIO: Children, Young People and Families

SUBJECT: Children in Care and Children in Care of Other Local Authorities (CICOLA's)

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 To highlight risks and concerns regarding fragmented commissioning and quality assurance of this vulnerable cohort.

1.2 To ascertain senior management and partnership support of this priority area and to address concerns appropriately.

1.3 To present an update report regarding the current numbers of Children in Care of Other Local Authorities (CICOLA's) and the possible impact on services with Halton.

1. **RECOMMENDATION: That** The Board note the progress made on notification and ask for a further report to be presented in six months

3.0 SUPPORTING INFORMATION

3.1 The Commissioning Partnership has highlighted Children in Care as a priority within the new Commissioning Framework.

3.2 There is currently a health action plan for children in care that has been completed by Bridgewater. There is also a local authority action plan for Children in Care. There are some cross cutting themes such as the notification process that are duplicated within both plans.

3.3 The Children in Care strategy is required to be refreshed to ensure local and national political changes are reflected and outcomes appropriately achieved.

3.3 With CCG's in place and changes within Bridgewater there is a need to review these plans and the governance arrangements and structure of the Children in Care Partnership Board to ensure commissioners and providers are held to account to deliver improvements in standards and outcomes for children in care. There is a need to integrate plans and work streams to ensure joint improvements are made.

3.4 Cheshire West and Chester and Halton are developing a joint Children in Care Participation Service. This service will allow the young people in care to reflect their views within the action plan. The Children in Care will be able to support the development of the strategy/action plan and the changes with the board structure through the children in care participation service.

3.5 Within the current notification process Local Authorities have statutory duties in determining the most appropriate placement for a looked after child. It is mandatory that the placing social worker informs the looked after nurse in the new authority. However it is now understood that this is a national problem as social workers are not informing placing authorities about these children and young people.

3.6 It had been agreed that the Looked After Nurse (Bridgewater) would keep the up to date CICOLA list, however there is a need to review this process to ensure that the authority is fully aware of the children. The LAC Nurse has recently informed commissioners that they do not have access to all children and young people who have been placed in the borough due to the lack of other authorities notifying the looked after children.

3.7 The revised Children in Care Partnership board will be tasked at prioritising the notification process and how to improve the quality is improved for children coming into and leaving the borough.

3.7 The CCG have recently been working with Bridgewater to audit current practice to help improve standards and have concerns with the following areas:

- the timely production of paperwork for medicals
- the priority attached to the medicals by other services
- resource issue as only 1 nurse available
- Time taken by social care to provide paperwork for initial medicals from the time of entry to care.
- Length of time from receipt of paperwork to clinic date
- Length of time to receive the medical report
- Length of time from receipt by the LAC team to send out the report to social care
- Length of time between health assessment request sent out to HV/SN and return of paperwork
- Length of time from receipt of notification to receiving records from the placing authority
- The notification process
- The placing authority lack of requesting a health assessment?
- The young person having unmet health needs on arrival

3.8 There has been development in Bridgewater where the LAC nurse will be moved to Lister Road to be co-located with the Community Paediatricians and School Nursing. The move to One Bridgewater would also result in additional admin support to the Halton service to allow the production of the

data required by the CCG to enable us to claim from other CCG's for work done by Ann/our other health professionals so we can offset against bills received.

3.9 At any time there are a total of around 60,000 children that are looked after in the UK – this represents 0.5% of all children. Over the course of any year a total of 85,000 children will spend some time being looked after. Nationally 40% of children remain looked after for less than 6 months with 15% being looked after for 5 yrs or longer.

4.0 THE NOTIFICATION PROCESS

4.1 The current notification process for authorities is that the placing social worker should notify the new authority with a notification form. Although this is mandatory and expected there have been instances where this has not been completed. Instances where it is recognised that there has been a delay or lack of completion then the Local Authority Designated Officer (LADO) will be informed to ensure a complaint is returned to the local authority raising safeguarding concerns.

4.2 The LAC nurse currently provides the local authority a monthly update of the list. The Looked after Child Nurse should also implement an initial health assessment. This is required to be completed within 2 weeks of a child's placement.

4.3 To improve the accuracy of the list Halton Borough Council have also developed a provider forum where all the providers are asked to complete and return when CICOLA's arrive into the borough. The process is repeated when the child leaves the placement and is discharged from the provision.

4.4 The Clinical Commissioning Group (CCG) will also be engaging the GP's within this process and encouraging the GP's to complete a notification to the local authority.

4.5 Further work is being implemented to ensure all children are accounted for and attend appropriate educational provision.

4.6 A request has also been made regionally to ascertain if there are good examples of maintain accuracy of an integrated list. There has been no positive feedback at the moment. The government are consulting on a new policy to be launched later this year 'Reforming children's homes care' and 'Improving safeguarding for looked after children'. This policy will have three functions with one of them being to improve the notification process:

1) Prior to a new provider opening a Childrens home a risk assessment will be completed between the police, local authority and the new provider which will inform Ofsted in relation to registering the provider /provision and refusing
2) The provider will notify the local authority when a young person is new to the placement and area as well as when they leave.

3) Improve provider standards in preventing child sexual exploitation.

4.7 It is acknowledged that despite the new consultation Halton borough Council and its partners need to work together to improve the notification process. There are further improvements required which will improve the accuracy of the list:

1) To focus on just Halton children and young people as currently St Helens children and young people are still on the list.
2) To have separate sheet/section for end of placement/children leaving Halton (To include where have they gone to.
3) To have mandatory start date of the placement
4) The CCG have also stated that they would want date of initial health assessment completed onto list
5) To have the child's current school placement included onto the list
6) To have when the child leaves the placement

4.8 The governance arrangements of the Children in Care Partnership Board is currently being reviewed along with terms of reference and membership.

4.9 The Board will be responsible for developing an integrated strategyand action plan being accountable to the safeguarding board and commissioning partnership.

5.0 The Children in Care Participation service will support the development of the plans to ensure that the young person's perspective is part of the process.

5.1 To review the Healthy Care Sub Group and review the Terms of Reference, membership and purpose of the group.

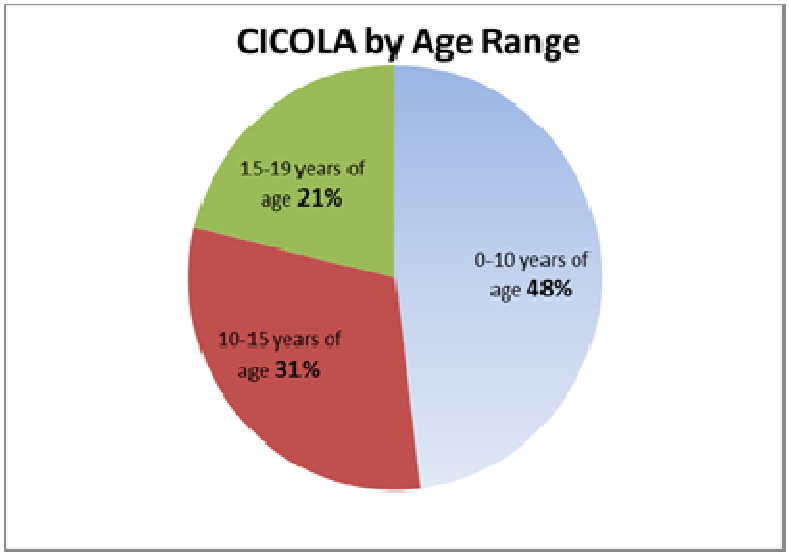
5.2 Further work is undertaken to get a more accurate picture on how many CICOLA's reside in Halton, ensuring that the procedures around notifications of CICOLA's are appropriately utilised.

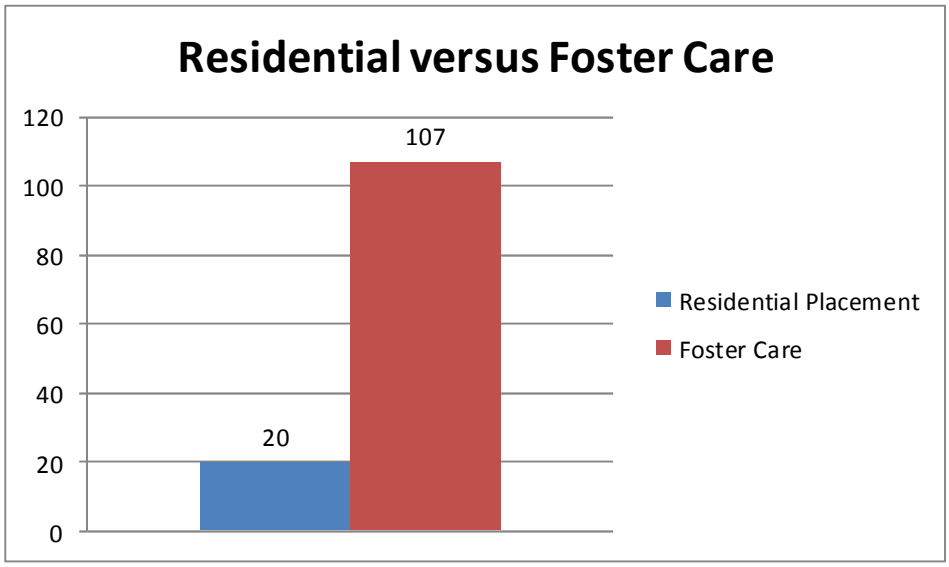
6.0 CICOLA PROFILE

6.1 Below is an attached table demonstrating where the numbers of children are predominantly coming from. There are currently 138 Children on the CICOLA list (11 of these have an unknown address). It is not known where 7 children have come from. Recent work with the Clinical Commissioning Group (CCG) has led to the development of a joint CICOLA list.

