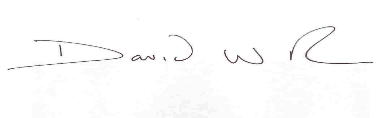
Public Document Pack

Executive Board

Thursday, 21 November 2013 2.00 p.m.
The Boardroom, Municipal Building



Chief Executive

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

PART 1

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1. MINUTES	
2. DECLARATION OF INTEREST Members are reminded of their responsibility to declare any Disclosable Pecuniary Interest or Other Disclosable Interest which they have in any item of business on the agenda, no later than when that item is reached or as soon as the interest becomes apparent and, with Disclosable Pecuniary interests, to leave the meeting during any discussion or voting on the item.	
3. CHILDREN YOUNG PEOPLE AND FAMILIES PORTFOLIO	
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Please contact Angela Scott on 0151 511 8670 or Angela.scott@halton.gov.uk for further information.
The next meeting of the Committee is on Thursday, 12 December 2013

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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 3a

REPORT TO:	Executive Board
DATE:	21 November 2013
REPORTING OFFICER:	Independent Chair, Halton Safeguarding Children Board
PORTFOLIO:	Children, Young People and Families
SUBJECT:	Halton Safeguarding Children Board : Annual Report 2012-13
WARD(S)	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 The purpose of this report is to present the Executive Board with Halton LSCB Annual Report 2012-13 for information.

2.0 **RECOMMENDATION: That the Executive Board**

1) **welcome the report;**

2) **note the recommendations; and**

3) **ensure that appropriate action be taken to address the matters raised.**

3.0 **SUPPORTING INFORMATION**

3.1 Keeping children and young people safe and promoting their welfare continues to be a high priority for the Council and partner agencies. The Lead Member for Children's Services attends the LSCB Main Board as a participant observer, and the LSCB Chair meets with the Lead Member, Chief Executive and Strategic Director on a quarterly basis to ensure there is an effective working relationship between the Children's Trust and LSCB, and that the LSCB is working effectively.

3.2 The LSCB Annual Report provides a rigorous and transparent assessment of the performance and effectiveness of local services to safeguard and promote the welfare of children and young people. It should identify areas of weakness, the causes of those weaknesses and the action being taken to address as well as other proposals for action. The report includes lessons from reviews undertaken within the reporting period including: Serious Case Reviews, Practice Learning Reviews and Child Death Reviews. The report also lists the contributions made to the LSCB by partners and

details the LSCB's expenditure.

From November 2013 LSCBs become subject to inspection in their own right. The LSCB Annual Report is a grade descriptor within the inspection framework. It is published in the public domain.

3.3 In terms of the report's content:-

- The **Chair's Executive Summary** references the significant NHS reforms, publication of the revised Working Together guidance, capacity amongst partners to deliver effective safeguarding services, revisions to the inspection framework and service provision in the priority areas of child sexual exploitation, domestic abuse and children in care;
- The **Accountability Arrangements** between the Children's Trust and the LSCB which include more robust challenge reporting between the two, and political accountabilities via the Lead Member and Chief Executive;
- **Safeguarding Activity** includes data across the safeguarding continuum from Early Help to Child Protection, Children in Care, including Children in the Care of Other Local Authorities living in Halton and Adoption;
- **Learning from Practice** includes Practice Learning Reviews, audits and child death processes;
- The **Local Authority Designated Officer** section has been included to provide information on allegations management;
- **Private Fostering** contains a summary of annual activity;
- **Voice of Children and Families** provides evidence from partners on their how practice and service delivery has been influenced by children and families and future commitments;
- The **Lay Members** provide an overview of their role;
- **Training Activity** summarises multi-agency training and impact on outcomes for children and families;
- The **Sub Groups** section outlines progress and forthcoming priorities of the Sub Groups – Scrutiny & Performance, Policy & Procedures, Child Sexual Exploitation and Missing Children, Learning & Development and Safer Workforce;
- **Priority Areas** reports on progress in relation to Early Help, Domestic Abuse and Child Sexual Exploitation;
- The **Progress against Business Plan 2011-13** highlights the achievements and intended impact;
- The **Budget** reports on the financial viability of the Board.

4.0 **POLICY IMPLICATIONS**

4.1 The LSCB has an action plan in place to ensure compliance with the revised guidance *Working Together to Safeguard Children* published

March 2013. This has required revisions to safeguarding policies and procedures, including Halton's Levels of Need Framework and Pan-Cheshire Multi-Agency Safeguarding Children Procedures.

5.0 **OTHER/FINANCIAL IMPLICATIONS**

5.1 The LSCB is currently funded via contributions from the Council, Schools, Cheshire Constabulary, NHS Halton CCG, Cheshire Probation and Cafcass. Currently the LSCB is financially sustainable. However contributions have reduced during recent years with the LSCB losing contributions from Connexions, the Child Death Grant and year on year reductions from the Schools Forum. The Cheshire & Merseyside LSCB Chairs are undertaking an analysis of LSCB budgets which will be reported to the Directors of Children's Services.

6.0 **IMPLICATIONS FOR THE COUNCIL'S PRIORITIES**

6.1 **Children & Young People in Halton**
The LSCB and Children's Trust have a formal protocol in place that sets out the accountability arrangements between the two. The Safeguarding Children Board is a formal consultee of the Children & Young People's Plan. Also, the Safeguarding Children Board's priorities are referenced in the Joint Strategic Needs Assessment.

6.2 **Employment, Learning & Skills in Halton**
The LSCB has statutory functions regarding training, supervision and safer recruitment to support a skilled, competent and confident workforce across the partners working in the borough with children & young people, families and adults who may be parents/carers.

6.3 **A Healthy Halton**
The safeguarding of children is fundamental to their health and well-being. The LSCB is expected to influence the Joint Strategic Needs Assessment by ensuring it takes into account safeguarding children priorities.

6.4 **A Safer Halton**
The effectiveness of Safeguarding Children arrangements is fundamental to making Halton a safe place of residence for children and young people. The LSCB is working closely with Halton Domestic Abuse Forum as one of the LSCB's priority areas is the impact of domestic abuse on children and young people.

In addition the LSCB has been working to develop links with the Licensing Board as this is a fundamental area in terms of identifying potential community areas of activity in relation to child sexual exploitation.

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

7.0 **RISK ANALYSIS**

7.1 The LSCB Annual Report is expected to provide a rigorous and transparent assessment of the performance and effectiveness of local services to safeguard and promote the welfare of children and young people. This includes identifying areas of weakness which impact on outcomes for children in the borough, and will be a focus for future Ofsted inspection of the Local Authority. The risk is that an inspection may take place before there is evidence that the work being undertaken to address priorities for improvement has evidenced impact.

The LSCB Independent Chair, Audrey Williamson, has resigned after chairing the LSCB since it was formed in 2006. Audrey has made a huge contribution to the development of the LSCB, ensuring that the LSCB operates as a robust strategic partnership and offering both challenge and support as appropriate. Halton and Cheshire West & Chester are working together to appoint a replacement as Audrey is also resigning from her role as Independent Chair of Cheshire West & Chester LSCB. An advert has been placed requesting expressions of interest to Chair both, or one, LSCB. Interviews are due to take place on 16th December. The recruitment process is being led by the respective local authority Chief Executives as set out in *Working Together to Safeguard Children*, 2013. Should Halton fail to appoint to the post, interim arrangements will be progressed.

8.0 **EQUALITY AND DIVERSITY ISSUES**

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

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

Document	**Place of Inspection**	**Contact Officer**
Children Act 2004	DfE Website	Tracey Holyhead
Working Together to Safeguard Children (2013)	DfE Website	Tracey Holyhead

Halton Safeguarding Children Board

Annual Report 2012-13

October 2013

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14. Budget 2012-13

Appendices

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B. HSCB Membership
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D. Child Death Overview Panel Report 2012-13

Halton Local Safeguarding Children Board (LSCB)
Safeguarding children is everyone's responsibility

Our priorities are:
To identify and prevent children suffering harm.
To protect children who are suffering, or are at risk of suffering harm.

1. Foreword
Welcome to Halton Local Safeguarding Children Board Annual Report. I hope you will find it useful in understanding the way all services in Halton work together to safeguard children who may be at risk of harm. This annual report is intended to provide information for a wide ranging audience including Halton residents and staff in all agencies responsible for safeguarding children and promoting their welfare.

The report sets out how the LSCB works; the structure and resources that support its work and the specific areas of work it must cover. These are important as all the professionals need to work together to make sure we have a skilled workforce supported by strong and effective working arrangements. It recognises the challenges faced by organisations in the current financial climate but which continue to make keeping children in Halton safe a priority.

The report provides information on how many children in Halton need protecting and require additional support, and how agencies have worked together to provide this support. The report highlights the achievements of the LSCB and identifies priorities for future work. It shows how we continue to scrutinise and challenge the work of partner agencies and promote a culture of openness and learning. By doing this we seek to improve the safety and well being of the children of Halton.

Finally I would like to take this opportunity to thank the small team which supports the LSCB for all its work this year and all those staff across Halton who work so hard in this difficult and complex area; they are central to keeping children and young people safe in Halton.

Audrey Williamson
Independent Chair
Halton Local Safeguarding Children Board

2. Chair's Executive Summary
Halton is a largely urban area of 125,700 people. Its two biggest settlements are Widnes and Runcorn that face each other across the River Mersey, 10 miles upstream from Liverpool. The population of Halton was in decline for over a decade, but has recently started to increase, projected to grow to 129,300 in 2021. Halton shares many of the social and economic problems

more associated with its urban neighbours on Merseyside. Deprivation has stayed relatively level in the Borough over recent years.

There are 24,900 children and young people living in Halton. This is 20% of the population. The LSCB is responsible for coordinating and ensuring the effectiveness of services in Halton in safeguarding and promoting the welfare of children and young people.

The LSCB has strong governance arrangements and is well positioned to influence partnerships across Halton. The Chair has a seat on both the Health and Wellbeing Board and the Children's Trust Board. Last year's LSCB Annual Report was presented at both of these partnerships and was well received. There is a good understanding of the role and responsibilities of the LSCB.

There have been significant NHS reforms; Halton's Clinical Commissioning Group (CCG) is now in place and the accountability and assurance framework outlining arrangements to secure children's and adult safeguarding in the future NHS has been published. Shadow arrangements during 2012-2013 ensured that this year the new CCG could play a strong role in the LSCB which has been welcomed.

Responsibility for Public Health services has transferred to the Local Authority. This offers opportunities to focus on specific services, for example commissioning School Health provision to better focus on services for vulnerable children. Increasingly Public Health will play a strong role in the work of the LSCB and inform the Joint Strategic Needs Assessment on the needs of vulnerable children.

The government continues to implement policy changes which may affect children, the full impact of the Welfare Reforms will be felt in 2013-14. The LSCB and its partners are concerned at the potential impact this will have on families in the borough, and how this could lead to an increase in demand for services. The government continues to progress with significant welfare reform and the LSCB expects all agencies to monitor and consider the impact of the reforms and the possible impact in its reporting.

The government published the revised version of Working Together guidance at the end of March 2013. This guidance sets out clear expectations of the role and functions of the LSCB and re-emphasises the importance of the role of multi-agency work to protect children, the importance of the LSCB's role in monitoring the effectiveness of that work and the development of a single assessment to replace the current initial and core assessment. The LSCB has instigated plans to ensure that it fulfils these requirements throughout 2013/14.

The LSCB will continue to constructively scrutinise the capacity of agencies to deliver high quality services that meet the needs of vulnerable children. The LSCB regularly receives reports from key agencies detailing capacity and potential gaps in service. One particular area of focus has been the capacity

of Children's Social Care services to recruit permanent managers for operational teams. The LSCB recognises there is a plan in place to address this and will continue to monitor to assure itself that social workers are receiving the appropriate quality supervision with manageable caseloads.

One of the primary roles of the LSCB is to scrutinise and assess the performance and effectiveness of local services in safeguarding children. This is undertaken in a range of ways, for example it receives regular and detailed reports on the outcomes of multi-agency audits of cases. There is strong participation from practitioners across all agencies in undertaking this work increasing the learning and identification of both good practice and areas for development. This year there was increased involvement of families to ensure that managers and practitioners hear directly the experiences of families receiving services. The audit tool used by Children & Families Services to undertake their audits has been well designed and has been recognised by Ofsted as an effective way of scrutinising complex work.

Through audits the LSCB noted a consistent theme regarding difficulties of timely distribution of notes by Children's Social Care from a range of safeguarding meetings, following challenge to Children's Social Care they responded with additional administrative resources. This positively impacts on supporting families and partners to have written clarity on reasons for involvement and measurable plans.

LSCB members met practitioners across the partnership at the annual LSCB and Children's Trust Frontline Event. In 2012/13 we learned how thresholds and levels of need were used in everyday practice. It was identified that more work was needed to increase understanding across the partnership and as a result the Levels of Need guidance was revised and strengthened.

The LSCB recognises the importance of early help to meet the needs of children and preventing the need for intervention at a later stage. Early help for young children is developing well; the challenge now is to ensure this extends to meet the needs of older children at an early stage. The LSCB has recognised that there are growing numbers of older children requiring care who may have benefitted from earlier intervention and support. The LSCB will scrutinise services for children who do not yet meet the threshold for services from Children's Social Care. It will also increase its scrutiny of outcomes for older Children in Care and those who leave the care system.
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The expected multi-agency inspection framework has been put on hold and the government is consulting on a revised inspection framework for children in need of help and protection, children looked after and care leavers. This will include reviewing the effectiveness of the LSCB. The LSCB has recognised the need to strengthen its understanding of its impact and effectiveness in improving safeguarding services for vulnerable children in Halton. As a result the LSCB has:

- Undertaken frontline visits to staff, with the objective of developing an understanding of each other's roles and responsibilities.

- Tested out the understanding of the Escalation Policy to ensure agencies can challenge and resolve differences in order that children receive the right services at the right time.
- Established an action plan to address the findings from this exercise and to strengthen links between frontline staff and LSCB members
- Started to strengthen the performance framework to increase its scrutiny function
- Recognised the need to increase learning from case reviews. While the Executive group has led on this area increased capacity to enhance learning and reflective practice across the partnership is required and will be put in place this year

Finally the LSCB looks at outcomes for particular groups of children, ensuring that gaps in services are identified and addressed. These include:

- Children at risk of sexual exploitation. The LSCB has established an Operational Group as a forum for multi-agency information sharing on potential victims, perpetrators and community areas of activity to help its understanding of the scope and profile of child sexual exploitation.
- Children who experience domestic abuse in the home. The LSCB has identified the lack of service for this group of children and welcomed the response by the Children's Trust in commissioning services. A perpetrator programme is being piloted in the autumn of 2013 and a service to support children and parents directly affected by the impact of domestic abuse will also begin then.
- Children in Care both those who live in Halton and those placed by other Local Authorities. The LSCB recognises that these children may be particularly vulnerable and have a range of needs including health needs which must be met. The LSCB will increase its focus on services for those groups in addition to services for care leavers in the coming year.

During this last year the LSCB has experienced a significant change in organisations; this has meant a change in LSCB representation and the need to form new partnerships. Despite the change in personnel attending the LSCB, partners have continued to engage in its work enabling the LSCB to continue to offer strong leadership across the partnership to carry out its role in ensuring a coordinated approach in delivering services to children in need of safeguarding.

3. Accountability Arrangements:

The LSCB continues to have an Independent Chair, who has been a consistent presence, chairing the LSCB since 2006. The Chair is an active participant in the LSCB Chairs' network meetings at a Cheshire & Merseyside, North West and national level. This benefits the LSCB in that we are able to share good practice with other LSCBs and enter into collaborative working arrangements. For example, a planned event for the Cheshire & Merseyside

LSCBs to launch the joint Child Sexual Exploitation Strategy; a joint arrangement to have a CSE data post across the four Cheshire LSCBs.

The Chair also ensures that she visits the Social Work Duty Service to observe practice and enable staff to raise any operational concerns. This provides an opportunity to understand the pressures at the frontline first hand. For example, social workers raised concerns about additional support services for families where domestic abuse is identified which the Chair raised at the LSCB. As a result, the Halton Domestic Abuse Forum is leading on the commissioning of services for children and adult victims, and a programme for non-statutory perpetrators.

During 2012-13 reporting arrangements between the Children's Trust and the LSCB were revised to ensure greater challenge between the two. The LSCB presents a report to the Trust on areas of challenge which the Trust formally responds to. Examples of the areas identified through this challenge reporting include commissioning Domestic Abuse services; the potential duplication of scrutiny of commissioning; and Workforce Strategy.

The LSCB is a formal consultee of the Trust's Children & Young People's Plan. As such, the LSCB ensures that the Plan gives priority to keeping children safe. The LSCB also provides information for the Joint Strategic Needs Assessment, within which the priorities of both the Safeguarding Children Board and Children's Trust are reported.

The Lead Member for Children's Services attends the LSCB Main Board as a participant observer. In addition, quarterly meetings are held between the Local Authority's Chief Executive, the Lead Member, Chair of the LSCB and Director of Children's Services. This is so that the Chief Executive and Lead Member can ensure that there is an effective working relationship between the Children's Trust and LSCB, and that the LSCB is working effectively.

The LSCB Annual Report is formally presented to the Executive Board of the Local Authority to ensure that the elected members are informed of the work of the LSCB and the effectiveness of safeguarding arrangements in the borough. In addition, the Annual Report is also presented to the Safeguarding Adults Board, Health & Wellbeing Board, Clinical Commissioning Group and to the Chief Constable and Police & Crime Commissioner of Cheshire Constabulary.

4. Safeguarding Activity 2012-13

How Safe are our Children & Young People in Halton?

All services and the community in Halton need to be vigilant in reporting concerns where they think that a child may be at risk of harm. We also need to ensure that children are provided with opportunities to speak out when they are at risk, or are being harmed. Specialist services such as Children's Social Care and the Police can only intervene to protect children if they are alerted to concerns. The following information regards children and young people in

Halton who have been identified by the Local Authority and partner agencies as being in need of safeguarding.

At the end of 2012-13 the level of Children in Need in Halton was 638 per 10,000 population. This was calculated on the number of open cases including children subject to Child Protection Plans, Children in Need, Care Leavers and those receiving an assessment. This is a slight reduction on the previous year (646). The rate is below the national average (652 2011/12), and significantly lower than the average for similar and statistical neighbours (726 2011/12).

The LSCB scrutinises the impact and effectiveness of early help and the contacts and referrals received by Children's Social Care to ensure that thresholds are being applied appropriately. In order to address the low rates of Child Protection Plans and Children in Need Children's Social Care will be reporting upon a range of activity and its impact over the forthcoming year to the LSCB as a priority area for improvement. This includes an audit of contacts and referrals, revision of the Contact and Referral process and implementation of a single frontdoor to ensure appropriate management of contacts and referrals at that point. Work will also be undertaken between Children's Social Care managers and the police to review how s47 enquiries and strategy discussions are recorded to raise the profile of risk assessment and analysis.

Additional information can be found in the Board's Performance Report Card 2012-13 at Appendix C of this report. An addendum to the Annual Report will be published in January 2014 following the publication of national comparator data; this will provide a picture of how Halton compares both nationally and with similar authorities.

Children with a Child Protection Plan

Children become subject of a Child Protection Plan when it has been identified that they are in need of protection from either neglect, physical, sexual or emotional abuse. Only children who are the most vulnerable have child protection plans.

114 Child Protection Plans were commenced in 2012-13. For 2 children this was a second or subsequent Child Protection Plan. The numbers of Plans are amongst the lowest proportion nationally, and are lower than those of comparator local authorities. The LSCB continues to receive quantative and qualitative data in order to challenge Children's Social Care on this. The LSCB has noted that the number of children subject to Child Protection Plans and Children in Care are now increasing.

Category of Abuse for Child Protection Plans:

	2010-11	**2011-12**	**2012-13**
Neglect	44%	38%	38%
Sexual	3%	10%	10%
Physical	22%	13%	9%
Emotional	31%	39%	43%
Mixed			4%

NB Children may change category of abuse during the course of the plan and therefore may appear in more than one category:

The data regarding category of abuse in Child Protection Plans open at the end of the year shows a reduction in the percentage of Plans under the category of neglect. As this reduction has been sustained, it indicates the impact of early help and support in Halton. The increase in Plans due to emotional abuse reflects the need to protect children living in households where they are at risk of harm due to domestic abuse. This informed the LSCB's decision to identify the impact of domestic abuse on children and young people in the borough as a priority and challenging the Children's Trust on the lack of service provision for children and families.

41 children moved in to Halton with Child Protection Plans in place from other local authorities and were given a temporary plan in Halton. The majority return to the area they came from. For all those children who remained resident in Halton a transfer conference was convened within the national timescale.

The LSCB receives quarterly information regarding agencies' attendance at and reports provided to Initial and Review Child Protection Conferences in line with the required standards. Further work needs to be progressed with all agencies to ensure that these standards are recognised and adhered to. Where agencies were unable to attend a conference, reports were submitted in most instances; where reports were not submitted this was addressed directly with the agency concerned by the Safeguarding Unit.

In recognition of the need to improve in this area, a focus group has been working across Halton, Cheshire West & Chester and Warrington to consider ways to better support greater involvement of GPs at conference; this will now include the Lead GP for Safeguarding within NHS Halton CCG. Current statistics evidence that GP's submitted reports to 51% of Initial Conferences and 49% of Review Conferences: these figures represent an upward trend but are not at the level required by the LSCB. This will continue to be an area of scrutiny for the LSCB, overseen by the Scrutiny & Performance Sub Group, with quarterly reporting from the Safeguarding Unit.

Children in Care

At 31st March 2013 there were 145 Children in Care. This was an increase of 17% from April 2012 to March 2013. In particular there has been a significant increase in the numbers of older children being admitted to care, aged 11 years or over.

Analysis of entrants in to the care system indicates that for some children, had they received targeted early help and support then they may not have needed to come in to care. The LSCB sees scrutiny of the effectiveness of early help and support as a priority in the forthcoming year, and has directed the Children's Trust to examine how multi-agency early help is coordinated for older children.

The average length of time in care has decreased to 3.4 years from 3.8 years, ranging in time from 2 days to 17 years. This indicates that good permanency planning is in place for these children.

Approximately 70% of Children in Care are placed within foster care settings, with a further 13% placed in another family setting. At 31st March 2013 14 young people were placed with external residential care providers. Of those 1 young person was placed within an independent children's home in Halton; 7 were placed within 20 miles of the borough and 6 were placed over 20 miles from the borough. Of those, 1 young person was placed within a secure welfare placement; 1 in a Young Offenders Institution; and the remaining 4 were living in placements to meet their specific needs. This is good performance and recognises the need for Halton children to remain close to their communities.

The LSCB receives regular reports on Children in Care to ensure the effectiveness of safeguarding arrangements for this particularly vulnerable group. The LSCB has asked the Children's Trust to focus upon this group of children and young people as a priority area. The Trust is currently revising its structures to ensure robust oversight of this group of children and young people via the Children in Care Partnership Board.

Children in Care of Other Local Authorities (CiCOLA)
Some children living in Halton are Children in Care of other local authorities; this means that they live in foster care placements, independent children's homes or within a Leaving Care / Semi Independent placement where the placement has been arranged by another local authority.

At the end of the year there were 138 such children living in Halton. It is notable that the number of children living in Halton from boroughs in other parts of the country has reduced significantly. This is due to a number of factors including the impact of the sufficiency duty that requires local authorities to place children within 20 miles of their home unless there are specific circumstances that mean this is not an option. In addition Halton's Integrated Commissioning Manager has worked with the Planning Department to confirm that providers have appropriate permissions to operate; shared information with local providers regarding Halton's requirements; and liaised

with the Missing from Care Service, Police, Youth Offending Service and shared qualitative information on placements with placing local authorities.

This has led to a reduction in independent children's homes in the borough of 20% - from 15 homes to 12 – and a reduction in the number of placements (beds) of 29% - from 37 to 26. Planning permission for a new four-bedded children's home in Halton has also been refused. The reduction in children's homes in Halton is the opposite of the national trend that indicates a 10% increase in the number of independent children's homes.

This is beneficial in that fewer children are being placed in the borough more than 20 miles from their own homes. Also, the needs of these children can have a significant impact upon local provision as these children often have specific needs and vulnerabilities that impact on services such as the Police, Child & Adolescent Mental Health Service, Education, Housing and Youth Offending Service.

Children Missing from Home & Care
Missing children are vulnerable to a number of risks, including sexual exploitation. Identification and access to appropriate services for missing children is important. The Pan-Cheshire Missing from Home & Care Protocol has improved identification and service response to children, ensuring clear definitions of missing and absence are understood by agencies. This has meant that the Police no longer receive inappropriate referrals such as where a Child in Care is late coming home, but their whereabouts are known.

Halton leads on behalf of the Pan-Cheshire local authorities on commissioning of the Missing from Home Service provided by Catch 22. In previous years there had been a high number of missing incidents relating to CiCOLAs who were going missing on multiple occasions. Targeted work has reduced this and in 2012-13 the majority of children reported as missing in Halton were missing from home (58%).

Catch 22 undertake return interviews following missing incidents. From this we can identify the reasons children state for going missing and the areas where they go to. The most frequent reasons for going missing were reported as family conflict, boredom & socialising, to see family and peer pressure.

Halton accounted for 30% of total missing incidents reported to Catch 22 which was the highest percentage across Cheshire. However, this appeared to be due to appropriate identification and referral to the service in comparison with other areas within Cheshire. Early reporting during 2013-14 appears to reflect this with other areas showing an increase in referrals compared to Halton.

The LSCB has requested that Catch 22 undertake further analysis of the age of children referred to the service as it appears to be lower than the Pan-Cheshire average. End of year reporting in Halton stated that the average age was 13 -14 years.

Children who are Adopted
The government has identified adoption as an area of focus nationally in order to increase the number of children adopted, whilst also reducing the length of time for an adoption to take place. Stringent levels of performance have been set for local authorities resulting in a number failing to reach standards. This has not been the case in Halton. The number of adoptions from care during the reporting period was 35. The average time between a child entering care and moving in with their adoptive family was 567 days which is better than the England average of 636 days and is shorter than the threshold set by government.

Early Help and Support in Halton
In some instances children may have additional needs which are not child protection related, or which if addressed at an early stage will prevent the need to refer to Children's Social Care at a later point. The child and family may need a range of supportive services to address these additional needs. The Common Assessment Framework (CAF) is a voluntary process, requiring informed consent of the family or young person, dependent upon age and understanding, whereby the child's needs can be assessed holistically, services delivered in a coordinated manner and reviewed regularly.

At the end of 2012-13 there were 315 open CAFs in Halton. This compares to 233 open CAFs at the end of March 2012 and 132 at the end of March 2011. Over the year there has been an approximate 26% increase in the number of CAFs.

This has been helped by the development and launch of Halton Children's Trust's Early Help Strategy. The impact has been that all partners are aware of Halton's priorities, which facilitates working more effectively across the workforce, as well as reinforcing the Common Assessment Framework and the importance of the Lead Professional. The introduction of the revised Halton Levels of Need Framework developed with the support and involvement of all relevant stakeholders across the partnership has meant clearer direction for the workforce to reach decisions about the level of a safeguarding need a child may require in a single or multi agency context. At times where further support is required in more complex cases the Early Help Panel has been developed to provide a forum where staff can receive support and share information to be more effective in helping families they are involved with and creating seamless services for them.

The continued development of co-location arrangements for multi-agency practitioners has been a priority for Halton. Successful co-location at Warrington Road Children's Centre working within the Early Help & Support model has allowed for testing out improved ways of working towards better outcomes for families, evidenced by increased cooperation and communication between teams at case and service level. This has prompted further co-location by developing a similar model at Kingsway Learning Centre.

A process to regularly audit CAFs is now embedded, and CAFs are also included in the multi-agency practice audits. The LSCB receives reports on CAF audits via the Scrutiny & Performance Sub Group. Findings from audit activity are reported in the next section: Learning from Practice.

5. Learning from Practice

LSCBs are required to consider holding a Serious Case Review when abuse or neglect is known or suspected to be a factor in a child's death, life threatening injury or serious sexual abuse, and there are concerns about how professionals may have worked together. The purpose of a Serious Case Review is to:

- Establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children.
- Identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result; and
- As a consequence, improve multi-agency working when it comes to protecting children.

In some cases, the criteria for holding a Serious Case Review may not have been met but a review of the case may provide an opportunity to identify learning. Under such circumstances the LSCB will consider undertaking a Practice Learning Review.

During the year there were no Serious Case Reviews either commissioned or ongoing from previous years. Two Practice Learning Reviews were concluded, and the LSCB will scrutinise how learning has been embedded in practice from these during 2013-14.

Learning from Halton's Practice Learning Reviews:
The Practice Learning Reviews identified learning as:

- Missed opportunities to analyse the significance of an increasing number of domestic abuse incidents
- Missed opportunity to initiate a Core Assessment where a detailed analysis of the children's needs could have taken place
- Missed opportunities for agencies to use the LSCB Escalation Policy
- Improvements to be made in the frequency of supervision and management oversight of social workers
- The need to review agency procedures on risk management and escalation
- Good communication was identified in one case both between Children's Social Care, Midwifery and Health Visiting Services in Halton and across borders with another area

Child Death Overview Panel:

The LSCB's Child Death Overview Panel reviews all cases where a child died before their 18th birthday. The death may have been expected, such as where the child had a life limiting condition; or may have been unexpected or accidental, for instance sudden infant death or suicide. In 2012-13 there were five child deaths of Halton children; this was an increase of one compared with 2011-12 but continues to be lower than previous years. A full report from the Child Death Overview Panel is at Appendix D.

Audit Activity:
The LSCB also receives reports on audit activity which supports its objective to scrutinise the effectiveness of the work of partners to safeguard and promote the welfare of children. Audits of practice also provide an opportunity to assess how well the lessons from learning and improvement activity including Serious Case Reviews, Practice Learning Reviews and the Child Death Review process have been embedded into frontline practice.

During 2012-13 the LSCB received reports on audit activity in relation to the Common Assessment Framework (CAF), Children & Family Services cases, Children & Family Services supervision practice, in addition to the three Multi-Agency practice audits undertaken by the LSCB.

No of cases audited per cohort

Category of audit case	**Grand Total**	**Cohort population**	**% of cohort audited**
Adopters	4	17	24
Child in Care	27	130	21
Child in Need	52	624	8
Child Protection	12	95	13
Contact	48	972	5
Family Support	35	305	11
Fosterer	4	78	5
Private Fostering	1	1	100
CAF	39	292	13
Supervision Audits	19	123	15

Findings from audit activity led to:

- Workshops for staff in the Children & Families Service on communication and use of direct work tools with children, with auditors subsequently finding that individual practitioners were able to readily discuss the daily lived experience of individual children they were working with.
- Revisions to the School Health Service safeguarding assessment tool to include the requirement to record the child's views and wishes.
- The Midwifery Service revising their risk assessment tool to include a focus on social needs.
- No children were identified as having been left at risk of significant harm.

The focus for audit activity in 2013-14 will be:

- To increase the number of contributions from the child and family in the audit processes.
- To increase the multi-agency audit activity, including practitioner focus groups.
- To receive more information from partner agencies about their auditing activity, its impact and effectiveness.
- To revisit previous practice or process recommendations in order to evidence that improvements have been embedded.
- To disseminate identified good practice widely across the workforce.
- To ensure that the recommendations and themes identified from any Practice Learning Reviews are fed into the auditing process.

6. Local Authority Designated Officer (LADO):

Each local authority has a Local Authority Designated Officer (LADO). The LADO must be informed of all allegations relating to adults who work with children whether they are a paid member of staff, foster carer or volunteer, where there is concern or an allegation that the person has:

- Behaved in a way that has harmed, or may have harmed, a child.
- Possibly committed a criminal offence against or related to a child; or
- Behave towards a child or children in a way that indicates they may pose a risk of harm to children.

The LADO's role includes providing advice and guidance to employers and voluntary agencies; management and oversight of individual cases; monitoring the progress of cases to ensure that they are dealt with as quickly as possible, consistent with a thorough and fair process. This is part of the process of ensuring that safer workforce practices are in place that safeguard children from individuals and practices which may be harmful. This process also safeguards staff by ensuring that malicious or unfounded allegations are thoroughly investigated and resolved in a timely manner.

39 allegations were reported to the LADO during 2012-13, compared with 36 in the previous year.

The LADO noted an increasing number of consultations and allegations made against professionals who are using Facebook and other social media sites to make contact with young people. This has highlighted that a number of organisations do not require staff to sign a code of conduct regarding contact with children and young people outside the work setting, including via social media. The LSCB will therefore be advising all agencies to ensure that staff, including volunteers, are made aware of expectations of behaviour at the point of induction and regularly thereafter.

The LADO undertook briefings to Head Teachers in 2012-13 in response to a request from schools. This was coordinated by the primary school

Headteacher representative on the Board. 40 Head Teachers attended. The LADO also undertook briefing sessions with school governors and the Children's Independent Provider Forum.

The LADO made a number of recommendations to the LSCB in their annual report which will be actioned during the forthcoming year. These are:

i. To amend the consultation form and re launch across all agencies.
ii. To revise the procedures for LADO.
iii. To advise all agencies of good practice to be included in standards/expectations at the point of induction for all staff regarding contact and communication with children and young people
iv. To continue to forge links with faith and voluntary groups.
v. To record all consultations and include in LADO reports to HSCB.

7. Private Fostering:

LSCBs are expected to ensure that effective processes are in place to promote the notification of private fostering arrangements in their local area. This includes raising awareness amongst staff and the public of what constitutes a private fostering arrangement and the requirement to notify Children's Social Care. The local authority is required to provide an annual Private Fostering Report to the LSCB, which the LSCB reviews and responds to any findings as necessary.

During 2012-13 six private fostering notifications were received by the Local Authority. This was an increase of five on the previous year, and in line with the number received in 2010-11. Of these four were deemed suitable for Private Fostering arrangements. All were acted upon appropriately within 7 working days, with visits to children taking place at least 6 weekly in line with Private Fostering regulations 2005. Two of these arrangements ended in the year, and two were still open at 31st March 2013. A steering group oversees the Private Fostering action plan and awareness raising, reporting directly to the LSCB.

8. The Voice of Children & Families:

The LSCB has consulted with groups of young people to identify how they would like to find out about its work and how they can influence this work. The LSCB Business Manager met with young people involved in a variety of youth provision in Halton to raise awareness of the LSCB, explore safeguarding messages and identify communication methods that the young people felt would be most effective. The young people preferred communication via social media and visits to them at the places they were already attending as part of the youth provision, such as C-Rmz. They did not want to attend meetings specifically held for participation. As a result of this feedback the LSCB is visiting community settings to engage young people in awareness raising on issues such as child sexual exploitation; and reviewing its use of social media.

LSCB members also undertook visits to frontline practitioners across a range of services, where they asked staff to provide evidence of how the voice of the child was influencing their service. Staff were able to give examples of how they had changed their own practice as a result, clearly demonstrating how they were listening to children & young people in their work.

The LSCB is currently involved in a project with Professor Jan Horwath, Sheffield University, in collaboration with Cheshire West & Chester and Telford & Wrekin LSCBs. The aim of the project is to develop working practices, models and training to help staff understand what life is like in terms of the daily lived experience for children subject to Child Protection Plans. The aim is to create meaningful Child Protection Plans which will provide a way to measure the impact of interventions on outcomes for the child and family. The pilot will begin in September 2013.

A researcher from Gloucester University is also working with the LSCB on a project to elicit the views of children and young people on their experiences of the child protection system. The aim of the research is to identify ways to improve their experiences. The LSCB will be receiving progress reports during the forthcoming year.

Partners have also engaged in activity to ensure that the voice of children and families influences practice and service delivery.

The Safeguarding Unit has:

- Introduced personalised letters to children featuring a photograph of the Independent Reviewing Manager (IRM).
- Introduced business cards so that the IRMs can write down the dates of future meetings and ensure that the young person has their contact details, supporting the young person to make independent contact.
- Introduced tracker cards designed by young people to be completed by young people at Children in Care reviews to monitor the progress of recommendations made by the IRM. There are plans to introduce this in to Child Protection conferences in future to track recommendations in Child Protection Plans.
- Young people routinely advise the IRMs as to where they want their reviews to take place and who they would like invited.
- Following requests from parents, all parents are contacted prior to a child protection conference offering an opportunity to meet with the Chair before. There has also been an increase in advocates attending conference to ensure that parents are fully aware and understand what is being discussed, and that their views are considered as part of the Plan.

Cheshire Police has:

- Made significant improvements in how they deal with young people who are arrested in connection with criminal investigations, reducing the number of young people brought into police custody.
- Ensured rigorous risk assessments and support for all those arrested.

- Continually monitored all arrests and will be reporting to the LSCB for scrutiny.

Children's Social Care has:
- Delivered workshops to social workers on the use of practical tools for effectively communicating with children and young people.
- Provided all social workers with resources to undertake direct work with children and young people.

Cheshire Probation has:
- Trained staff to develop risk management plans and sentence plans to clearly put the child at the centre when safeguarding is an issue.
- Introduced specific, personal objectives that provide evidence of the impact they are seeking to achieve for the child/family and the outcomes.

Bridgewater Community Healthcare Trust has:
- Developed the School Health Service to ensure that the child's voice is heard, for example via holistic health assessments for all children subject to a Child Protection Plan which identify any health needs which are of concern to the child.

5 Boroughs Partnership has:
- Transformed services to improve waiting times for assessment and intervention following feedback from children and families, meaning that the first assessment is within 10 days.
- Ensured better engagement with the CAF model by the Child & Adolescent Mental Health Service following challenge from the LSCB.

St Helens & Knowsley Teaching Hospitals NHS Trust has:
- Applied the Laming Compliance Audit on a quarterly basis within Paediatrics which includes the voice of the child as a criteria and measure.
- Embedded into assessment detailed analysis of the child's perspective on the nature of the problem and their preferred outcomes from interventions, particularly amongst 10 – 16 year olds, often with a mental health focus.
- All children and young people over the age of 12 years who are admitted to the Trust have the opportunity to complete an 'Adolescent Screening Tool' covering general health issues but also open questions around domestic abuse, drug and alcohol use, smoking and sexual health; completion and analysis has led to specific interventions being generated with individual children and young people.

Warrington & Halton Hospitals NHS Trust has:
- Obtained children's views to develop care and services offered. For example, via focus groups for children with epilepsy, diabetes and visual impairment; and a monthly coffee morning for hearing impaired children.

- Captured the views of children and families at discharge meetings, extracting any themes to inform practice.
- Ensured that CAFs completed by the hospital staff on young people always record the views of the young person.
- Used in-house training to stress the importance of asking children about their injury / life / seeking their views. There has been increasing evidence in notes of practitioners documenting information such as the history from the child as a result.

Public Health has:

- Held focus groups with children on the Fit4Life Programme to understand the high drop out rate, leading to the programme being opened up to the whole class so that children do not feel singled out by attending. The programme now runs across all primary schools in Halton and the excess weight rate for all children has fallen significantly.

Future plans for 2013-14:

Cheshire Police will:

- Focus on 'the voice of the child' at the heart of policing activity.
- Develop a new IT referral process that ensures officers understand and capture the child's voice to inform risk assessments and decision making.

NHS Halton Clinical Commissioning Group will:

- Ensure that commissioned health services have a systematic and on-going engagement process in place which demonstrates changes made to service delivery through the influence of children and young people's voices.
- Require all health providers to submit evidence of compliance on an annual basis.
- Ensure that challenge and scrutiny is applied through performance and contractual management.

Halton Borough Council – Children & Enterprise Directorate will:

- Review all Children in Need cases, including the degree to which the voice of the child is demonstrated in the planning process.
- Emphasise the centrality of the child in assessment and provision.

5 Boroughs Partnership NHS Trust will:

- Strengthen the therapeutic services offered to children and their carers in Halton in response to feedback received.
- Implement a service user participation plan to build on its work to elicit the views of children and carers, and adapt services accordingly.

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St Helens & Knowsley Teaching Hospitals NHS Trust will:

- Complete an annual audit to assess the Trust's position and compliance in listening to the voice of the child.
- The new post of Patient Experience Manager will develop more appropriate and robust ways of understanding and responding to the voice of the child.

9. Lay Members

As Lay Members we contribute to the LSCB's work by supporting stronger public engagement in local child safety issues, raising awareness and contributing to an improved understanding of the LSCB's safeguarding work in the community. We gather local information, for instance via questionnaires on topics such as Private Fostering, to inform LSCB discussions and bring an independent view to the LSCB enabling members to focus on the concerns, needs and feelings of children & young people and their families living in Halton.

We have spent the day with the Local Authority Child in Need Teams in Widnes and Runcorn where we met managers and staff, observed their practice and asked them about their work. We provided a written report to the LSCB following our visits. Staff spoke about how they felt they are the best agency to capture the voice of the child and of how important it is to listen and get the child's point of view. Managers and staff work well together; they carry out frequent audits of their practice; they look at and scrutinise others' file work to see what they have done well or if there is anything missing; and have regular briefings looking at tasks, timescales and assessments, what's working well, or if there are any areas of development needed. The teams are aware of the role of the LSCB and access information via the LSCB website and training.

Staff were concerned about a rise in Domestic Abuse cases, and the need for specialist services to support their work. The LSCB has challenged the Children's Trust on this and specialist support services are now being commissioned.

As Lay Members it is clear that we need to work together in partnership to ensure that the children of Halton have the best opportunities in life to develop to their full potential. This can only be achieved if we work together in partnership with schools, settings and other services and organisations with a shared understanding helping us to develop our role, enabling us to establish links, share information and raise an awareness to get the message out there, that together we can make a difference to the children and families of our local and surrounding communities.

Marjorie Constantine & Yvonne Shelley, Halton LSCB Lay Members

10. Training Activity:

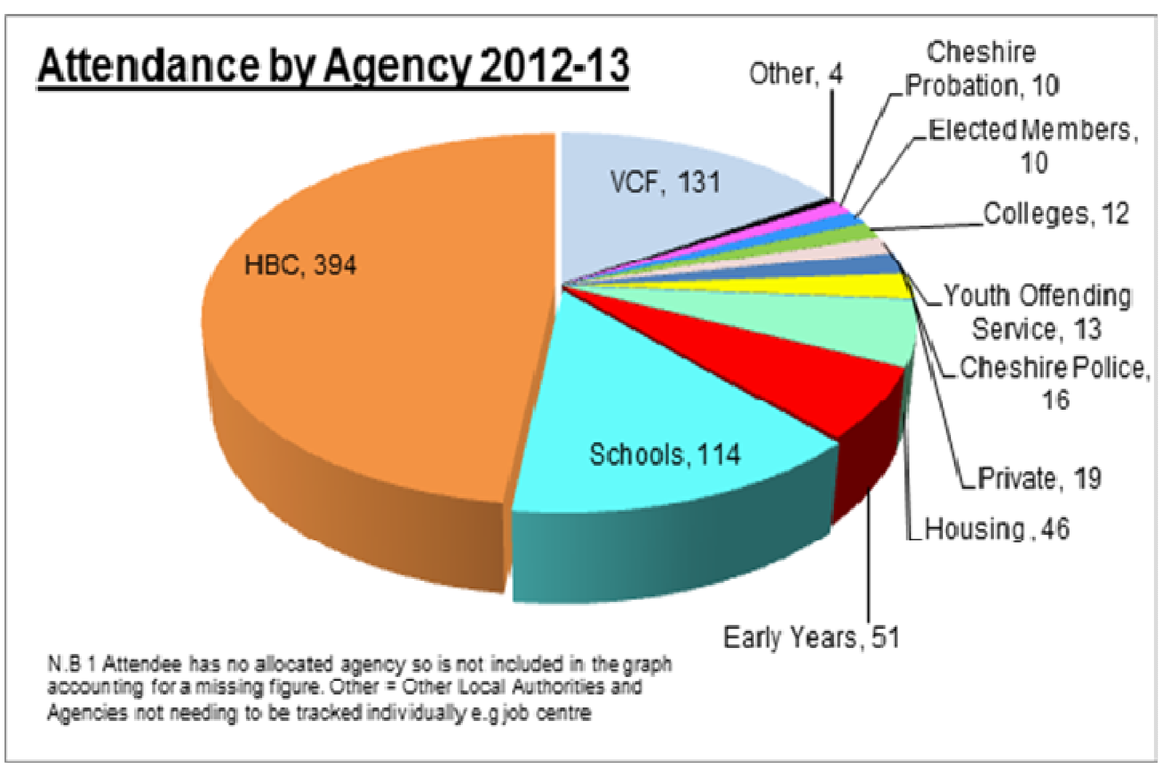
The LSCB has a responsibility to ensure that appropriate safeguarding training is available to the workforce across the borough. It does this by undertaking an annual Training Needs Analysis; quality assuring single

agency safeguarding training packages; and delivering multi-agency training. This work is led by the Learning & Development Sub Group.

The 2012-13 training programme saw 36 courses delivered with 1092 places accessed. This was a considerable increase of 64% on the previous year. The training programme included new courses on Child Sexual Exploitation, Multi-Agency Public Protection Arrangements (MAPPA), Safeguarding Children with Disabilities and Understanding Sexual Abuse. Lessons from national, regional and local Serious Case Reviews (SCRs) and Practice Learning Reviews were disseminated via SCR workshops.

The LSCB also promoted national e-learning packages via its website on both child trafficking and forced marriage as staff need to ensure they keep up to date on all areas of safeguarding, and should be alert to issues which they may be less likely to encounter.

Overall Agency Attendance on HSCB Courses 2012-13



The LSCB also hosted a session on the Duty to Refer facilitated by the Disclosure and Barring Service which focussed upon changes to recruitment practices following implementation of the Protection of Freedoms Act 2012.

In order to measure the impact of training the LSCB measures knowledge outcomes immediately after the training. This is followed up 3 months later by measuring the impact of training against improved outcomes for children. All courses showed an increase in knowledge with the most marked increases related to the Domestic Abuse for Practitioners, Sexual Abuse and Working Together Refresher courses.

Improved outcomes for children included young people safeguarded and supported with regards to sexual exploitation; identification of a potential perpetrator of sexual exploitation; identification of physical harm leading to the young person being safeguarded; and the implementation of direct work with young people on recognising healthy relationships.

Partner agencies are required to submit their level 2 Basic Awareness safeguarding courses for quality assurance. This included an e-learning package from 5 Boroughs Partnership, and face to face courses delivered to schools, Riverside College and Bridgewater Community Healthcare Trust.

Priorities for the 2013-14 training programme include:

- Revising all courses to ensure they reflect the changes included in Working Together to Safeguard Children 2013.
- Developing Domestic Abuse training to focus upon the impact on children.
- Further developing Child Sexual Exploitation training across agencies and the LSCB.
- Delivering Lessons from Practice training as part of the Learning & Improvement Framework.
- Delivering training on working with resistant families in response to national learning from SCRs.
- Delivering more courses jointly with neighbouring LSCBs across Cheshire and Merseyside.

11. HSCB Sub Groups:

Scrutiny & Performance Sub Group

The role of this Sub Group is central to the monitoring and evaluation function of the LSCB. The child's journey performance report card, based upon recommendations in the Munro Review, provides the data behind the detailed commentary reports, from early help through to adoption. This has enabled the Sub Group to challenge more effectively, for example addressing the lack of engagement by Tier 3 Child & Adolescent Mental Health Services (CAMHS) in the CAF process. The outcome of which has been that CAMHS practitioners have since initiated CAFs and been identified to undertake the Lead Professional role, ensuring that children and young people already engaged with specialist mental health provision are accessing appropriate early help and support services under Halton's Levels of Need Framework.

Section 11 Audits are undertaken to ascertain how effective organisations are in meeting their duties to safeguard children and young people under the Children Act 2004. This includes having up to date safeguarding procedures that staff know how to access; having an identified Safeguarding Lead; adhering to safer recruitment practices. The Sub Group has overseen Section 11 Audits of commissioned services undertaken by the Children's Commissioning Team. This identified a number of services where

safeguarding procedures needed to be revised and safer recruitment practices needed to be embedded. These areas were addressed with providers via the Children's Commissioning Team, supported by the LSCB. Providers undertaking the Section 11 audits included youth provision, contact centre, counselling services and play services.

Section 175/157 Audits of schools were also completed. These relate to the safeguarding duties of schools under the Education Act 2002. As a high proportion of children in the borough are of school age and attend an educational setting it is important that schools are clear of their safeguarding duties and can identify areas of strengths and weakness. The Primary Head Teacher representative on the LSCB reported positively on the audits as they were a means of improving safeguarding awareness and practice within the schools. There was an excellent return rate of 97%.

The audits identified themes apparent across a number of schools in the borough including:

i. Safeguarding training needs for Senior/Deputy Designated Persons – this is being addressed by LSCB increasing the number of level 3 Working Together and Refresher sessions and targeting places.
ii. The need for a consistent approach to retention and secure destruction of Child Protection records at transition – this is being addressed by LSCB agreeing the standard and including in a template Safeguarding Policy for schools.
iii. Safeguarding training needs for Governors – this is being addressed by ensuring a variety of approaches to safeguarding training are available to governors, including induction booklets, e-learning and modular training packages.
iv. Support needed to produce Allegations Management procedures – this is being addressed by working with schools on template procedures and developing awareness of the LADO role with schools.

Action plans have been sent to schools and outcomes will be reported when the next annual audits take place.

The Sub Group has also benefitted from the appointment of a Quality Assurance Officer, who has improved communication with performance leads in partner agencies and has provided additional capacity to the audit work undertaken by the LSCB.

Priorities for 2013-14 include:

- Identifying key performance indicators from partner agencies and including within the LSCB's performance reporting.
- Developing an audit schedule whereby partners will report their safeguarding audit activity to the Sub Group.

Policy & Procedures Sub Group

The Sub Group ensures that the Pan-Cheshire Multi-Agency Safeguarding Procedures and local Practice Guidance are reviewed and fit for purpose.

Revisions have been made to the Pan-Cheshire Procedures to reflect a Rule 43 decision from Cheshire's Coroner. This is made when a Coroner feels that evidence at an inquest gives rise to a concern that circumstances creating a risk of other deaths will occur and that action should be taken to prevent or eliminate or reduce such risks. The procedures were also amended to reflect an increased focus upon recognition of the potential of Child Sexual Exploitation. The Sub Group has also been working on a Pan-Cheshire Forced Marriage Protocol, in collaboration with the Merseyside LSCBs.

The Sub Group has quality assured a number of safeguarding policies and procedures from a diverse section of organisations working in Halton. This supports effective safeguarding practice.

Priorities for 2013-14 include:

- Reviewing the Pan-Cheshire Multi-Agency Safeguarding Children Procedures to ensure compliance with Working Together 2013.
- Progressing a Pan-Cheshire Policy & Procedures Sub Group meeting.

Child Sexual Exploitation (CSE) Sub Group

The Sub Group has made progress against its action plan developed in line with the national CSE action plan, and informed by a range of reports and nationally identified areas of learning. This Group reports to the Pan-Cheshire Strategic Group chaired by the DI form the Police strategic Public Protection Unit who is also a member of the LSCB. The Strategic Group has worked with Merseyside Police and LSCBs to launch a joint CSE Strategy which will improve joint working across neighbouring local authorities and police forces, safeguarding victims and disrupting and prosecuting perpetrators.

Both the LSCB and partner agencies have delivered training to frontline staff, which has resulted in staff recognising children at risk of CSE, thereby acting to safeguard children and identify potential perpetrators. Cheshire and Merseyside police and LSCBs have jointly delivered CSE events to promote their joint strategy and working.

Cheshire Police has made improvements to how information and intelligence regarding sexual exploitation is obtained and recorded, to support the LSCB's awareness of understanding of this issue. This has been supported by extensive training and awareness across the constabulary's workforce and the appointment of a dedicated Detective Sergeant in the role of CSE/Missing Person Coordinator.

A multi-agency Operational Group has been developed, that has been meeting monthly since February. The focus of the group is to identify children at risk of CSE, ensure referrals to agencies are made, identify potential perpetrators and local areas of concern referred to as 'hotspots'. The work of this group is developing as more cases are referred in line with the level of awareness.

Priorities for 2013-14 include:

- Expand remit of the Sub Group to include children missing from home, care and education in recognition of the increased vulnerability of such children to sexual exploitation.
- Engage with the Pan-Cheshire Communications Sub Group on awareness and education.
- Improving data collection and sharing of information between partners regarding potential victims, perpetrators and hotspots.
- Raising awareness amongst young people and the public.
- Developing Practice Guidance for staff
- Ensuring the systems are embedded relating to CSE

Learning & Development Sub Group

A joint Learning & Development Sub Group was established in November 2012, reporting to both Safeguarding Boards in Halton. The joint Sub Group has overseen a joint Safeguarding Training Needs Analysis, and opportunities to jointly deliver training. This has included the Alerter Workshop and the Duty to Refer event delivered by the Disclosure & Barring Service.

The Sub Group oversees the LSCB Training Programme which has responded to requests from partners to amend content and delivery to meet the needs of the workforce. In total 1092 training places were taken up during 2012-13 compared with 698 in the previous year. This reflects revisions to the training programme, with new courses becoming available, and the impact of targeting some sectors to improve attendance.

The Sub Group has further developed how it measures the impact of training in terms of improved outcomes for service users. Examples of staff identifying safeguarding concerns and going on to protect children and young people are detailed in the Training Activity section of this report.

Priorities for 2013-14 include:

- Ensuring that the workforce responsible for CSE awareness raising with children and parents/carers has the appropriate level of knowledge and skills.
- Developing engagement with the Voluntary, Community & Faith Sector.
- Developing a joint Learning & Development Strategy.
- Delivering joint safeguarding training to elected members.
- Continuing to evaluate the impact of training on outcomes for service users.

Safer Workforce Sub Group

The Safer Workforce Sub Group continues to report to both Safeguarding Boards in Halton. The Sub Group has focussed its attention on the changes that have been taking place following the implementation of the Protection of Freedoms Act 2012. It has also approved a Safer Recruitment training course for the Adults Sector that puts the training of recruitment panel members on a similar footing to that across the Children's Sector.

In recognition of the need to strengthen the Sub Group a review of membership, terms of reference and work plan is underway.

Priorities for 2013-14 include:
- Reviewing membership and terms of reference.
- Monitoring Safer Recruitment practices across partners.
- Developing a process to oversee audit of supervision practices across partners.

Safeguarding Unit Meeting and Safeguarding Children Operational Group (SCOG)

The aim of the Safeguarding Children Operational Group (SCOG) is to provide a multi-agency forum for operational managers to meet to discuss safeguarding practice, identifying areas where improvements in multi-agency working can be made and promoting good safeguarding practice. It is solution focussed with SCOG reporting directly to the Safeguarding Unit meeting, which in turn reports to the LSCB Executive. Both SCOG and the Safeguarding Unit Meeting are chaired by the Divisional Manager for Safeguarding, Quality and Review.

Examples of the work undertaken by SCOG and the Safeguarding Unit Meeting include the introduction of a system to flag children subject to Child Protection Plans with acute Healthcare settings; review of Practice Guidance on police checks; and improving telephone contact with Children's Social Care following implementation of a new system across the Local Authority.

12. Priority Areas 2012-13:

The following areas were identified as priorities in 2012-13 to ensure the effective scrutiny of safeguarding arrangements in Halton:

Early Help:

During the year the LSCB ratified the revised Levels of Need Framework that were developed by the Children's Trust. The LSCB planned and delivered a launch event with the Trust at the joint Frontline Event in April 2013.

The Trust plans to undertake a training and skills analysis which will be reported to the LSCB's Learning & Development Sub Group. A representative from the Children's Trust Workforce Strategy Group now attends the LSCB's Learning & Development Sub Group, reporting formally on a six monthly basis, and the LSCB's Training Officer continues to attend the Workforce Strategy Group to ensure good communication and strengthen reporting on this area of business between the two.

The Children's Trust has piloted its multi-agency Induction Programme, which facilitates the workforce learning together and understanding the range of roles and agencies operational in the borough. This has helped to ensure that staff receive consistent messages and information on Halton's priorities. The LSCB will receive reports from the Children's Trust on the impact of the Induction Programme.

Domestic Abuse:

The gaps in Domestic Abuse services were highlighted by the LSCB. This was formally raised at the LSCB Chair's quarterly meetings with the Local Authority's Chief Executive and Lead Member. In addition the LSCB funded a development session for Halton Domestic Abuse Forum (HDAF) to strengthen the Forum's work. A Senior Director from Children's Services now chairs HDAF, strengthening the links between Children's and Adult Services.

The LSCB welcomes the commissioning of additional Domestic Abuse services during the forthcoming year that will improve outcomes for children and families. Performance measures will be established to measure the impact of these services on outcomes for children and young people.

Child Sexual Exploitation:

The LSCB has established a Child Sexual Exploitation (CSE) Sub Group in recognition of the work that needed to be undertaken. There is a strong Pan-Cheshire CSE & Missing From Home Strategic Group which the LSCB contributes to and locally the LSCB's CSE Action Plan is informed by the Pan-Cheshire and national action plans.

Progress this year has included:

- Ratifying the Pan-Cheshire CSE Strategy and Protocol.
- Delivering training and awareness sessions to staff.
- Identifying CSE champions across partners.
- Providing evidence to the Office of the Children's Commissioner's enquiry into CSE in gangs and groups.

There are strong plans for the year including:

- Funding a CSE post to support information sharing and collation across partners, helping the LSCB to understand further the scale of the problem across the borough.
- Development of an Operational Group to share information and identify potential victims, perpetrators and community areas of concern.
- Further awareness raising amongst children & young people, parents and the public.
- Training for staff working in licensed settings such as the hospitality industry and taxi companies.

13. Progress against Business Plan 2011-13:

1. Maintain Structures for Halton Safeguarding Children Board to be enable it to fulfil its statutory functions and respond to local and national change

	Action required	Intended Impact	Achievements
1.1	Review the structure and current HSCB activity in the context of other strategic partnerships in order to ensure that the Board is effective and efficient.	Board continues to undertake its objectives and functions effectively.	Established joint Learning & Development Sub Group with Safeguarding Adults Board. Established CSE Sub Group. Established Pan-Cheshire Child Death Overview Panel.
1.2	Establish clear links and governance arrangements with key strategic partnerships in Halton.	Strategic partnerships are accountable for safeguarding children in their work.	Protocol agreed between LSCB and Safeguarding Adults Board.
1.3	Revise the protocol in place with the Children's Trust to ensure effective governance arrangements are in place that help the Board meet the requirements of the Munro recommendations.	The Board and Children's Trust are clear on how their roles differ and hold each other to account, providing robust challenge as appropriate.	Protocol revised.
1.4	To ensure that HSCB contributes effectively to the Children and Young People's Plan, and that the	Safeguarding children is embedded in the CYPP.	LSCB continued to be formal consultee of Children & Young People's Plan.

	safeguarding dimension in the planned delivery of services is effective, by influencing other strategic partnerships.		

2. Provide comprehensive guidance for Agencies and Individuals which facilitates partnership working to Safeguarding Children and Young People

	Action required	Intended Impact	Achievements
2.1	Maintain HSCB Safeguarding procedures in a current and easily accessible format ensuring amendments are made to reflect changing guidance & legislation	The workforce, including volunteers, have access to up-to-date procedures to support them in safeguarding children.	Amendments made to Pan-Cheshire procedures to reflect Rule 43 letter issued by Coroner. Amendments made to reflect priority of CSE.
2.2	Provide a supportive and Quality Assurance role for all agencies, organisations and the voluntary sector in their development of Safeguarding related policies and procedures	The workforce, including volunteers, have access to up-to-date procedures to support them in safeguarding children.	Ratification of a number of agencies' safeguarding policies & procedures.

3. Support the development of a safe and informed workforce including voluntary sector

	Action required	Intended Impact	Achievements
3.1	Training Needs Analysis is	Workforce has necessary skills and	Training Needs Analysis completed with

	conducted and reported to the Children's Trust to ensure Safeguarding training is provided to Children's Workforce	knowledge to effectively safeguard children.	Safeguarding Adults Board.
3.2	Quality assure level 1 and 2 safeguarding training delivered by stakeholders.	Workforce has necessary skills and knowledge to effectively safeguard children.	Quality assured several training packages.
3.3	Ensure that appropriate level 3 specialist Multi-Agency Safeguarding training is available to Halton's workforce.	Workforce has necessary skills and knowledge to effectively safeguard children.	LSCB multi-agency Training Programme in place. Courses added to reflect LSCB priorities.
3.4	Evaluate Safeguarding related training and its impact on practice and outcomes for children and young people in Halton	Inform future learning & development activity to improve outcomes for children and families from a suitably skilled and knowledgeable workforce.	Process for measuring impact of training upon outcomes for children revised and more qualitative information received.
3.5	Ensure the lessons from national, regional and local SCRs and Multi-Agency Practice & Learning Reviews are disseminated across the workforce, including the Voluntary Sector	Improved safeguarding and reducing the likelihood of similar circumstances occurring in the future.	Workshops on lessons learnt delivered.

3.6	Ensure that those staff who may undertake IMRs and chronologies as part of SCRs and Multi-Agency Practice & Learning Reviews are appropriately trained.	Effective SCR and PLR processes are in place, ensuring that recommendations are implemented to reduce likelihood of similar circumstances occurring in the future.	Executive members registered with NSPCC training website.
3.7	Provide development and support to members of the Child Death Overview Panel to enable them to fulfil their role to review the deaths of C&YP	Effective Child Death Review process is in place, ensuring that recommendations are implemented to reduce likelihood of deaths under similar circumstances in future.	Development event for Pan-Cheshire CDOP.

4. Maintain a capability to scrutinise Safeguarding practice and procedure in both single and multi-agency settings

	Action required	**Intended Impact**	**Achievements**
4.1	Ensure that appropriate processes are in place to measure the effectiveness of local work to safeguard and promote the welfare of children.	Children are effectively safeguarded.	Section 175/157 Audits of schools undertaken. LSCB recruited a Quality Assurance & Safeguarding Development Officer to provide additional capacity to the LSCB to support its scrutiny work.
4.2	Ensure that appropriate processes are developed to scrutinise the effectiveness of Early Help in Halton.	Children access Early Help appropriately, preventing unnecessary escalation up the Levels of Need.	6 monthly reports to LSCB in place. LSCB has directed Children's Trust to undertake work on levels of need and coordination of early help to older young people.
4.3	Ensure that appropriate processes are in place to	Children are effectively safeguarded in situations of Domestic Abuse.	Reports from Halton Domestic Abuse Forum received regularly.

	measure the impact of Domestic Abuse on children & young people and the effectiveness of reduction strategies.		Domestic Abuse services in process of being commissioned.
4.4	Scrutinise performance of Safeguarding activity to ensure Partners are working effectively together and targeting resources effectively in areas of Safeguarding need and identified compromised care.	Children are effectively safeguarded.	LSCB received regular reports from the Safeguarding Unit on safeguarding activity, alongside reports from partners. LSCB recruited a Quality Assurance Officer to provide additional capacity to support this area.
4.5	Provide scrutiny of the implementation of Single and Multi-Agency Action Plans arising out of Serious Case Reviews and Multi-Agency Practice & Learning Reviews undertaken by Halton Safeguarding Children Board.	Improved safeguarding and reducing the likelihood of similar circumstances occurring in the future.	LSCB undertook Multi-agency Practice & Learning Reviews and signed off the action plans. Further scrutiny will be undertaken during the year via the audit process.

4.6	Work with the Pan-Cheshire LSCBs to develop a regional CDOP that will review the deaths of all children and young people under 18 who normally reside in the area.	Reducing the likelihood of deaths in similar circumstances occurring in the future. Board undertaking its Child Death functions more efficiently.	Established Pan-Cheshire Child Death Overview Panel.
4.7	Conduct in-depth and meaningful reviews of cases which meet the criteria for Serious Case and Multi-Agency Practice & Learning Reviews as laid out in Chapter 8 of 'Working Together to Safeguard Children'.	Improved safeguarding and reducing the likelihood of similar circumstances occurring in the future.	Two Practice Learning Reviews completed.

5 Engage with Children and Young People, their families and communities in developing and promulgating the Safeguarding agenda

	Action required	Intended Impact	Achievements
5.1	Develop the Young People's Participation Group jointly with the Children's Trust to ensure the meaningful and effective participation of children and young people in Halton with Halton Safeguarding Children Board.	Children inform the Board's priorities, and hold the Board to account for its work.	Consultation events have taken place with children & young people on specific topics and generally on what would help with Board engagement.
5.2	Ensure that the Lay Members are providing effective challenge	The community informs the Board's priorities, and hold the Board to	Lay Members attend Main Board and Scrutiny Sub Group.

	and scrutiny to the work of the Board on behalf of the community across Halton.	account for its work.	
5.3	To ensure that all target groups are engaged and informed of the role and work of Halton Safeguarding Children Board through an effective Communication Strategy	Raise the profile of the Board across all stakeholders.	Board members visited frontline staff to raise profile of LSCB.
5.4	Provide guidance and information in a suitable format to inform target audiences of Safeguarding related activity in Halton.	Ensuring that safeguarding awareness raising takes place across all stakeholders in an efficient manner.	Revised and further developed safeguarding messages to staff and public, such as how to report safeguarding concerns and e-safety.
5.5	To have a presence at key events and activities to promote the work of Halton Safeguarding Children Board and the Safeguarding Agenda.	Ensuring that safeguarding awareness raising takes place across all stakeholders in an efficient manner.	Attended public and staff events. Delivered Frontline event with Children's Trust.
5.6	To promote key Safeguarding themes through the organisation of workshops/ events and engaging in local and national campaigns.	Ensuring that safeguarding awareness raising takes place across all stakeholders in an efficient manner.	Supported and delivered safeguarding session at Crucial Crew for Year 5 pupils across Halton.

14. Budget:

Income 2012-13

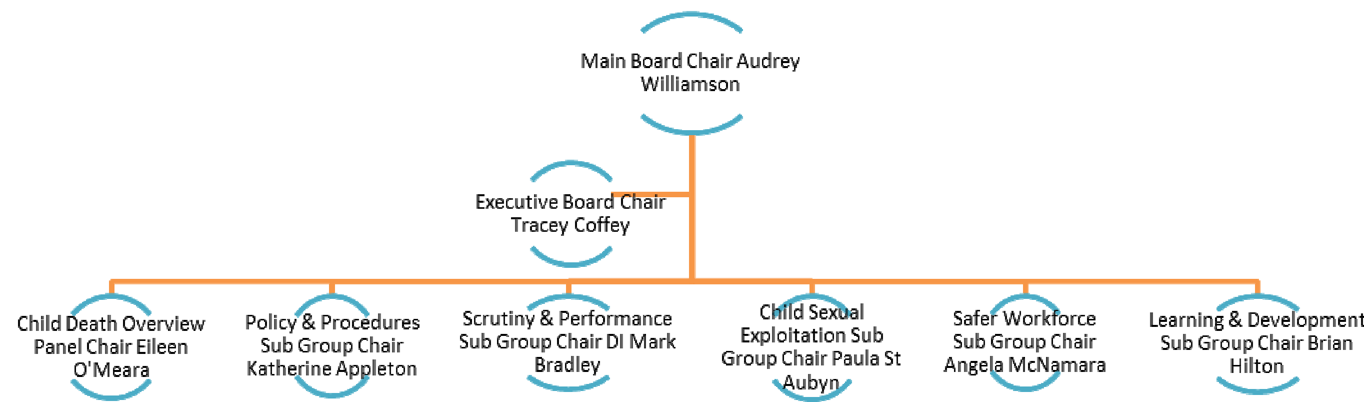
AGENCY	CONTRIBUTIONS
HBC – Children & Enterprise Directorate	45,817
HBC - Schools	33,000
NHS Merseyside/Halton CCG	45,817
Cheshire Constabulary	20, 000
Cheshire Probation	3, 230
Cafcass NW	550
Training Income	124
Carry Forward 2011-12	133, 365
Total:	**281, 903**

Expenditure 2012-13

Staffing	126, 419
Multi-Agency Training	14, 736
Staff Training including Travel Expenses	1, 802
Learning & Improvement Activity	11, 762
Advertising & Marketing	6, 455
Recharge/Overheads & Miscellaneous	10, 736
TOTAL:	**171, 910**
Carry Forward:	161, 703
Total:	333, 613

2012-13 Budget	£51, 710
Net Expenditure from figures above	£51, 710

Appendix A
HSCB Structure March 2013



Appendix B
HSCB Membership & Attendance 2012-13:

Attendance Log			19.06.2012	18.09.2012	11.12.2012	19.03.2013
			Meetings 2012-2013			
Independent and Overseeing Members	**Audrey Williamson (Independent Chair)**		✓	✓	✓	✓
	Cllr Ged Philbin, Lead Member Children & Young People (Participant Observer)		✓	✓	A	D
Lay Members	Marjorie Constantine, Lay Member		✓	✓	✓	✓
	Yvonne Shelley, Lay Member		✓	✓	✓	✓
Local Authority	Gerald Meehan, Strategic Director, Children & Enterprise, HBC		A	A	✓	A
	Steve Nyakatawa, Operational Director, Learning & Achievement, HBC		D	✓	D	✓
	Paula St Aubyn, Divisional Manager, Safeguarding Quality & Review, HBC		✓	A	✓	✓
	Tracey Coffey, Operational Director, Children & Families, HBC		✓*	✓*	✓	A
	Lindsay Smith, Divisional Manager, Mental Health, Communities Directorate, HBC		A	✓	✓	D
	Mike Andrews, Community Safety Manager, HBC		D	A	D	✓
	Sarah Ashcroft, Domestic Abuse & Sexual Violence Coordinator, HBC		D	✓	✓	A
	Catherine Johnson, Principal Performance Officer, HBC		✓	✓	✓	D
	Helen Rimmer, Legal Services, HBC		R*	✓*	A*	A
Health	Dr Suprio Bhattacharyya, Designated Doctor for Child Protection, Bridgewater Community Healthcare Trust		✓	✓	✓	A
	Michelle Bradshaw, Assistant Director of Child & Family Health Services, Bridgewater Community Healthcare Trust		✓	R	R	R
	Corina Casey-Hardman, Head of Midwifery, Bridgewater CHT		D	A	A	A
	David Melia, Director of Nursing - Warrington and Halton Hospital		D	A	✓	R
	Phil Dearden, St Helens & Knowsley Teaching Hospitals NHS Trust		✓	✓	✓	✓
	Dr David Lyons, GP, Grove House Medical Practice, LMC Representative		A	D	✓	D
	Linda Kellie, Head of Service, 5 Boroughs Partnership		R	R	✓	R
	Jan Snoddon, Chief Nurse, NHS Halton CCG		✓*	✓*	A*	✓
	Eileen O'Meara, Director of Public Health		A	D	✓	A

Attendance Log			Meetings 2012-2013			
			19.06.2012	18.09.2012	11.12.2012	19.03.2013
	Ann Dunne, Designated Nurse, NHS Merseyside		✓*	A*	A*	✓
Police	Martin Cleworth, Superintendent Northern BCU, Cheshire Police		D	D	D	R
	Mark Bradley, Detective Inspector, Public Protection Unit, Cheshire Police		A	✓	D	✓
	Nigel Wenham, Cheshire Police – Strategic Public Protection Unit		✓*	A*	R	✓
Criminal Justice Services	John Davidson, Probation Officer, Cheshire Probation		✓	R	D	✓
	Gareth Jones, Head of Service, CWHW YOS		A	A	✓	A
CAFCASS	Tom Cheadle, Service Manager, Cafcass		D*	D*	D*	R
Schools and Colleges	Dee Denton, Head Teacher, Lunts Heath Primary, Primary Headteacher Rep		✓*	✓	D	✓
	Andrew Keeley, Headteacher, St Chad's, Secondary Headteacher Representative		✓	✓	✓	✓
	Jane Ainsworth, Governor, The Heath, Halton Association of Governors Rep		-	-	-	✓
	Paula Mitchell, Programme Manager, Riverside College		A	✓	✓	✓
Housing Sector	Niall McDonnell, Liverpool Housing Trust		D	D	D	D
HSCB	Tracey Holyhead, Business Manager		✓	✓	✓	✓
	Rosie Lyden, Safeguarding Training & Development Officer		✓	✓	✓	A
	Rhonda Saul, Quality Assurance & Safeguarding Development Officer		-	-	-	✓
Note Taker	Kimberley Harrison, Senior Administration Officer, HBC		✓	✓	✓	✓

*Denotes attendance of previous Board Member in this role
A = Apologies
R = Designated Representative Attended
D = Did Not Send Apologies
- = New Member of the Board

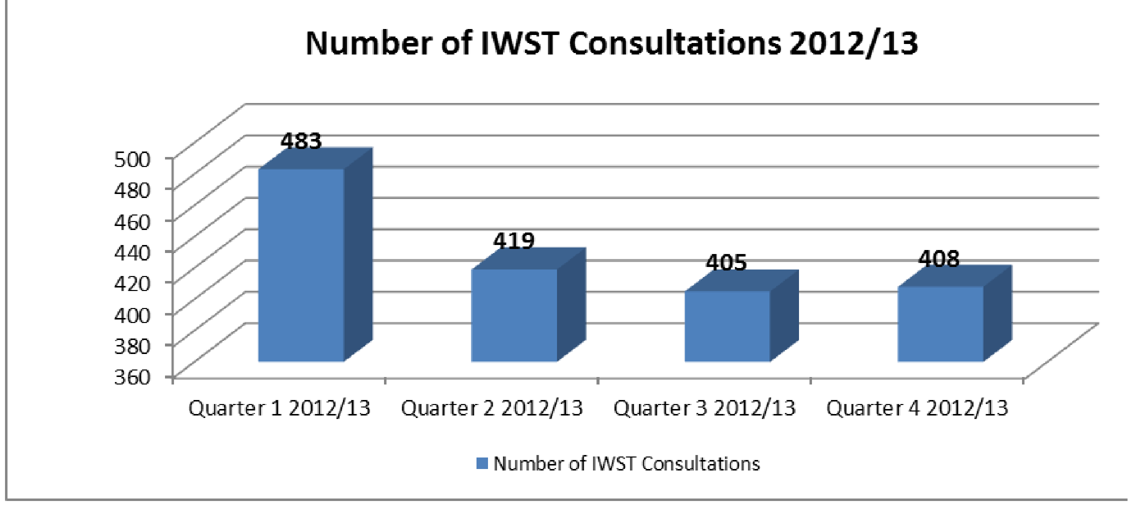
Previous Membership

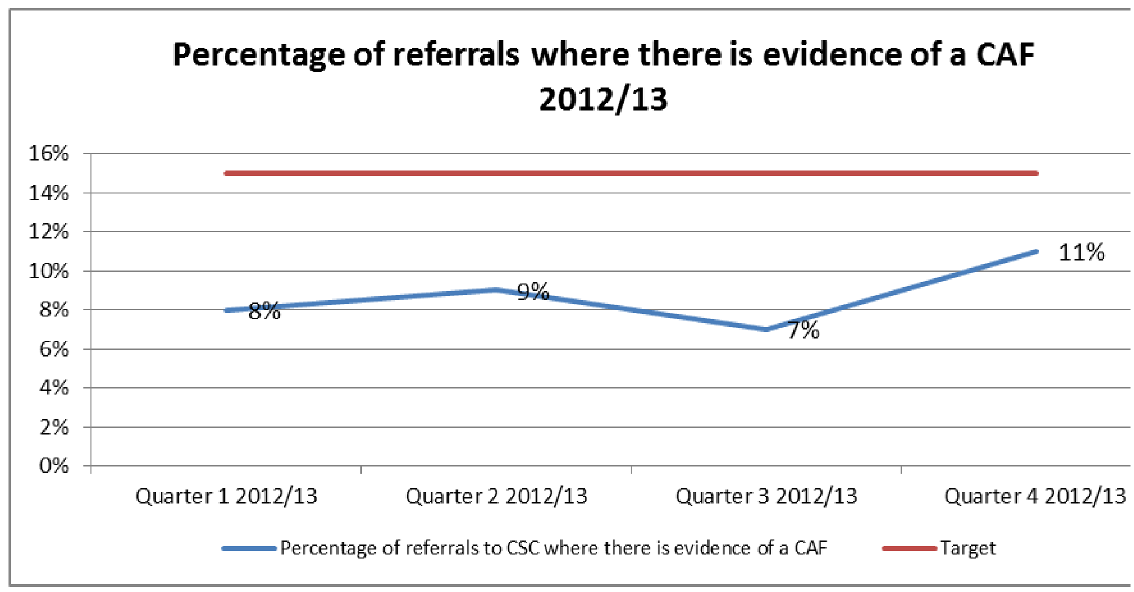
Tracey Coffey, Operational Director, Children & Families replaced Nigel Moorhouse, Operational Director, Children & Families, HBC
Helen Rimmer, Legal Services, HBC replaced Rob Barnett, Legal Services, HBC

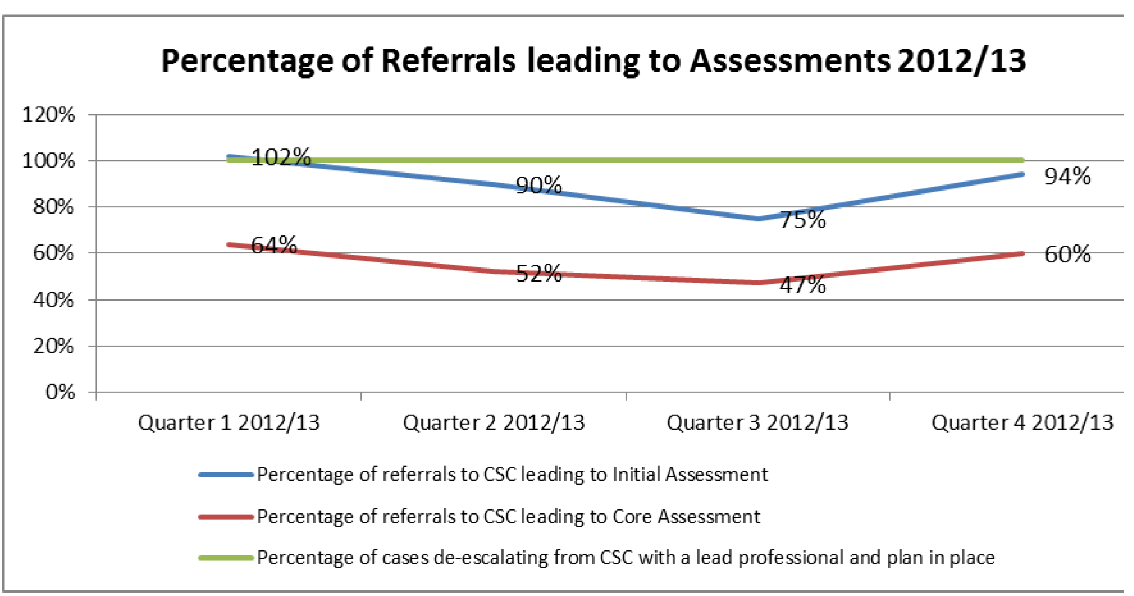
Jan Snoddon, Chief Nurse, NHS Halton CCG replaced Jane Lunt, Operational Director, Child & Family Health Commissioning, NHS Merseyside
DCI Nigel Wenham, Cheshire Police, Strategic Public Protection Unit replaced DCI Giles Orton, Strategic Public Protection Unit, Cheshire Police
Ann Dunne, Designated Nurse, NHS Halton CCG replaced Charlie Whelan, Designated Nurse, NHS Merseyside
Dee Denton, Head Teacher, Lunts Heath Primary, Primary Headteacher Rep replaced Vicky Pierce, Headteacher, Fairfield Infants, Primary Headteacher Rep

Appendix C
LSCB Performance Report Card 2012-13

Process Measures
Processes measuring the journey of the child, including the work of the Integrated Working Support Team, the escalation and de-escalation of cases to and from Children's Social Care







This chart details the percentage of referrals to Children's Social Care which continue to an Initial Assessment (90%+) or Core Assessment (50%+) which is a proxy for those cases where the referral is appropriately identified as at the correct level of need to warrant a thorough assessment of need and support through the statutory service.