6.2 The main referrer into the borough is Liverpool followed by Knowsley. It is worth noting that there has been a significant reduction of CICOLA's moving into Halton from boroughs many mile away.

Placing Local Authority	***Age of child 0-10***	***Age of child 10-15***	***Age of child 15-19***
Knowsley	12	1	2
Manchester	1	1	2
Liverpool	26	10	7
St Helens	4	0	0
Wakefield	1	0	0
Essex	0	1	0
Warrington	3	5	2
West Yorkshire	1	0	0
Lancashire	2	0	2
Shropshire	0	0	2
East Berks	0	0	1
South Staffordshire	1	0	0
Huddersfield	0	1	1
Buckinghamshire	0	0	1
Cheshire East	2	2	1
Wirral	2	0	1
South Devon	0	1	0
Leeds	1	0	2
Sefton	0	3	0
Blackburn/Darwin	0	1	0
London	0	0	2
Oxford	0	1	0
Rochdale	1	0	1
Birmingham	0	0	1
Aylesbury	0	0	1
Salford	0	1	0
Wigan	0	3	0
Oldham	0	2	0
Wakefield	1	0	0
Derbyshire	0	0	1
Brent	0	0	1
Telford and Wrekin	0	1	0
Cheshire West and Chester	2	1	1
Wolverhampton	0	0	1
Total	**60**	**38**	**33**





7.0 POLICY IMPLICATIONS

There are no policy implications

8.0 OTHER IMPLICATIONS

No other implications

9.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

10.0 Children and Young People in Halton

Children in Care are a Children's Trust priority area

11.0 Employment, Learning and Skills in Halton

Children in Care are a Children's Trust priority area

12.0 A Healthy Halton

Children in Care are a Children's Trust priority area

13.0 A Safer Halton

Children in Care are a Children's Trust priority area

14.0 Halton's Urban Renewal

Children in Care are a Children's Trust priority area

15.0 RISK ANALYSIS

A risk analysis will need to be undertaken as apart of the ongoing work around CICOLA's

16.0 EQUALITY AND DIVERSITY ISSUES

The nature of this work is to support equality and diversity

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

Document	Place of Inspection	Contact Officer
Equality Impact Assessment (2011)	Contracts & Commissioning Team, Second Floor, Rutland House	Barbara Butterworth

REPORT TO: Safer Policy and Performance Board

DATE: 12th November 2013

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Community Safety

SUBJECT: Business Planning 2014 -17

WARDS: Boroughwide

1.0 PURPOSE OF THE REPORT

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

2.0 RECOMMENDATION: That the Board

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

3.0 SUPPORTING INFORMATION

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

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

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

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

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

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

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

4.0 POLICY IMPLICATIONS

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

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

5.0 OTHER IMPLICATIONS

5.1 Directorate Plans will identify resource implications.

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

6.0 IMPLICATIONS FOR THE COUNCILS PRIORITIES

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

7.0 RISK ANALYSIS

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

8.0 EQUALITY AND DIVERSITY ISSUES

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

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

9.1 There are no relevant background documents to this report.

REPORT TO: Safer Policy & Performance Board

DATE: 12th 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 Safer Policy & Performance Board:

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

3.0 SUPPORTING INFORMATION

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

3.3 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.

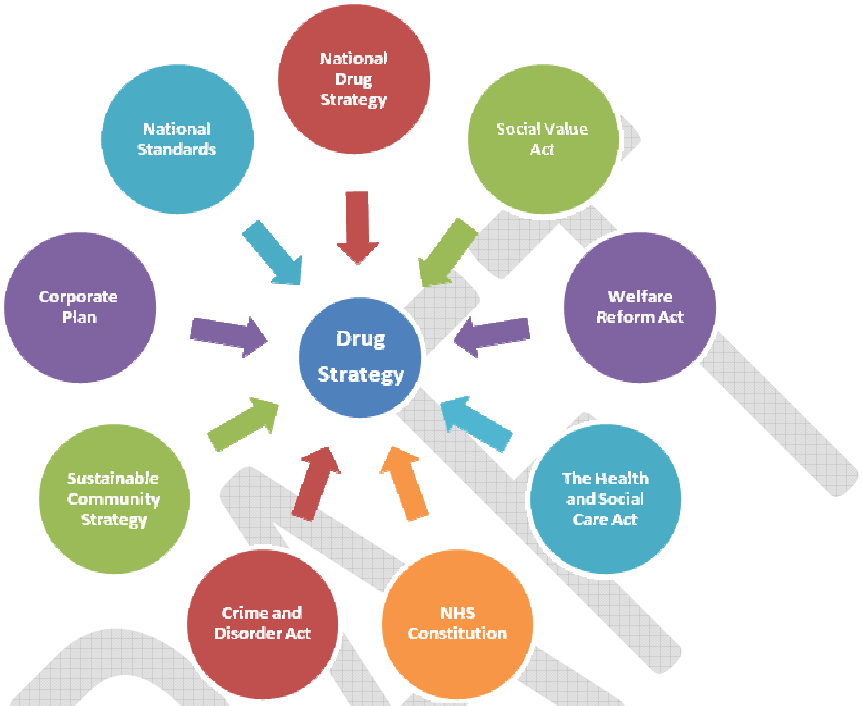
To help achieve the vision, we have adopted the objectives above with each containing a set of priorities as detailed below. The Strategy goes on to explain why each of the priorities has been selected, what we hope to achieve and how we plan to achieve it.

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.

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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.

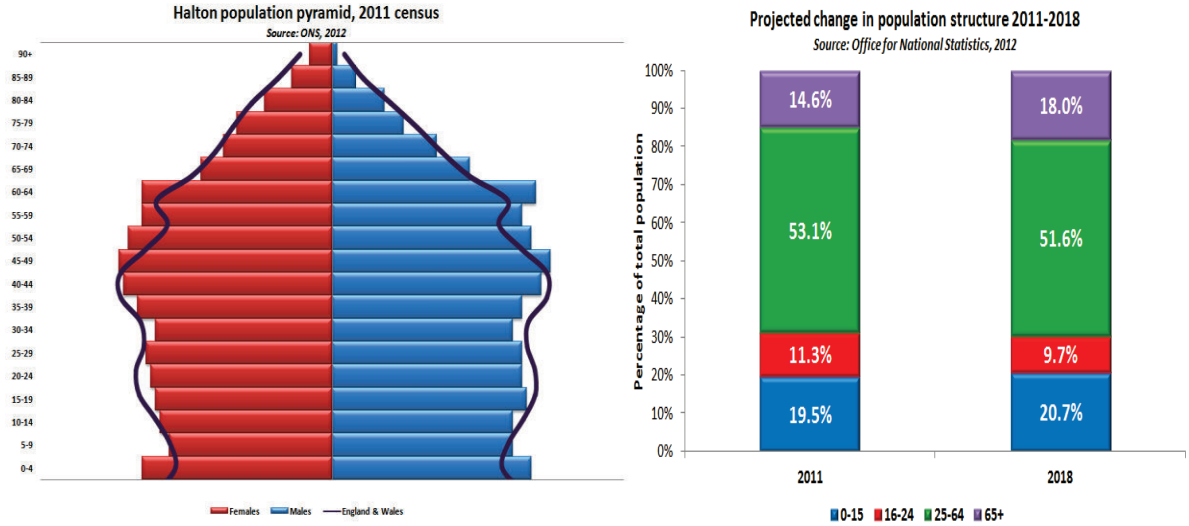
The quality standard requires that services should be commissioned from and coordinated across all relevant agencies encompassing the whole drug use disorder care pathway. An integrated approach to provision of services is fundamental to the delivery of high quality care to adults with drug use disorders.

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:

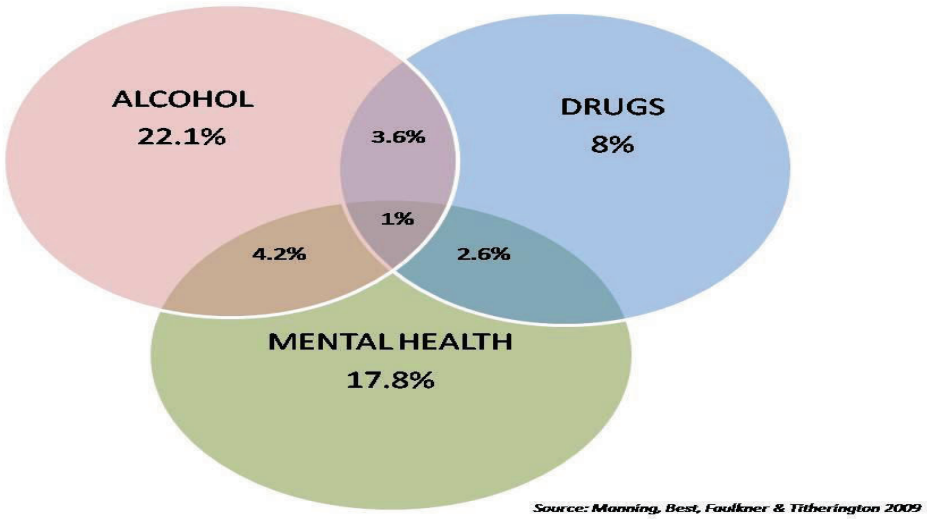
- increasing introspection and social isolation, with friendship difficulties (e.g. the young person is
- unlikely to visit or invite friends to their own home), anxiety or depression (for which psychoactive
- medication may be prescribed); attempts to escape their family home (e.g. by leaving home at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

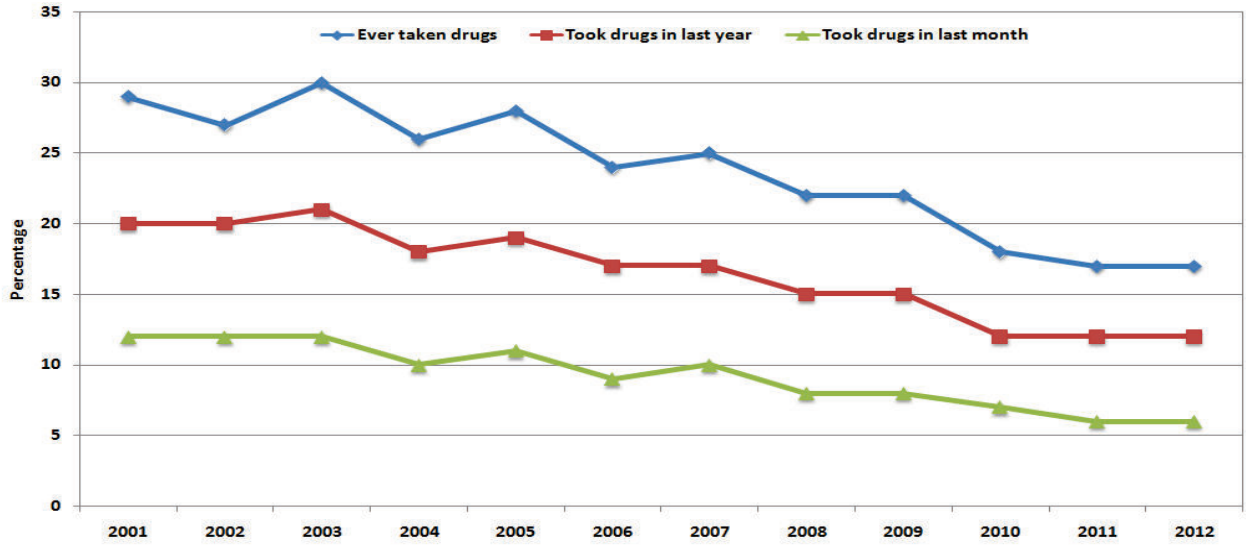
2.5. Estimated Prevalence of substance misuse in Halton

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.

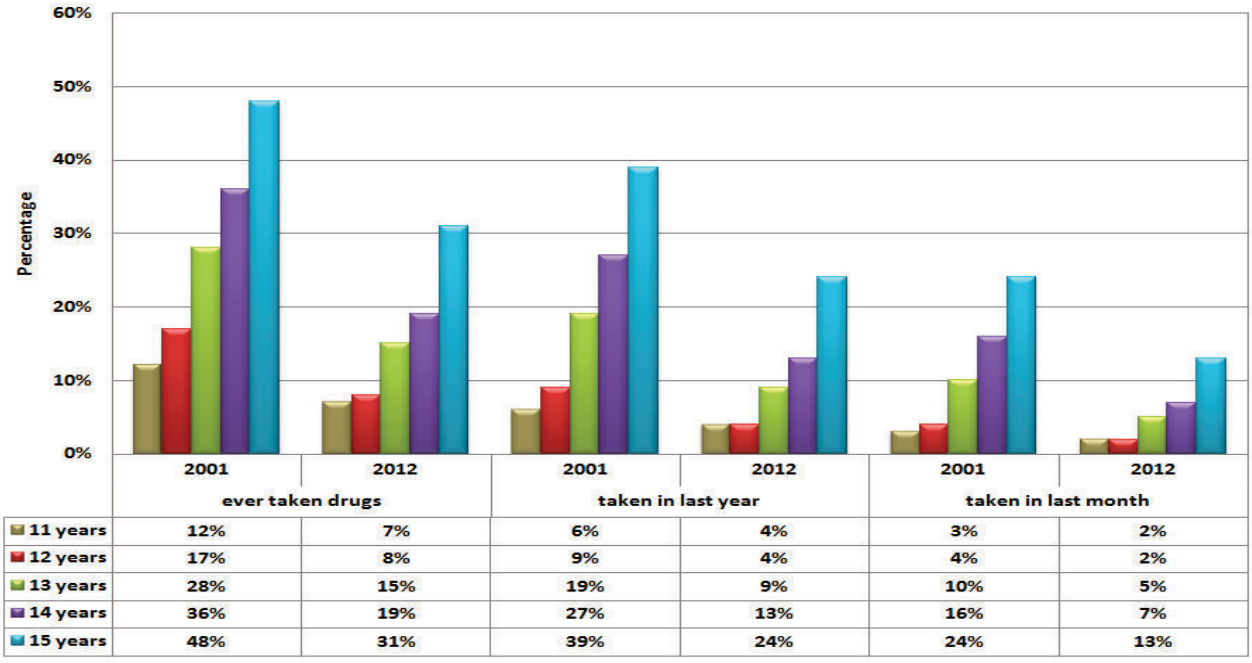
Figure 3: National trend in drug use amongst 11-15 year olds, 2001 to 2012



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

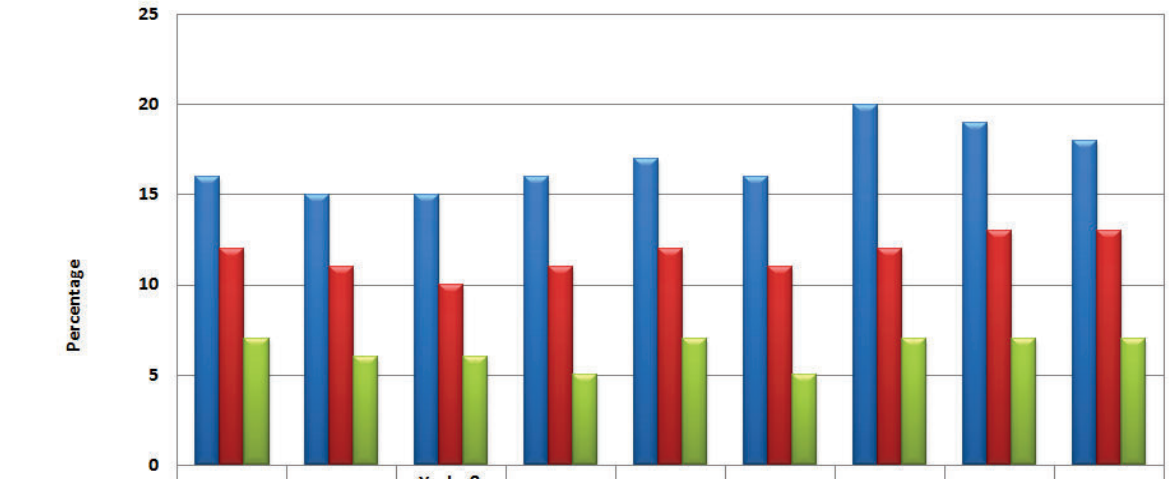


	2001	2012	2001	2012	2001	2012
	ever taken drugs		taken in last year		taken in last month	
11 years	12%	7%	6%	4%	3%	2%
12 years	17%	8%	9%	4%	4%	2%
13 years	28%	15%	19%	9%	10%	5%
14 years	36%	19%	27%	13%	16%	7%
15 years	48%	31%	39%	24%	24%	13%

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.

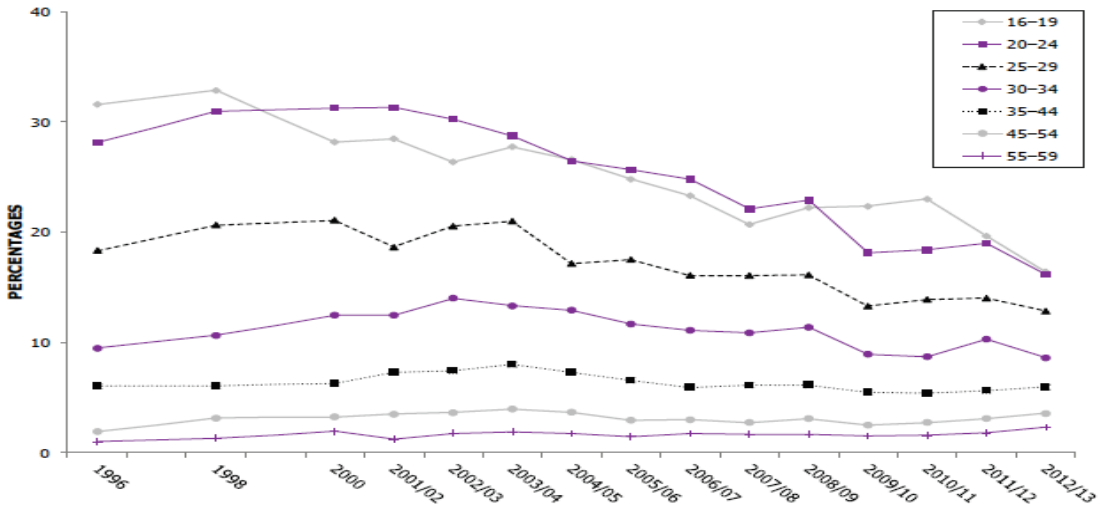
As in previous years cannabis was the most commonly used type of drug in the last year, in 2011/12 6.9% of 16-59 years (equivalent to 5,025 Halton residents) had used cannabis in the last year followed by powder cocaine (2.2% or 1,602 Halton residents) and ecstasy (1.4% or 1,020 Halton residents).

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].