The chart also details the percentage of cases de-escalating from social care where there is a requirement to have a lead professional and plan in place who have this. This has consistently been reported at 100% for the whole year through the management of these cases down the level of need by the identification of the lead professional at the final Child In Need Planning meeting.

Outcome Indicators
Indicators which measure the impact on the outcomes chosen as priorities

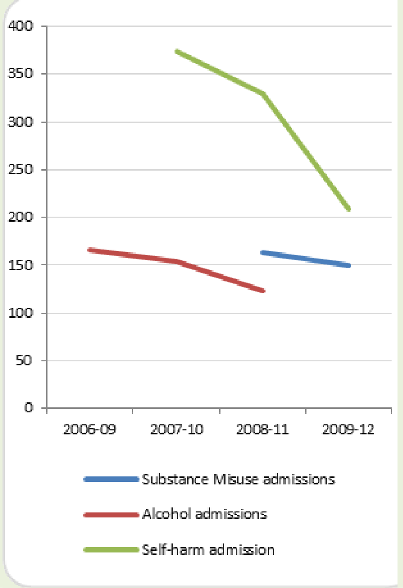
Children and Young People are protected from significant harm

Reduction in the number of children reported missing on more than 3 occasions in the quarter

60
50
40
30
20
10
0
Q3 2011/12
Q4 2011/12
Number of YP
Number of episodes

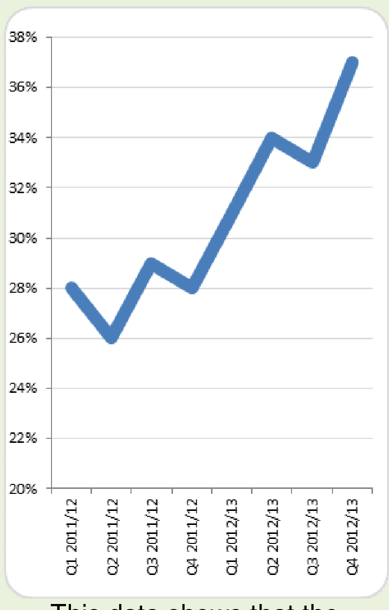
Q4 shows a slight increase in numbers; we have 54 repeat episodes from 11 repeat runners, however in this count there are 17 repeat episodes from 4 repeat CICOLA's. The service is working with all partners to reduce impact for future.

Reduction in hospital admissions related to self-harm, substance misuse or alcohol



This data is taken from the published CHIMAT profiles. Locally produced and more recent data is currently awaited.

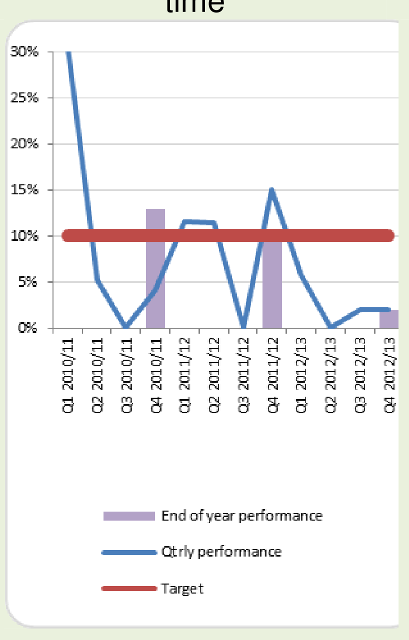
Reduction in the percentage of repeat MARAC



This data shows that the percentage of repeat MARAC's (rolling 12 months) has increased over the past 2 years.

Children and Young People who have been subject to significant harm are supported effectively and appropriately to prevent further harm

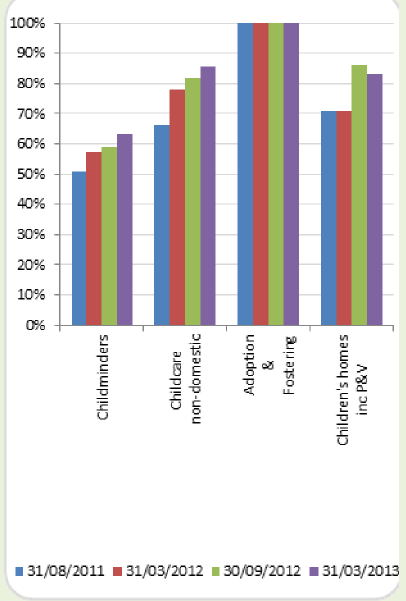
Reduce the percentage of children subject to a child protection plan for a second or subsequent time



Whilst Halton's performance can vary across the year given the small numbers in the cohort, Halton targets at 10% by the end of the year.

Currently for two of the children for whom child protection plans have been developed this is their second plan and the cumulative performance for the year is 2%, significantly below the target.

Increase the percentage of all inspected services with good or outstanding overall judgment



Performance is improving across the services in Early Years with a higher percentage of settings achieving good or outstanding for their latest inspections although there is still some progress to be made.

There are a number of newly registered children's homes within the LA boundary who have yet to have an inspection report published. The data in relation to Children's Homes covers 6 establishments.

Increase the percentage of schools who have completed their Section 175 Safeguarding Audits

2 establishments did not return their section 175 audits from those required.

Performance Measures
Measures where performance will impact on the outcomes chosen as priorities

	2011/12	Q1	Q2	Q3	Q4	Target	Alert & DOT
Percentage of Initial Assessments completed within timescales (10 working days)	75%	79%	89%	75%	73%[1]	85%	☒ ↓
Percentage of Core Assessments completed within timescales (35 working days)	86%	72%	76%	79%	70%[2]	92%	☒ ↓
Percentage of Initial Child Protection Conferences held within 15 working days of S47 enquiry start	81%	89%	84%	n/a	n/a[3]	100%	☒ ↓
Percentage of Initial Child Protection Conferences held within 15 working days of decision to hold a conference	100%	100%	100%	100%	100%	100%	☑ →
Percentage of Child Protection Plans that have lasted 2 years of more when ceasing	0%	0%	0%	0%	0%	0%	☑ →
Percentage of Child Protection Review Conferences held within timescale	100%	100%	100%	100%	100%	100%	☑ →
Percentage of Child Protection Initial Conferences with reports from GP's	75%	50%	67%	69%	62%	100%	☒ ↓
Percentage of Child Protection Review Conferences with reports from GP's	55%	57%	48%	61%	76%	100%	☒ ↑
Percentage of children and young people participating in the Children in Care process through their statutory reviews (age appropriate)	97%	100%	100%	100%	100%	100%	☑ ↑

1 Provisional awaiting quality assurance as part of Statutory Returns process

2 Provisional awaiting quality assurance as part of Statutory Returns process

3 Provisional awaiting quality assurance as part of Statutory Returns process

Appendix D
Child Death Overview Panel (CDOP) Report

All Boards have a statutory requirement to review the circumstances of death of every child under the age of 18 years, who normally reside in the borough. This is in order to identify any issues – known as "modifiable factors" - that, if changed, could help to reduce the risk of deaths under similar circumstances in the future.

Halton's CDOP has met as a multi-agency group chaired by the Director of Public Health. The core membership of the Panel includes: Public Health, Designated Doctor, Designated Nurse, Midwifery Services, 5 Boroughs Partnership NHS Trust, Cheshire Police, Children's Social Care, Learning & Improvement and Safeguarding Unit. Other representatives from relevant agencies are invited to attend Panel meetings as required.

Preventable child deaths are defined as those in which modifiable factors may have contributed to the death. These are factors which, if changed, could reduce the risk of injury or death in other children, although we cannot say that they would have prevented this particular child from dying.

Parental Involvement in the CDOP

Every death is a tragedy for the family concerned, even where everything that could have been done has been done. All bereaved parents receive a letter and additional information explaining the Panel process. A practitioner currently working with the family hand delivers the letter to the parents, which provides an opportunity to answer any immediate questions regarding the process. In addition, parents can arrange to speak to the CDOP Chair should they wish.

Child Deaths

In 2012-13 there were 6 child deaths; however, it has subsequently been agreed that one of the child deaths will not be reviewed as the child died at only 20 weeks gestation. (The CDOP considers child deaths following live births from 22 weeks gestation onwards.) This is a slight increase on 2011-12 when there were 4 child deaths. However the number of child deaths continues to be lower than those in the initial years of the CDOP.

The Panel completed reviews on the death of one child, from April 2012-March 2013. In addition, a review of the death of a child was completed up to the point of Coroner's inquest. Consideration was also given to work undertaken by NHS Merseyside in relation to a further death that was awaiting a Coroner's inquest. This was a reduction of six in comparison to the previous year. This was due to two deaths awaiting Coroner's inquest, and two deaths occurring in the latter months of the year. From 1st April 2013 a Pan-Cheshire

CDOP arrangement will come in to place with dedicated admin and processes in place to ensure that information is collected to strict timescales.

Using national guidance, the Panel considered whether any of the following factors may have contributed to children's deaths and whether they could be improved to reduce the risk in future:

- Factors intrinsic to the child - e.g. health issues, life limiting conditions
- Factors related to care or parenting
- Factors in the environment - e.g. hazards, road safety limits
- The delivery of services - e.g. delayed medical response.

The panel determined that no modifiable factors which may have contributed to the child's death were present in the case reviewed.

	April 2008-March 2009	April 2009-March 2010	April 2010-March 2011	April 2011 – March 2012	April 2012–March 2013
Number of Deaths	**14**	**12**	**14**	**4**	**6**
	April 2008-March 2009	April 2009-March 2010	April 2010-March 2011	April 2011-March 2012	April 2012–March 2013
Number of Reviews	**9**	**14**	**13**	**7**	**1**

Category of death	April 2008-March 2009	April 2009-March 2010	April 2010-March 2011	April 2011-March 2012	April 2012-March 2013
Deliberate inflicted injury, abuse or neglect	0	2	0	0	0
Suicide or Deliberate Self Inflicted Harm	0	0	1	0	0
Trauma & Other External Factors	1	1	1	0	0
Malignancy	0	1	0	0	0
Acute medical & surgical condition	0	0	1	0	0
Chronic medical condition	4	2	2	2	0
Chromosomal, Genetic or Congenital Anomalies	1	3	1	2	0
Perinatal/Neonatal Event	2	4	5	2	0

Infection	0	0	0	0	0
Sudden Unexpected, Unexplained Death	1	1	0	1	1
Total number of deaths reviewed	**9**	**14**	**13**	**7**	**1**

Ages of children who died	April 2008-March 2009	April 2009-March 2010	April 2010-March 2011	April 2011-March 2012	April 2011-March 2012
0 - 27 days	3	4	5	3	4
28 – 364 days	3	5	3	2	0
1 year - 4 years	4	4	2	0	1
5 - 9 years	0	1	1	0	0
10 - 14 years	0	0	0	2	1
15 - 17 years	0	0	2	0	0

As the number of child deaths is small it has been difficult to identify trends. Moving to a Pan-Cheshire CDOP arrangement will provide a larger population which should allow for identification of learning and themes. This may include areas for collaborative working to further reduce the number of child deaths in the Cheshire region. This should be a more efficient arrangement in terms of administration and staff attendance, and will provide a standard agreed approach to reviewing CDOP cases across Cheshire.

Agenda Item 4a

REPORT TO: Executive Board

DATE: 21 November 2013

REPORTING OFFICER: Strategic Director - Communities

PORTFOLIO: Health and Wellbeing

SUBJECT: Halton - A place without Loneliness

WARD(S): Borough-wide

1.0 **PURPOSE OF REPORT**

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

2.0 **RECOMMENDATION: That the Board**

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

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

3.0 **SUPPORTING INFORMATION**

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

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

3.3 We will be one of the first Local authorities to adopt a strategic approach to combating loneliness and therefore the outcomes of the project will be of national importance both to practice and research in this field, and has been endorsed by the National lead for the campaign to end loneliness:
"Your strategy is excellent…….I was particularly pleased that you've been consulting

the older population in Halton….this is a solid plan. Would you be happy for us to use this as an example for other health and well-being boards…"

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

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

4.0 **POLICY IMPLICATIONS**

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

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

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

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

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

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

5.0 **FINANCIAL IMPLICATIONS**

5.1 The project aims to work within the existing financial budgets of the organisations concerned. It is planned that the robust partnership working already in existence will be utilised in making the project a success. The Health Improvement Team has been

reconfigured to now contain an older people's team who will be one of the main new contributors to the initiative.

6.0 **IMPLICATIONS FOR THE COUNCIL'S PRIORITIES**

6.1 **Children & Young People in Halton**

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

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

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

6.3 **A Healthy Halton**

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

6.4 **A Safer Halton**

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

6.5 **Halton's Urban Renewal**

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

7.0 **RISK ANALYSIS**

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

8.0 **EQUALITY AND DIVERSITY ISSUES**

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

9.0 **REASON(S) FOR DECISION**

9.1 To ensure that Halton can continue to effectively address the Government's national agenda around preventing and alleviating loneliness.

10.0 ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

Other approaches would not have involved a partnership approach to tackling the issue and as the issue of preventing and alleviating loneliness can only be effectively tackled via a partnership approach other options were quickly discounted.

11.0 IMPLEMENTATION DATE

11.1 December 2013.

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

None identified.

Halton - A Place without Loneliness

Scoping Document

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

1. Introduction

There is growing recognition that loneliness is a formidable problem which impacts on an individual's health and quality of life and even on community resilience with 10-13% of the population estimated to be acutely lonely. There is increasing evidence that people who are lonely are more likely to use health and social care services and a developing confirmation, through personal stories, of the emotional costs and misery that loneliness can cause.

Loneliness is a complex state which has been described as the discrepancy between desired and achieved levels in the quantity and quality of social relations. In simple terms, the mismatch between the quantity and quality of our relationships, and the expectations we have of what level of relationships would make us content and happy. Loneliness can thus be viewed as a subjective emotion. "If a person thinks they are lonely, then they are lonely" (Beaumont 2013).

Loneliness can be a passing emotion, be associated with certain situations or it can be persistent and long standing. For instance people can feel lonely when older children leave home, be lonely at family gatherings due to hearing loss, or suffer from deep rooted and ceaseless loneliness.

Loneliness and social isolation are often connected but there are important distinctions between the two concepts. Some people report feeling lonely despite having a good deal of contact with family friends while others feel content and even

glory in their solitude. A distinction is also sometimes made between lack of a close friend or partner (emotional loneliness) and lack of a social network of friends (social

loneliness). The good news is that many older people are willing and eager to do something about loneliness given the right support.

2. Loneliness and Health

Loneliness has a very negative impact on health. Some estimates put the health impact of loneliness as equivalent to smoking fifteen cigarettes each day, of greater severity than not exercising and twice as harmful as obesity (Holt-Lundstad 2010). The lonelier a person is, the more likely they are to experience increased depressive symptoms. Loneliness has been linked to hypertension and high blood pressure and in developing cardiovascular disease. Lonely individuals have double the risk of contracting Alzheimer's disease while having a dementia increases our chance of feeling lonely. Lonely people also have an increased chance of being admitted to care homes and hospitals. Experiencing loneliness can make it more difficult to manage smoking, alcohol consumption and eating habits (Campaign to End Loneliness 2013). With an increasing research base demonstrating the major health consequences of loneliness, it seems remarkable that more attention and resources have not been focused on the issue. This may well be because the very word "loneliness" has been avoided as it is associated with emotions that are not the state's concern. It may also be because we have concentrated more on the concept of social isolation which may well require a different type of intervention.

Public health interventions which address key health challenges for older people can also be targeted towards lonely people, especially as insensitivity to the issue is likely to limit the success of the interventions. These include increasing physical activity which creates opportunities to develop social networks, health screenings and community resilience events. Falls prevention programmes can be vital in helping older people retaining their social connectedness by maintaining their mobility.

3. Loneliness and Quality of Life

While the negative outcomes of loneliness on health are becoming clearer, the impact of loneliness on a person's quality of life is of equal importance. A number of studies have identified relationships as having a significant impact on living a long and healthy life. Quality of life measures identify good social relationships as the key dimension in bringing quality to most people's lives. One study with older people discovered that over 80% said that relationships brought quality to their lives by providing companionship, confidence and generally making life bearable. Many others described how poor social relationships reduced their quality of life. And it is these stories of the personal and emotional costs of loneliness which should be the main drivers of our response. "At a profounder personal level loneliness means the loss of hope, energy and contribution from so many daily lives spent in quiet desperation" (Cann 2012).

4. The National Context

Age UK have been critical of the lack of national initiatives around the loneliness agenda. “The leaders of our health, housing, environment and social care systems need to place social isolation alongside the standard menu of public health challenges, as urgent and in need of action. This requires strategy, programmes and targets, not lip-service in speeches or policy documents.” (Paul Cann, Chief Executive, Age UK Oxfordshire).

The Office of National Statistics has recently produced a series of short articles examining the well-being of older people, one of which gives a national picture of loneliness. The key points include:

- 9 per cent of respondents said they felt lonely often.
- A higher percentage of those aged 80 and over reported feeling lonely some of the time or often when compared to other age groups (46 per cent of those aged 80 and over compared to the average of 34 per cent for all aged 52 and over).
- Those who report feeling lonely sometimes or often are much more likely to report a lower level of satisfaction with their lives overall.
- People who had been widowed, separated or divorced or those who were in poor health were more likely to report feeling lonely.
- There is a strong association between reported feelings of loneliness and reported limitations in performing daily activities.
- Limitations in daily activities together with other changes in circumstances such as loss of partner or losing touch with friends as age increases are likely to contribute to the increase in reported feelings of loneliness in the oldest age groups.
- In all age groups a higher percentage of women than men reported feeling lonely some of the time or often, the differences were larger in the older age groups.

Some other national statistics about loneliness:

- **6 - 13% of older people say they feel very or always lonely**
- **6% of older people leave their house once a week or less**
- **17% of older people are in contact with family, friends and neighbours less than once a week, and 11% are in contact less than once a month**
- **Over half (51%) of all people aged 75 and over live alone**
- **Almost 5 million older people say that the television is their main form of company**
- **ELSA estimates 1 in 6 adults aged over 50 are socially isolated (Campaign to End Loneliness)**

5. Causes of loneliness

The causes of loneliness can give us indications of how to identify and locate people who are lonely. Causes include:

- Poor health
- Sensory loss
- Loss of mobility
- Moving into care or moving house
- Reduced/low income
- Bereavement
- Retirement
- Becoming a carer/ceasing to care/ change of role
- Other change, e.g. giving up driving

Feelings of loneliness can also be caused by wider societal issues such as poor access to transport, poor physical environment and housing, high crime rates and issues associated with new technology. These causes also indicate the importance of partnership working in overcoming the phenomenon.

6. Neighbourhood and individual responses.

Action at neighbourhood level is vital to the success of any loneliness initiative. Communities can play an important part in both combating and aggravating loneliness. Research demonstrates that supporting communities to develop resilience to loneliness can be effective in tackling the issue and lead to age friendly neighbourhoods. Successful interventions have included improved public seating and public meeting places, upgraded pavements and street lighting, developing intergenerational contact and improving local transport. Community Development Officers will thus play a crucial role in the effectiveness of any campaign by harnessing the strengths of older people. Workshops have been piloted with older people in Halton asking the basic question "What would it take to make this place a better place to grow older in?" The actions from these workshops should form the basis of our local area response to loneliness.

Interventions on an individual level will require inventive solutions. The nature of loneliness can mean that there are challenges around identifying and approaching people who are lonely. Knowledge of the risk factors associated with loneliness will be important in targeting the initiative as will strong partnership arrangements to ensure vital joint working.

7. What we already have

The Borough already provides a number of initiatives which can help alleviate loneliness as part of the Health and Wellbeing Service. These include Community Bridge Builders, Sure Start to Later Life, Health Improvement Team, Adult Placement Service, Wellbeing Enterprises, Age UK, Red Cross, Community Development and Sports Development. There are well established referral pathways between these agencies established through relationships made through PIP (Partnerships in Prevention) and the Health and Wellbeing Board and steering groups. The general feeling within PIP and the Health and Wellbeing Steering Group is that some good work is being done around social isolation but we have little focus or data on loneliness per se.

- Sure Start to Later Life has a small befriending service supported by volunteers.
- Community Bridge Builders can provide support to older people to engage in community activities.
- There are intergenerational initiatives being developed around the loneliness agenda within the Borough.
- There is an initiative being developed with care homes to twin them with local schools.

- A small Visbuzz project is being developed. Visbuzz is a simple Skype type tablet which enables older people to keep in touch with family, friends and carers.
- Some of the social groups facilitated by the Health Improvement Team swap telephone numbers and become telefriends to each other. There are existing social groups for older people but plenty of scope for the development of new groups, initially facilitated by the Health and Wellbeing Service with an eye to the groups becoming independent of agencies as quickly as possible.
- Many of the local third sector agencies provide activities which alleviate loneliness. For example, Wellbeing Enterprises run eight week life skills courses designed to equip people to cope with, among other things, depression and loneliness, while Age UK and The Red Cross have numerous activities to combat loneliness
- Currently there is a mapping exercise being undertaken to identify community assets including activity groups which is being facilitated by Community Development who also arrange many local events.

8. What actions/ interventions we will develop to combat loneliness

The flowchart below is a visual representation of appropriate interventions that will be developed by the project Steering Group.

The existing Sure Start to Later Life volunteer/befriending service currently has 12 active volunteers. This service will be expanded by incorporating some of the volunteers from the Health and Wellbeing Service and by advertising within existing agencies such as Halton borough Council. The strong relationship with Halton and St. Helens Voluntary and Community action will be utilised to further expand the service. It is hoped that the number of volunteers will at least double to 24 in the first year. Relationships developed through the Partnerships in Prevention Group (PIP), for example Age UK, The Red Cross, Community Transport and the Health and Wellbeing Service will strengthen this arm of the project.

It is sometimes assumed that older people in care homes will have plenty of company. This is sometimes not the case. The project will thus also include a theme of “twinning” care homes with local schools. It is hoped that schools will adopt a local care home and initially establish visits and events. There are many possible creative outcomes of this work including alleviating loneliness, facilitating residents to develop relationships in the community and encouraging intergenerational contacts.

A Visbuzz scheme will be piloted with up to 100 local older people. The scheme will enable lonely older people to keep in contact with family, friends and carers.

Existing telefriending services in the borough will be examined and reviewed to identify how effective such interventions are and if it is worthwhile further developing such services.

Current research on loneliness identifies social groups as the most effective intervention, especially where older people themselves are choosing the activities to be undertaken by the group. Staff from the Health and Wellbeing Service will facilitate the development of existing social groups, where appropriate, and support the establishment of new groups.

The project will take an intergenerational approach wherever possible. The Community Warden and Reablement service are currently identifying older people who have expressed feelings of loneliness and who are agreeable to visiting a local school to take part in a “Halton-Past and Present” venture. In this scheme older people will be positively viewed as holders of important memories rather than being judged on the more negative concept of loneliness. The Grange area has been identified for an initial scheme and the Grange Comprehensive School has commenced preparation briefings for some of their students.

Many of the above projects will require vital input from volunteers building on already robust work within the Health Improvement Team, Sure Start to Later Life, Age UK and Halton and St.Helens VCA. There will be a particular focus on lonely older people becoming volunteers.

Loneliness awareness training will be delivered to staff and the general public across the borough. In this context the Making Every Contact Count (MECC) developments will be crucial to the success of the project.

9. What success will look like

The outcomes of the project will be an improvement in the quality of life of older people in the borough and cost savings by preventing the need for more acute services. The following case study demonstrates savings but also illustrates the transformational potential of combating loneliness.

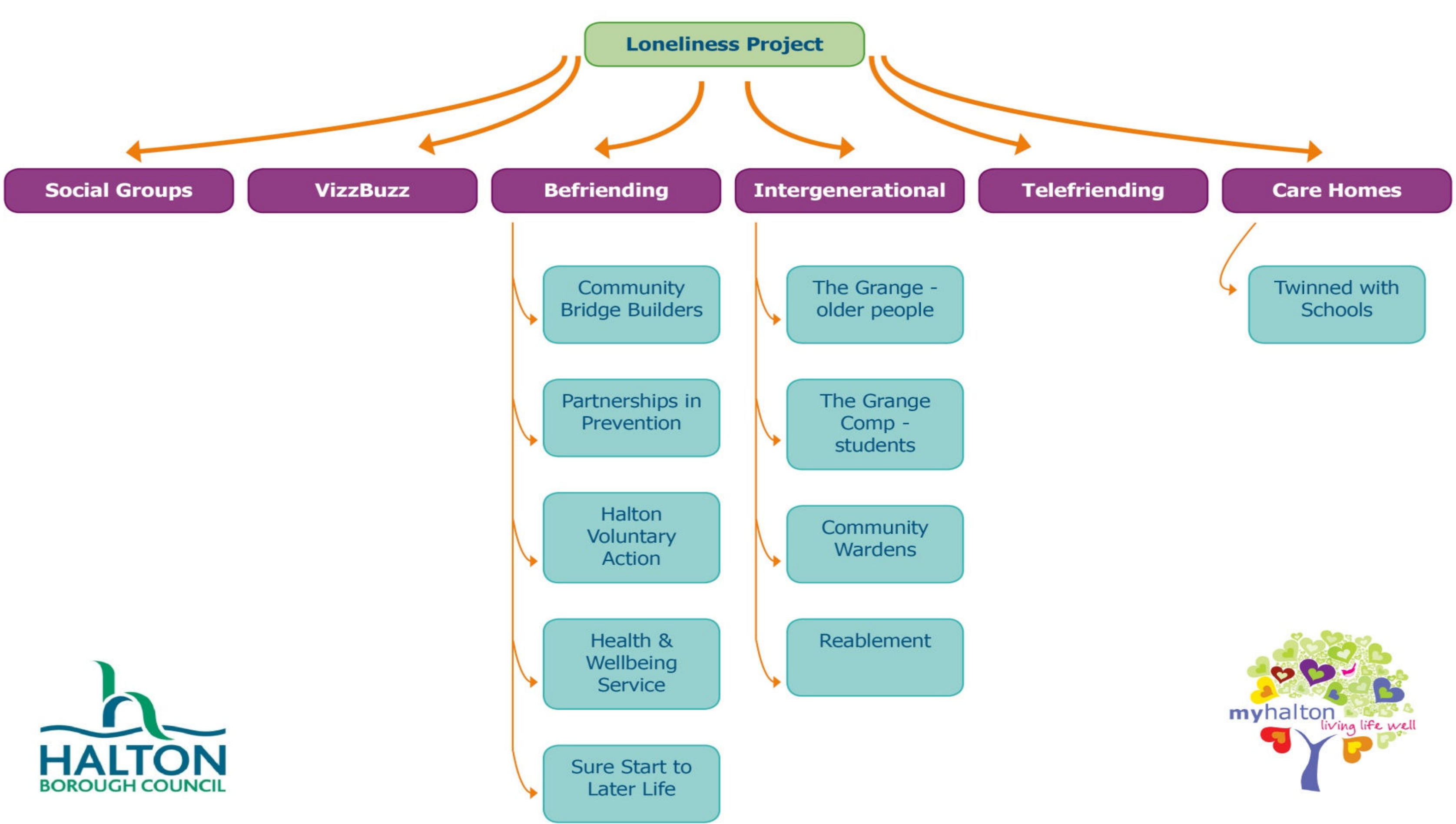
V described himself as being “lost” after losing his wife four years ago after 52 years of marriage. His life consisted of “TV, looking at four walls, being miserable, and completely lonely.” He had no friends locally. He became a volunteer befriender with Sure Start to Later Life. Through his volunteering V met Mrs.S who was also in her eighties; S described herself as unsteady on her feet and very lonely. V would accompany S on trips out shopping and support her when she was a bit unsteady on her feet. He made her laugh and they were good company

for each other. Both describe their lives as changing from “miserable and lonely” to “glorious”. “Loneliness is a disease but now I’m living again; our lives have turned upside down”. Both report feeling “alive and well, physically and mentally. We are living again; it is so natural it is unbelievable. None of this would have happened if I hadn’t volunteered for Sure Start to Later Life.”

Not only has the intervention transformed the couple’s lives but the potential savings to the health and social care economy are significant. Mrs. S was certainly heading for a permanent care home placement and possible falls related injuries. The couple now support each other rather than relying on support from health and social care agencies.

10.How will we measure our interventions?

There has been a lack research evidence of the effectiveness of measures of loneliness. There are thus a number of measures which the project will be testing out including the De Jong Loneliness scale and the SWEMWEBS tool for measuring wellbeing. Outcomes will also be tracked to examine the difference that the various interventions have made to people’s lives using the outcome domains from the Care Quality Commission.



Loneliness Project
Social Groups
VizzBuzz
Befriending
Intergenerational
Telefriending
Care Homes
Community Bridge Builders
Partnerships in Prevention
Halton Voluntary Action
Health & Wellbeing Service
Sure Start to Later Life
The Grange - older people
The Grange Comp - students
Community Wardens
Reablement
Twinned with Schools
HALTON BOROUGH COUNCIL
myhalton living life well

In the current financial climate efforts to combat loneliness need not be arduous. Much of the infrastructure to tackle the issue already exists in Halton. Better targeting of these resources and creative partnership working between statutory and voluntary will greatly increase the benefits to lonely people and provide cost effective solutions to the problem of loneliness.

11. References

The following documents have been useful in writing this strategy:

Bowling A conference presentation:http://www.campaigntoendloneliness.org.uk/loneliness-conference/ See also Bowling A*, Good Neighbours: measuring quality of life in older age*, ESRC and ILC (2010) http://www.ilcuk.org.uk/index.php/publications/publication_details/good_neighbours_measuring_quality_of_life_in_old_age

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Phongsavin.P.et al. Journal of Ageing Health. August 14th 2013. Age, Gender, Social Contacts, and Psychological Distress. Findings from the 45 and Up Study.

Combating Loneliness. A guide for local authorities. Local Government Association and Campaign to End Loneliness

Loneliness Harms Action Pack. Campaign to End Loneliness supported by Calouste Gulbenkian Foundation

Loneliness-The State we're in. Campaign to End Loneliness and Oxfordshire Age UK

Measuring National Well-being – Older people and loneliness, 2013
Jen Beaumont. Office for National Statistics 11th April 2013

Preventing loneliness and social isolation: interventions and outcomes. SCIE Research Briefing. October 2011

Appendix 1

The following are statements from local stakeholders and older people on the topic of loneliness. As far as possible the actual words of the person have been used. The comments have informed the strategy.

What is the current reality about loneliness in the Borough? That is, what is working, what are we proud of?

1/ I think most isolated/ hard to reach older people feel lonely. They are then in this bubble where being alone is their comfort zone, so it is very difficult to break through this. i.e Daytime TV trap.

Services current at the moment are working hard to tackle this; however the individual has to want to change their lifestyle. I personally am very proud of our DayTrippers group now having over 240 members. With the help of Halton Community Transport we facilitate door to door transport for Day Trips and Meals Out to places which are just not accessible to those who don't have transport. People are meeting up with past friends, having lost touch and also making new ones, so it is very much having a positive effect on people in the Borough. It eases lonely people into mixing socially, as they travel on the bus with people and realise there is others in the same boat as they are. Friendships are flourishing, people looking out for each other creating natural support which is just fab!

2/ The Community Bridge Building Team use a person centred approach to enable a person to identify mainstream activities and social groups within their local community and provide initial support to the person to help them settle into the groups and make new friends and look at natural support.

We have a positive relationship with the Social Work Team and if a person is unable to sustain themselves in the community then we can liaise with the Social Worker for direct payments.

We have built up key allies within the community and there are new groups for older people/luncheon clubs setting up new groups.

There are improvements for people with early onset dementia and there are a couple of groups set up that they can attend offering respite for the person who cares for them and activities for the person in a supportive environment. The recent one is at Chapelfields on a Friday morning and they are also in the process of setting one up on a Wednesday morning.

There is more education and training available to support staff to have a basic knowledge of people with Dementia.