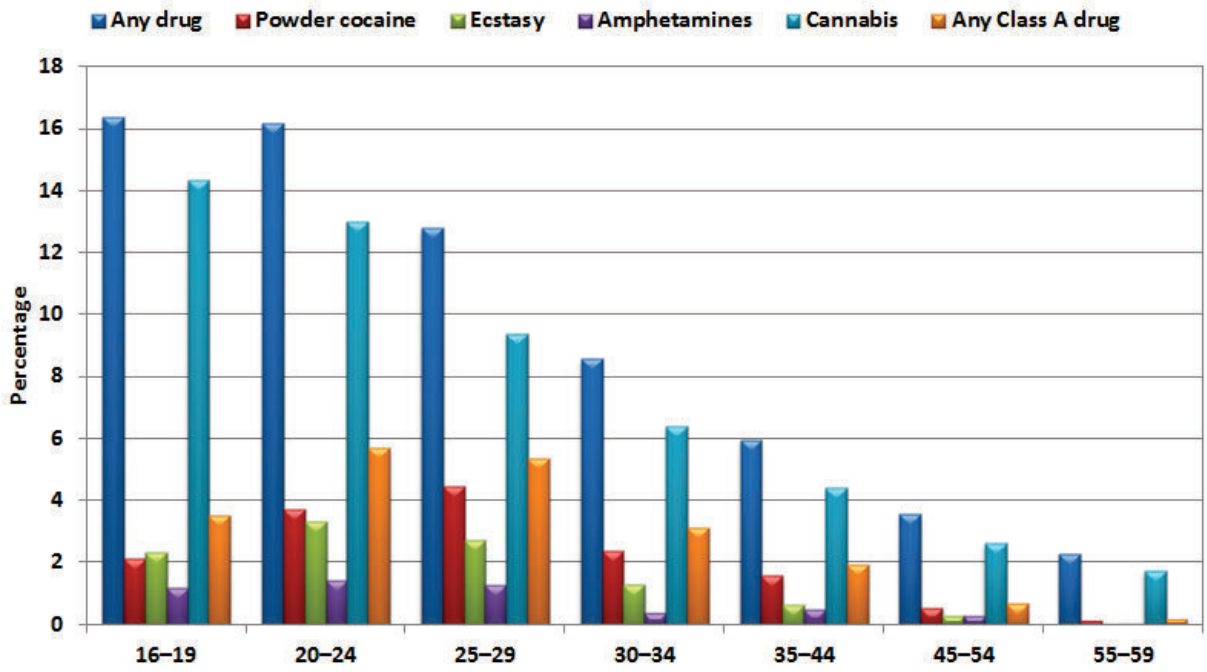
Figure 7: Proportion of 16 to 59 year olds reporting use of any drug in the last year by age group, 1996 to 2012/13 Crime Survey for England and Wales



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

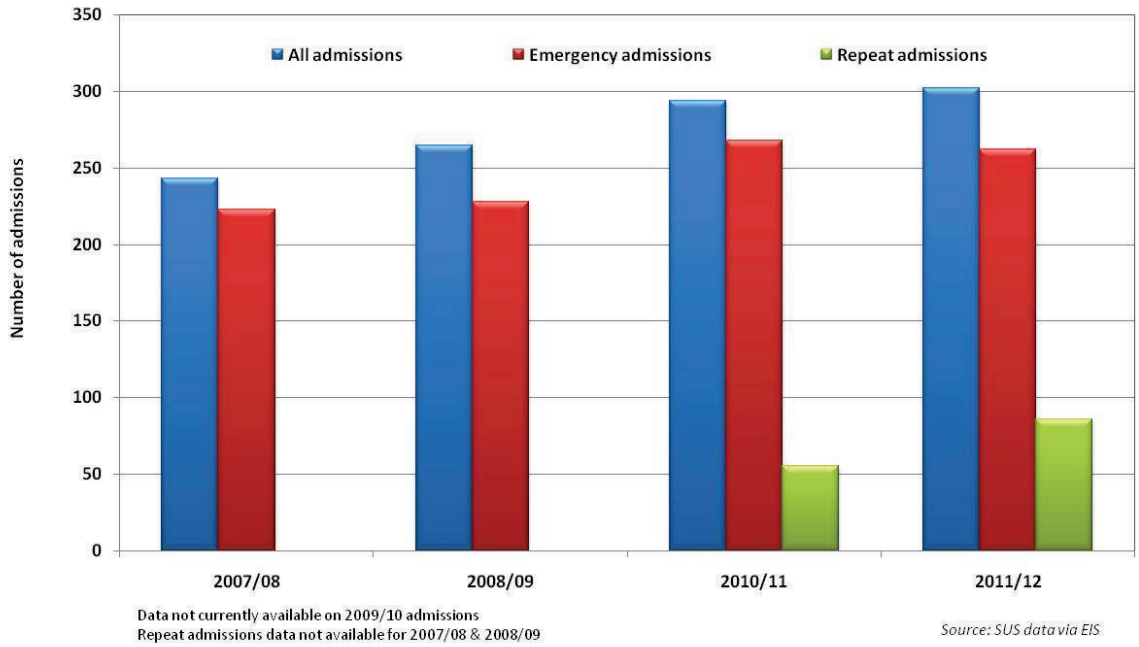
3.1. Hospital Admissions

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.

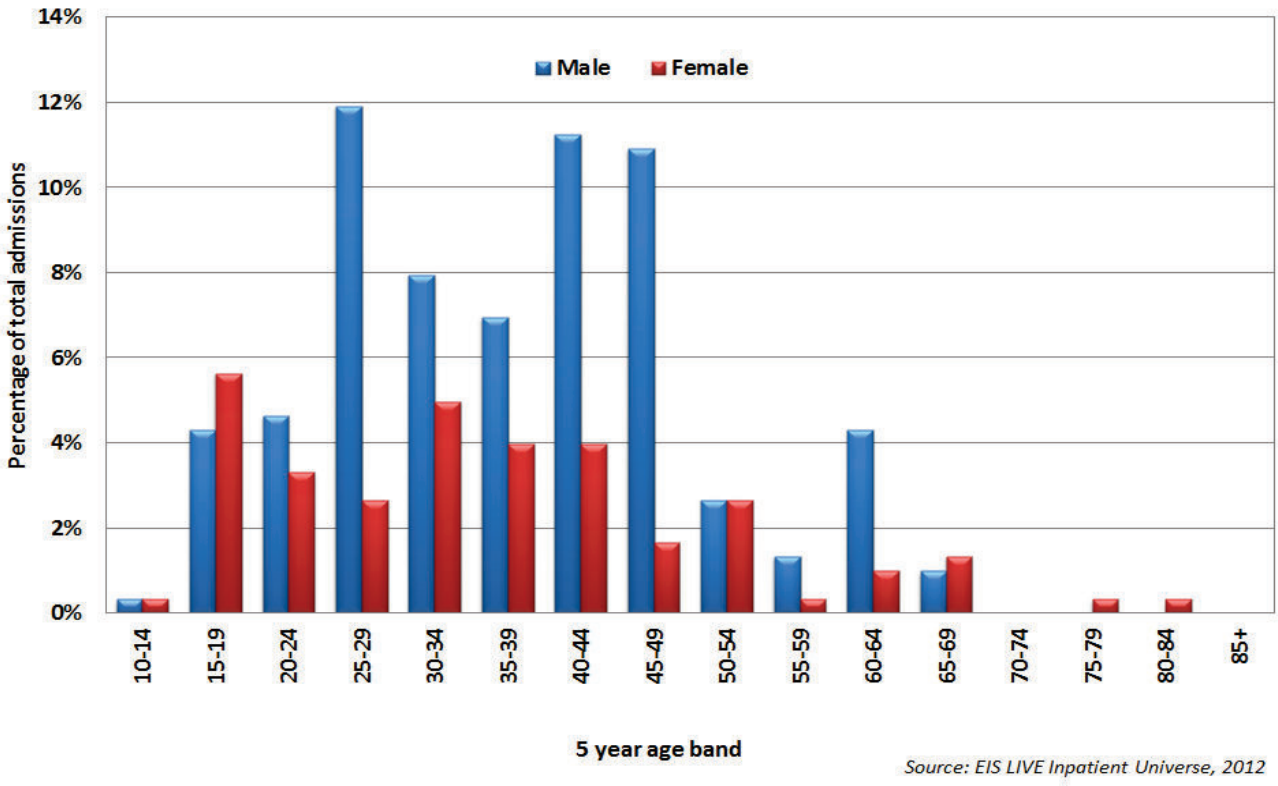
Figure 10: Trend in drug related hospital admissions in Halton