3/ I think there are several areas that impact greatly on loneliness in the Borough. The main being the overall landscape; estates are very fragmented and people become isolated easily if they don't have transport or the means to get from A to B. Money is a huge barrier for people to access and attend services that may be in place; if it's a choice between food and a class etc. then we know what people need more. Fear – many people lack confidence and once they get on the slippery slope of isolating themselves it's gets harder to get out. There are a lot of services for young, families and school age and then it jumps to elders. What happens when you are in your 40's, 50's?

Proud of trying to combat all of the above in the arts provision we offer – making classes as accessible as possible, trying to go to people and make relationships before expecting them to engage and also bringing in people and product that is appealing to a wide section of the communities we work within.

4/ I suggest the initiative of the joint wellbeing strategy and programme with CCG is proving successful and is spreading to GP Practices and Community Centres. One of its main features is that it is FREE at the point of access and I suggest this feature should remain. (lonely people might have the money, but to pay involves some commitment, which such people find difficult to make).

5/ Recharge programme

Community Bridge Builders

Telephone support

Befriending

Wellbeing project –Mark Swift

House bound services?

Local care support workers –social service providers

Chair based exercise groups

6/ Live life well website has a section on older people socialising section

Participation groups

Stay Safe service

People's Register of Traders

Helping Hands Halton Open Money Advice Service

Products and services

Information services

7/ SAQ/ Carer’s Assessments can identify if someone is lonely or has little opportunity to meet people.

Community Bridge Building Team is available to increase opportunities for employment and education, activities and social groups, through which individuals can meet other people and form friendships.

Carers Centre to support carers and prevent isolation.

Development of Children’s Centres and Community Centres with groups and activities for all age ranges.

Adult Placement service – allows those cared for and carers to socialise with others.

Day Services.

8/ Sure Start and Bridge Builders, local community initiatives i.e. Sheltered Housing Schemes, Age UK.

9/ Development of services –SS2LL / Bridgebuilding and Day Services.

Adult family placement is an expanding and effective service that reduces loneliness.

The work the Visual Impairment team does to ensure people have access to equipment and support that keeps them in touch with the world around them.

10/ Hard to identify for people not involved with services but the long term impact on this group can be significant leading them to require contact with services due to mental health and physical health problems.

11/ When we do identify people in the Borough that require some lower level support to reduce loneliness this can take some time to access possibly due to waiting lists/high demand for current pool of volunteers. This is particularly true of people with additional needs (mobility and personal care needs especially) as many services cannot provide the additional support needed within existing Day Services.

12/ Within our groups lots of the clients have made good friendships and now do things together outside their groups.

Clients actively promote our services and encourage their friends to join who may be lonely.

We have lots of programmes that promote health and wellbeing, and people who are lonely may be suffering from health issues that may be related to their loneliness, so this will benefit them.

The pilot of a tele friending service.

13/ I think there are people in our communities who don’t necessarily come into contact with any service area and are disconnected to their local community and local services.

I think community centres make a vital contribution to tackling social isolation and building a sense of belonging to the local community, in particular where there are community café’s which enables drop in and social contact.

What are the issues and concerns about loneliness in the Borough?

1/ Transport is still a massive issue for people, along with mobility & health problems. Also lack of instant support for people can result in them losing interest or motivation to do something other than sit around, as it can be a while before the support is available. More immediate support needs to be available for people with Dementia and other mental health issues, as they sometimes need more specialist help which may be too much to ask of a volunteer at times.

2/ Families do not live locally and therefore unable to identify when their relative is lonely.

People live busy lifestyles.

The person does not know how to ask for help or access services.

People lack motivation and become happy within the boundaries of their own home

3/ That they are tackled in short bursts and there isn't a consistent approach to the problem. The communities we work in see Council Officers as not in the 'real' world and it's tricky to break through this barrier. There has to be a grass roots method (CDW methods).

4/ There are still hard to reach lonely people and barriers to their participation need to be tackled such as transport and accompanying service.

How do we contact those who do not use services - not on Housing Lists, Benefit Lists etc. but all would be on a GP practice list. Could we use their information to make contact?

There is a big shyness issue and a sensitive approach is needed - fear of official connections is wide spread - a befriending service may work.

Although some of the lonely people may be accessing groups/activities already many of them are not and sometimes those that are accessing services are still lonely.

Lonely people mostly want someone to talk to and listen to them and often teams are restricted to the amount of time available to offer this service.

5/ Transport/travel to and from available groups

Engagement with the housebound

Transport

6/ Poverty – this may restrict the opportunities individuals have to meet new people.

Care Leavers – can become lonely when moving on to own accommodation, this can lead not wanting the tenancy and mismanagement of the tenancy or sometimes eviction if the person is unhappy with their situation and

Adults - moving on to their own accommodation as above.

Older people living alone – may have little opportunity to socialise, particularly if they are not accessing the community.

Young Carers – may become isolated as a result of their caring role – young carers support, CAF.

7/ Main difficulty I perceive is transport and support required as people's needs increase in the group setting, also home visits.

8/ I would stress that loneliness is not only in OPs, but the young and isolated are often lonely but find it difficult to admit to - there is no shame in it , but some feel this way and we must remove that somehow - cross generational work could help.

9/ A lot of loneliness is due to family relationship breakdown-I'm minded of one case where the lady in question had not seen her son for several years as his late father (her husband) had fallen out with the son's wife. He only lived a mile away! It was sad for her despite the protestations of managing all right. Variations on this seem to be a common theme and no amount of social participation can heal the wounds. I'd like to see some sort of conciliation service offered to estranged families, where disputes don't seem too serious.

10/ From my service area there is an increasing demand from individuals who simply need to talk and pass the time of day with someone, this is particularly noticeable in community centres where on occasion they have approached members of staff for assistance with paperwork regarding benefits, utilities, etc. For some people, they don't have any family or network around them to do this.

What opportunities exist in the Borough that we could utilise?

1/ We need to work together as providers to identify those who may be lonely, and speak to them offering options and alternatives. This really needs to be based on personal preference, as I think a lot of people assume because someone is lonely that they need to change things. This is quite often the case where people are happy in their lives and decline change, but family or professionals make referrals as they think they know what is best for that person. It just causes frustration and confusion for them and results in barriers going up. I think it would be great if there is a way we can inform people about things going on, without following the assessment process, that way those who are put off by service intervention can choose to access things independently.

2/ There are many groups available to offer information, advise and support.

Local churches offer groups and luncheon clubs

Community Centres offer activities and social groups

3/ Building on the peer-peer tele-friending service we are piloting in our groups
Targeting the venues where lonely people will frequent, such as GPs
Pharmacy delivery teams could be skilled up to recognise lonely people they may be delivering medicines to

4/ Existing older peoples groups and organisations

Time banks

Church based visiting schemes

GP Contacts

5/ If you have a look at the activities in Churchill Hall, that is a good example of what some over 50's need.
The reason being most of the activities are during the day time,

The Brindley have some great evening shows that finish around 10pm/10.30pm but transport is difficult. That could be area we could look at.

6/ Local centres with staff trained in giving personal care, and knowledge of working with people who have dementia. Increase in befriending service

7/ We have a Relationship Centre in Halton

8/ Knowledge of the above groups so that support can be identified and appropriate social groups could be organised

9/ Targeted support could be available in community venues.

What would be your vision/dream for loneliness in the Borough?

1/ Recruit more volunteers to offer support to people in need. Actual lonely people would benefit from doing this – Kill two birds with one stone in effect. They would be providing a very worthwhile opportunity to others whilst combating their own loneliness. I would love this to develop into a network of lonely people, who could be matched together to form friendships. Sort of like a friendship agency (and possibly dating too!). It could link in with the Vis Buzz project.

2/ That every older person has contact/access to another person every day and in times of need (Visbuzz idea).

3/ That individuals have as many opportunities to be active within the community and to socialise at a level they are comfortable with.

4/ Local services available to people who may not fit traditional concepts of being in need of support but are feeling lonely.

5/ Services responsive and able to signpost and provide support aimed at reducing the long term impact of loneliness on people.

6/ To live in a Borough where loneliness did not exist and to have robust services in place that prevent this from happening.

7/ To make lonely people realise there are others like them and everyone can have a friend/buddy available to contact anytime (rather like AA) - a massive voluntary force harnessed to provide this individual contact for all those who need it. Especially those who live alone.

8/ That we can alleviate this feeling for some; buddy people up with those who are engaged and gradually have a community that's one.

9/ Utopia would be a strong sense of community spirit where local communities look out for each other and it doesn't require any intervention from service providers, strong resilient and caring communities in Halton.

What actions do you think need to be taken to address loneliness in the Borough? (Think "outside the box" as well as inside it!)

1/ Funding to support new innovative ideas. Positive staff to develop new projects. Funding to support volunteer recruitment drive.

2/ Integrate the tele-friending service in all groups that older people frequent.

Set up a befriending service that is not only phone calls but also a home visiting service not just for signposting but to have a conversation with and about the client.

Have a robust training programme for both carers of older people and also older people themselves so that they have awareness of how loneliness impacts on health and wellbeing and how they can access services to combat loneliness
Utilise every opportunity to find the lonely people in the Borough, i.e. Pharmacies, GPs, Hospital outpatients, care homes, taxi drivers & HCT etc.
Consultation with lonely clients to find out what they think will work

3/ Telephone link for all older people advertised on local radio/TV

Information booklet given to all over 50's of support groups/help lines

More locally organised groups in neighbourhoods where there are lots of older people

Intergenerational work – links between schools/colleges

Bring your grandparents/older neighbours to school/uniform group

Bring your children to older peoples community activities

4/ 5 GREAT Ways workshops/personal confidence building

Men in sheds

Befriending an elderly neighbour – giving information packs/Signposting

Ensure that all assessments discuss the issue appropriately with those we work with and that other agencies identify if they are concerned that someone is lonely and support them as far as possible.

Check what is available in the Borough for individuals. Workers to be emailed opportunities in the Borough.

5/ Skype, organised activities/interest groups, more trained volunteers, Rota of home visits for lonely people, increase of responsibility of local religious groups, Community bobbies doing regular checks on the more vulnerable.

Could existing services be expanded further to ensure that demand is met more quickly?

6/ Typical lonely/depressed/suicidal type mental health campaigns are aimed at people who have already been lonely for an extended period of time and for whom it has already affected their mental health. Could we establish support through places like third sector groups/Community Centres/Libraries/Parks and Gardens and Leisure Centres for example aimed at pulling people into groups and support networks aimed at reducing loneliness at a much earlier stage (likely to be well before they reach health/mental health and social services?)

7/ Could there be a poster and local media campaign highlighting current and existing groups across 3rd sector, Parks and Leisure Services as well as looking for new groups to be developed aimed at this group of people)

8/ Are men one of the groups that needs to be targeted most e.g. single men middle aged and up??

9/ How do we contact those who do not use services - not on Housing Lists, Benefit Lists etc. but all would be on a GP Practice List. Could we use their information to make contact?

There is a big shyness issue and a sensitive approach is needed - fear of official connections is wide spread - a befriending service may work

10/ Get out and amongst the communities more! Not with 'Council' boards and badges but be seen to care and be consistently 'present' at ground level. Bring the estates together and stop this feeling and fear of difference. Equality is a huge issue and although there is a lack of diversity when there is its very visible and this can escalate problems and insight a feeling of loneliness. We need to tackle all of this from a young age and get to those who are really alone through whatever means possible.

11/ The Library bus goes out to local areas and people's homes maybe they could identify older people who are housebound or socially isolated and make referrals to appropriate services, or staff from these services spending time on the bus and chatting to the staff and home owners.

12/ We need to support residents being connected, that might be to a neighbour, a service area, an activity, I guess this is sure start to later life territory. We need to provide a positive safe environment where people feel comfortable coming out their front doors and participating or indeed inviting people into theirs. Befriending arrangements and buddy support seems to work well but only happens in some areas of service. One point of contact who can address all concerns for residents would help, not sending people from pillar to post so they end up feeling exasperated, a model whereby people feel valued and want to contribute something back, identify their skills and strengths, timebanks maybe?

Appendix 2: Key Research Messages

- As people age they become more likely to have reduced contacts with family and friends .They are also more likely to be less mobile and have reduced income. These factors and others such as increased likelihood of hearing and sight deterioration can cause older people to be vulnerable to loneliness.
- Loneliness and isolation pose severe risks to health and can lead to early death. The effect of loneliness on life expectancy exceeds the impact of factors such as physical inactivity and obesity, and has a similar effect to that of cigarette smoking and alcohol consumption. Older people who are lonely have a greatly increased risk of developing Alzheimer's disease and have an increased use of health and social care services.
- Information services, community navigation services and befriending schemes have been shown to be successful in reducing people's feelings of loneliness and to be cost effective. Older people want such 1-1 services to be flexible and fashioned in accordance with individual's needs and preferences. Users of such services report finding them useful in maintaining and often increasing their engagement with community activities. Befriending schemes can be effective in reducing depression. "We need to invest in proven projects". (SCIE).
- The outcomes from mentoring services are less clear; one study reported improvements in mental and physical health, another that no difference was found.
- Older people who are part of a social group are likely to live longer than those who are not.
- There is some evidence that young adults experience similar levels of loneliness to much older people.
- There is some evidence to suggest that ethnic minority elders are among the loneliest as are people over 80 years of age. Gay men and lesbians are at greater risk of loneliness as they age as they are more likely to live alone and have less contact with relatives.
- Robust partnership working needs to be in place if services designed to reduce loneliness are to be effective and sustainable.
- Supporting older people to create, maintain and sustain existing and new relationships can reduce feelings of loneliness. Research also suggests that supporting older people to plan to maintain relationships and activities would be a worthwhile assistive mechanism. This could be particularly effective in the form of pre-retirement courses.

- Technology can be useful in alleviating loneliness where it assists in maintaining relationships with family and friends and where it is available to housebound older people, older people living with HIV/AIDS and people who live in communal housing.
- The research around effective interventions is somewhat inconclusive but indicates that reliance on one method of intervention is likely to lead to an ineffective response as is concentrating on social isolation at the expense of loneliness. A multi-pronged approach to the problem seems to be more effective.
- Well targeted loneliness interventions can substantially decrease spending on health and social care services. SCIE give case studies of befriending schemes saving £300 per person per year and Community Bridge Builder / Sure Start to Later Life type services saved even more. Group activities in one study indicated savings of £800 on health care use compared to the control group.
- Interventions are more likely to be effective where older people have been involved in the planning, development, delivery and assessment of interventions.
- More research is necessary to investigate the effectiveness of services particularly with different genders and populations.
- Although specific interventions can be effective, it is important that general services and activities are geared up to meet the needs of lonely people.
- There is a consistent relationship between increased frequency in phone contacts, social visits, and social group contacts and reduced risk of psychological distress adjusted for demographic and health factors.

Appendix 3: Action Plan

Action No.	Action	Responsible person	Timescale	Progress
1	Create a Loneliness Project steering group. This should include older people who should be involved in the creation and development of the project.	Peter Ventre	September 2013	
2	Identify actions that are likely to be effective in developing a strategic action plan which demonstrates top to bottom commitment to combating loneliness.	Peter Ventre	Ongoing	Initial Action Plan proposed
3	Identify people within the Borough that are at risk of, or suffer from, loneliness. This task could be facilitated through the Health and Wellbeing Steering Board and involve close consultation and the participation of older people. This will help define the local loneliness issue and involve many local agencies in shaping the agenda.	Sue Wallace-Bonner/Steering Group	December 2013	
4	Regularly measure loneliness and mapping need through JSNA and/or lifestyle surveys. Use this to monitor impact of interventions. There are currently no measures for loneliness included in	Sue Wallace-Bonner/Steering Group	January 2014	

	the JSNA.			
5	Include measures for reducing loneliness in any outcome-based commissioning (e.g. of voluntary sector groups and independent service providers) and in Council strategies for ageing - ensuring awareness of the subject in all areas of the Council's work.	Mark Holt/Steering Group	Ongoing	
6	Build on the asset based community approaches already being developed by the Council and its partners. Community Development will be a key partner in ensuring the project is developed locally.	Nicky Goodwin/ Steering Group	Ongoing	Community asset mapping exercise underway
7	Improve information and advice on existing services and activities that reduce loneliness and isolation. Community Bridge Builders, Sure Start to Later Life, Community Wellbeing Project, Health Improvement Team, Health and Wellbeing service and Adult Placement service are key existing services to facilitate this. Ensure these existing services and the many other services in the Borough focus on loneliness rather than just social isolation.	Peter Ventre/ Steering Group	Ongoing	Loneliness awareness training being developed as part of healthy ageing package of training. To be delivered to appropriate services first and then to widest possible audience
8	Support the voluntary and community sector to build referral partnerships with primary healthcare bodies (GPs, Community Nurses), Fire Services and Social Workers.			
9	Work with local transport providers to improve	Sue Wallace-Bonner/	Ongoing	

	accessibility for Older People	Steering Group		
10	Evaluate and improve physical environment E.g. are there plenty of benches available for people to rest on whilst shopping?	Sue Wallace-Bonner/ Steering Group	On going	
11	Identify what is going well. How could best practice be replicated across the Borough?	Peter Ventre/Steering Group	Ongoing	
12	Take an intergenerational approach to loneliness. There is some evidence to suggest that younger people experience loneliness as much as older people.	Peter Ventre/Steering Group		Initial intergenerational pilot being developed with Care Homes and schools- Wardens service and Grange Comprehensive School
13	Approach local businesses (particularly those with a significant proportion of older customers) and ask them to identify and make changes that can improve social networks/environment for older people in the community.	Peter Ventre/Steering Group		
14	Develop loneliness awareness/combating loneliness training for the general public and staff. This will support ensuring general services are geared up to meet the needs of lonely people.	Peter Ventre/ Steering Group	November 2013	Loneliness/falls awareness training being developed as part of healthy ageing package of training. Training to target widest possible audience e.g. refuse collectors, drivers, wardens and anyone else who may come in contact with lonely older people. The Making Every Contact Count(MECC) agenda will be an important reference

				point for this part of the project
15	Psychological support should be available, where necessary, to older people who experience extreme loneliness. This issue should be the focus of partnership working between health, the local authority and the voluntary sector.	Sue Wallace-Bonner/Steering group	Ongoing	
16	Develop pathways with GP's for "social prescriptions". That is, GP's referring to appropriate agencies those people who are lonely or at increased risk of being lonely, at risk of falling or who have fallen.	Mark Swift/Steering Group	November 2013	
17	Develop a loneliness pathway alongside the existing falls prevention pathway.	Peter Ventre	October 2013	
18	Test existing measures of loneliness and wellbeing for their effectiveness	Peter Ventre/Steering Group	Ongoing	
19	Make project part of Making Every Contact Count (MECC) agenda	Peter Ventre	November 2013	
20	Develop existing volunteer network for Health and Wellbeing Service	Peter Ventre/Steering Group	Ongoing	Volunteers from Health Improvement Team about to join loneliness project work stream.
21	Complete a review of the scoping strategy based on the data and evidence base developed	Peter Ventre/PH consultant	April 2014	

REPORT TO:	Executive Board
DATE:	21 November 2013
REPORTING OFFICER:	Strategic Director, Communities
PORTFOLIO:	Community Safety
SUBJECT:	Draft Night Time Economy Scrutiny Review Report
WARD(S)	Borough-wide

1.0 **PURPOSE OF THE REPORT**

1.1 To present the Safer Policy and Performance Board Scrutiny Review of the Night Time Economy for consideration by the Executive Board.

2.0 **RECOMMENDATION: That the Board**

1) **comment on the findings of the Scrutiny Review (attached at Appendix 1); and**

2) **endorse the Scrutiny Review and consider the financial implications identified in section 5.**

3.0 **SUPPORTING INFORMATION**

3.1 This report (attached as Appendix 1) was commissioned by the Safer Policy and Performance Board. A scrutiny review working group was established with seven Members from the Board, Operational Director, Community Safety Manager, Commissioning Manager and Principal Policy Officer.

3.2 The report was commissioned because the night time economy brings many positive benefits to the borough, from job creation, spending in our local economy and provision of a diverse range of activities for local people, including restaurants, arts centre, ice rink, cinemas, etc. However, to continue the development of our thriving night time economy, it is important that it is accessible, safe, clean, well-managed and offers a range of activities to suit residents across a wide age range and attract visitors to the borough.

3.3 The scrutiny review was conducted through a number of means between November 2012 and August 2013, as follows:

- Monthly meetings of the scrutiny review topic group;

- Presentations by various key members of staff from the Council and partners (detail of the presentations can be found in Annex 2 contained within Appendix 1);
- Provision of information;
- Visit to the CCTV Control Room

4.0 **POLICY IMPLICATIONS**

4.1 Existing policies are endorsed by the report.

5.0 **FINANCIAL IMPLICATIONS**

5.1 The recommendations are highlighted within the Appendix of the Scrutiny Review Report. Due to budgetary constraints, the key priorities from the recommendations in the report have been identified here. These first four recommendations have potential funding requirements that would need to be investigated further:

i) Area Forums to be consulted regarding the possibility of funding a pilot radio scheme for taxi operators in Halton;
ii) Look to extend the wrist band scheme (used to identify over 18's, following age checks) at the Stadium and other establishments;
iii) Investigate the possibility of working with food establishments in town centres and colour coding packaging from each business establishment, so that we could identify where the litter is from; and
iv) Investigate options to provide additional CCTV monitoring capability at peak times, possibly by using police officers on restricted duties. Other options may be possible but required further consideration due to Data Protection and cost issues.

The last four recommendations are unlikely to require additional funding and could be undertaken within our current resources.

v) Whilst Members recognised that it cannot be an enforceable condition through licensing, Members were keen for establishments to be encouraged to participate in the Pub Watch Scheme, which was recognised as best practice;
vi) Investigate the possibility of developing a mandatory Code of Conduct for licensed premises;
vii) The Night Time Economy Scrutiny Group recognised that we needed to build on the existing partnership approach, but we also needed to investigate potential ways to get local landlords and businesses on board to bring about change. A possible example was for landlords who were often best placed to identify vulnerable people who regularly drank to excess working with health care teams to help signpost individuals to services where appropriate; and

viii) The Council was currently exploring the opportunity of a scheme to enforce Fixed Penalty Notices. As yet no decision had been made.

6.0 **IMPLICATIONS FOR THE COUNCIL'S PRIORITIES**

6.1 **Children & Young People in Halton**
N/A

6.2 **Employment, Learning & Skills in Halton**
N/A

6.3 **A Healthy Halton**
Elements of the Night Time Economy Scrutiny Review impact on this priority, for example, underage alcohol sales and alcohol reduction plan. Implementing a six-month report on test purchasing, along with the continued monitoring of underage sales will ensure our good performance is maintained.

6.4 **A Safer Halton**
The scrutiny review report and recommendations support the Council's strategic priority of a Safer Halton. Taking on board the recommendations from the report will be positive steps to improving all aspects of the Night Time Economy for the residents of Halton.

6.5 **Halton's Urban Renewal**
N/A

7.0 **RISK ANALYSIS**

7.1 The report and recommendations support the Council's strategic priority of a Safer Halton. Taking on board the recommendations from the report will be positive steps to improving the Night Time Economy for the residents of Halton.

8.0 **EQUALITY AND DIVERSITY ISSUES**

8.1 The implementation of the recommendations will help to improve the Night Time Economy for all residents within Halton.

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

None.

Safer PPB Night Time Economy Scrutiny Review

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Report

August 2013

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1.0 PURPOSE OF THE REPORT

The purpose of the report, as outlined in the initial topic brief (at *Annex 1*) is to:

- Gain a better understanding of the issues relating to the night time economy in Halton, what works well and what could be improved?
- Examine the effectiveness of the current services that support the night time economy, how they work together and whether they deliver timely and effective action to address the needs of businesses and visitors to our night time economy
- Gain an understanding of the role of partner agencies in providing a safe, well managed night time economy in Halton
- Consider national and local best practice in relation to management of the night time economy
- Explore accreditation for the management of the night time economy in Halton, through the Purple Flag scheme. This scheme provides recognition that town centres are well managed and acts as an indicator for a safe night out, in the way that Green Flags do for quality parks and Blue Flags for safe and clean beaches.

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2.0 STRUCTURE OF THE REPORT

This report is structured with an introduction, a brief summary of the methodology followed by evidence, analysis with findings/conclusions and recommendations. The annexes include the topic brief, methodology detail and an action plan to capture the recommendations from the scrutiny review.

3.0 INTRODUCTION

3.1 Reason the scrutiny review was commissioned

The night time economy brings many positive benefits to the borough, from job creation, spending in our local economy and provision of a diverse range of activities for local people, including restaurants, arts centre, ice rink, cinemas etc. However to continue the development of our thriving night time economy, it is important that it is accessible, safe, clean, well-managed and offers a range of activities to suit residents across a wide age range and attract visitors to the borough.

Management of the night time economy cuts across numerous council services including licensing, transport, environmental health, planning, community safety, trading standards, street cleansing and town centre management as well as services provided by partners including health

and policing. It is only by working together particularly in these times of austerity, that we will be able to develop a thriving night time economy. The scrutiny review will provide a good opportunity to look at our night time economy, what works well and what could be improved to provide a safe, accessible, well managed night time economy that meets the needs of residents and businesses and attracts visitors to the borough.

3.2 Policy and Performance Boards

This report was commissioned as a scrutiny working group for the Safer Halton Policy and Performance Board.

3.3 Membership of the Scrutiny Working Group

Membership of the Scrutiny Working Group included:

Members	Officers
Cllr Norman Plumpton Walsh (Chair) Cllr Pauline Sinnott Cllr John Gerrard Cllr Margaret Ratcliffe Cllr Darren Lea Cllr Martha Lloyd Jones Cllr Sue Edge	Paul McWade – Operational Director for Commissioning and Complex Needs Chris Patino – Operational Director for Community and Environment Mike Andrews – Community Safety Manager Debbie Houghton – Principal Policy Officer Amanda Lewis – Commissioning Manager

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4.0 Methodology Summary

This scrutiny review was conducted through a number of means:

- Monthly meetings of the scrutiny review topic group;
- Presentations by various key members of staff and partners (detail of the presentations can be found in *Annex 2*);
- Provision of information;
- Visit to the CCTV Control Room

5.0 Evidence (summary of evidence gathered) and Analysis with findings/conclusions

5.1 Transport and the night time economy

Jeff Briggs, lead officer Transport Co-ordination gave an overview of bus services that operate during the hours of the night time economy in both Widnes and Runcorn. John Findlow, Licensing Enforcement

Officer also presented an overview of taxi licensing and the taxi service that operates in Halton. Key points raised were:-

- Very few buses run after midnight although a number of pubs and bars have late licenses until 3.30/4.00am with one in Widnes opening until 5am.
- The council has a responsibility to provide taxi ranks in proportion to the number of licensed vehicles, ten of which are located in town centres.
- Taxi services across the borough operate a reliable, cost effective (prices haven't gone up in 2.5 years) safe mode of transport out of town centres late at night.
- Key issues for taxi operators including future bridge tolls which will impact on taxi charges and costs and the negative impact of late night bridge closures which result in delays and increased costs for operators.

5.1.1 Conclusion

Getting people home quickly and safely following a night out is essential for a well-managed night time economy. However any additional services would need to be commercially viable and funded by the operators.

5.1.2 Recommendations:

- **Work with commercial operators to improve the late night bus services that they offer. In particular:-**

  - **Commercial bus operators be asked to consider funding a commercial bus service (funded by the operators) to and from the Hive and Runcorn. (The Topic Group recognise that this would not currently be commercially viable but may be in the future)**
  - **Commercial bus operators be asked to consider providing the funding to extend the late night service from Liverpool to Halton operating it as a pick up as well as a drop off service (To be funded by commercial operators if economically viable)**

- **Whilst it is recognised that there is currently no demand for a taxi rank at the Hive, this should be kept under review, in case this situation changes.**

- **Area Forums be consulted re: possibility of funding a pilot radio scheme for taxi operators in Halton**

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- **If funding is available from businesses/transport operators, then consider a consultation exercise (survey) to determine who are accessing the HIVE, how individuals are traveling to and from the HIVE and to ascertain levels of demand for public transport and:-**
- **If commercially viable, bus operators should consider the potential to possibly fund the extension of the existing service routes to the HIVE e.g. Buses 79 and 82 – however this would be dependent on demand/potential future demand**
- **Consider the development of a transport app that will tell users the location of bus and taxi services, provide contact details etc, should funding become available**

5.2 Purple Flag

An overview of the Purple Flag scheme was given at the first meeting by Debbie Houghton and this was followed at a later meeting by a presentation by Dave Watson, from Warrington Borough Council. Dave had worked with partners to gain Purple Flag accreditation for Stockton Heath in Warrington. Key points from the discussion included:-

- Purple Flag five key elements
- Gap analysis against Purple Flag criteria
- Positive benefits of Purple flag accreditation
- Transition between daytime and evening economy
- Policing and other services active within the night time economy

It was agreed to complete a gap analysis for Halton against the Purple flag criteria as part of the Scrutiny Topic Group work.

5.2.1 Conclusion

Purple Flag criteria are considered best practice in the management of the night time economy. However due to the costs and the work involved, which extends beyond the remit of this Topic Group, it was agreed that applying for Purple Flag status is not appropriate at this time.

5.2.2 Recommendations:

- **Work towards the completion of a self- assessment/ gap analysis for the town centre areas in Widnes and Runcorn, using the Purple Flag criteria as a guide (consider both as 1 town centre).**

5.3 Licensing Enforcement

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Bill Seabury (HBC Licensing Officer) and Chris Carney (Cheshire Police Licensing Officer) gave a presentation on licensing enforcement. The key points discussed included:-

- **Door Staff** training and the good working relationship with licensing officers
- **Communication through NightNet** -Radios within night time establishments which link through to the police and cctv control room to report any issues.
- **Forensic boxes** located within establishments and the role of staff in using them to collect evidence following incidents
- **Relationship** between police and council licensing staff and joint working to address licensing issues in Halton.
- **Role of licensing -** The licensing enforcement role is proactive and works with businesses. The police do patrols and have a passive drug dog to detect drugs and it is testament to the good working relationship that in a significant number of cases it is the pubs themselves that request licensing visits.

5.3.1 Conclusion

- The licensing role works well in Halton and there is a good relationship between the licensing teams in the council and police with landlords and door staff

5.3.2 Recommendations:

Members wanted to accompany the licensing team when they are visiting premises to observe. (This visit was cancelled due to unforeseen circumstances)

Whilst members recognise that it cannot be an enforceable condition through licensing, members were keen for establishments to be encouraged to participate in the PubWatch scheme, which is recognised as best practice.

Investigate the possibility of developing a mandatory Code of Conduct for licensed premises.

5.4 Alcohol related Crime Data

Mike Andrews, Community Safety Manager presented members with crime and alcohol related data for Halton. There discussion covered:-

- Number of people being arrested and taken into custody for being drunk and disorderly

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- People drinking at home before they go out and incidents happening when they do go out and are turned away from bars for being drunk.
- High concentrations of off licenses in some areas which can cause problems as there is such easy availability of alcohol

5.4.1 Conclusion

There are links between alcohol and crime, although many of the problems result from drinking at home rather than in bars and clubs.

5.4.2 Recommendations:

- **Continue to monitor alcohol related crime through regular reports to the Safer PPB and work together with health services and others to encourage people to drink sensibly.**

- **Continue to promote Arc Angel, which is a national scheme, to licensed premises in Halton**.

5.5 Widnes Street Pastor Service

The Reverend Jeremy Duff gave an introduction to the Street pastor Service, a national scheme already in place in other areas and which is to be introduced in Widnes. Key aspects of the scheme and the issues discussed are below:-

- The Street Pastor service is essentially a good Samaritan scheme, where trained volunteers are on hand to offer assistance to those in need.
- The Widnes scheme will operate between 11pm and 4am at Victoria Square on a Saturday night.
- The Street Pastor Service was well received by members of the Scrutiny Topic Group

5.5.1 Conclusion

The Widnes Street pastor Service was well received by members, although was not operational at the time of the presentation.

5.5.2 Recommendations:

- **Members would like to go out and witness the Street Pastor Service in action when it is operational. This was agreed with the Rev Jeremy Duff but no date has been arranged.**

- **Review the Street Pastor Scheme and its success through a report to the Safer PPB in 6 months.**

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– **If the Street Pastor Service is considered a success (following a review and report to the Safer PPB) members would like to ask the Runcorn churches to support a similar scheme to operate in Runcorn Town Centre.**

5.6 Underage Alcohol Sales

Phil Ramsden, Community Safety and Enforcement Team leader at Warrington Borough Council, gave an overview of the role of the joint Consumer Protection Service that he manages on behalf of Halton and Warrington councils. Key points discussed were:-

- Test Purchases and failure rates in Halton
- Parental responsibility - it is often parents who supply alcohol to their children rather than retailers selling illegally
- Responsible Retailers courses
- Role of Consumer Protection in raising alcohol awareness
- Operation Ice which targets the use of and supplying of fake IDs

5.6.1 Conclusion

The work of consumer protection in tackling underage sales is essential. Operation Ice was well received as a means of tackling the use and supplying of fake IDs. However the problem with parents supplying their children with alcohol is a more difficult issue and we know that this is a common problem in Halton.

5.6.2 Recommendations:

Continue to monitor underage sales to ensure that our good performance is maintained. Also we need to check the frequency of the test purchasing as part of the joint contract with Warrington Borough Council, with six monthly reports to the Safer PPB.

5.7 Alcohol Harm data for Halton

Amanda Lewis, Commissioning Manager for Halton presented a report on alcohol related health issues for Halton. Key areas discussed included:-

- Binge drinking culture
- Alcohol related hospital admissions
- Availability and cost of alcohol
- Attitudes and to alcohol and changing people's mind sets.

5.7.1 Conclusion

It is recognised that Halton and the North West has significant alcohol related health problems, which are worse than other areas.

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5.7.2 Recommendations:

Tackling alcohol related health problems will continue to be a key priority for the council and its partners. We recognise that it is only by continuing to work together that we will start to address this problem. Six monthly update reports to Safer PPB.

5.8 Alcohol Harm Reduction Plan

Collette Walsh, Head of Alcohol at NHS Merseyside, Halton and St Helens presented the Alcohol harm reduction Plan and how this Plan builds upon the good work that has been happening to date. Key themes were:-

- Strong infrastructure for alcohol treatment in place in Halton
- Need to change hearts and minds and help people make informed choices about their drinking
- Drinking at home is the biggest health issue relating to alcohol
- Collection of A& E data on where people had their last drink, so we can work with those pubs and clubs
- Alcohol as a coping mechanism particularly in difficult times
- Work with GPs to identify vulnerable people at risk of becoming problem drinkers so we can help people much earlier.

5.8.1 Conclusion

Robust alcohol treatment services are now in place, but more needs to be done on changing attitudes to alcohol. Drinking at home remains the biggest problem. We need to work together to identify individuals who would benefit from treatment services particularly early intervention services.

5.8.2 Recommendations:

- **Look to introduce an alcohol free bar in Halton.**

- **The NTE Scrutiny Group recognise that we need to build on the existing partnership approach but we also need to investigate potential ways to get local landlords and businesses on board to bring about change. A possible example is for landlords who are often best placed to identify vulnerable people who regularly drink to excess working with health care teams to help signpost individuals to services where appropriate.**

5.9 Tales from behind the bar

Chris Patino, DM Community and Environment gave some background information on the Stadium, which has the largest alcohol sales in the borough. Chris was accompanied by Adam and Graham who have

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worked at the Stadium for over 10 years. They gave members their perspective as bar managers on alcohol sales. At a later meeting John Caldwell (Stadium Bar Manager), gave a further perspective, reinforcing the points below. Key points discussed included:-

- Use of wristbands as proof of age
- Importance of common sense in dealing with individuals who are drunk
- Role of PubWatch
- Issue with people smuggling alcohol into the stadium to drink whilst attending an event

5.9.1 Conclusion

The Stadium is well managed and has systems in place to deal with underage drinking and managing those who become drunk whilst attending events at the Stadium. There are rarely any problems with drinking on match days and there is usually friendly banter between fans.

5.9.2 Recommendations:

- **We need to continue to monitor underage sales to ensure that our good performance is maintained. Also we need to check the frequency of the test purchasing as part of the joint contract with Warrington Borough Council**

- **Look to extend the wrist band scheme (used to identify over 18s following age checks) at the Stadium to other establishments**

5.10 Cleansing and the night time economy

Paul Wright, DM Open Space Services gave an overview of the council's approach to street cleansing and the issues we have to deal with that are associated with the night time economy . Key areas covered by the discussion include:-

- The council's approach to street cleansing. Particularly on a Saturday and Sunday morning
- Fast food wrappers are a significant problem
- The cost and scale of street cleansing associated with litter
- Role of volunteer litter pickers
- The council's approach to litter enforcement

5.10.1 Conclusion

The council's approach to street cleansing is effective with the resources we have available. However litter collection and disposal costs are significant. Fast food wrappers are a particular problem.