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

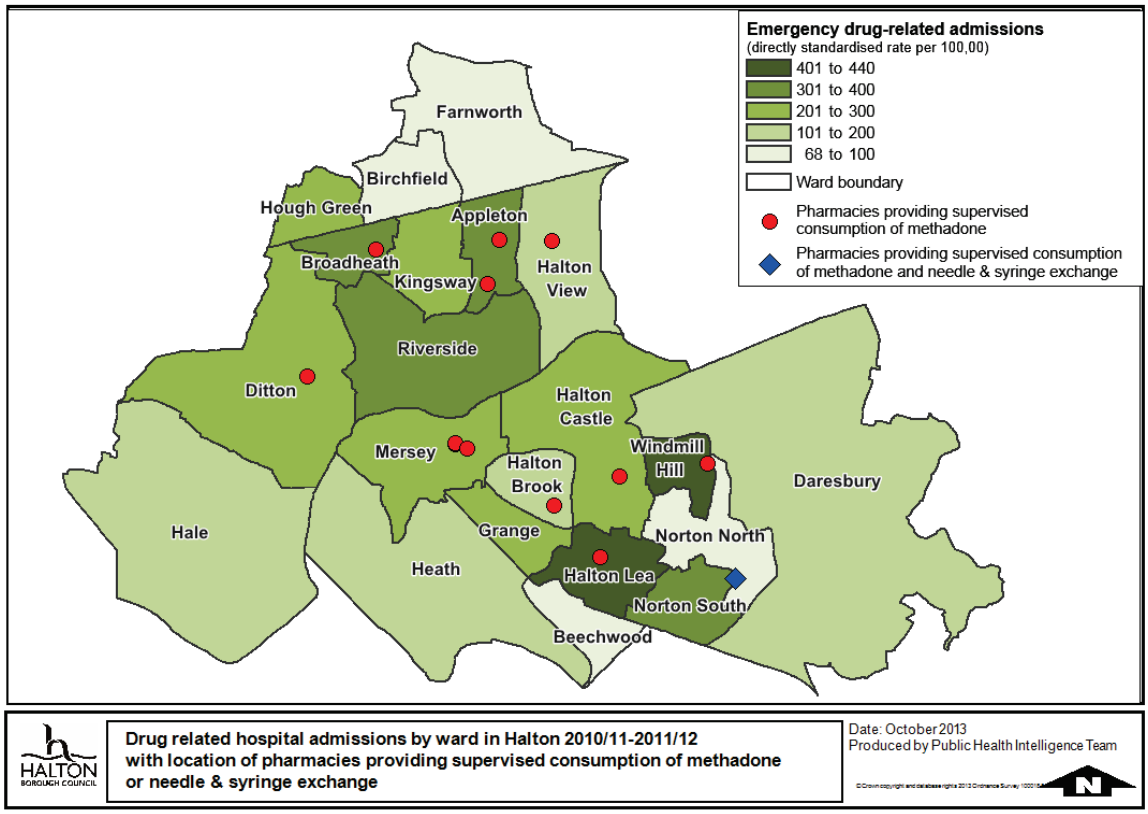
ICD 10 code	ICD Description	No. of admissions 2008/09	No. of admissions 2010/11	No. of admissions 2011/12
F11	Mental and behavioural disorders due to use of opioids	81	72	58
F12	Mental and behavioural disorders due to use of cannabinoids	27	20	49
F13	Mental and behavioural disorders due to use of sedative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

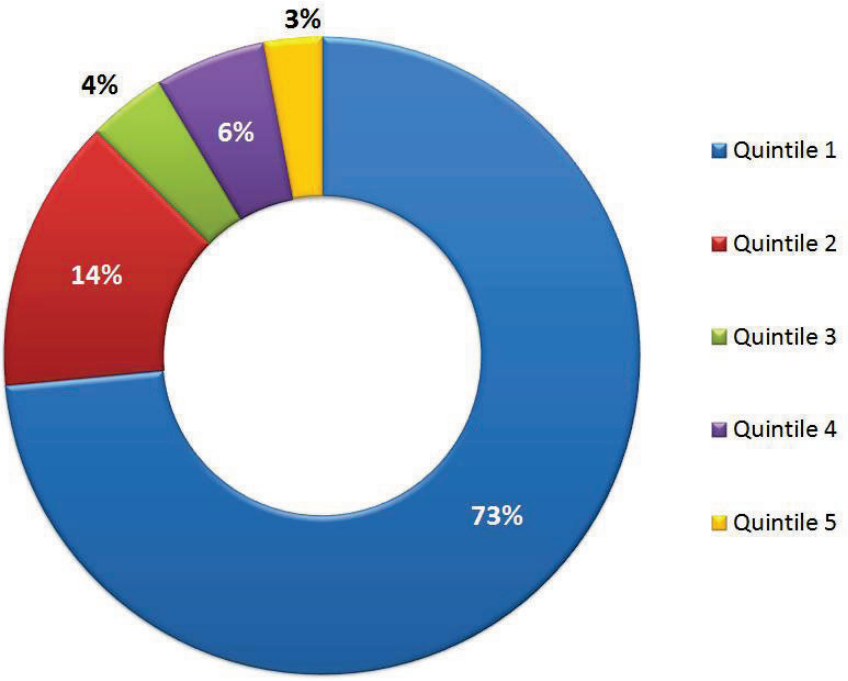
Figure 12: Drug-related hospital admissions (directly standardised rate per 100,000 population) by ward in Halton 2010/11 - 2011/12, with location of pharmacies providing supervised consumption of methadone or needle and syringe exchange.



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)



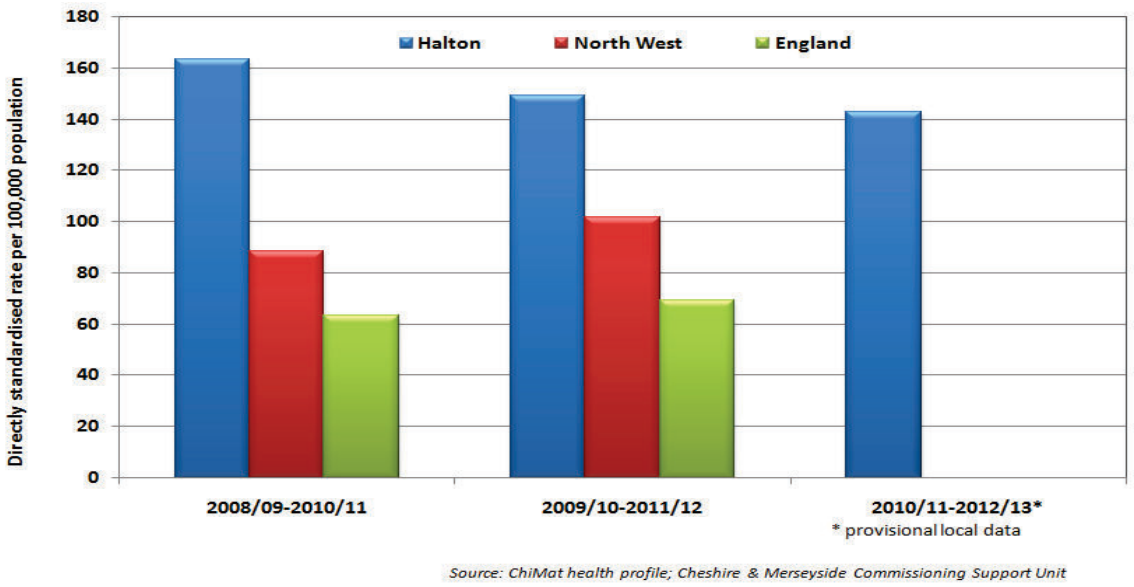
3.1.2. Substance misuse

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

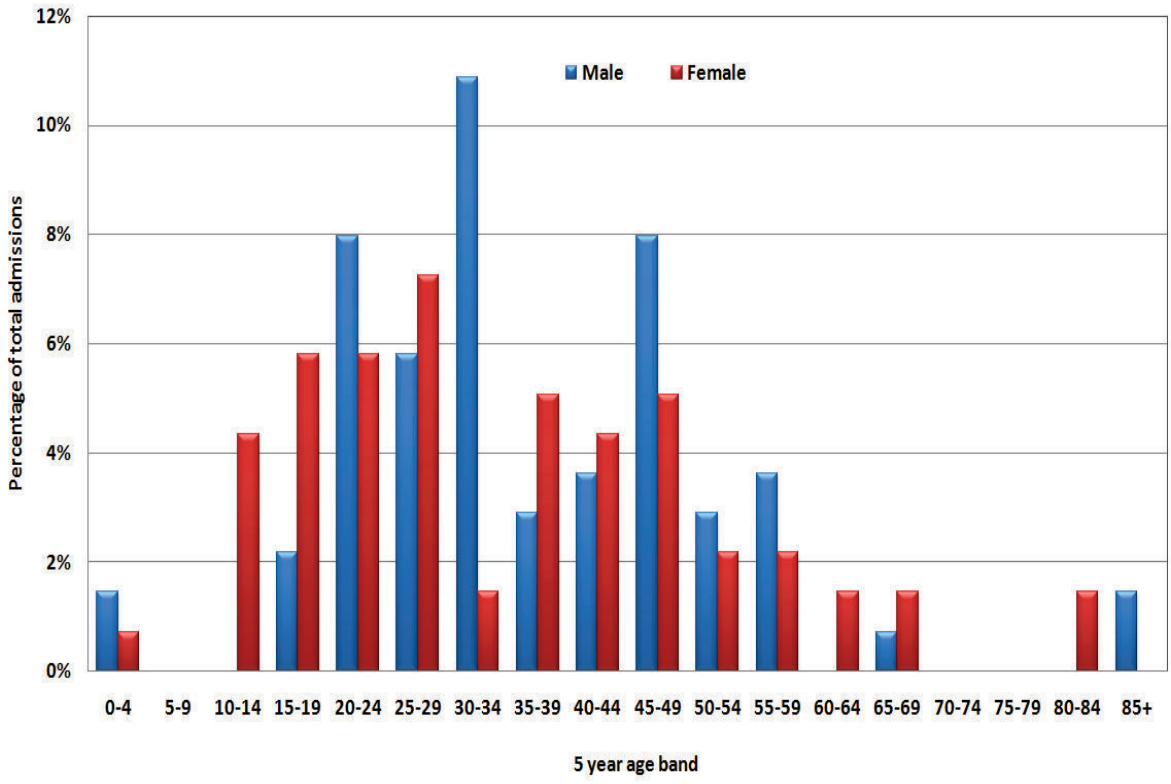
Data relating to substance misuse hospital admissions is not published nationally for all ages, but local data shows that the number has increased to 138 in 2012/13.

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).

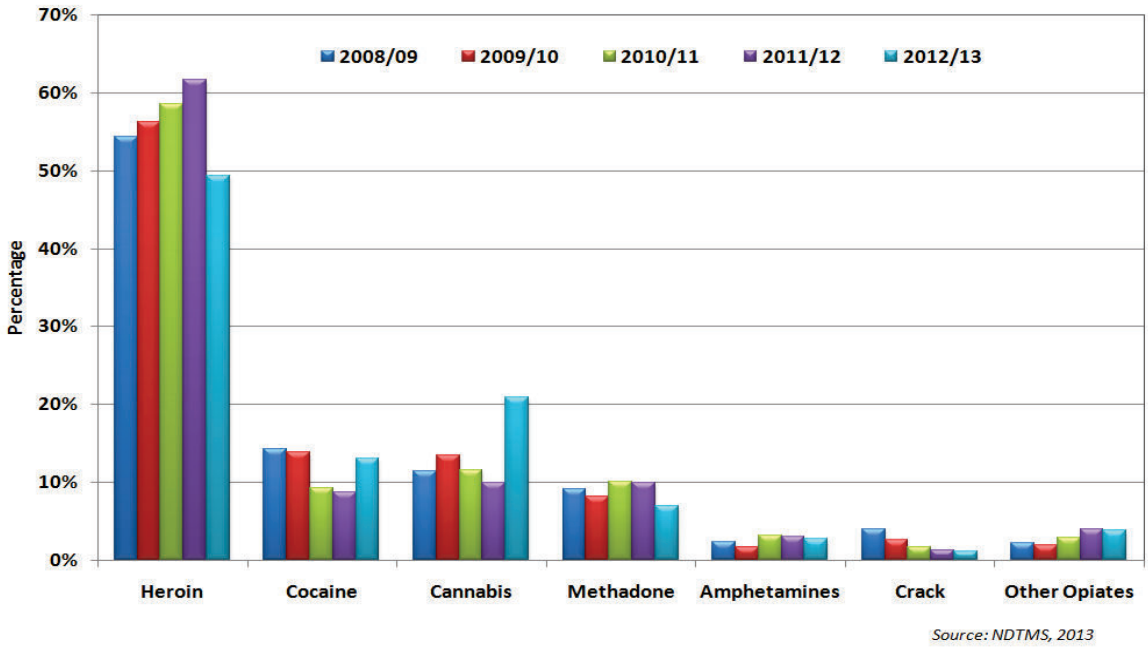
Table 10: Primary drug used

	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

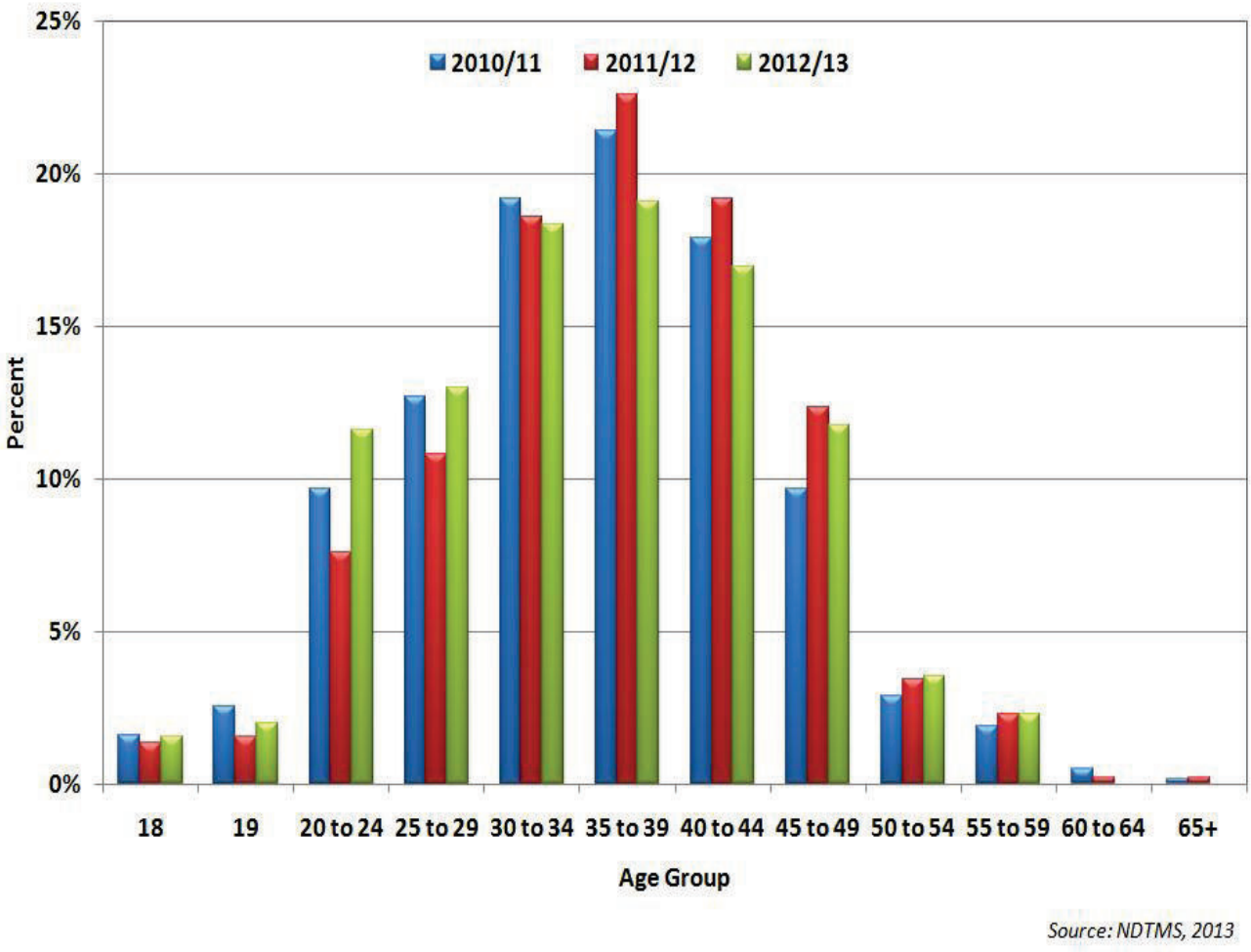
	Halton			North West	England
	2010/11	2011/12	2012/13	2012/13	2012/13
Crack	29.5%	27.5%	26.4%	19.9%	22.3%
Alcohol	10.8%	9.1%	12.5%	10.2%	11.5%
Methadone	6.8%	8.0%	5.3%	6.3%	4.3%
Cannabis	4.3%	3.2%	5.3%	6.2%	8.1%
Cocaine	4.4%	3.8%	3.5%	2.8%	3.1%
Amphetamines	0.8%	0.8%	2.3%	2.6%	2.5%
Heroin	2.9%	2.7%	1.5%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



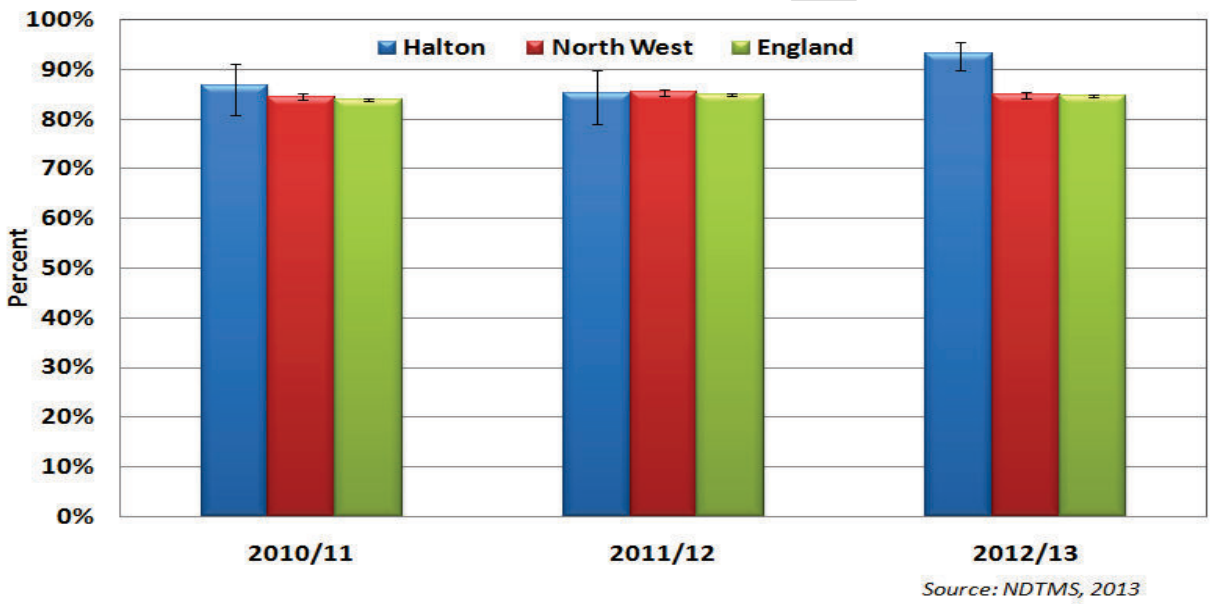
Source: NDTMS, 2013

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.