5.10.2 Recommendations:

- **The Council is currently exploring the opportunity of a scheme to enforce Fixed Penalty Notices. As yet no decision has been reached.**

- **Put information in 'In Touch' and 'Inside Halton' re: the amount and cost of litter collection**

- **Investigate the possibility of working with food establishments in town centres and colour coding packaging from each business establishment, so that we can identify where litter is from.**

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5.11 Planning and the night time economy

Alasdair Cross, Team Leader Planning, Economy, and Transport Strategy gave an overview on the role of planning and how this relates to the night time economy. Key issues discussed:-

- The role of planning in influencing the night time economy by identifying / promoting land for night time economy uses or seeking to restrict the development of certain uses in certain areas.
- Planning permission and hot food takeaways
- Policy restrictions within the UDP
- Breakdown of unit planning classifications in town centres and how these have changed over time

5.11.1 Conclusion

Planning has a role to play in identifying land for night time economy uses in town centres. There are significant numbers of hot food takeaways and planning are tackling this issue by seeking to resist new fast food establishments, however the potential for this is limited in the town centres, until the UDP policies which relate to old use classifications can be updated. . Existing planning permissions and established uses will remain.

5.11.2 Recommendations:

Planning policy is increasingly out of date (predating changes to Use Class Order). Delivery and Allocations Local Plan is being prepared.

5.12 Site Visit to CCTV Control room

Members of the Scrutiny Topic Group visited the CCTV Control Room at Runcorn town Hall. Stephen Rimmer accompanied members and gave them an overview of the service.

- There are 101 cctv cameras operating across the borough, covering the town centres, local centres, the Hive, bus station at Halton Lea, CRMz and cemeteries.

- The cctv control room has a direct phone line to the police and airwave radio. The control room is staffed 24 hours a day, 365 days a year.

- Currently there are six operators and one supervisor operating the system. The system is transferring to a wireless connection to save on phone charges.

- The cameras are operated by the control room staff. They can angle the cameras and zoom in or out to monitor events as necessary.

- Businesses registered through Shop Watch and Pub Watch can log into the control room system to report problems and communicate with staff and other businesses.

- All images are kept for a 31 day period, after which time they are deleted. The images are of good quality and on 542 occasions last year the images were used by the police

CCTV Report to Executive Board 28th Feb 2013 http://members.halton.gov.uk/documents/s28502/CCTV%20Monitoring.pdf

5.12.1 Conclusion

The CCTV control room has links with the police via radio and the Pubwatch radio schemes in Runcorn and Widnes and the images are of excellent quality.

5.12.2 Recommendations –

- **Investigate options to provide additional CCTV monitoring capability at peak times, possibly by using police officers on restricted duties. Other options may be possible but require further consideration due to Data Protection and cost issues.**

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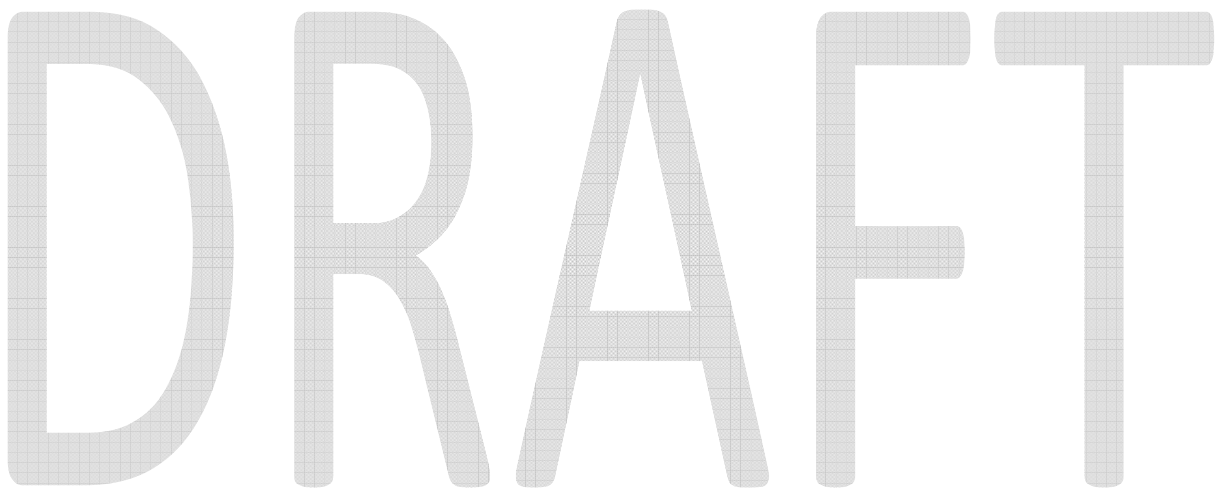
6.0 Overall Conclusion

This scrutiny review has been both a successful and a worthwhile exercise in terms of covering all the outputs and outcomes from the initial topic brief and gaining a sound knowledge and understanding of the issues affecting and resulting from the night time economy in Halton.

It is recognised that there is much good practice happening in Halton and our town centres are well managed through the excellent working relationships between the council and our partners and indeed businesses and the public.

There are recommendations for further improvement that have been identified from this scrutiny review and these have been arranged into an Action Plan at Annex 5 for ease of reference and monitoring.



Annex 1

TOPIC BRIEF

Topic Title: Night Time Economy

Officer Lead: Operational Director (Commissioning and Complex Care)

Planned start date: November 2012

Target PPB Meeting: 2013

Topic Description and scope:
A review of the current issues associated with the night time economy across Halton, focusing on understanding how services support businesses and visitors to our night time economy and the discharge of statutory responsibilities/duties and guidance relating to the night time economy.

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Why this topic was chosen:
The night time economy brings many positive benefits to the borough, from job creation, spending in our local economy and provision of a diverse range of activities for local people, including restaurants, arts centre, ice rink, cinemas etc. However to continue the development of our thriving night time economy, it is important that it is accessible, safe, clean, well-managed and offers a range of activities to suit residents across a wide age range and attract visitors to the borough.

Management of the night time economy cuts across numerous council services including licensing, transport, environmental health, planning, community safety, trading standards, street cleansing and town centre management as well as services provided by partners including health and policing. It is only by working together particularly in these times of austerity, that we will be able to develop a thriving night time economy. The scrutiny review will provide a good opportunity to look at our night time economy, what works well and what could be improved to provide a safe, accessible, well managed night time economy that meets the needs of residents and businesses and attracts visitors to the borough.

Key outputs and outcomes sought:

- A better understanding of the issues relating to the night time economy in Halton, what works well and what could be improved?
- Examine the effectiveness of the current services that support the night time economy, how they work together and whether they deliver timely and effective action to address the needs of businesses and visitors to our night time economy
- An understanding of the role of partner agencies in providing a safe, well managed night time economy in Halton
- Consider national and local best practice in relation to management of the night time economy

- Explore accreditation for the management of the night time economy in Halton, through the Purple Flag scheme. This scheme provides recognition that town centres are well managed and acts as an indicator for a safe night out, in the way that Green Flags do for quality parks and Blue Flags for safe and clean beaches.

Which of Halton's 5 strategic priorities this topic addresses and the key objectives and improvement targets it will help to achieve:

A Safer Halton:

Key Objective A: To investigate and tackle the underlying causes of crime and disorder and respond effectively to public concern by reducing crime levels, with a particular focus on reducing the levels of crime that disproportionately affect some of the more deprived areas

Key Objective B: To tackle alcohol and drug/substance abuse in all its forms, supporting the victims and their families and taking enforcement action against perpetrators.

Key Objective C: To tackle alcohol and drug/substance misuse problems and the resulting harm that is caused to communities, families and individuals.

Key Objective D: We will work together to reduce fear of crime and increase public confidence in the police, council and other agencies to respond to reports of crime and anti social behaviour and tackle any potential tensions within communities.

Nature of expected/desired PPB input:

Member led scrutiny review of the Night Time Economy.

Preferred mode of operation:

- Invite speaker from a council who have been awarded a Purple Flag for their management of the night time economy, to provide an overview of the process and associated costs and benefits.
- Meetings with/presentations from relevant officers within the Council to examine current practice regarding managing our night time economy
- Invite partners including the police and health services to give their perspective of the night time economy in Halton
- Accompany the police on a night shift in our town centres, to see the issues they have to deal with resulting from the night time economy.

Agreed and signed by:

PPB chair ………………………. **Officer …………………………….**

Date …………………………….. **Date ……………………………….**

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Annex 2

METHODOLOGY DETAIL

a) Presentations

The following officers gave presentations as part of this scrutiny review:

Name of officer	**Title of Presentation**
Jeff Briggs - Lead Officer Transport Co-ordination	Transport and the night time economy
John Findlow (JF) – HBC Licensing Enforcement Officer	Taxi Service in Halton
Debbie Houghton – Principal Policy Officer	Overview of Purple Flag Scheme
Mike Andrews – Community Safety Manager	Crime levels in Halton
Bill Seabury – Alcohol Licensing Enforcement Officer Chris Carney – Cheshire Police Licensing Officer	Licensing and the night time economy
Amanda Lewis – Commissioning Manager	Alcohol related Data for Halton
Collette Walsh - Head of Alcohol NHS Merseyside - Halton and St Helens	Alcohol Strategy and Action Plan
Dave Watson - Community Safety and Licensing Manager, Warrington Borough Council	Purple Flag Scheme Stockton Heath, Warrington
Phil Ramsden - Community Safety and Enforcement Team Leader, Warrington Borough Council	Under age Alcohol Sales
Reverend Jeremy Duff – Vicar at St Paul's Church, Widnes	Widnes Street Pastor Service
Paul Wright – DM Open Spaces Services	Cleansing and the Night Time Economy
Alasdair Cross – Team Leader Planning, Economy and Transport Strategy	Overview on the role of planning and how this relates to the night time economy
Chris Patino – OD – Community and Environment John Caldwell/ Adam/Graham (Stadium Bar manager and bar staff)	Tales from behind the bar

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Communities Directorate

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Annex 3

Documents Considered including Best Practice within the review

National Guidelines:

Purple Flag Scheme
http://www.purpleflag.org.uk/

Halton Borough Council documents:

Corporate Plan – 2011 – 2016

Sustainable Community Strategy – 2011 – 2026

CCTV Report to Executive Board 28th Feb 2013
http://members.halton.gov.uk/documents/s28502/CCTV%20Monitoring.pdf

Safer PPB Night Time Economy Scrutiny Review
ACTIONS PLAN

Action No.	Action	Who	Timescale	Progress Update
TRANSPORT				
1	**Work with commercial operators to improve the late night bus services that they offer. In particular:-** **Commercial bus operators be asked to consider funding a commercial bus service (funded by the operators) to and from the Hive and Runcorn. (The Topic Group recognise that this would not currently be commercially viable but may be in the future)** **Commercial bus operators be asked to consider providing the funding to extend the late night service from Liverpool to Halton, operating it as a pick up as well as a drop off service (This would be funded by commercial operators if economically viable)**	Jeff Briggs		**Update from Ian Boyd** For the operation of the night buses it would cost approximately £60,000 per annum in subsidy to the operators to provide such a service. This would be to provide two journeys around Widnes and Runcorn and due to the significant costs, would not be viable at this time.

2	**Whilst it is recognised that there is currently no demand for a taxi rank at the Hive, this should be kept under review, in case this situation changes.**	John Findlow		It is recognised that demand is not currently there but this should be kept under review.
3	**Area Forums be consulted re: possibility of funding a pilot radio scheme for taxi operators in Halton**	Cllr Norman Plumpton Walsh/ Mike Andrews		
4	**If funding should become available, possibly from businesses/transport operators, then consider a consultation exercise (survey) to determine who are accessing the HIVE, how individuals are traveling to and from the HIVE and to ascertain levels of demand for public transport and:-** **If commercially viable, bus operators should consider the potential to possibly fund the extension of the existing service routes to the HIVE e.g. Buses 79 and 82 – however this would be dependent on demand/potential future demand**	Jeff Briggs		Not planned at this time, but should be considered if funding should become available in the future Not commercially viable at this time but to be kept under review should demand change
5	**Consider the development of a transport app that will tell users the location of bus and taxi services, provide contact details etc, should**	Jeff Briggs		No funding currently available but should be considered should this situation change

	funding become available			
6	**Investigate options to provide additional CCTV monitoring capability at peak times, possibly by using police officers on restricted duties. Other options may be possible but require further consideration due to Data Protection and cost issues.**	Stephen Rimmer		Needs further investigation prior to any action being taken
PURPLE FLAG AUDIT				
7	**Work towards the completion of a self-assessment/ gap analysis for the town centre areas in Widnes and Runcorn, using the Purple Flag criteria as a guide (consider both as 1 town centre).**	Mike Andrews/Debbie Houghton		Work on-going
LICENSING				
8	**Members wanted to accompany the licensing team when they are visiting premises to observe. (This visit was cancelled due to unforeseen circumstances)**			It was not possible to re-schedule the visit during the period of the review

9	**Whilst members recognise that it cannot be an enforceable condition through licensing, members were keen for establishments to be encouraged to participate in the PubWatch scheme, which is recognised as best practise.**	Mike Andrews		All licensed premises are members of Pub Watch, however their attendance cannot be made an enforceable condition on a premises licence.
10	**Investigate the possibility of developing a mandatory Code of Conduct for licensed premises.**			
STREET PASTOR SERVICE				
11	**Members would like to go out and witness the Street Pastor Service in action when it is operational. This was agreed with the Rev Jeremy Duff.**	Mike Andrews/Jeremy Duff		Widnes Street Pastor Service went live on 1st June. It was not possible to arrange a visit during the Scrutiny Topic Group Review period.
12	**Review the Street Pastor Scheme and its success through a report to the Safer PPB in 6 months.**	Mike Andrews		Street Pastor Service Report has been planned into the Safer PPB Work Plan
13	**If the Street Pastor Service is considered a success (following a review and report to the Safer PPB in 6**	Mike Andrews		

	months) members would like to ask the Runcorn churches to support a similar scheme to operate in Runcorn Town Centre.			
TRADING STANDARDS				
14	**Continue to monitor underage sales to ensure that our good performance is maintained. Also we need to check the frequency of the test purchasing as part of the joint contract with Warrington Borough Council with six monthly reports to the Safer PPB.**	Eileen O'Meara		
HEALTH				
15	**Tackling alcohol related health problems will continue to be a key priority for the council and its partners. We recognise that it is only by continuing to work together that we will start to address this problem. Six monthly update reports to Safer PPB.**			Six monthly updates to be provided to the Safer PPB on alcohol related health issues.
16	**Investigate the possibility of introducing an alcohol free bar in**	Mike Andrews.		Mike Andrews to discuss with relevant

	Halton.			partners and to investigate a possible trial at the Select Stadium and report back to the Safer PPB, within the next 6 months
17	**The NTE Scrutiny Group recognise that we need to build on the existing partnership approach but we also need to investigate potential ways to get local landlords and businesses on board to bring about change. A possible example is for landlords who are often best placed to identify vulnerable people who regularly drink to excess working with health care teams to help signpost individuals to services where appropriate.**	Mike Andrews/Amanda Lewis		
COMMUNITY SAFETY				
18	**Whilst members recognise that it cannot be an enforceable condition through licensing, members were keen for establishments to be encouraged to participate in the PubWatch scheme, which is recognised as best practice**	Mike Andrews/ Licensing Team		

19	**Look to extend the wrist band scheme (used to identify over 18s following age checks) at the Stadium to other establishments**	Mike Andrews/ Licensing Team		
20	**Continue to promote Arc Angel, which is a national scheme to licensed premises in Halton**.	Mike Andrews		Generally establishments in Halton perform over and above the requirements of the Arc Angel standard, so they are performing well.
21	**Continue to monitor alcohol related crime through regular reports to the Safer PPB and work together with health services and others to encourage people to drink sensibly.**	Mike Andrews		
STREET CLEANSING				
22	**The Council is currently exploring the opportunity of a scheme to enforce Fixed Penalty Notices.**	Paul Wright		No decision has been made at the time of writing this report
23	**Put information in 'In Touch' and 'Inside Halton' re: the amount and cost of litter collection**	Paul Wright		
24	**Investigate the possibility of working with food establishments in town centres and colour coding packaging**	Paul Wright		This would involve the voluntary co-operation from food

	from each business establishment, so that we can identify where litter is from.			establishments and would need to be funded by the premises themselves

Agenda Item 6a

REPORT TO: Executive Board

DATE: 21 November 2013

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Health & Wellbeing / Community Safety

SUBJECT: 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 Safer Halton Partnership Drug Strategy 2014-2018 and accompanying evidence document.

2.0 **RECOMMENDATION : That Executive Board**

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

2) **comment on the Safer Halton Partnership Drug Strategy.**

3.0 **SUPPORTING INFORMATION**

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

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

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

3.4. The 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 a 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 **REASON(S) FOR DECISION**

9.1 To ensure that Halton continues to meet the requirements of the National Drug Agenda, to ensure effective prevention and treatment services are delivered locally to tackle the issues associated with drug misuses and the impact on individuals, families and communities of Halton.

10.0 **ALTERNATIVE OPTIONS CONSIDERED AND REJECTED**

10.1 Other approaches to the drug strategy had been considered including a Local Authority only strategy. It is clear that drug misuse impacts on all areas of society and a joint approach to the drug strategy is the most appropriate way to co-ordinate all partners' responses to address the identified areas.

11.0 **IMPLEMENTATION DATE**

11.1 January 2014

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

None.

Halton Clinical Commissioning Group

Safer Halton Partnership

Drug Strategy

2014 to 2018

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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.

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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

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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.

Priority	
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

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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

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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.

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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

Prevention of substance misuse and associated harm to the individual, families and communities

Maximising the health and well-being of individuals and communities affected by drug use.

Preventing and reducing harm to children, young people, adults and families affected by drug misuse

Protecting communities through tackling drug supply and drug related crime.

(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

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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)

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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.

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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

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	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

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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

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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.

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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.

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	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.

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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.

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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.

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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.

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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.

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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.

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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	

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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	

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					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	

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					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.
	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	Treatment programmes tailored to meet criminal justice sanctions based on changing demands and needs. Multi-agency agreements will be developed as required.

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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.	

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<table>
<tr><td>To review and revise protocols and working arrangements with key partners.</td><td>To review and revise protocols and working arrangements with key partners.</td><td>June 2014</td><td>Commissioning Manager (A) and Substance Misuse Service.
Partners as identified.</td><td>Staff time.</td><td>Increased number of referrals to treatment services by key agencies

Reduction in drug related admissions to hospital.</td></tr>
<tr><td rowspan="2">Improve individual's physical and mental well-being.</td><td>To provide screening, testing and vaccination for Blood Borne viruses.</td><td rowspan="2">Throughout period of strategy with quarterly review.</td><td rowspan="2">Substance Misuse Service, Health Improvement Team and GP practices</td><td rowspan="2">Staff time to complete the appropriate actions.
Cost associated with vaccinations and testing equipment.
Substance Misuse Budget

Health Improvement Team</td><td rowspan="2">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</td></tr>
<tr><td>To provide Health Check assessments to all individuals in the treatment service.</td></tr>
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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.

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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.

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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

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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

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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

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Safer Halton Partnership

Drug Strategy

Evidence Paper
2014 to 2018

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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.

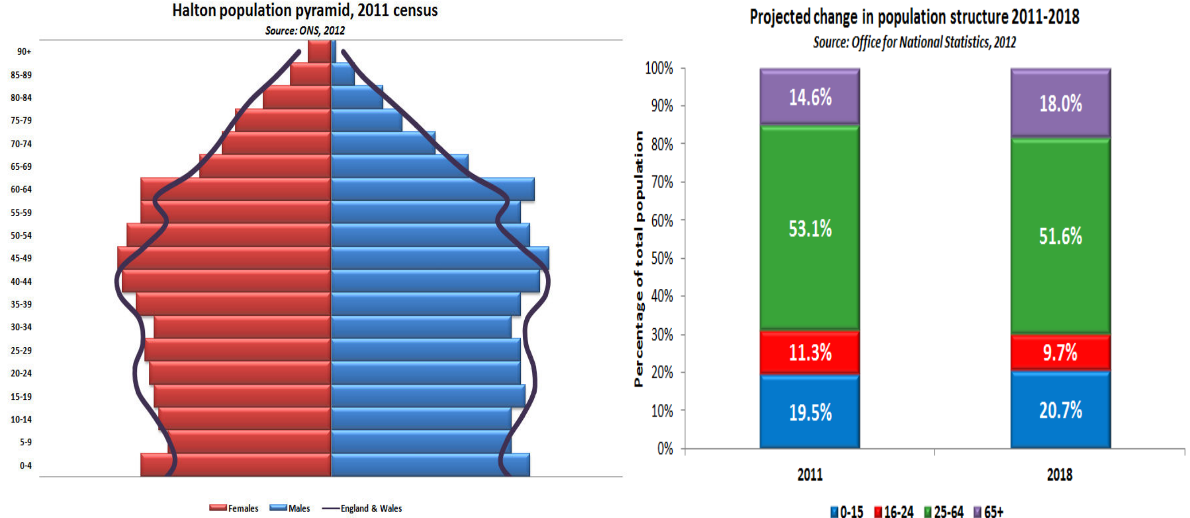
The quality standard requires that services should be commissioned from and coordinated across all relevant agencies encompassing the whole drug use disorder care pathway. An integrated approach to provision of services is fundamental to the delivery of high quality care to adults with drug use disorders.

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.

Family factors:

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

Economic factors:

- Neighbourhood deprivation and disintegration.

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

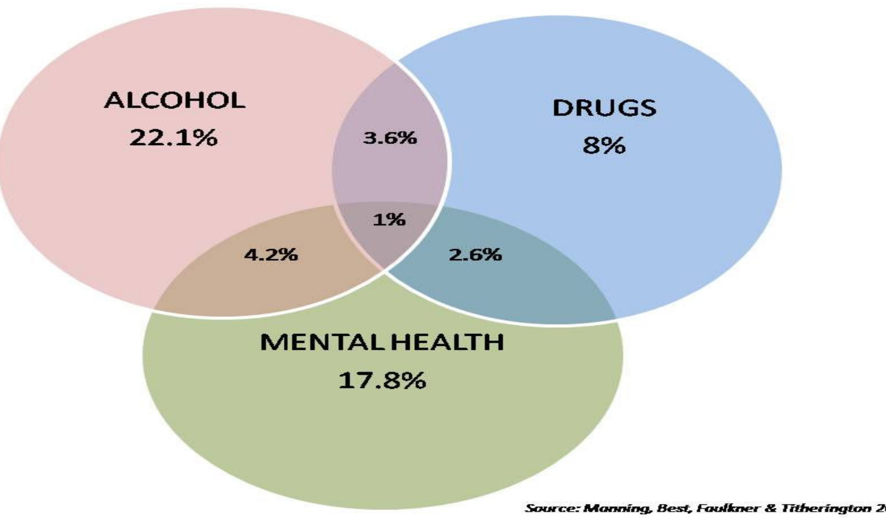
Adulthood

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

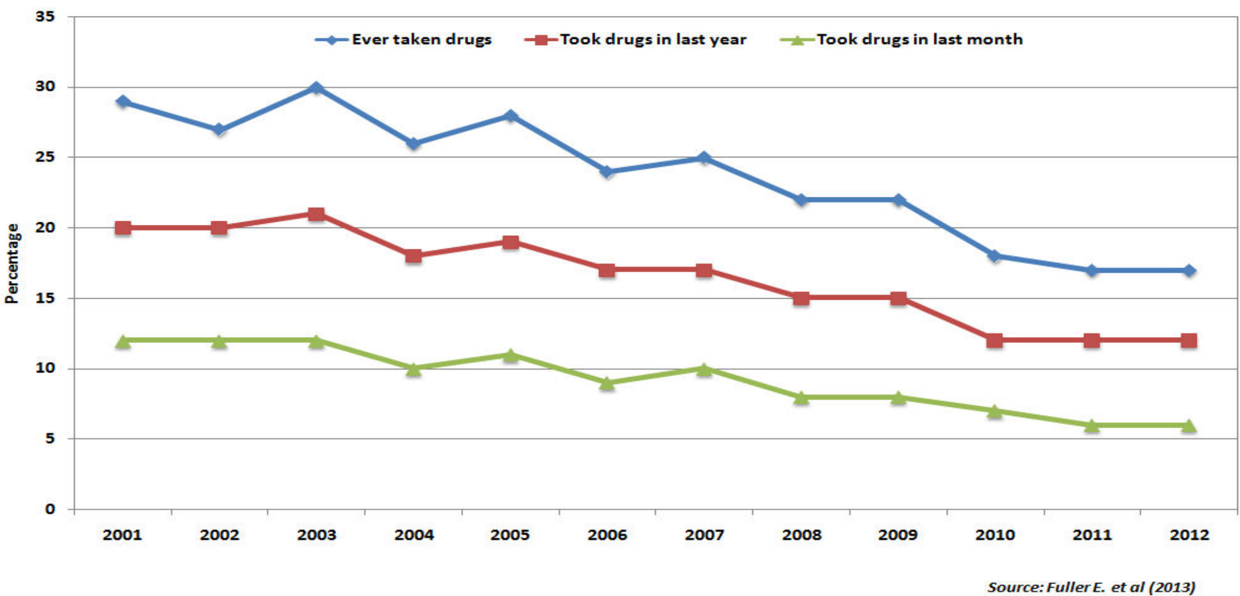
2.5. Estimated Prevalence of substance misuse in Halton

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]

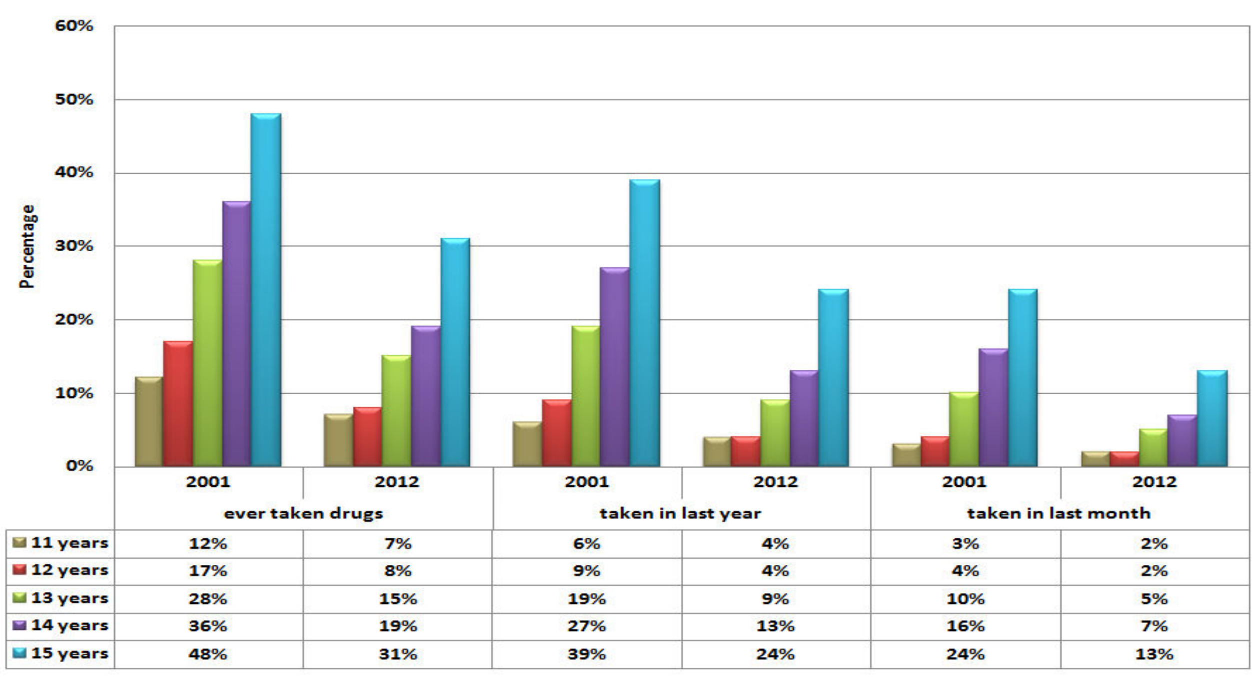
In England, there has been an overall decrease in drug use reported by 11- 15 year olds since 2001. The prevalence of lifetime drug use fell from 29% in 2001 to 17% in 2012. There were also decreases in the proportion of pupils who reported taking drugs in the last year from 20% in 2001 to 12% in 2012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



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.

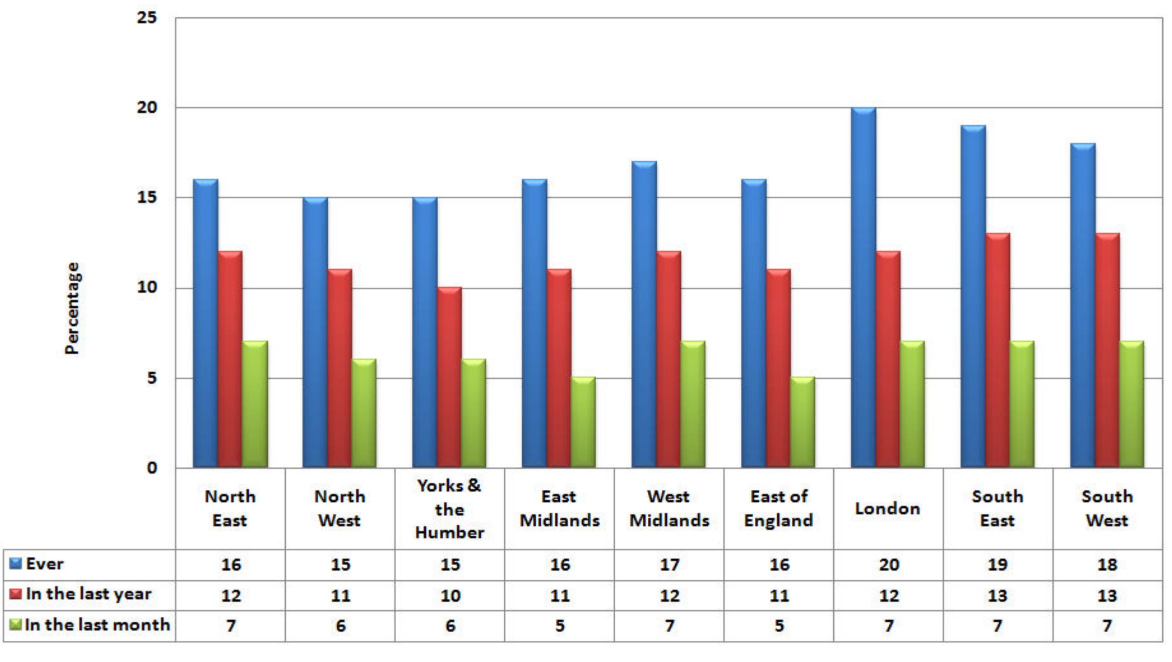
Figure 4: Percentage of young people who have ever taken drugs, taken them in the last year and taken them in the last month, by age, national picture 2012 compared to 2001



	ever taken drugs		taken in last year		taken in last month	
	2001	2012	2001	2012	2001	2012
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%

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

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.

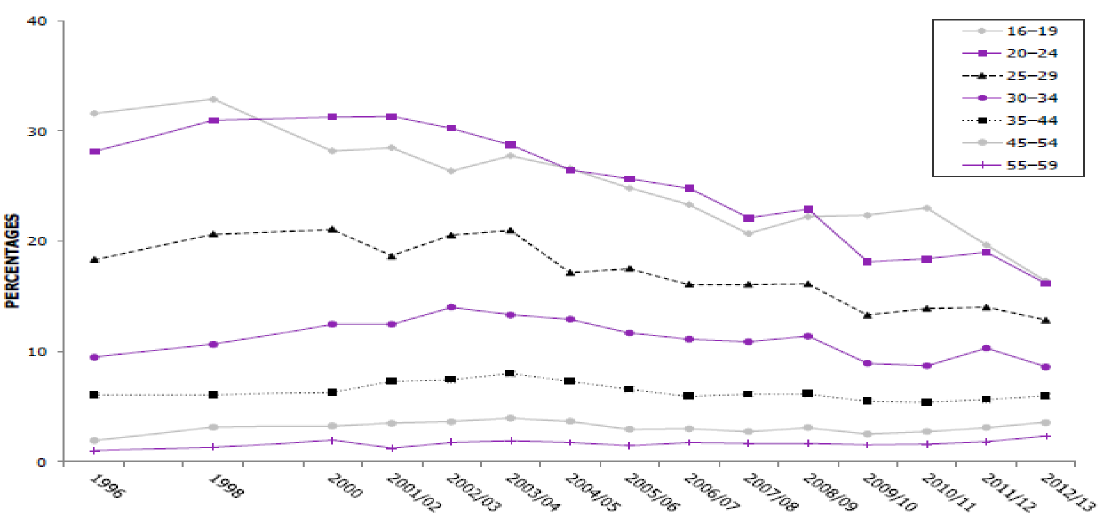
As in previous years cannabis was the most commonly used type of drug in the last year, in 2011/12 6.9% of 16-59 years (equivalent to 5,025 Halton residents) had used cannabis in the last year followed by powder cocaine (2.2% or 1,602 Halton residents) and ecstasy (1.4% or 1,020 Halton residents).

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].

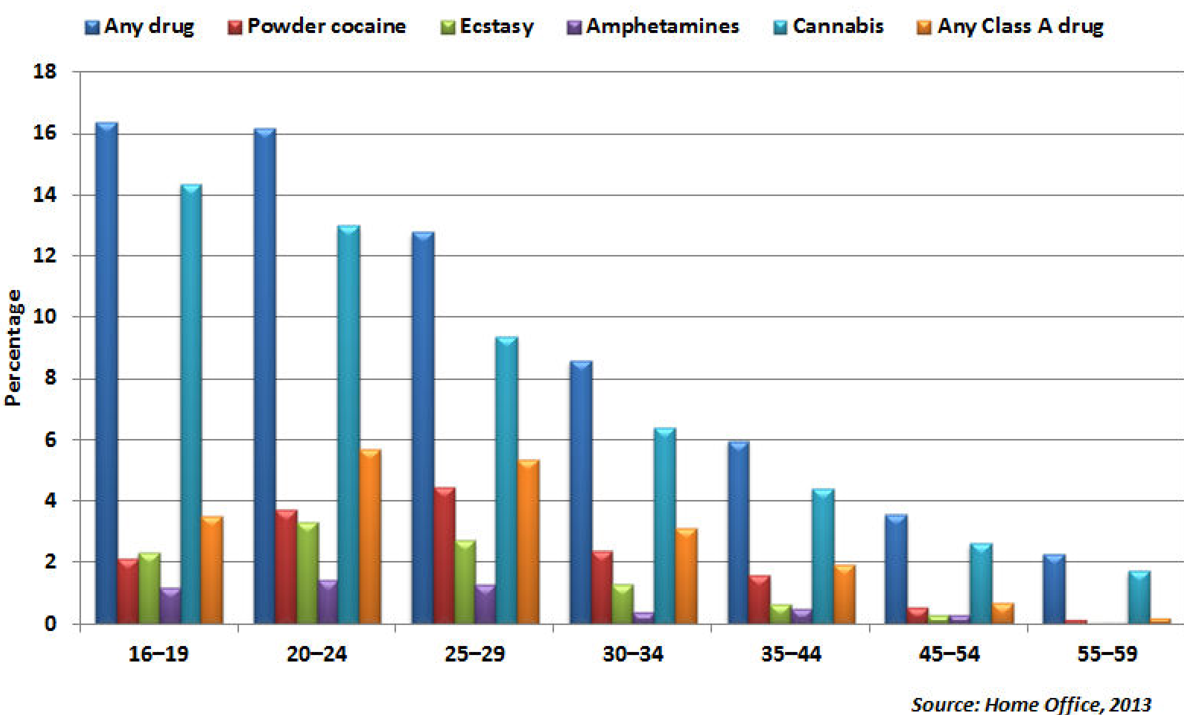
Figure 7: Proportion of 16 to 59 year olds reporting use of any drug in the last year by age group, 1996 to 2012/13 Crime Survey for England and Wales



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



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, meph)	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 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

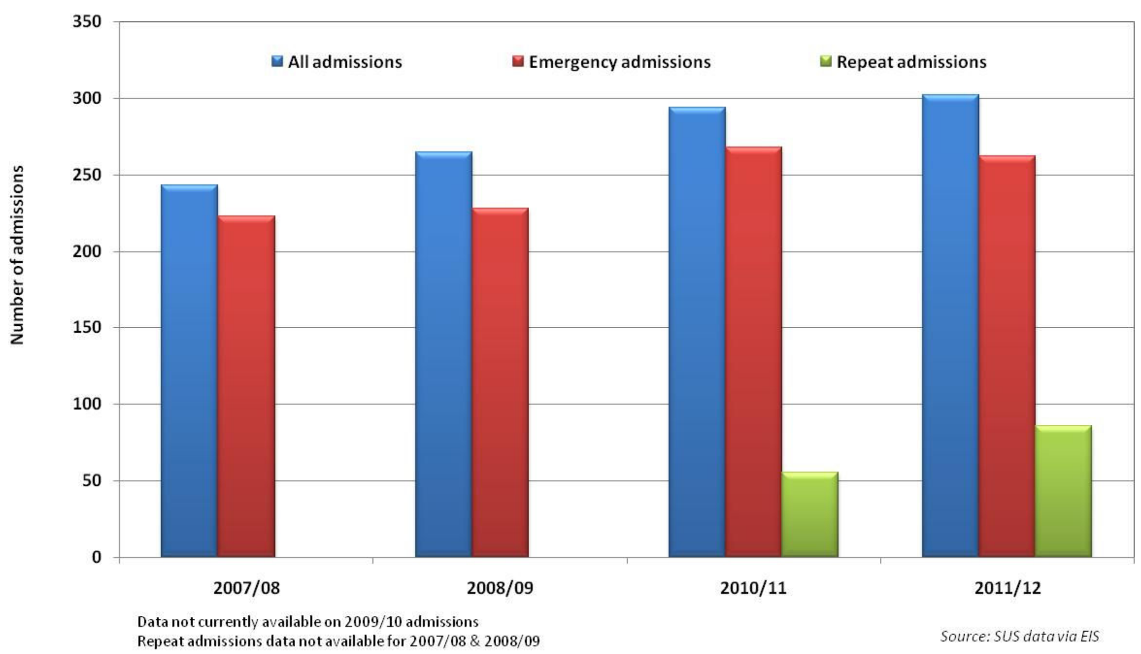
3.1. Hospital Admissions

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.