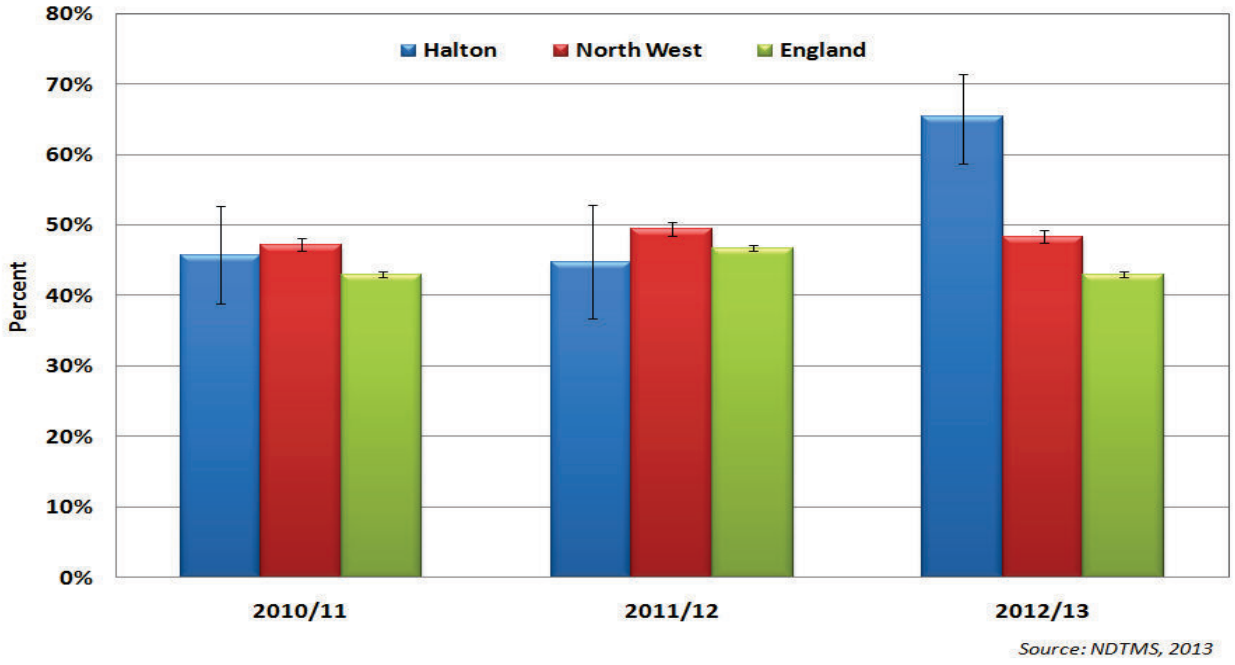
In Halton during 2012/13, 93% of people were 'successfully retained in effective treatment' compared with 87% in 2010/11. This means that the Halton 2012/13 percentage was significantly higher compared to the North West and England.

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'.

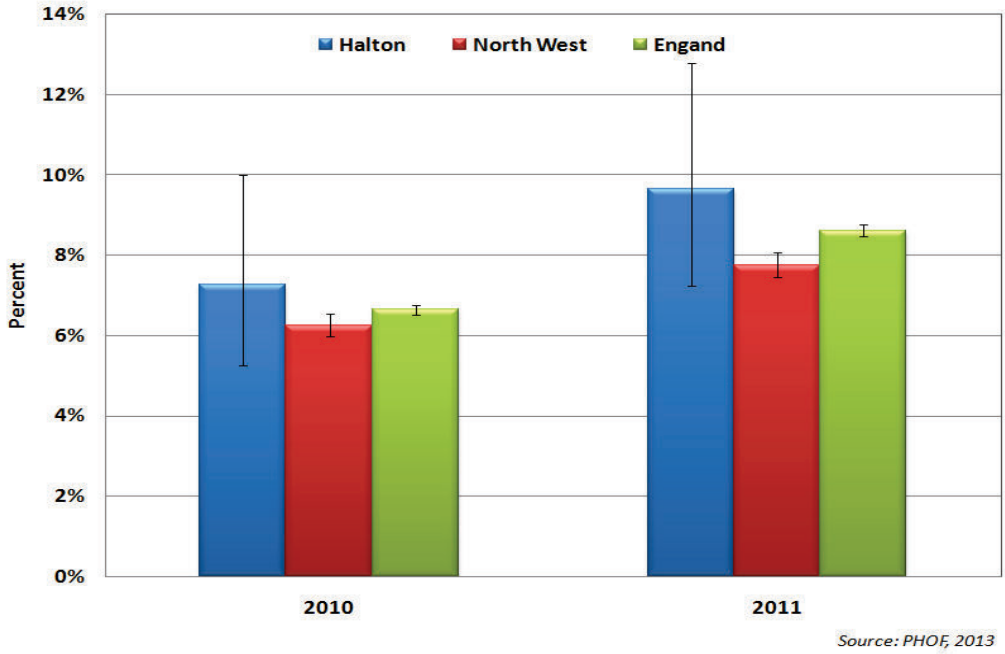
Figure 19: Percentage of exits which are completed (planned) during each year, 2010/11 to 2012/13



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.

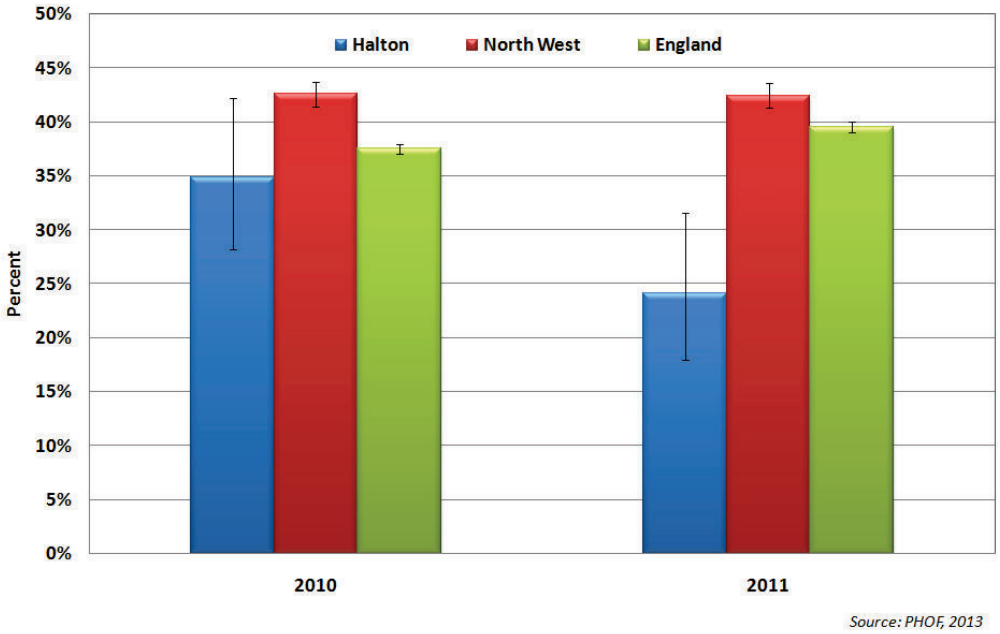
This data relates to people who have successfully left drug treatment and do not re-present to treatment within 6 months.

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.

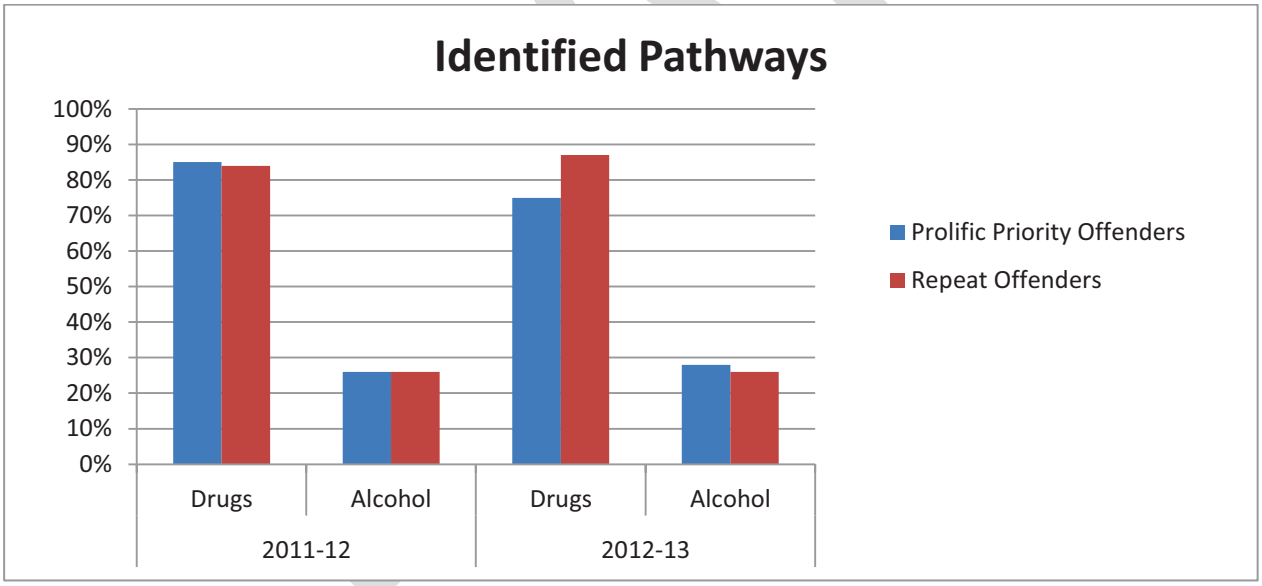
The National Probation Service for England and Wales is a statutory Criminal Justice Service, mainly responsible for the supervision of offenders in the community and the provision of reports to the criminal courts to assist them in their sentencing duties. Information extracted from the Strategic Needs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