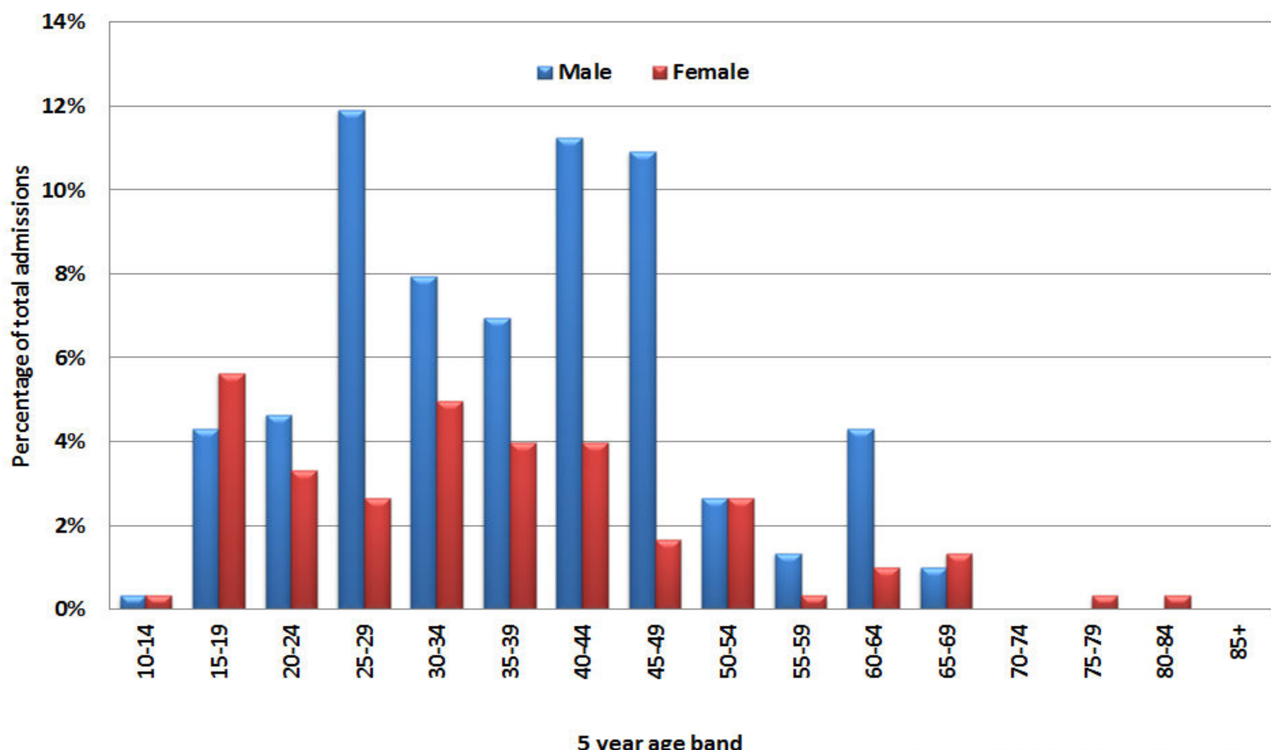
Figure 10: Trend in drug related hospital admissions in Halton



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



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

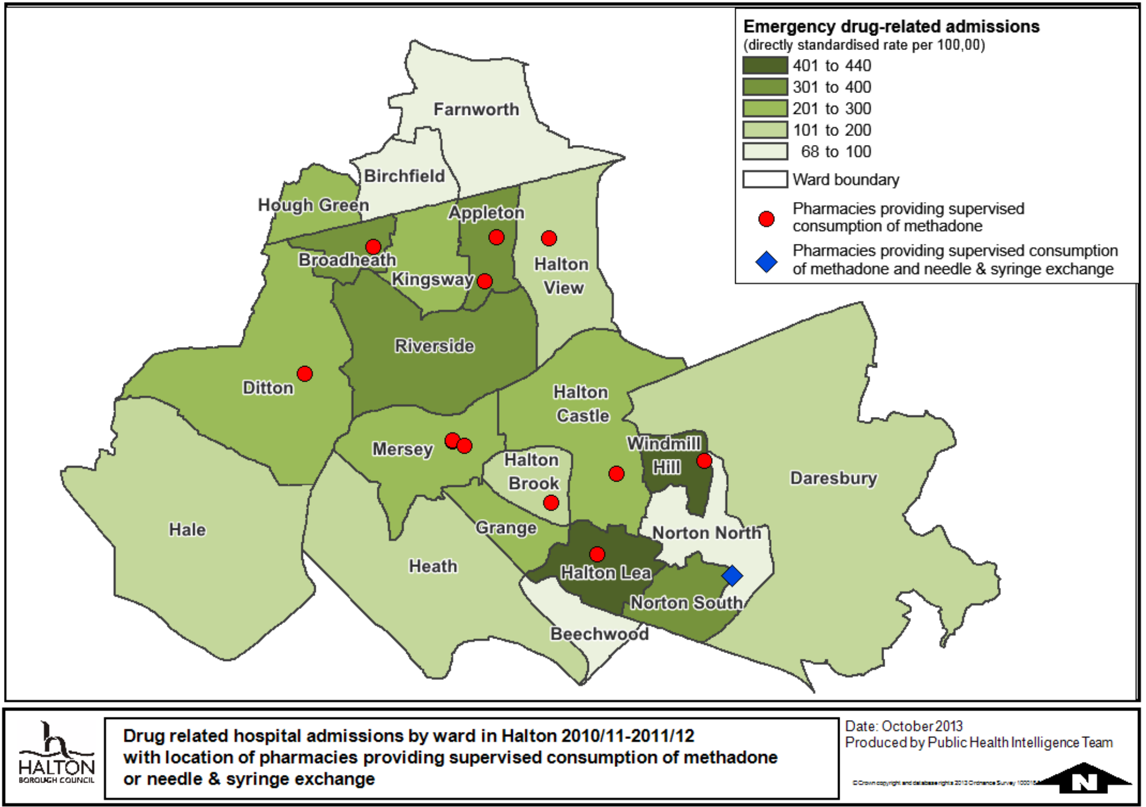
ICD 10 code	ICD Description	No. of admissions 2008/09	No. of admissions 2010/11	No. of admissions 2011/12
F11	Mental and behavioural disorders due to use of opioids	81	72	58
F12	Mental and behavioural disorders due to use of cannabinoids	27	20	49
F13	Mental and behavioural disorders due to use of sedative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

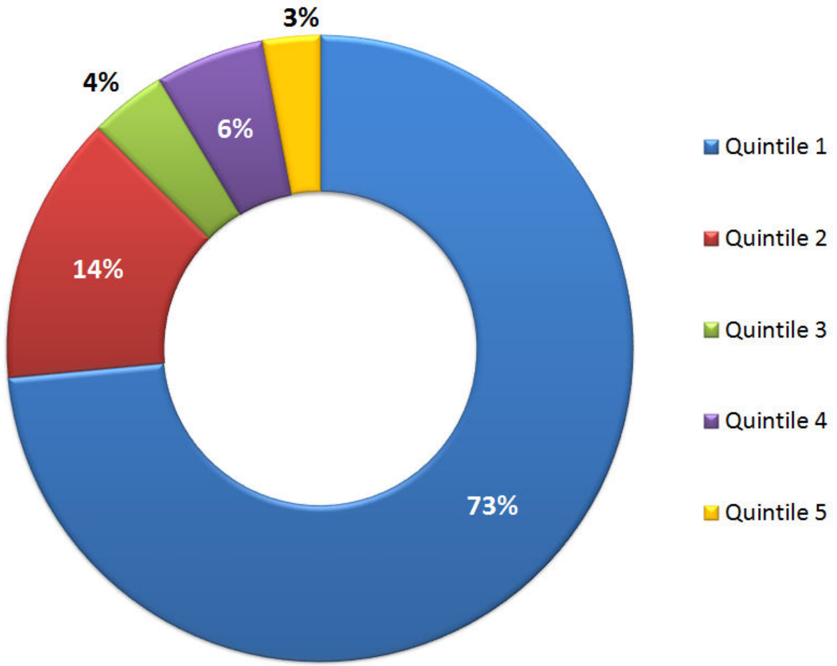
Figure 12: Drug-related hospital admissions (directly standardised rate per 100,000 population) by ward in Halton 2010/11 - 2011/12, with location of pharmacies providing supervised consumption of methadone or needle and syringe exchange.



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)



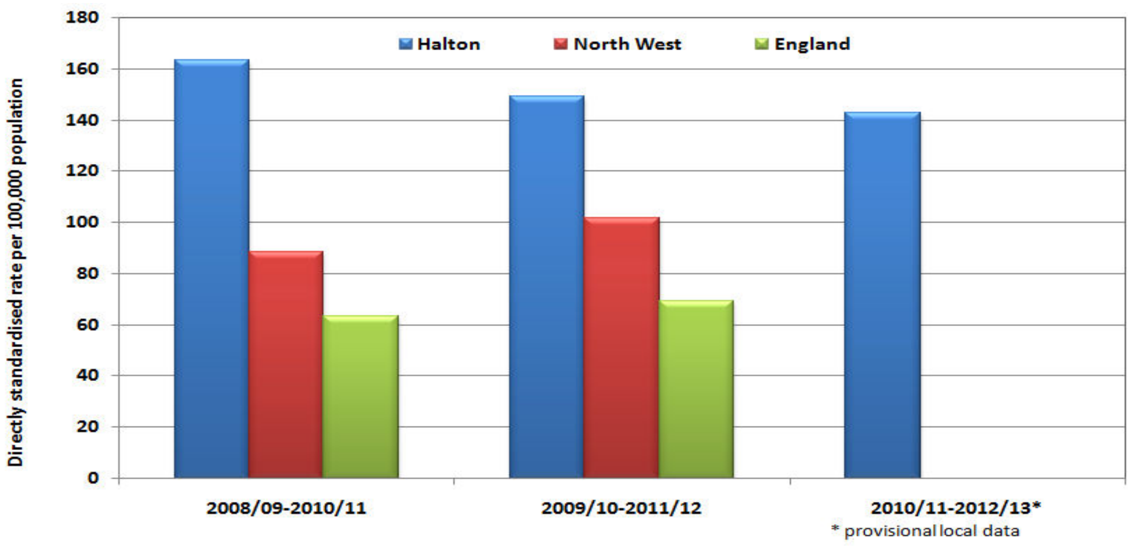
3.1.2. Substance misuse

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



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

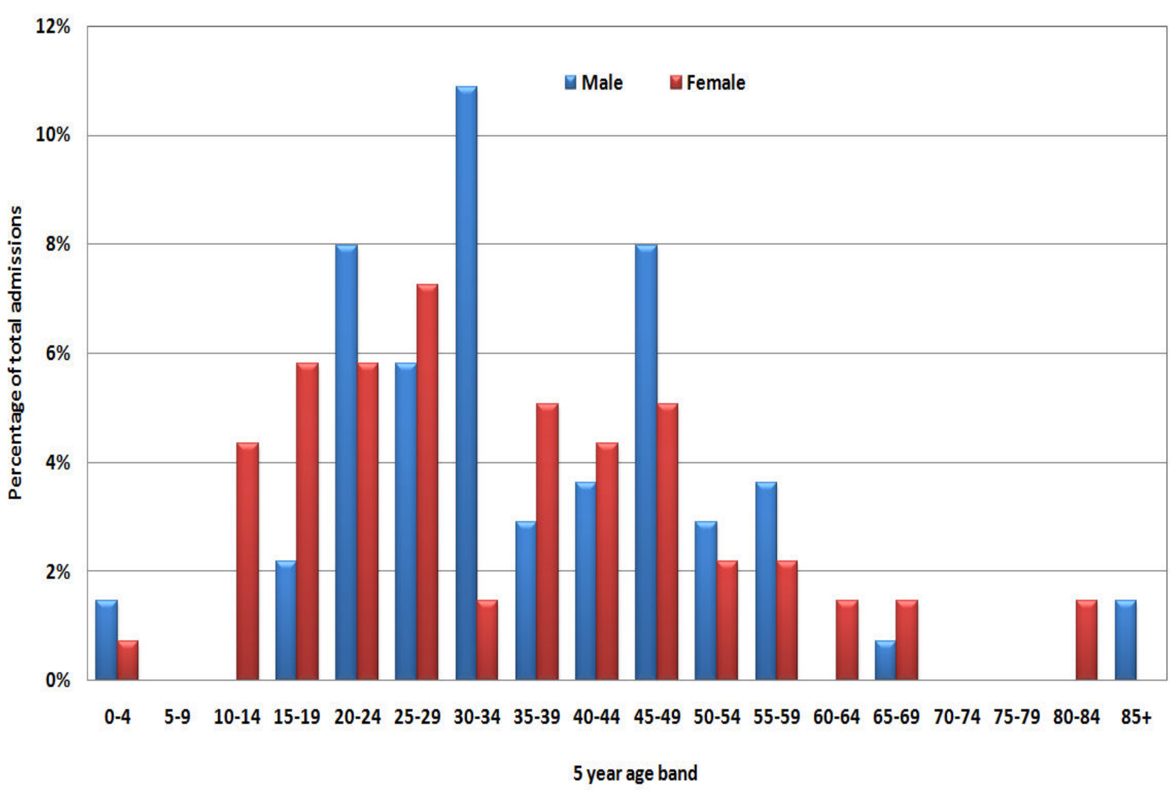
Data relating to substance misuse hospital admissions is not published nationally for all ages, but local data shows that the number has increased to 138 in 2012/13.

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).

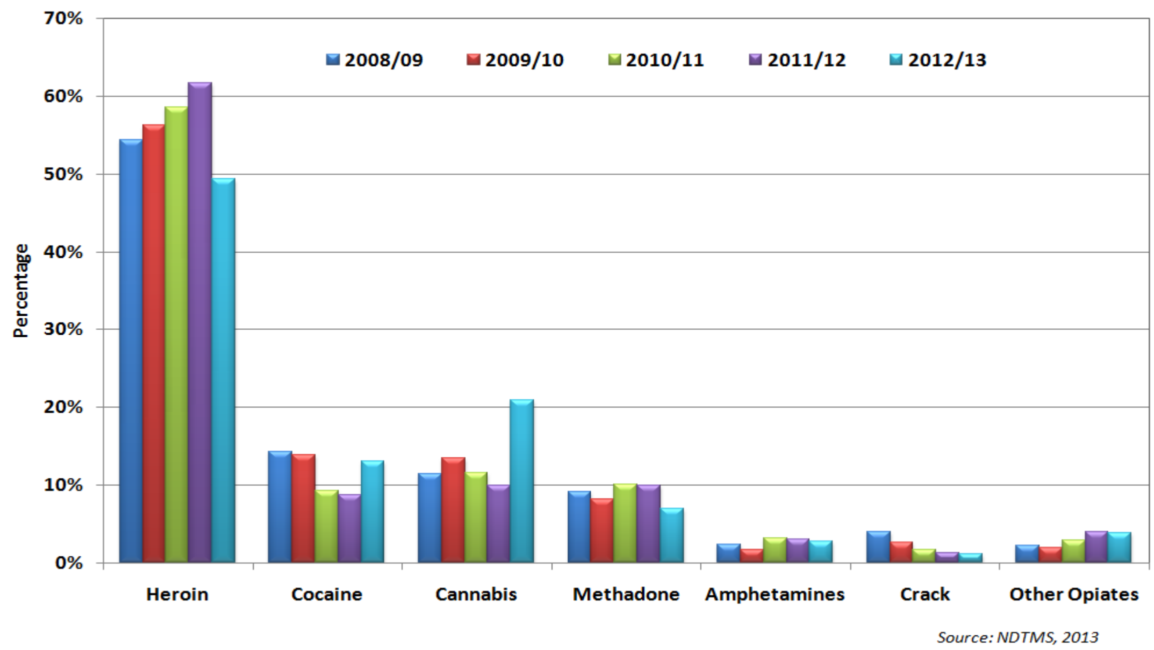
Table 10: Primary drug used

	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

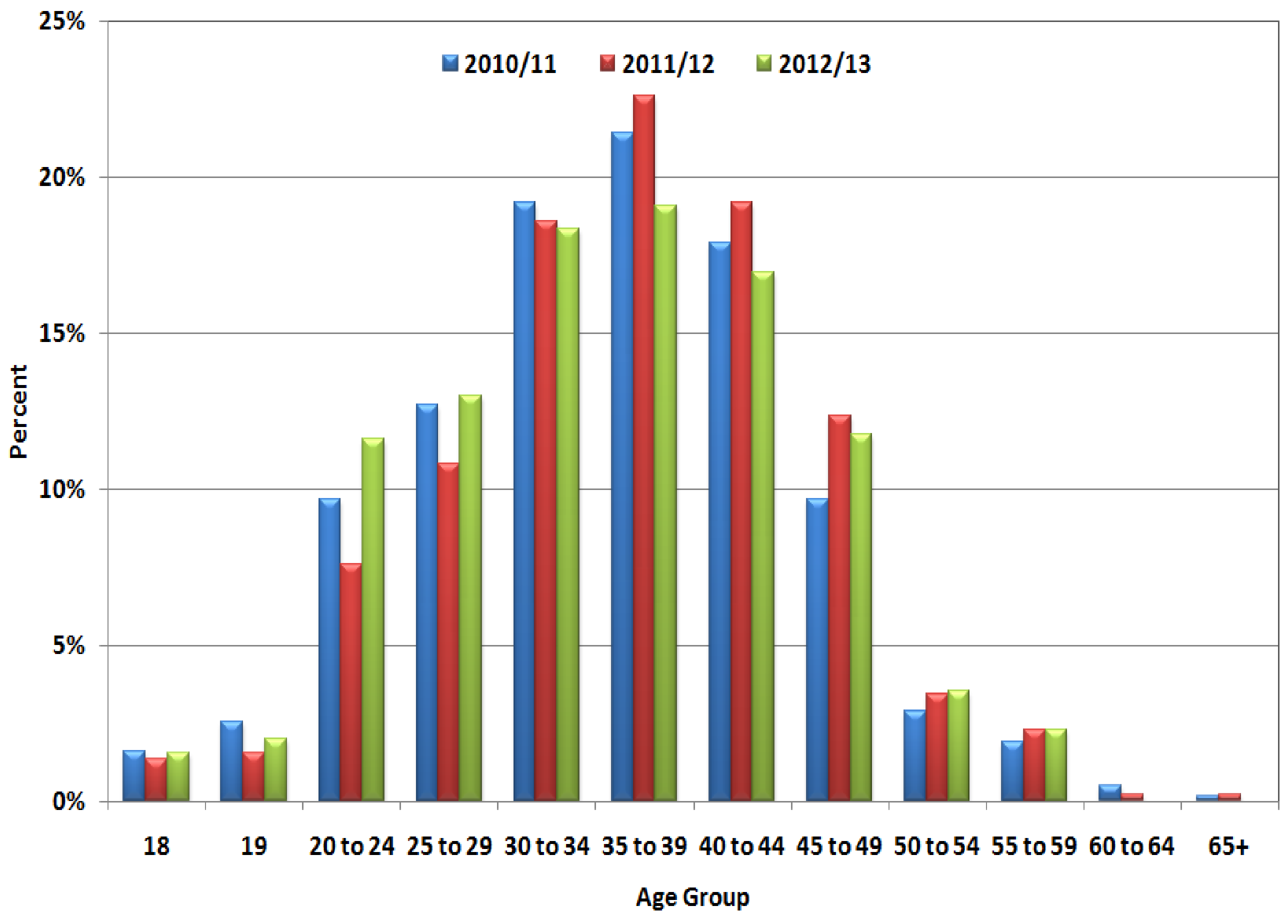
	Halton			North West	England
	2010/11	2011/12	2012/13	2012/13	2012/13
Crack	29.5%	27.5%	26.4%	19.9%	22.3%
Alcohol	10.8%	9.1%	12.5%	10.2%	11.5%
Methadone	6.8%	8.0%	5.3%	6.3%	4.3%
Cannabis	4.3%	3.2%	5.3%	6.2%	8.1%
Cocaine	4.4%	3.8%	3.5%	2.8%	3.1%
Amphetamines	0.8%	0.8%	2.3%	2.6%	2.5%
Heroin	2.9%	2.7%	1.5%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



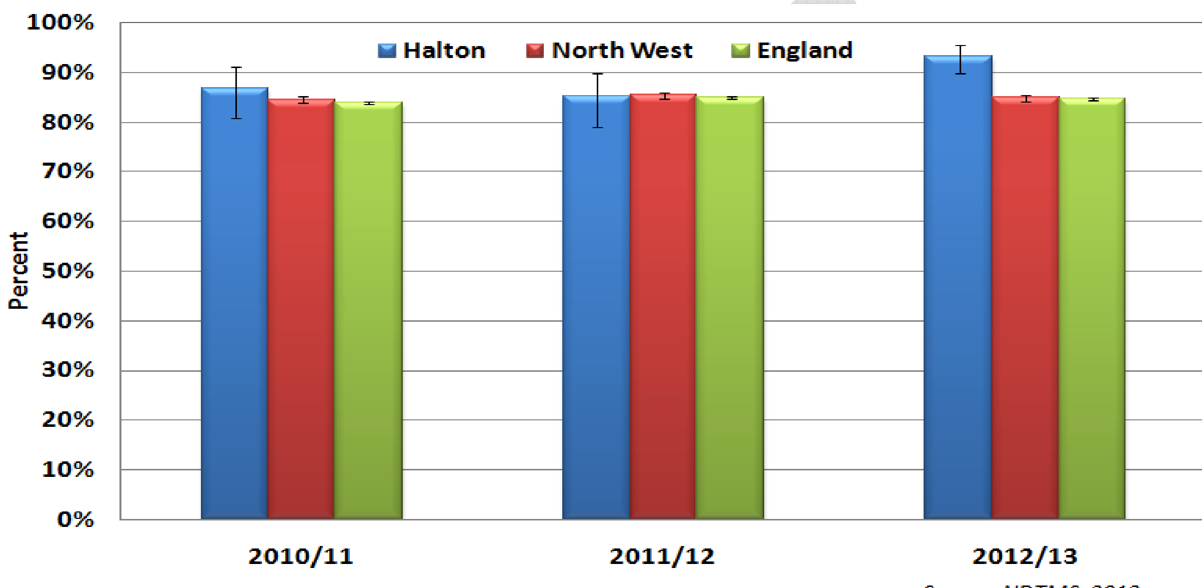
Source: NDTMS, 2013

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.

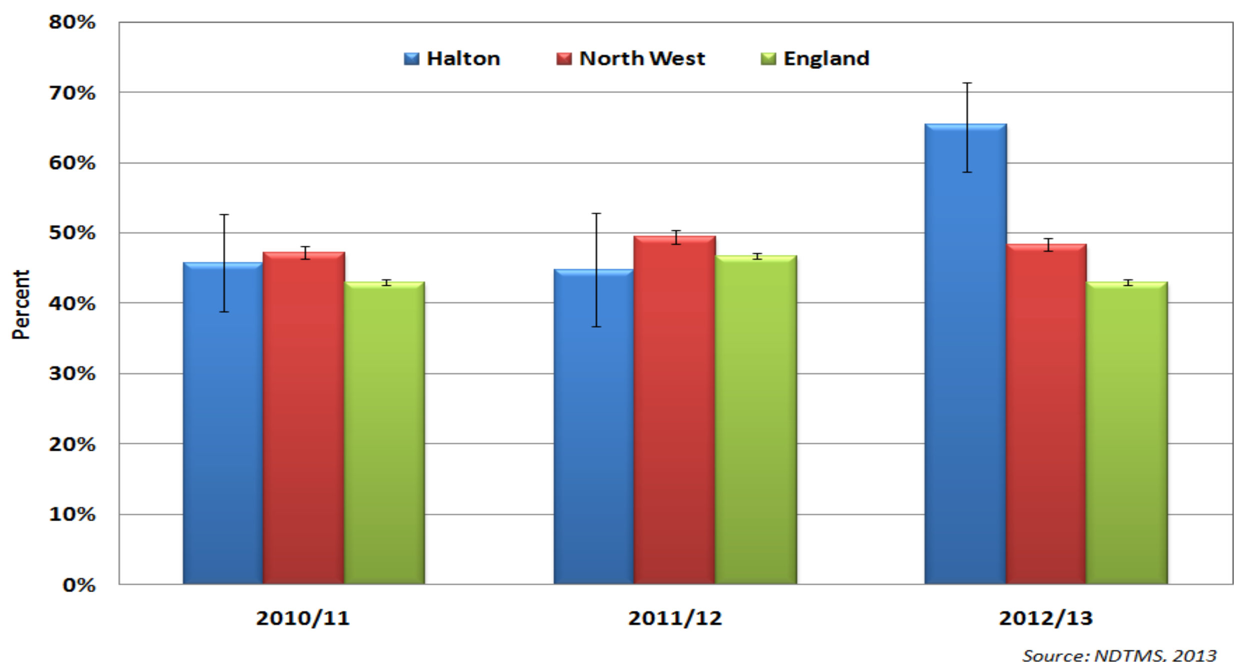
In Halton during 2012/13, 93% of people were 'successfully retained in effective treatment' compared with 87% in 2010/11. This means that the Halton 2012/13 percentage was significantly higher compared to the North West and England.

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

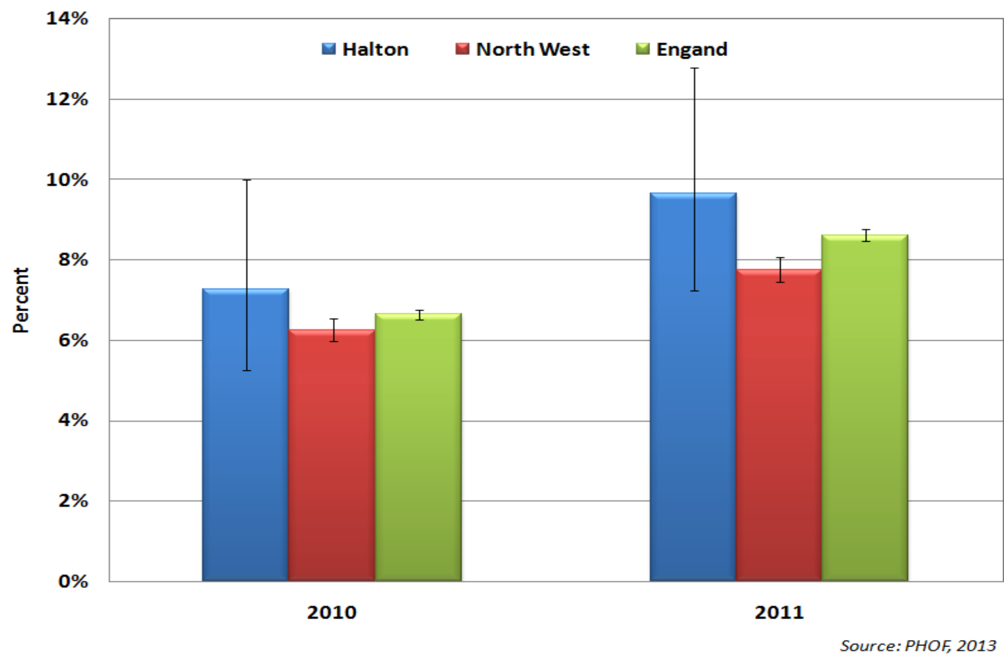


Source: NDTMS, 2013

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.

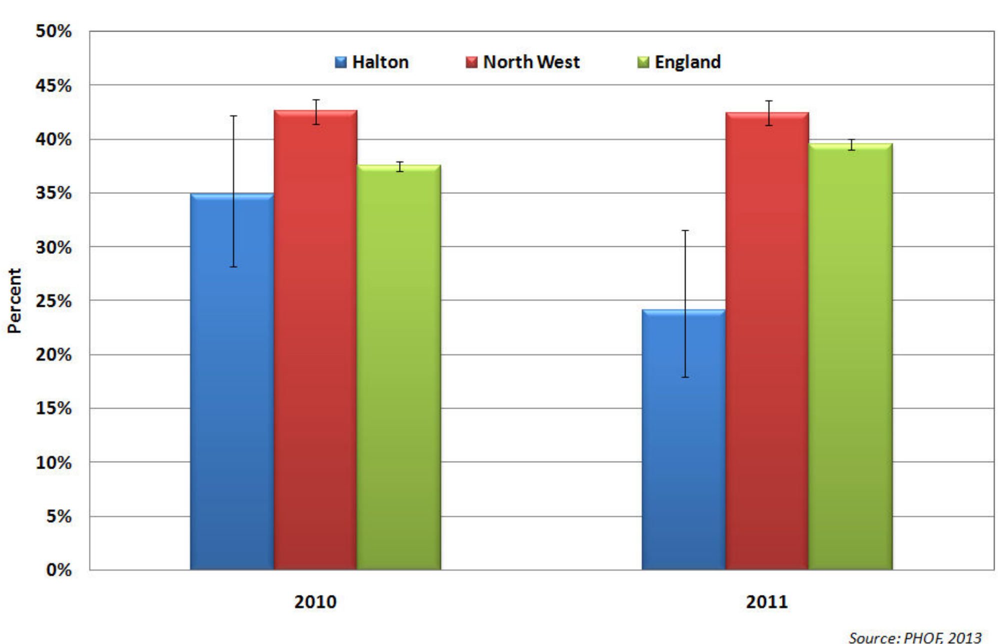
Figure 20: Successful completion of drug treatment,- opiate users, aged 18 to 75 years, 2010 and 2011



Source: PHOF, 2013

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.

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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.

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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

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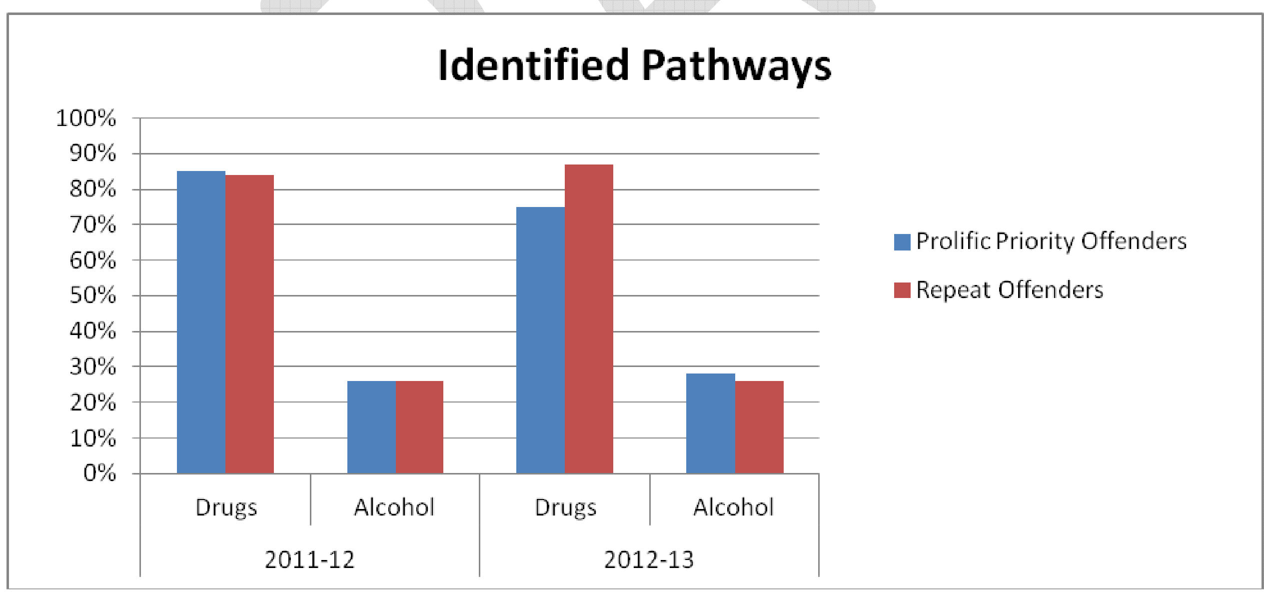
over 40. Nearly a half, 46% of offenders aged between 18 and 20 were 'currently using' compared to 35% in the 21 to 40 age range and 17% for those aged over 40. Women offenders were also slightly more likely to be 'currently using' than male offenders, and a higher proportion were using Class A drugs (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.

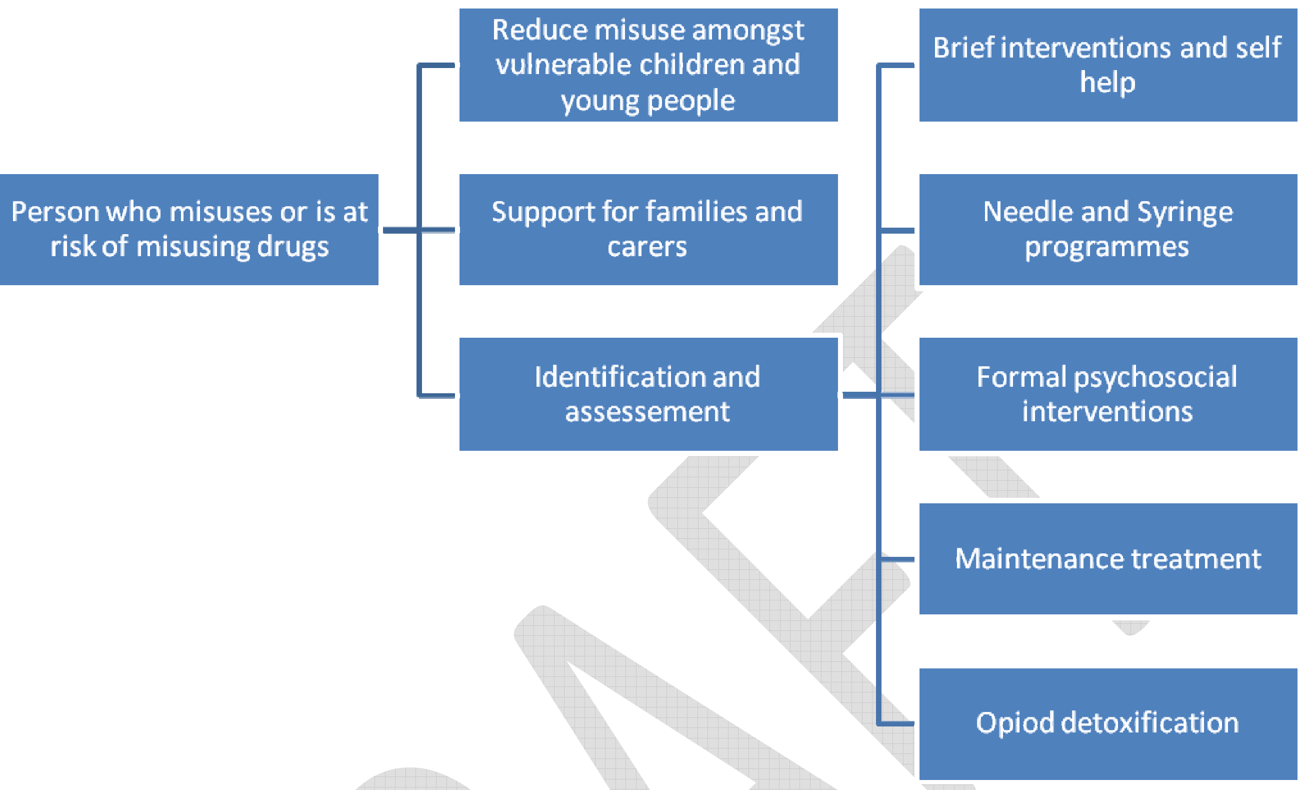
In early adolescence, children are often exposed to legal and illegal substances such as cigarettes and alcohol for the first time. When they enter secondary school, teens may encounter greater availability of drugs and social activities where drugs are used. At the same time, many behaviours that are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

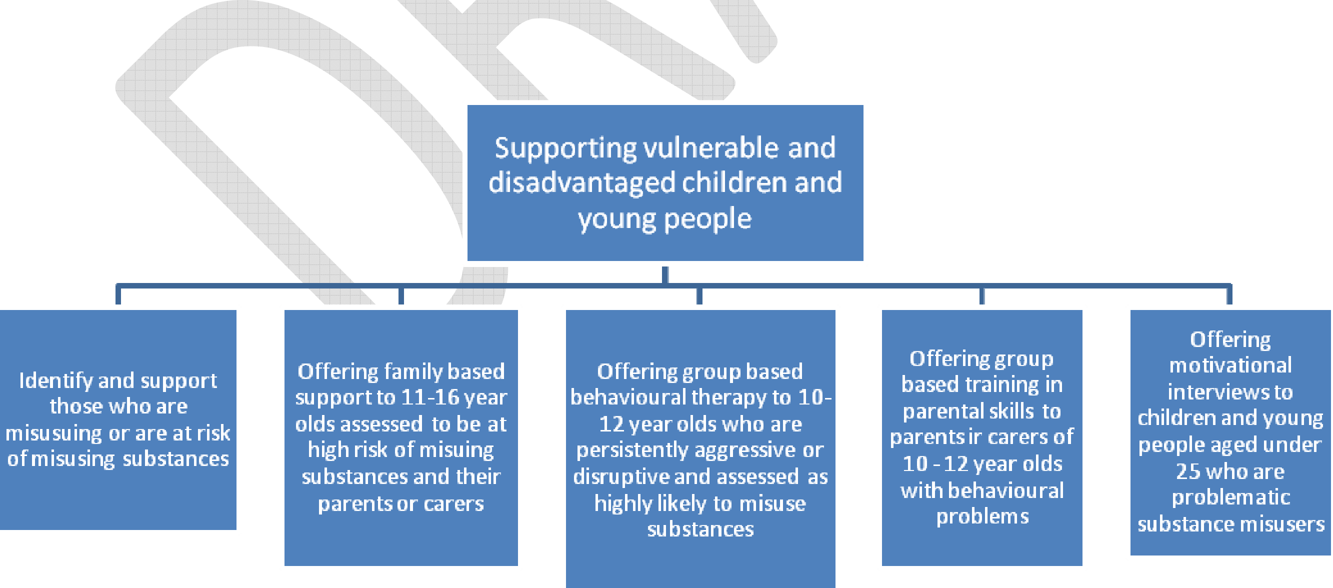
Family support plays a central part, including very early intervention with vulnerable families (particularly parents using drugs themselves). Drug Education and prevention work is delivered through schools and nationally through the FRANK campaign although review is needed to determine how to support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

[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

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**.