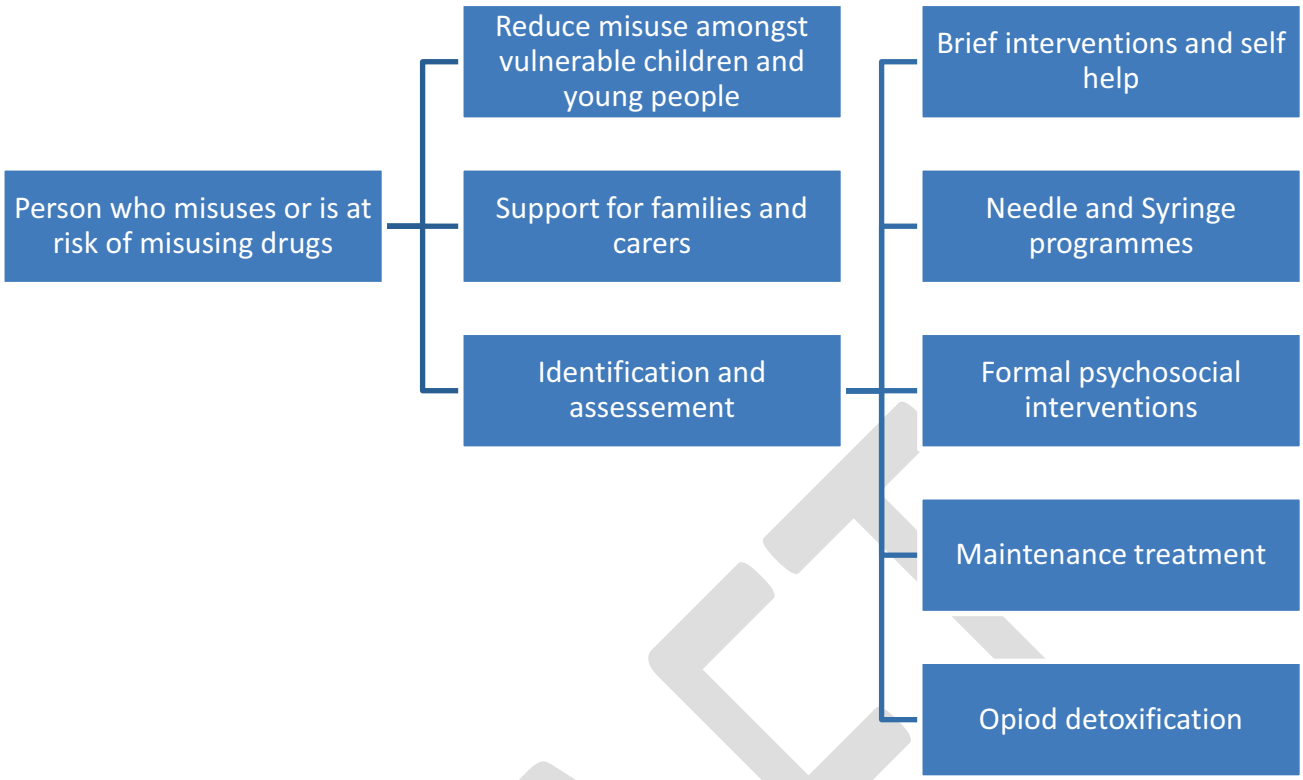
In early adolescence, children are often exposed to legal and illegal substances such as cigarettes and alcohol for the first time. When they enter secondary school, teens may encounter greater availability of drugs and social activities where drugs are used. At the same time, many behaviours that are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

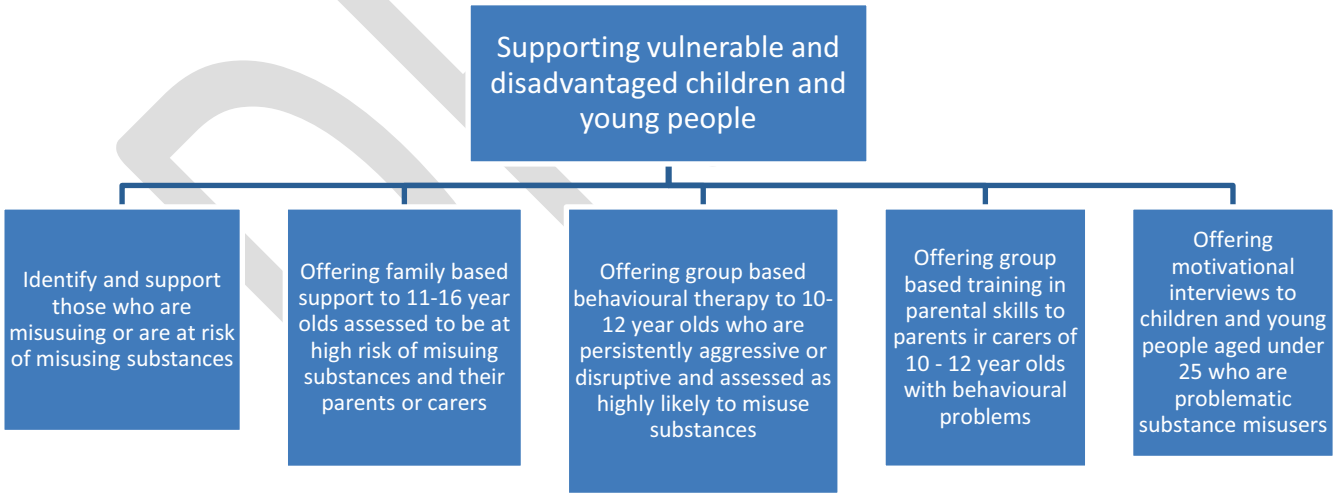
Family support plays a central part, including very early intervention with vulnerable families (particularly parents using drugs themselves). Drug Education and prevention work is delivered through schools and nationally through the FRANK campaign although review is needed to determine how to support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

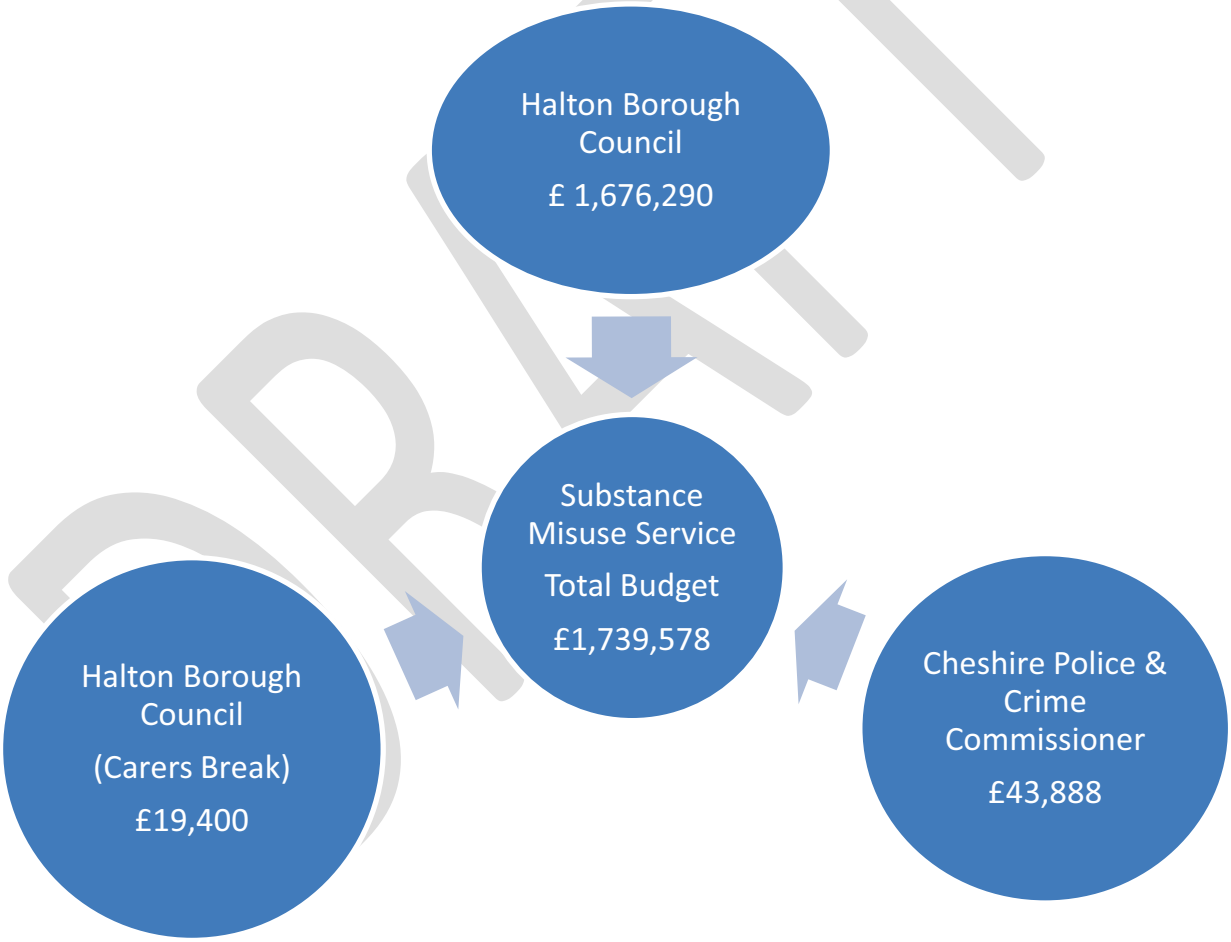


Table 12: Budget received for 2012/13 for substance misuse service (including drugs and alcohol)

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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