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.**



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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

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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.

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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

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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.

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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

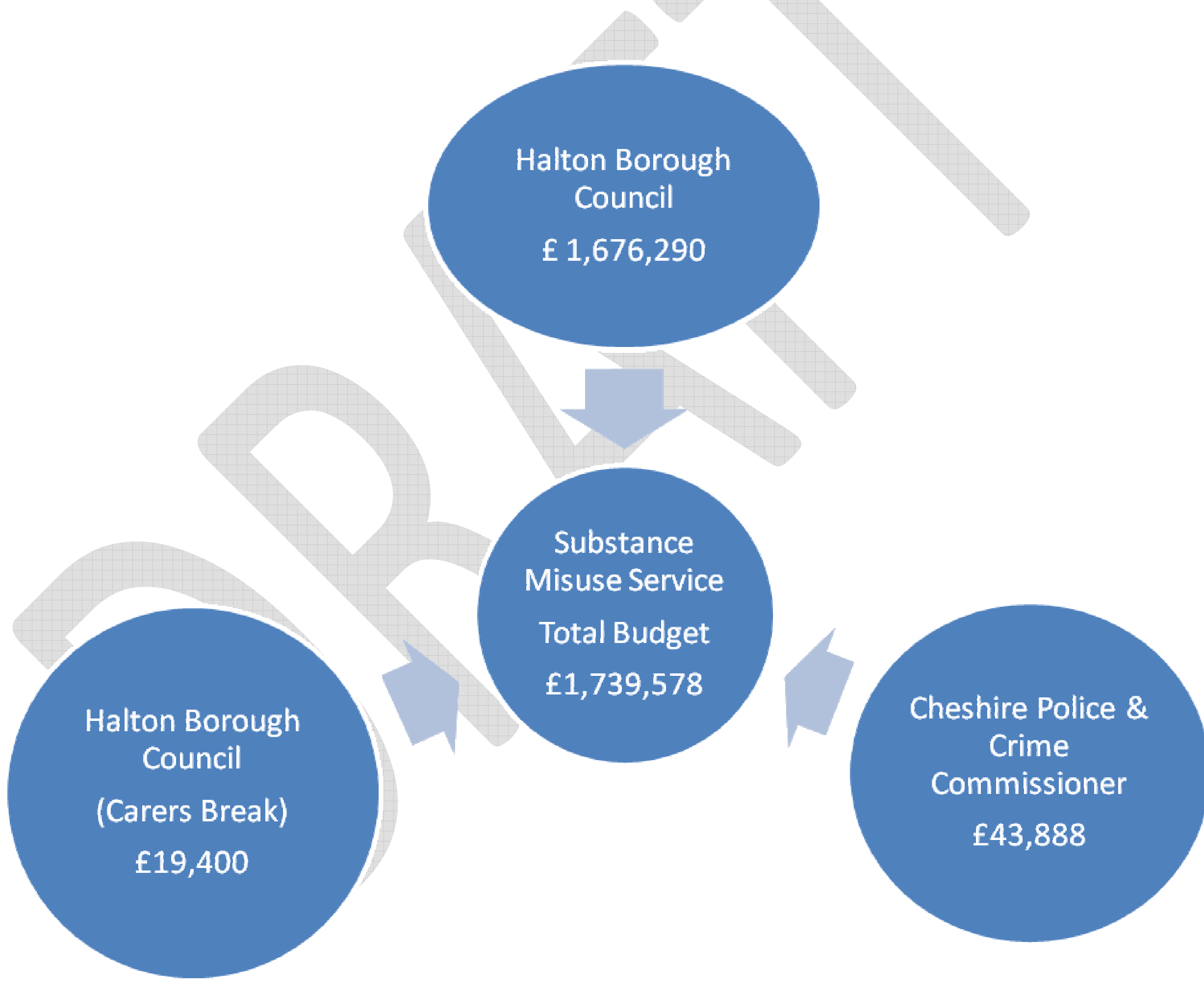

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Table 12: Budget received for 2012/13 for substance misuse service (including drugs and alcohol)

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.

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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.

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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

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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;

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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.

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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.

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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.

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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

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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).

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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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Agenda Item 7a

REPORT TO: Executive Board

DATE: 21 November 2013

REPORTING OFFICER: Operational Director – Finance

PORTFOLIO: Resources

SUBJECT: Determination of the 2014/2015 Council Tax Base

WARD(S): Borough-wide

1.0 PURPOSE OF REPORT

1.1 There is a requirement for the Council to determine the 'Tax Base' for its area and also the tax base for each of the Parishes.

1.2 The Council is required to notify the council tax base figure to Cheshire Fire Authority, the Cheshire Police and Crime Commissioner and the Environment Agency by 31st January 2014. The Council is also required to calculate and advise the Parish Councils of their relevant tax bases.

2.0 RECOMMENDED: That

(i) Council set the 2014/15 Council Tax Base at 31,400 for the Borough, and that the Cheshire Fire Authority, the Cheshire Police and Crime Commissioner and the Environment Agency be so notified; and

(ii) Council approve the Council Tax Base for each of the Parishes as follows;

Parish	Tax Base
Hale	643
Halebank	494
Daresbury	150
Moore	316
Preston Brook	319
Sandymoor	950

3.0 SUPPORTING INFORMATION

Council Tax Base

3.1 The 'Tax Base' is the measure used for calculating the council tax and is used by both the billing authority (the Council) and the major precepting authorities (the Cheshire Fire Authority and the Cheshire Police and Crime Commissioner), in the calculation of their council tax requirements.

3.2 The tax base figure is arrived at in accordance with a prescribed formula, and represents the estimated full year number of chargeable dwellings in the Borough, expressed in terms of the equivalent of Band 'D' dwellings.

The Council Tax Base for 2014/15

3.3 The council tax base is calculated using the number of dwellings included in the Valuation List, as provided by the Listing Officer, as at 30th October 2013. Adjustments are then made to take into account the estimated number of discounts, voids, additions and demolitions during the period 30th October 2013 to 31st March 2014.

3.4 From 2013/14 onwards, the tax base calculation includes an element for the Council Tax Reduction Scheme (the replacement for Council Tax Benefit). The estimate amount of Council Tax Support payable for 2014/15 is converted into the equivalent number of whole properties which are deducted from the total. The reduced tax base will not result in an increase in Council Tax as the Council's budget requirement will be reduced by payment of a grant in lieu of Council Tax Benefit.

3.5 An estimated percentage collection rate is then applied to the product of the above calculation to arrive at the tax base for the year.

3.6 Taking account of all the relevant information and applying a 96.5% collection rate, the calculation for 2014/15 gives a tax base figure of 31,400 for the Borough as a whole.

3.7 Taking account of all the relevant information and applying a 96.5% collection rate, the appropriate tax base figure for each of the Parishes is as follows

Parish	Tax Base
Hale	**643**
Halebank	**494**
Daresbury	**150**
Moore	**316**
Preston Brook	**319**
Sandymoor	**950**

4.0 POLICY AND OTHER IMPLICATIONS

4.1 There are no direct policy or other implications arising from this report.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 The council tax base enables the Council to set the level of council tax to be charged for 2014/15, the income from which supports all of the Council's priorities.

6.0 RISK ANALYSIS

6.1 There would be a loss of income to the Council if the council tax base is not approved, as it would not be possible to set the level of council tax to be charged for 2014/15.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 There are no direct implications arising from this report

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

Document	Place of Inspection	Contact Officer
Working Papers	Kingsway House	P. McCann

Agenda Item 7b

REPORT TO: Executive Board

DATE: 21 November 2013

REPORTING OFFICER: Operational Director – Finance

PORTFOLIO: Resources

SUBJECT: 2013/14 Half Year Spending

WARD(S): Borough-wide

1.0 PURPOSE OF REPORT

1.1 To report the Council's overall revenue and capital spending position as at 30th September 2013.

2.0 RECOMMENDED: That

1) **all spending continues to be limited to the absolutely essential;**

2) **Strategic Directors ensure overall spending at year-end is within their total operational budget; and**

3) **Council approve the revised capital programme as set out in Appendix 3.**

3.0 SUPPORTING INFORMATION

Revenue Spending

3.1 Appendix 1 presents a summary of spending against the revenue budget up to 30th September 2013, along with individual statements for each Department. In overall terms revenue expenditure is £0.308m below the budget profile. However the budget profile is only a guide to eventual spending and experience shows that spending is usually lower in the first half of the financial year and is likely to accelerate towards the end of the year. Directorates should continue to limit all spending to the absolutely essential to ensure that each Directorate's spending at year-end is within its total operational budget.

3.2 Total spending on employees is £0.288m below budget profile at the end of the 2nd quarter. During the year to date a number of posts have been held vacant across the Council, a number of these will need to be eventually filled whilst others will have been put forward as saving proposals for 2014/15. The vacant posts have helped Directorates achieve staff turnover saving targets for the year to date. It is important that Directorates continue to tightly control staffing, as the position to date is relatively marginal in terms of the total employee budget of approximately £68m.

3.3 Expenditure on general supplies and services is £0.362m under budget against a budget profile of £6.2m at 30th September 2013, which equates to approximately 5.8%. The variance in spend on the supplies & services budget is evidenced across the three Directorates and can be partly linked to improved procurement procedures. Additionally spend is limited to what is absolutely essential.

3.4 Expenditure on children's residential placements is £0.416m above the profiled budget of £0.871m for the period to 30th September 2013. Whilst every effort is made to use in house services this is not always possible during periods of high demand for long term placements. The demand on this service will always be unpredictable and the forecast for the remainder of the year indicates the trend for high demand will continue. The forecast outturn position for the whole year estimates spend will be £0.8m over the approved budget.

3.5 Spending on in-house adoption has been high for the year to date and at the half-way point for the year, spend is £0.3m above budget. Some special guardianship allowances have recently been re-assessed and subsequently increased.

3.6 Whilst nationally there are signs of a slight upturn in the economy there is still pressure on income targets for the year to be met. This is particularly apparent in terms of fees and charges for leisure and recreation services, income targets for previous year saving proposals, catering sales and rental income for some industrial estates.

3.7 From 1st April 2013 Halton Borough Council (HBC) and the Clinical Commissioning Group (CCG) agreed to pool their resources due to the increasing challenges for the Health and Social Care economy in Halton, The gross pooled budget excluding grant is approximately £35m. This will result in the alignment of systems, more effective and efficient joint working, improved pathways, speed up of discharge processes, transforming patient/care satisfaction and set the scene for the future sustainability of meeting the current and future needs of people with complex needs.

3.8 There was a marginal underspend against the pooled budget to date of £0.03m for the first half of the financial year. However, this expenditure by nature is volatile and fluctuating depending on the number and value of new packages being approved and existing packages ceasing, trends of expenditure and income will be scrutinised in detail throughout the year to ensure a balanced budget is achieved at year-end. Attached at Appendix 2 is a statement of spending against the Complex Care Pooled Budget up to 30th September 2013.

3.9 The collection rate for Council Tax is slightly below (1.1%) what it was at this stage last year, although the impact of the reduction is netted off against an increase in the amount of Council Tax billed. The overall collection rate for the year was anticipated to be lower than in previous years due to the introduction of the localised Council Tax scheme. The

forecast retained element of business rates is in line with what was set as the Council's business rate baseline for the year.

3.10 The Council's overall net spending is marginally below the budget profile at 30th September 2013. Nevertheless, it is important that budget managers continue to closely monitor and control spending and income. The first tranche of saving proposals for 2014/15 will be considered by Council in December and the early implementation of these savings will help ensure spending will be within budget at year-end.

Capital Spending

3.11 The capital programme has been revised to reflect a number of changes in spending profiles and funding as schemes have developed. These are reflected in the capital programme presented in Appendix 3. The schemes which have been revised within the programme are as follows;

(i) Mersey Gateway Land Acquisition
(ii) Lowerhouse Lane Depot – Upgrade Works
(iii) Cremators at Widnes Crematorium
(iv) Widnes Town Centre Initiative
(v) Stadium Gym Equipment
(vi) Stadium Minor Works
(vii) Grangeway Court
(viii) Litter Bins
(ix) Widnes Recreation Site
(x) Travellers Site Warrington Road
(xi) Runcorn Hill Park

3.12 Capital spending to 30th September 2013 totalled £22.4m, which is 99% of the planned spending of £22.7m at this stage. This represents 39% of the total capital programme of £57.8m (which assumes a 20% slippage between years).

Balance Sheet

3.13 The Council's Balance Sheet is monitored regularly in accordance with the Reserves and Balances Strategy which forms part of the Medium Term Financial Strategy. The key reserves and balances have been reviewed and are considered prudent and appropriate at this stage in the financial year.

4.0 POLICY AND OTHER IMPLICATIONS

4.1 None.

5.0 FINANCIAL IMPLICATIONS

5.1 It is vital spend continues to be monitored on a regular basis to ensure net spend remains within the approved budget.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 There are no direct implications, however, the revenue budget and capital programme support the delivery and achievement of all the Council's priorities.

7.0 RISK ANALYSIS

7.1 There are a number of financial risks within the budget. However, the Council has internal controls and processes in place to ensure that spending remains in line with budget.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1072

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

APPENDIX 1

Summary of Revenue Spending to 30th September 2013

Directorate / Department	Annual Budget £'000	Budget To Date £'000	Actual Spend £'000	Variance To Date (overspend) £'000
Children and Families Services	16,596	7,647	8,255	(608)
Children's Organisation and Provision	11,488	-237	-399	162
Learning and Achievement	7,417	2,874	2,704	170
Economy, Enterprise & Property	3,497	784	826	(42)
Children and Enterprise	**38,998**	**11,068**	**11,386**	**(318)**
Human Resources	0	-391	-430	39
Policy, Planning & Transportation	16,082	4,541	4,450	91
Legal & Democratic Services	776	307	256	51
Finance	5,110	1,108	896	212
ICT & Support Services	189	-766	-765	(1)
Public Health	1,549	1,274	1,268	6
Policy and Resources	**23,706**	**6,073**	**5,675**	**398**
Community & Environment	25,337	7,745	7,819	(74)
Prevention & Assessment	26,950	9,812	9,716	96
Commissioning & Complex Care	13,561	7,216	7,166	50
Communities	**65,848**	**24,773**	**24,701**	**72**
Corporate & Democracy	**-13,438**	**55**	**-101**	**156**
	115,114	**41,969**	**41,661**	**308**

CHILDREN & ENTERPRISE DIRECTORATE

Children & Families Department
Revenue Spending as at 30th September 2013

	Annual Budget £'000	Budget to Date £'000	Expenditure to Date £'000	Variance to Date (overspend) £'000
Expenditure				
Employees	8,016	4,089	4,100	(11)
Premises	418	201	206	(5)
Supplies & Services	1,332	511	437	74
Transport	34	6	5	1
Agency Related Expenditure	305	147	141	6
Commissioned Services	404	157	147	10
Out of Borough Placements	1,600	871	1,287	(416)
Out of Borough Adoption	80	56	43	13
Out of Borough Fostering	414	137	110	27
In House Adoption	387	84	382	(298)
In House Foster Carer Placements	1,695	868	919	(51)
Care Leavers	316	121	100	21
Family Support	113	37	23	14
Capital Financing	11	9	9	0
Total Expenditure	**15,125**	**7,294**	**7,909**	**(615)**
Fees & Charges	-113	-56	-62	6
Adoption Placements	-42	0	0	0
Transfer to/from Reserves	-1,726	-1,322	-1,322	0
Early Intervention Grant	0	0	0	0
Government Grant Income	0	0	0	0
Reimbursements & Other Grant Income	-222	-20	-21	1
Total Income	**-2,103**	**-1,398**	**-1,405**	**7**
NET OPERATIONAL BUDGET	**13,022**	**5,896**	**6,504**	**(608)**
Premises Support Costs	347	174	174	0
Transport Support Costs	91	42	42	0
Central Support Service Costs	3,090	1,535	1,535	0
Asset Rental Support Costs	46	0	0	0
Total Recharges	**3,574**	**1,751**	**1,751**	**0**
Net Expenditure	**16,596**	**7,647**	**8,255**	**(608)**

Childrens Organisation & Provision Department
Revenue Spending as at 30th September 2013

	Annual Budget £'000	Budget to Date £'000	Expenditure to Date £'000	Variance to Date (overspend) £'000
Expenditure				
Employees	3,602	1,658	1,609	49
Premises	438	29	29	0
Supplies & Services	1,191	524	514	10
Transport	5	1	1	0
Agency Related Expenditure	1,954	255	251	4
Commissioned Services - Youth Serv.	900	450	450	0
Commissioned Services	1,695	509	500	9
Connexions	1,123	442	363	79
Capital Financing	11	10	10	0
Nursery Education Payments	2,170	1,737	1,737	0
Schools Contingency Costs	397	0	0	0
NQT Contingency	230	0	0	0
Schools Non Delegated Support	99	3	3	0
Schools Transport	866	320	338	(18)
Special Education Needs Contingency	1,129	155	155	0
Total Expenditure	**15,810**	**6,093**	**5,960**	**133**
Fees & Charges	-271	-22	-22	0
Transfer to / from Reserves	-571	-571	-571	0
Dedicated Schools Grant	-10,926	-5561	-5561	0
Reimbursements & Other Income	-461	-332	-341	9
Schools SLA Income	-527	-527	-547	20
Total Income	**-12,756**	**-7,013**	**-7,042**	**29**
NET OPERATIONAL BUDGET	**3,054**	**-920**	**-1082**	**162**
Premises Support Costs	167	86	86	0
Transport Support Costs	272	152	152	0
Central Support Service Costs	1,141	445	445	0
Asset Rental Support Costs	6,854	0	0	0
Total Recharges	**8,434**	**683**	**683**	**0**
Net Expenditure	**11,488**	**-237**	**-399**	**162**

Learning & Achievement Department
Revenue Spending as at 30th September 2013

	Annual Budget £'000	Budget to Date £'000	Expenditure to Date £'000	Variance to Date (overspend) £'000
Expenditure				
Employees	3,870	1,436	1,374	63
Premises	10	7	7	0
Supplies & Services	982	157	61	96
Agency Related Expenditure	91	41	35	6
Commissioned Services	34	0	0	0
Independent School Fees	1,584	692	692	0
Asset Recharges	3	1	1	0
Inter Authority Recoupment	811	198	198	0
Speech Therapy	120	60	60	0
Total Expenditure	**7,505**	**2,592**	**2,428**	**164**
Income				
Fees & Charges	-153	-27	-32	5
Government Grant Income	-77	-39	-39	0
Inter Authority Income	-578	-15	-15	0
Reimbursements & Other Income	-40	-5	-6	1
Schools SLA Income	-39	-32	-32	0
Total Income	-887	-118	-124	**6**
NET OPERATIONAL BUDGET	**6,618**	**2,474**	**2,304**	**170**
Premises Support Costs	112	56	56	0
Transport Support Costs	19	10	10	0
Central Support Service Costs	667	334	334	0
Asset Rental Support Costs	1	0	0	0
Total Recharges	**799**	**400**	**400**	**0**
Net Expenditure	**7,417**	**2,874**	**2,704**	**170**

Economy, Enterprise & Property Department Revenue Spending as at 30th September 2013

	Annual Budget £'000	Budget to Date £'000	Expenditure to Date £'000	Variance to Date (overspend) £'000
Expenditure				
Employees	4,360	2,184	2,225	(41)
Repairs & Maintenance	2,541	1,264	1,262	2
Energy & Water Costs	603	283	279	4
NNDR	647	806	809	(3)
Rents	372	291	291	0
Marketing Programme	85	15	12	3
Promotions	60	12	6	6
Supplies & Services	1,240	536	526	10
Capital Financing	7	4	4	0
Other	4	5	5	0
Agency Related Payments	176	90	90	0
Total Expenditure	**10,095**	**5,490**	**5,509**	**(19)**
Fees & Charges	-501	-398	-398	0
Rent - Markets	-758	-382	-382	0
Rent - Industrial	-970	-440	-422	(18)
Rent – Commercial	-516	-324	-320	(4)
Government Grant Income	-916	-431	-431	0
Transfer from Reserves	-215	-100	-100	0
Recharges to Capital	-649	-325	-325	(0)
Reimbursements & Other Grant Income	-370	-39	-38	(1)
Schools SLA Income	-501	-501	-501	0
Total Income	**-5,396**	**-2,940**	**-2,917**	**(23)**
NET OPERATIONAL BUDGET	**4,699**	**2,550**	**2,592**	**(42)**
Premises Support Costs	1,498	767	767	0
Transport Support Costs	38	16	16	0
Central Support Service Costs	1,707	870	870	0
Asset Rental Support Costs	2,390	0	0	0
Repairs & Maintenance Recharge Income	-2,185	-1,093	-1,093	0
Accommodation Recharge Income	-2,759	-1,380	-1,380	0
Central Supp. Service Rech Income	-1,891	-946	-946	0
Total Recharges	**-1,202**	**-1,766**	**-1,766**	**0**
Net Expenditure	**3,497**	**784**	**826**	**(42)**

POLICY & RESOURCES DIRECTORATE

Human Resources
Revenue Spending as at 30th September 2013

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (overspend) £'000
Expenditure				
Employees	1,657	749	743	6
Employee Training	290	22	24	(2)
Supplies & Services	205	118	115	3
Capital Financing	1	1	1	0
Total Expenditure	**2,153**	**890**	**883**	**7**
Income				
Fees & Charges	-54	-42	-65	23
Reimbursements & Other Grants	-64	-49	-49	0
School SLA's	-390	-382	-391	9
Transfers from Reserves	-32	0	0	0
Total Income	**-540**	**-473**	**-505**	**32**
Net Operational Expenditure	**1,613**	**417**	**378**	**39**
Recharges				
Premises Support	72	36	36	0
Transport Recharges	16	8	8	0
Asset Charges	1	0	0	0
Central Support Recharges	505	252	252	0
Support Recharges Income	-2,207	-1,104	-1,104	0
Net Total Recharges	**-1,613**	**-808**	**-808**	**0**
Net Departmental Total	**0**	**-391**	**-430**	**39**

Policy, Planning & Transportation
Revenue Spending as at 30th September 2013

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (overspend) £'000
Expenditure				
Employees	4,958	2,290	2,303	(13)
Other Premises	236	70	62	8
Hired & Contracted Services	438	129	129	0
Supplies & Services	309	154	145	9
Street Lighting	1,793	750	734	16
Highways Maintenance	2,225	580	580	0
Bridges	96	37	37	0
Fleet Transport	1,235	630	630	0
Lease Car Contracts	622	494	494	0
Bus Support – Halton Hopper Tickets	173	102	102	0
Bus Support	531	259	259	0
Out of Borough Transport	51	21	17	4
Capital Financing	406	406	417	(11)
Grants to Voluntary Organisations	68	34	34	0
NRA Levy	62	31	29	2
Mersey Gateway	4,966	2,018	2,018	0
Total Expenditure	**18,169**	**8,005**	**7,990**	**15**
Income				
Sales	-503	-187	-182	(5)
Planning Fees	-506	-283	-330	47
Building Control Fees	-81	-41	-54	13
Other Fees & Charges	-268	-268	-285	17
Rents	-8	-4	-2	(2)
Grants & Reimbursements	-171	-130	-132	2
School SLAs	-39	-39	-44	5
Recharge to Capital	-2,736	-995	-995	0
Transfer from Reserves	-2,567	-1,022	-1,022	0
Total Income	**-6,879**	**-2,969**	**-3,046**	**77**
Net Controllable Expenditure	**11,290**	**5,036**	**4,944**	**92**
Recharges				
Premises Support	770	333	332	1
Transport Recharges	568	305	305	0
Asset Charges	7,432	0	1	(1)
Central Support Recharges	3,200	1,600	1,601	(1)
Departmental Support Recharges	446	0	0	0
Support Recharges Income – Transport	-4,699	-2,196	-2,196	0
Support Recharges Income – Non Transport	-2,925	-537	-537	0
Net Total Recharges	**4,792**	**-495**	**-494**	**(1)**
Net Departmental Total	**16,082**	**4,541**	**4,450**	**91**

Legal & Democratic Services
Revenue Spending as at 30th September 2013

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (overspend) £'000
Expenditure				
Employees	1,976	956	928	28
Supplies & Services	339	175	168	7
Civic Catering & Functions	29	1	0	1
Mayoral Allowances	21	21	20	1
Legal Expenses	207	113	119	(6)
Total Expenditure	**2,572**	**1,266**	**1,235**	**31**
Income				
Land Charges	-97	-48	-51	3
School SLA's	-48	-48	-67	19
License Income	-268	-134	-117	(17)
Other Income	-28	-18	-31	13
Transfers from Reserves	-68	-59	-59	0
Total Income	**-509**	**-307**	**-325**	**18**
Net Operational Expenditure	**2,063**	**959**	**910**	**49**
Recharges				
Premises Support	122	61	61	0
Transport Recharges	33	17	15	2
Asset Charges	19	0	0	0
Central Support Recharges	484	242	242	0
Support Recharges Income	-1,945	-972	-972	0
Net Total Recharges	**-1,287**	**-652**	**-654**	**2**
Net Departmental Total	**776**	**307**	**256**	**51**

Finance Services
Revenue Spending as at 30th September 2013

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (overspend) £'000
Expenditure				
Employees	7,396	3,508	3,378	130
Supplies & Services	535	324	312	12
Other Premises	133	78	49	29
Agency Related	1	0	0	0
Insurances	1,686	1,092	1,087	5
Charitable Relief	120	0	0	0
Concessionary Travel	2,247	1,097	1,098	(1)
Capital Financing	6	3	9	(6)
Discretionary Support Scheme	626	26	26	0
Discretionary Housing Payment	311	141	141	0
Rent Allowances	52,960	25,417	25,417	0
Non HRA Rebates	49	31	31	0
Total Expenditure	**66,070**	**31,717**	**31,548**	**169**
Income				
Fees & Charges	-99	-34	-71	37
SLA to Schools	-728	-728	-725	(3)
NNDR Administration Grant	-169	0	0	0
Hsg Ben Administration Grant	-1,166	-583	-583	0
Rent Allowances	-52,370	-25,417	-25,417	0
Discretionary Support Scheme	-787	-787	-787	0
Discretionary Housing Payment	-311	-141	-141	0
Reimbursements & Other Grants	-497	-447	-462	15
Liability Orders	-373	-369	-363	(6)
Non HRA Rent Rebates	-49	-33	-33	0
Transfer from Reserves	-295	-9	-9	0
Total Income	**-56,844**	**-28,548**	**-28,591**	**43**
Net Controllable Expenditure	**9,226**	**3,169**	**2,957**	**212**
Recharges				
Premises	426	213	213	0
Transport	60	30	30	0
Asset Charges	24	0	0	0
Central Support Service	2,838	1,421	1,421	0
Support Service Income	-7,464	-3,725	-3,725	0
Net Total Recharges	**-4,116**	**-2,061**	**-2,061**	**0**
Net Department Total	**5,110**	**1,108**	**896**	**212**

ICT & Support Services
Revenue Spending as at 30th September 2013

	Annual Budget £'000	Budget to Date £'000	Actual to Date £'000	Variance to Date (Overspend) £'000
Expenditure				
Employees	5,504	2,674	2,580	94
Supplies & Services	612	266	256	10
Computer Repairs & Software	554	285	280	5
Communications Costs	407	308	310	(2)
Other Premises	15	8	18	(10)
Capital Financing	266	133	133	0
Total Expenditure	**7,358**	**3,674**	**3,577**	**97**
Income				
Fees & Charges	-555	-226	-136	(90)
SLA to Schools	-209	-209	-201	(8)
Transfers from Reserves	-40	0	0	0
Total Income	**-804**	**-435**	**-337**	**(98)**
Net Controllable Expenditure	**6,554**	**3,239**	**3,240**	**(1)**
Recharges				
Premises	418	209	209	0
Transport	20	10	10	0
Asset Charges	1,646	0	0	0
Central Support Services	1,019	510	510	0
Support Service Income	-9,468	-4,734	-4,734	0
Net Total Recharges	**-6,365**	**-4,005**	**-4,005**	**0**
Net Department Total	**189**	**-766**	**-765**	**(1)**

Public Health
Revenue Spending as at 30th September 2013

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (underspend) £'000
Expenditure				
Employees	1,433	663	653	10
Supplies & Services	48	17	15	2
Consumer Protection Contract	393	219	231	(12)
Other Agency	20	20	17	3
Contracts & SLA's	5,971	2,371	2,347	24
Transfer to Reserves	207	0	0	0
Total Expenditure	**8,072**	**3,290**	**3,263**	**27**
Income				
Other Fees & Charges	-68	-34	-21	(13)
Sales Income	-26	-26	-24	(2)
Reimbursements & Grant Income	-7	-7	0	(7)
Government Grant	-8,510	-2,127	-2,128	1
Total Income	**-8,611**	**-2,194**	**-2,173**	**(21)**
Net Operational Expenditure	**-539**	**1,096**	**1,090**	**6**
Recharges				
Premises Support	47	23	23	0
Central Support Services	2,014	145	145	0
Transport Recharges	27	10	10	0
Net Total Recharges	**2,088**	**178**	**178**	**0**
Net Departmental Total	**1,549**	**1,274**	**1,268**	**6**

COMMUNITIES DIRECTORATE

Community & Environment
Revenue Spending as at 30th September 2013

	Annual Budget £'000	Budget To Date £'000	Actual to Date £'000	Variance To Date (overspend) £'000
Expenditure				
Employees	12,107	5,881	5,985	**(104)**
Other Premises	1,366	745	683	**62**
Supplies & Services	1,457	665	626	**39**
Book Fund	225	129	129	**0**
Promotional	264	108	70	**38**
Other Hired Services	1,019	305	306	**(1)**
Food Provisions	835	343	323	**20**
School Meals Food	1,660	546	529	**17**
Transport	55	27	18	**9**
Other Agency Costs	877	60	64	**(4)**
Waste Disposal Contracts	4,799	1,030	1,015	**15**
Leisure Management Contract	1,492	634	655	**(21)**
Grants To Voluntary Organisations	333	142	141	**1**
Grant To Norton Priory	222	111	113	**(2)**
Rolling Projects	6	6	6	**0**
Capital Financing	54	11	11	**0**
Total Spending	**26,771**	**10,743**	**10,674**	**69**
Income				
Sales Income	-2,174	-1,117	-1,058	**(59)**
School Meals Sales	-2,224	-737	-762	**25**
Fees & Charges Income	-2,655	-1,316	-1,251	**(65)**
Rents Income	-156	-68	-68	**0**
Government Grant Income	-111	-31	-38	**7**
Reimbursements & Other Grant Income	-443	-157	-185	**28**
Schools SLA Income	-278	-248	-232	**(16)**
Internal Fees Income	-104	-40	-35	**(5)**
School Meals Other Income	-2,265	-1,768	-1,790	**22**
Meals On Wheels	-218	-91	-102	**11**
Catering Fees	-173	-86	-33	**(53)**
Capital Salaries	-103	-51	-23	**(28)**
Transfers From Reserves	-62	0	0	**0**
Rolling Projects	-6	-6	-6	**0**
Total Income	**-10,972**	**-5,716**	**-5,583**	**(133)**
Net Controllable Expenditure	**15,799**	**5,027**	**5,091**	**(64)**
Recharges				
Premises Support	1,491	632	632	**0**
Transport Recharges	2,242	860	868	**(8)**
Departmental Support Services	9	0	0	**0**
Central Support Services	3,119	1,601	1,602	**(1)**
Asset Charges	3,052	0	0	**0**
HBC Support Costs Income	-375	-375	-374	**(1)**

Net Total Recharges	**9,538**	**2,718**	**2,728**	**(10)**
Net Departmental Total	**25,337**	**7,745**	**7,819**	**(74)**

Prevention & Assessment
Revenue Spending as at 30th September 2013

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (underspend) £'000
Expenditure				
Employees	6,921	3,199	3,136	63
Other Premises	68	22	19	3
Supplies & Services	472	247	244	3
Aids & Adaptations	113	20	20	0
Transport	5	3	3	0
Food Provision	18	9	13	(4)
Other Agency	68	24	25	(1)
Capital Finance	14	7	7	0
Contribution to Complex Care Pool	18,164	5,923	5,892	31
Total Expenditure	**25,843**	**9,454**	**9,359**	**95**
Income				
Other Fees & Charges	-222	-111	-116	5
Reimbursements & Grant Income	-662	-396	-397	1
Transfer from Reserves	-451	0	0	0
Capital Salaries	-84	0	0	0
Government Grant Income	-40	-13	-11	(2)
CCG Contribution to Service	-187	-314	-314	0
Total Income	**-1,646**	**-834**	**-838**	**4**
Net Operational Expenditure	**24,197**	**8,620**	**8,521**	**99**
Recharges				
Premises Support	373	195	195	0
Asset Charges	294	0	0	0
Central Support Services	2,447	1,175	1,176	(1)
Internal Recharge Income	-419	-204	-204	0
Transport Recharges	58	26	28	(2)
Net Total Recharges	**2,753**	**1,192**	**1,195**	**(3)**
Net Departmental Total	**26,950**	**9,812**	**9,716**	**96**

Commissioning & Complex Care
Revenue Spending as at 30th September 2013

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (overspend) £'000
Expenditure				
Employees	7,081	3,260	3,240	20
Premises	223	118	114	4
Supplies & Services	1,996	1,158	1,167	(9)
Emergency Duty Team	103	26	24	2
Carers Breaks	471	57	54	3
Transport	170	85	85	0
Contracts & SLAs	199	88	46	42
Payments To Providers	3,839	1,620	1,617	3
Other Agency Costs	734	376	387	(11)
Total Expenditure	**14,816**	**6,788**	**6,734**	**54**
Income				
Sales & Rents Income	-162	-110	-109	(1)
Fees & Charges	-169	-40	-30	(10)
CCG Contribution To Service	-846	-378	-374	(4)
Reimbursements & Grant Income	-870	-304	-315	11
Transfer From Reserves	-245	0	0	0
Total Income	**-2,292**	**-832**	**-828**	**(4)**
Net Operational Expenditure	**12,524**	**5,956**	**5,906**	**50**
Recharges				
Premises Support	304	152	152	0
Central Support Services	1,958	887	887	0
Transport Services	440	218	218	0
Asset Charges	82	3	3	0
Internal Recharge Income	-1,747	0	0	0
Net Total Recharges	**1,037**	**1,260**	**1,260**	**0**
Net Departmental Total	**13,561**	**7,216**	**7,166**	**50**

Corporate & Democracy
Revenue Spending as at 30th September 2013

	Annual Budget £'000	Budget to Date £'000	Actual Expendit ure £'000	Variance (Overspend) £'000
Expenditure				
Employees	738	157	160	(3)
Interest Payments	3,869	989	889	100
Members Allowances	760	380	372	8
Supplies & Services	502	220	249	(29)
Contingency	1,200	0	0	0
Levies	172	0	0	0
Capital Financing	2,286	0	0	0
Contribution to Reserves	1,220	0	0	0
Bank Charges	78	38	38	0
Audit Fees	203	89	89	0
Total Expenditure	**11,028**	**1,873**	**1,797**	**76**
Income				
External Interest	-374	-222	-302	80
Government Grants	-3,006	-2,204	-2,202	(2)
Fees & Charges	-39	-22	-24	2
Reimbursements & Other Grants	-382	-16	-16	0
Contribution from Reserves	-1,000	0	0	0
Total Income	**-4,801**	**-2,464**	**-2,544**	**80**
Net Controllable Expenditure	**6,227**	**-591**	**-747**	**156**
Recharges				
Premises	8	5	5	0
Transport	3	1	1	0
Asset Charges	1	0	0	0
Support Services	2,535	826	826	0
Support Service Recharges	-22,212	-186	-186	0
Net Total Recharges	**-19,665**	**646**	**646**	**0**
Net Departmental Total	**-13,438**	**55**	**-101**	**156**

APPENDIX 2

Complex Care Pooled Budget
Revenue Spending as at 30th September 2013

Note – Halton BC's net contribution towards the Complex Care Pooled Budget is included within the Prevention and Assessment Department statement shown in Appendix 1.

	Annual Budget £'000	Budget To Date £'000	Actual To Date £'000	Variance To Date (Overspend) £'000
Expenditure				
Employees	3,276	1,070	1,056	14
Contracts & SLA's	1,846	905	892	13
Transport	5	3	1	2
Joint Equipment Store	518	0	0	0
Adult Care:				
Residential & Nursing Care	18,421	7,036	6,916	120
Domiciliary & Supported Living	10,389	4,312	4,326	(14)
Direct Payment	2,518	1,490	1,632	(142)
Block Contracts	181	0	0	0
Day Care	404	171	166	5
Total Expenditure	**37,558**	**14,987**	**14,989**	**(2)**
Income				
Residential & Nursing Income	-4,294	-2,078	-2,093	15
Community Care Income	-1,451	-583	-597	14
Direct Payments Income	-128	-84	-90	6
CCG Contribution	-12,877	-6,306	-6,306	0
Reablement & S256 Grant	-1,273	-378	-378	0
Other Contribution to Care	-114	-57	-57	0
Transfer from Reserve	-100	0	0	0
Total Income	**-20,237**	**-9,486**	**-9,521**	**35**
Net Operational Expenditure	**17,321**	**5,501**	**5,468**	**33**
Recharges				
Central Support Recharges	313	156	156	0
Premises Support	115	58	58	0
Departmental Recharge	409	205	205	0
Transport recharges	6	3	5	(2)
Total Recharges	**843**	**422**	**424**	**(2)**
Net Expenditure	**18,164**	**5,923**	**5,892**	**31**

APPENDIX 3

Capital Expenditure to 30th September 2013

Directorate/Department	Actual Expenditure to Date	2013/14 Cumulative Capital Allocation			Capital Allocation 2014/15	Capital Allocation 2015/16
		Quarter 2	Quarter 3	Quarter 4		
	£'000	£'000	£'000	£'000	£'000	£'000
Children & Enterprise Directorate						
Schools Related						
Asset Management Data	1	1	3	5	0	0
Fire Compartmentation	1	1	10	20	0	0
Capital Repairs	600	600	1,000	1,379	0	0
Asbestos Management	9	9	8	10	0	0
Schools Access Initiative	35	35	75	113	0	0
Education Programme (General)	29	46	50	92	0	0
Short Breaks for Disabled Children	242	242	247	247	0	0
Basic Need Projects	0	0	0	1,160	0	0
School Modernisation Projects	102	150	350	648	0	0
Weston Primary School	0	0	18	18	0	0
Lunts Heath Primary School	115	115	134	134	0	0
St Bedes Infant School	0	0	116	116	0	0
St Bedes Junior School	233	233	348	366	0	0
Weston Point Basic Need	73	73	70	78	0	0
Ashley School	32	32	302	500	0	0
Early Education for 2 Year Olds	24	24	24	356	0	0
Wade Deacon High School (BSF)	962	962	1,300	1,423	0	0
The Grange (BSF)	3,806	3,806	5,000	5,841	0	0
Wade Deacon ICT	1,131	1,131	1,200	1,465	0	0
The Grange ICT	1,131	1,131	1,200	1,465	0	0

Directorate/Department	Actual Expenditure to Date £'000	2013/14 Cumulative Capital Allocation			Capital Allocation 2014/15 £'000	Capital Allocation 2015/16 £'000
		Quarter 2 £'000	Quarter 3 £'000	Quarter 4 £'000		
Employment, Economic Regeneration & Business Development						
Castlefields Regeneration	23	50	620	827	0	0
3MG	1,821	1,850	4,271	5,695	0	0
Widnes Waterfront	0	0	366	488	0	0
The Hive	88	108	160	214	0	0
Decontamination of Land	62	60	117	155	0	0
Daresbury SciTech Scheme	400	400	2,953	3,937	0	0
Queens Arms – Moore Lane	39	39	52	69	0	0
HBT Bus Park	71	71	71	71	0	0
Former Fairfield Site - Demolition	31	31	338	450	0	0
Former Fairfield Site – Contingency	1	1	38	50	0	0
Travellers Site Warrington Road	4	5	637	849	0	0
Widnes Town Centre Initiative	0	0	64	85	0	0
Lowerhouse Lane Depot - Upgrade	17	17	551	735	0	0
Disability Discrimination Act	39	39	108	150	300	300
Total Children & Enterprise	**11,122**	**11,262**	**21,801**	**29,211**	**300**	**300**

Directorate/Department	Actual Expenditure to Date	2013/14 Cumulative Capital Allocation			Capital Allocation 2014/15	Capital Allocation 2015/16
		Quarter 2	Quarter 3	Quarter 4		
	£’000	£’000	£’000	£’000	£’000	£’000
Policy & Resources Directorate						
ICT & Support Services						
ICT Rolling Programme	609	729	1,100	1,100	1,100	1,100
Policy, Planning & Transportation						
Local Transport Plan						
Silver Jubilee Bridge Maintenance	828	680	1,400	2,305	2,029	4,990
Bridge & Highway Maintenance	682	835	1,500	2,470	1,816	0
Integrated Transport & Network Management	132	135	420	725	1,020	0
Street Lighting – Structural Maintenance	53	55	105	105	200	200
Surface Water Management	0	0	160	214	0	0
Local Pinch Point Fund Programme – Daresbury Expressway	0	0	400	1,805	589	0
Mersey Gateway						
Early Land Acquisition	7,414	7,414	19,257	23,639	4,421	1,250
Development Costs	995	995	1,400	3,500	0	0
Other						
Risk Management	19	20	100	118	120	120
Mid-Mersey Local Sustainable Transport	7	7	113	150	270	0
Fleet Replacements	63	63	280	950	300	300
Total Policy & Resources	**10,802**	**10,933**	**26,235**	**37,081**	**11,865**	**7,960**

Directorate/Department	Actual Expenditure to Date	2013/14 Cumulative Capital Allocation			Capital Allocation 2014/15	Capital Allocation 2015/16
		Quarter 2	Quarter 3	Quarter 4		
	£'000	£'000	£'000	£'000	£'000	£'000
Communities Directorate						
Community Dept						
Stadium Minor Works	0	0	45	60	30	30
Stadium Gym Equipment	0	0	23	30	0	0
Widnes Recreation Site	0	0	2,010	2,680	0	0
Children's Playground Equipment	14	20	20	81	65	65
Landfill Tax Credit Schemes	13	17	30	340	340	340
Arley Drive	1	4	5	66	0	0
Crow Wood Park	0	0	9	13	0	0
Runcorn Hill Park	22	25	90	120	250	250
Open Spaces Scheme	45	45	45	51	0	0
Runcorn Cemetery Extension	1	3	6	9	0	0
Widnes Crematorium Cremators	0	0	297	396	0	0
Runcorn Busway Works for Gas Powered Buses	30	30	30	30	0	0
Litter Bins	29	29	38	50	20	20
Commissioning & Complex Care						
Grants for Disabled Facilities	150	150	438	584	0	0
Energy Promotion	0	0	4	6	0	0
Joint Funding RSL Adaptations	69	70	262	350	0	0
Stairlifts	112	125	187	250	0	0
Choice Based Lettings	5	5	5	7	0	0
Bungalows at Halton Lodge	0	0	300	400	0	0

Directorate/Department	Actual Expenditure to Date £'000	2013/14 Cumulative Capital Allocation Quarter 2 £'000	Quarter 3 £'000	Quarter 4 £'000	Capital Allocation 2014/15 £'000	Capital Allocation 2015/16 £'000
Bredon Respite Unit	13	13	13	13	0	0
Grangeway Court	0	0	260	347	0	0
Section 256 Grant/Contingency	0	0	22	29	0	0
Community Capacity Grant	0	0	0	0	351	0
Total Communities Directorate	**504**	**536**	**4,139**	**5,912**	**1,056**	**705**
TOTAL CAPITAL PROGRAMME	**22,428**	**22,731**	**52,175**	**72,204**	**13,221**	**8,965**
Slippage (20%)				-14,441	-2,644	-1,793
					14,441	2,644
TOTAL				**57,763**	**25,017**	**9,816**

REPORT TO:	Executive Board
DATE:	21 November 2013
REPORTING OFFICER:	Operational Director Finance
SUBJECT:	Medium Term Financial Strategy
WARD(S):	Borough-wide
PORTFOLIO:	Resources

1.0 PURPOSE OF REPORT

1.1 To establish the Medium Term Financial Strategy for 2014/15 to 2016/17.

2.0 RECOMMENDED: That

1) **the Medium Term Financial Strategy be approved;**

2) **the base budget be prepared on the basis of the underlying assumptions set out in the Strategy;**

3) **the Budget Strategy and Capital Strategy be approved;**

4) **the Reserves and Balances Strategy be approved;**

5) **the award of Council Tax support for 2014/15 remains at the 2013/14 level of 21.55%.**

3.0 SUPPORTING INFORMATION

3.1 The Medium Term Financial Strategy (MTFS) sets out a three-year projection of the Council's resources and spending. It has been based on information that is currently available but there is information yet to be received, primarily from Government and revisions will need to be made as new information becomes available.

3.2 Although the projections in the strategy must be treated with a considerable degree of caution, they clearly show there is need to make a significant level of savings over the next three years. This is an effect of the Government policy to reduce the national deficit through reductions in public sector funding. The strategy takes into account the:

- 2010 Comprehensive Spending Review published by the Government on 20th October 2010, covering the four year period to 2014/15
- 2013 Comprehensive Spending Review published by the Government on 26th June 2013 which only covered the financial year 2015/16
- 2014/15 and 2015/16 Technical Consultation on the Local Government Finance Settlement published by the Department for Communities and Local Government (DCLG) on 25th July 2013

3.3 The strategy provides initial guidance to the Council on its financial position into the medium term. The strategy identifies that revenue savings of approximately £15m, £17m, and £14m are required over the next three years. As a result a total of £46m will need to be removed from the Council's budget. This represents 26% of the gross expenditure budget. It continues to be a significant challenge to find sufficient savings over the medium term in order to balance the budget.

3.4 The Council's current financial position is sound. There are sufficient reserves and balances to meet existing known risks. In their report regarding Financial Resilience for the year ended 31st March 2013, the External Auditor (Grant Thornton LLP) stated that the Council has:

- A proven track record of keeping expenditure within budget.
- A structured approach to identifying and managing budget pressures.

3.5 In setting its revenue and capital budgets, the Council will need to have regard to its priority areas, namely:

- Healthy Halton
- Environment & Regeneration in Halton
- Children and Young People in Halton
- Employment Learning and Skills in Halton; and
- Safer Halton

3.6 These priorities are set out in more detail in the Council's Corporate Plan.

3.7 In summary, the Council's Medium Term Financial Strategy (MTFS) has the following objectives:

- To deliver a balanced and sustainable budget.
- To prioritise spending towards the Council's five priority areas.
- To avoid excessive council tax increases.
- To achieve significant cashable efficiency gains.
- To protect front line services as far as possible.
- To deliver improved procurement.

Budget Strategy

3.8 The MTFS shows that in order to balance the budget over the medium term there is a requirement not only to make significant cost savings of up to £15m in 2014/15 but also a further £17m in 2015/16 and £14m in 2016/17. In making these savings the Council will need to have in mind the objectives of the Medium Term Financial Strategy set out above.

3.9 The Council will identify savings by:

- Progressing the Efficiency Programme.
- Reviewing the portfolio of land and other assets, including its use of buildings in accordance with the Accommodation Strategy.
- Continuing to drive improved procurement across the Council.
- Identifying opportunities to generate new or additional sources of income.
- Reviewing (subject to negotiations) the terms and conditions of staff.
- Offering staff voluntary early retirement and voluntary redundancy under the terms of the Staffing Protocol.
- Delivering services in more efficient and effective ways such as via greater use of technology.
- Reducing the cost of services either by reducing spend or increasing income.
- Stopping some lower priority services.

3.10 Over the years the Council has prided itself that compulsory redundancies have been minimised. But given the scale of the savings facing the Council this will be difficult to achieve over the next three years.

Capital Strategy

3.11 The Asset Management Strategy sets out how the land and buildings that are in Council ownership or occupation are structured to support the Council's priorities. The capital programme is a major part of the Strategy.

3.12 The MTFS shows that there is sufficient resource to cover the cost of the current Capital Programme. However, in the current economic climate it is unlikely that the Council will receive significant levels of capital receipts. As such the opportunity for additional capital spending is severely limited and therefore, new spending can only take place for schemes that come with their own funding.

3.13 Prudential borrowing remains an option but the financing costs as a result of the borrowing will need to be found from savings within the revenue budget.

4.0 POLICY IMPLICATIONS

4.1 The MTFS represents the "finance guidelines" that form part of the medium term corporate planning process. These guidelines identify the financial constraints which the Council will face in delivering its key objectives, and are an important influence on the development of the Corporate Plan, Service Plans and Strategies.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 The MTFS provides a guide to projected receivable government grant over the three year term. The grant amounts included in the MTFS are assumed based on the latest information provided by Government, as new information comes to light forecast of future income streams will be updated. Decreases to grant income will create further budget pressures in the Council delivering its key objectives.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 The revenue budget and capital programme support the delivery and achievement of all the Council's priorities. Reductions of the magnitude identified within the strategy are bound to have a negative impact upon the delivery of those priorities.

7.0 RISK ANALYSIS

7.1 The MTFS is a key part of the Council's financial planning process, and as such minimises the risk that the Council fails to achieve a balanced budget.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 There are no direct equality and diversity issues.

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

Document	Place of Inspection	Contact Officer
Formula Grant Settlement 2013/14	Kingsway House	Alison Walker
Comprehensive Spending Review 2010 (CSR2010)	”	”
Comprehensive Spending Review 2013 (CSR2013)	“	“

Local Government Finance Settlement (Technical Consultation) 2014-15 and 2015-16	“	“

MEDIUM TERM FINANCIAL STRATEGY

2014/15 TO 2016/17

Finance Department

November 2013

1.0 INTRODUCTION

1.1 The Medium Term Financial Strategy (MTFS) sets out a three-year projection of the Council's resources and spending covering the period 2014/15 to 2016/17. The projections made within the MTFS must be treated with caution and require continuous updating as the underlying assumptions behind them become clearer.

1.2 The MTFS represents the "finance guidelines" that form part of the medium term corporate planning process. These guidelines identify the financial constraints which the Council will face in delivering its key objectives, and are an important influence on the development of the Corporate Plan, Service Plans and Strategies.

2.0 COMPREHENSIVE SPENDING REVIEW 2010

2.1 The financial year 2014/15 is the final year covered by the Government's Comprehensive Spending Review (CSR10) which was announced on the 20th October 2010, setting out the Government's public sector spending plans covering the four year period up to 2014/15.

2.2 The CSR10 set out how the coalition Government would carry out the deficit reduction plan. Overall it reported how Government departments would face a loss of funding of an average of 19% over the four years of the review in order to save £83 billion. The cuts to Local Government have been the highest for all Government departments, a reduction of 37% in real terms.

2.3 Following on from CSR10 the Government have introduced a number of new policies into the Local Government Finance system. These include:

a) setting public sector pay awards at an average of 1% per annum
b) funding for new development deals across core cities
c) the implementation of the New Homes Bonus (NHB) Scheme. The NHB scheme is designed to provide incentives and rewards for Councils and Communities who build new homes in their area. By 2014/15 it is forecast the annual cost of the scheme will be £891m. The funding for this is however met by top-slicing of Formula Funding along with a £250m contribution from Government. Top-slicing of Formula Funding takes money away from Councils with a high needs base (such as Halton) to those with a high tax base.
d) The Chancellor announced in his 2013 budget that Local Government funding would be cut by a further 1% in 2014/15 to help meet the national deficit reduction plan.

2.4 CSR10 made a grant available to councils to freeze council tax in 2011/12 at their 2010/11 levels. The scheme made funding available to councils equivalent to a 2.5% increase on 2010/11 council tax levels and paid in each of the four years of the spending review to compensate for council tax income foregone during the CSR10 period. The Council agreed to the conditions of the scheme and were allocated a grant of £1.087m in 2011/12.

2.5 As part of the 2011 Chancellors Autumn Statement, the Government made funding available for a further council tax freeze covering 2012/13. The grant of £1.087m was only available for one year and represented the equivalent of a 2.5% increase in council tax.

2.6 The Government made a further grant offer to Local Government to freeze council tax for 2013/14. However, this was only the equivalent of 1% increase in council tax and was available for two years only. The Council opted not to accept this freeze grant and approved a council tax increase of 1.9% for 2013/14.

3.0 COMPREHENSIVE SPENDING REVIEW 2013

3.1 The Comprehensive Spending Review 2013 (CSR13) was announced on the 26th June 2013. This set out the Government's public sector spending plans for one year only, this being the financial year 2015/16.

3.2 The CSR13 set out how the coalition Government will continue to carry out the deficit reduction plan. Overall Government departments will face a loss of funding of £11.5 billion in 2015-16. It was reported Local Government will face above average cuts of 8.2% in cash terms in financial year 2015/16.

3.3 A number of policies were introduced by CSR13. These include:

a) Council tax freeze grants for 2011/12 and 2013/14 are to be included in a Council's funding assessment for 2015/16. It was expected that the final year of payment for these grants would be 2014/15, but Government have amended the rules of the grant and they will continue to be paid for 2015/16. The MTFS assumes that the freeze grant for 2011/12 will fall out in 2016/17.

b) Council tax freeze grants for 2014/15 and 2015/16. These are to be offered at a rate of 1% for 2014/15 payable for two financial years and 1% for 2015/16 payable for one year only. If the Council opts to accept the freeze grants the estimated total value of them over the two financial years for Halton is £1.35m.

c) £3.8bn of social care and health budgets will be brought together by 2015/16 for joint commissioning and pooling. This will enable closer working in local areas, in order to deliver better services to older and disabled people keeping them out of hospital and avoiding long hospital stays. £200m will be made available for local authorities from the NHS in 2014-15, to ensure change can start immediately through investment in new systems and ways of working. It is difficult for the Council to take account of this additional funding yet, as there is no clear indication of the controls, conditions and new burdens associated with this funding.

d) Public sector pay awards will be restricted to 1%.

e) £400m will be top sliced from the New Homes Bonus (NHB) and passed to Local Enterprise Partnerships (LEPs) as part of the Single Local Growth Fund. It is estimated this will be approximately 30% of NHB which the Council was due to receive in 2015/16.

f) Education Services grant funding by the Department for Education will be cut by 25%. This is intended to be in line with the changing nature of the schools system. The Government will reduce central education support by reducing the Education Services grant by around £200 million in 2015-16.

4.0 TECHNICAL CONSULTATION – LOCAL GOVERNMENT FINANCE SETTLEMENT 2014/15 & 2015/16

4.1 On 25th July 2013 DCLG opened a technical consultation on the Local Government Financial Settlement for 2014-15 and 2015-16.

4.2 DCLG have provided exemplifications of funding for 2014/15 and 2015/16 for all local authorities. This now suggests there will be a funding cut of 10% and 14% in cash terms for each of the two years. The 2015/16 cut of 14% is significantly higher than the 8.2% announced in CSR13.

4.3 The difference in the level of cuts between CSR 2013 and the technical consultation is explained to some degree by a further top-slicing of the Revenue Support Grant (RSG) for separate funding pots. These include funding new social care burdens, funding for the Independent Living Fund, funding for capitalisation and an increased safety net for the Business Rates Retention Scheme.

4.4 Halton has responded to the consultation, as have Sigoma and the Liverpool City Region, and made DCLG aware of the unfairness of increasing funding cuts, so soon after the publication of CSR13.

5.0 LOCALISING COUNCIL TAX SUPPORT

5.1 In 2013/14 Government changed the way of funding council tax benefit. Previously, 100% funding had been provided by Central Government. Responsibility has now transferred to Local Government and Halton has introduced its own localised scheme. The scheme uses as a basis the previous regulations relating to Council Tax Benefit which will ensure that existing support for claimants with disabilities, claimants with children and claimants who are working are maintained. At the end of the existing calculation a reduction of 21.55% is made from every non pensioner award of benefit to cover the shortfall in the government grant allocation for Halton.

5.2 Funding for the local scheme is part provided through Revenue Support Grant from Government. In 2013/14 the level of grant awarded was shown separately within the formula for RSG, but from 2014/15 the grant is no longer separately identifiable. The assumption in the MTFS is that the level of grant will be reduced from 2013/14 as per the reduction to local government funding (14%), but this cannot be verified.

5.3 The MTFS therefore assumes that the level of council tax support given to existing claimants will remain at the rate of 21.55% for the period of the MTFS.

6.0 BUSINESS RATE RETENTION SCHEME

6.1 The Business Rates Retention scheme was introduced in April 2013, the intention of which was to reward councils for promoting economic development and generating future growth in business rates. At the time of the 2013/14 finance settlement the Government issued Halton with a retained (local share) business rates baseline of £24.4m. The intention is if Halton increases its local share of business rates above the baseline the increase is retained in full by the Council.

6.2 An estimate of business rates was prepared at the start of the current financial year and it was forecast that the business rates the Council will generate during 2013/14 will be in line with the baseline. It is difficult to predict the level of business rates for future years due to the unpredictability of the current economic climate and appeals on the rateable value of properties.

7.0 EXTERNAL SUPPORT

Settlement Funding Assessment

7.1 In 2013/14 (the first year of the business rates retention scheme) DCLG allocated Halton a settlement funding assessment of £78.9m. This was made up of £47.4m Revenue Support Grant and £31.5m business rates baseline funding. The business rates baseline funding includes £24.4m as the business rates baseline and £7.2m of top-up grant funding. Top-up grant funding is received as the Council's funding baseline is greater than the business rate baseline. The business rates baseline and funding level is set in the system until 2020 and uplifted each year by RPI only.

7.2 Indicative funding assessments for 2014/15 and 2015/16 have been received from DCLG as part of the technical consultation. These have been included within the MTFS and are as set out in table 2 below.

Table 2 –Halton's Funding Assessment

	13/14	14/15	15/16	% change from 13/14 to 15/16
Revenue Support Grant	47,409	38,563	27,601	-41.7%
Baseline Funding Level consisting of:				
Business Rates Baseline	24,370	25,164	25,871	6.2%
Top Up	7,170	7,404	7,611	6.2%
Total Baseline Funding Level	31,540	32,568	33,482	6.2%
Funding Assessment	78,949	71,131	61,083	-22.6%

7.3 Included within the funding assessment is an amount for formula funding based on what is known as the "four block model". This distributes grant over three blocks based upon Ministerial judgement. The system is not transparent making it difficult to identify the amount of grant received by individual councils for new functions or grant transfers.

7.4 The fourth block is the damping mechanism to ensure that all councils receive at least the minimum increase or decrease in grant, known as "the floor". In this way councils are protected from significant detrimental grant changes in comparison to other Councils. The floor level included in the 2013/14 finance settlement was set at 2.7%, Halton received £3.1m by way of damping, equivalent to 5.3% of the total formula funding it received. The continued existence of the floor mechanism is therefore extremely important for the Council's current and future funding.

Specific Grants

7.5 The level of specific grants received by Halton in 2013/14 is £101m, including the Dedicated School Grant of £83.1m.

7.6 The CSR10 introduced the New Homes Bonus grant, the aim of which was to "create a powerful, simple, transparent and permanent incentive which rewards councils that deliver sustainable housing development". The award of the grant is based on the additional number of new dwellings, a supplement for new social housing and payments for bringing empty homes back into use.

7.7 Halton was allocated a New Homes Bonus grant of £1.052m for 2013/14 which was used to balance the budget; this will be paid to the Council in each of the next three years. Halton will receive additional allocations in each year of the scheme, although the allocation for 2014/15 has not yet been announced. The Government have set aside £250m annually in each year of the spending review to part-fund the scheme, but funding beyond these levels will be met by top-slicing the councils' formula grant nationally.

7.8 CSR 2013 confirmed £400m of New Homes Bonus grant allocations will be top-sliced in 2015/16 to contribute towards the creation of the Single Local Growth Fund administered by the LEPs. It is estimated £400m will be approximately 30% of the value of the New Homes Bonus in 2015/16. Therefore it is assumed within the MTFS that the Council's NHB allocations will be reduced by 30% and passed directly to the LEP.

7.9 The Education Services Grant (ESG) was introduced in April 2013 as a means of passing funding to academy schools to fund central education services which are now the responsibility of academy schools.

7.10 ESG funding for 2013/14 came from a top-slice of councils' formula funding. ESG allocations for 2013/14 were allocated to local authorities and academy schools on a simple per pupil basis, according to the number of pupils for which they are responsible.

7.11 CSR 2013 confirmed funding for ESG would be cut by a further 25% from 2015/16.

7.12 Government have given no indication of cuts to funding for 2016/17, however, the MTFS assumes a cut of 10% to the Council's funding assessment. Each 1% cut to funding in 2016/17 equals a loss of Government grant of £0.6m.

7.13 The forecast decrease in the level of formula and specific grant funding for Halton is shown in Table 3 below:

Table 3 – Reduction in Grant 2014/15 to 2016/17

	2014/15 £000's	2015/16 £000's	2016/17 £000's
Reduction in Settlement Funding Assessment	-7,733	-10,966	-6,025
New Homes Bonus Funding Single Local Growth Fund	-	-470	-
Education Services Grant	-	-450	-
Cessation of 2011/12 Council Tax Freeze Grant			-1,086
In Year Reduction	-7,733	-11,886	-7,111
Cumulative Reduction	-7,733	-19,619	-26,730

7.14 The table shows over the next three years Halton will lose £27m in formula grant allocations, which represents a 34.2% reduction in the funding assessment received in 2013/14.

8.0 COUNCIL TAX FORECAST

8.1 For 2013/14 the Council Tax for a Band D property in Halton is £1,159.53 (excluding police, fire and parish precepts), which will generate income of £36.165m. Each additional 1% increase to Council Tax will generate £0.360m.

8.2 When setting Council Tax levels it is clear that higher increases reduce the requirement to make savings. However, there are other factors that need to be considered when determining the appropriate increase in Council Tax. These factors include:

- Halton has the 3rd lowest Council Tax level in the North West and the 42nd lowest in England for 2013/14,
- Halton's 2013/14 Council Tax is £73.16 (5%) below the average Council Tax set by councils in England.
- Inflation - the Consumer Price Index (CPI) as at August 2013 is currently at 2.7% and the Retail Price Index (RPI) at 3.3%.

- The spending review, welfare reforms, the slow housing market, inflation and high unemployment figures, which are all placing pressure upon the Council's funding and demand for services.

8.3 The Localism Act 2011 abolished capping of council tax increases and instead provides local residents with the power to approve or veto excessive council tax rises. For 2014/15 and 2015/16 the Government have confirmed that a rate of 2% will be set and any council tax rises above this will trigger a referendum.

8.4 The Government have announced a council tax freeze scheme for 2014/15 and 2015/16. The scheme will offer councils who freeze or reduce council tax in 2014/15 grant funding equivalent to 1% of their council tax requirement before the deduction for Council Tax Support. However, the funding will only be paid for two years. The Government have also offered a council tax freeze grant of 1% before the deduction for Council Tax Support for 2015/16, however this will only be paid for one year.

8.5 Should the Council accept the council tax freeze grants the grants will be worth an estimated £435,000 in each of the years for which they are payable. It should be noted that when the grant ends in 2016/17 the shortfall in grant funding will have to be found from either additional savings or increasing the Council Tax.

8.6 Table 4 below estimates the net amount of Council Tax income that will be produced for various % increases in Halton's Band D Council Tax for the next three years and assumes no change in council tax base. It also shows the value of Council Tax freeze grants over the three years:

Table 4 – Council Tax Income for 2014/15 to 2016/17

Projected Increases in Council Tax Income (£'000)	**2014/15 £'000**	**2015/16 £'000**	**2016/17 £'000**	**Total £'000**
0%	-	-	-	-
1%	362	365	369	1,096
2%	723	737	752	2.212
Council Tax Freeze Grant	435	870	-1,305	-

9.0 SPENDING FORECAST

9.1 The spending forecast provides an estimate of the increase in revenue expenditure that will be required over the next three years in order to maintain existing policies and programmes. In effect this represents an early estimate of the standstill budget requirement using the information that is currently available.

9.2 The scope of the forecast covers General Fund revenue activities that are financed through the Settlement Funding Assessment, Specific Grants and the Council Tax. School budgets are considered in Section 13.

9.3 The forecast includes the budgetary consequences of previous budget decisions, including one-off savings used to balance the 2013/14 budget; this adds £2.5m to the forecast for 2014/15.

9.4 Pay and price inflation is the biggest uncertainty and the single most costly factor in the spending forecast. As part of the Chancellor's 2011 Autumn Statement he informed that in order to maintain stability and meet the Government's fiscal rules, public sector pay awards would be set at an average of 1% for years 2013/14 and 2014/15. As part of the CSR13 it was announced that public sector pay awards would be further restricted to 1% for 2015/16. The spending forecast therefore assumes pay will increase by no more than 1% for each of the three years of the forecast.

9.5 Inflation has increased since this time last year, currently the Consumer Price Index (CPI) – the index by which the Government measures inflation - stands at 2.7% which is above the Government's 2% target. The spending forecast assumes that many items of supplies and services expenditure will continue to be cash limited. In other cases the forecast assumes an appropriate rate that reflects the picture of current and future prices.

9.6 The Council has a significant capital programme and the spending forecast includes the financing costs of the existing programme. Financing costs for the early land acquisition relating to the Mersey Gateway Project were previously funded from borrowings. It is expected that grant from Department of Transport (DfT) will be received during the period of the MTFS which will enable the Council to repay those borrowings. As a result, the net revenue costs associated with the capital programme are included in the forecast at a reduction of £0.9m in 2014/15, followed by an increase of £0.03m in 2015/16 and a reduction £0.3m in 2016/17.

9.7 During the period of the MTFS, construction will commence on the Mersey Gateway bridge. The Council will make a contribution towards the construction costs of the bridge funded by prudential borrowing, the financing costs of which will be met from future toll revenues and DfT grant. In order to manage the construction and operation of the Mersey Gateway the Council will establish the Mersey Gateway Crossings Board. The cost of operating the Board will also be met from future toll revenues and DfT grant.

9.8 For the three years of the forecast a 0.5% rise to cover the increasing costs of employer's superannuation contributions has been included. This is estimated to add an additional £0.3m for each year.

9.9 The disposal of waste using landfill is subject to Landfill Tax paid on top of landfill fees. The 2010 Emergency Budget announced that the standard rate for Landfill Tax would continue to increase annually by £8 per tonne until 2014/15 when it will cost £80 per tonne. It is estimated that an additional £0.2m will be required to fund the increase in Landfill Tax in 2014/15. It is assumed in the forecast that future increases beyond 2014/15 will be linked to the Retail Price Index (RPI).

9.10 The Borough's older population continues to increase with people living longer. Table 5 below shows Halton's population figures:

Table 5 – Halton's Population Breakdown 2012 Mid-Year Estimates

Age Range			
0-15	16-64	65+	Total
24,900	81,200	19,600	125,700

9.11 In the long term (to 2021) Halton's population is projected to grow by 3% from 125,700 to 129,300. The older people population is projected to grow by 26% from 19,600 to 24,700 in 2021. This is putting considerable pressure on the community care budget and therefore a further £0.3m is included in each year of the spending forecast.

9.12 SCOPE, a national charity, who support people with Cerebral Palsy have six registered residential homes in Halton supporting approximately 50 people. SCOPE has announced that they intend to de-register all homes. Halton will need to undertake assessments of residents needs and if required provide residential care, the cost of which is estimated to be £0.7m in 2014/15 rising to £2.1m by 2016/17 and is included in the spending forecast.

9.13 In January 2013 the Department for Work and Pensions published its White Paper on state pension reforms. Under the proposed changes the current basic and additional state pensions will be replaced by a single tier pension.

9.14 The proposals will mean the end of contracted out National Insurance payments. This will result in additional costs as the Council will pay higher National Insurance contributions. The estimated effect is an increase in National Insurance payments of 3.4% to the Council for each employee who is a member of the Local Government Pension Scheme.

9.15 The Chancellor confirmed in his 2013 budget report that the creation of the single tier state pension will be brought forward to 2016/17. Therefore this has been reflected in the spending forecast.

9.16 A key assumption that has been used in constructing the MTFS is that total spending in 2013/14 is kept within the overall budget. In particular it can be difficult to control 'demand led' budgets such as children in care and care in the community. In this context it is important to consider the contingency for uncertain and unexpected items. Due to the considerable uncertainty over inflation, interest rates, demand led budgets, impact of spending cuts and loss of income, the spending forecast includes a contingency of £2m in 2014/15, £2.5m in 2015/16 and £2.5m in 2016/17.

9.17 Table 6 summarises the Spending Forecast, which highlights likely increases in the net budget of £7.4m in 2014/15, £6.1m in 2015/16 and £7.1m in 2016/17.

Table 6 – General Fund Medium Term Standstill Spending Forecast

Increase in spending required to maintain existing policies and services	**Year on year change (£'000)**		
	2014/15	**2015/16**	**2016/17**
Full Year Effect of Previous Year Budget	2,541	-	-
Capital Programme	-914	35	-320
Pay and Price Inflation	1,714	1,766	1,820
Annual Pay Increments	500	500	500
Superannuation	250	250	250
Waste Disposal	267	-	-
Older Population	300	300	300
Scope – De-Registering Properties	700	700	700
Single Tier State Pension	-	-	1,300
Contingency	2,000	2,500	2,500
TOTAL INCREASE	**7,358**	**6,051**	**7,050**

10.0 THE FUNDING GAP

10.1 At this level of spending there is a funding gap with the forecast level of resources. Table 7 demonstrates the forecast gap between spending and forecast resources at different levels of Council Tax increase.

Table 7: Funding Gap with a given % increase in Council Tax

Council Tax Increase of:	**2014/15**	**2015/16**	**2016/17**
0%	15,091	17,104	14,161
1%	14,729	16,377	13,064
2%	14,368	15,644	11,949
Council Tax Freeze Grant	14,656	15,799	14,161

10.2 The table shows that savings of over £15m are forecast to be needed to balance next year's budget with further savings of £17m in 2015/16 and £14m in 2016/17, before any increase to Council Tax. The total funding gap is over £46m and represents 26% of the Council's gross expenditure budget.

10.3 This represents a significant challenge for the Council to balance its budget. As a result every aspect of the Council's budget needs to be scrutinised to identify potential savings. In addition, all opportunities will continue to be taken to generate additional income from charging for services, in order to reduce costs whilst maintaining levels of service delivery.

11.0 CAPITAL PROGRAMME

11.1 The Council's capital programme is updated regularly throughout the year. Table 8 summarises the fully funded capital programme.

Table 8 – Capital Programme

	2014/15 (£'000)	2015/16 (£'000)	2016/17 (£'000)
Spending	**12,971**	**8,715**	**4,379**
Funding:			
Prudential Borrowing	4,421	1,250	4,739
Grants	6,322	5,296	-
Revenue Financing	359	300	-
Capital Receipts	1,869	1,869	-
Total Funding	**12,971**	**8,715**	**4,379**

11.2 The current system of capital controls allows councils to support and fund the capital programme by way of prudential borrowing. Such borrowing is required to be:

- prudent
- affordable, and
- sustainable

11.3 The Council has used prudential borrowing provided that the cost of borrowing has been covered by revenue budget savings. The spending forecast continues this approach.

11.4 In previous years the Council has been extremely successful in attracting grants and contributions. In this way the Council has been able to undertake significant capital expenditure without financing costs falling on the budget.

11.5 In recent years a major source of funding the capital programme has been capital receipts. However, the number and value of assets now held is much less than it was and therefore no major capital receipts are included within the forecast.

12.0 RESERVES AND BALANCES

12.1 The Council's Reserves and Balances Strategy is attached in the Appendix. It sets out the Council's strategy in respect of the level of reserves and balances it wishes to maintain, by reference to the financial needs and risks associated with the Council's activities.

12.2 The level of balances and reserves will be reviewed as part of the budget and final accounts processes.

13.0 SCHOOLS BUDGET

13.1 Schools are fully funded by the Dedicated Schools Grant (DSG). The DSG is used to fund the Individual Schools Budget (ISB) which is allocated to schools by way of a formula and the central allocation in accordance with the revised Department for Education (DfE) guidelines.

13.2 The Schools Forum assesses and considers current and future arrangements and changes to schools funding, agreeing any formula changes.

13.3 In April 2013 schools received budgets based on the new funding formula which is the first step in a proposed move towards a national funding formula. It is envisaged that national funding formula will be implemented during the next spending review period.

13.4 From April 2013 funding is divided into three separate blocks within the Dedicated Schools Budget. These are the Schools Block, High Needs Block and Early Years Block.

13.5 Under the new funding guidelines, the amount of centrally held monies is tightly restricted for anything other than Early Years and High Needs provision.

13.6 Funding for schools converting to academies is paid directly to the academy from the Education Funding Agency rather than going through the Council. Included within the grant paid to the schools are monies that previously funded educational support services which the Council provides. There is an element of financial risk to the Council in future years if other schools choose to become academies which will lead to a shortfall in income to fund the expenditure for the central services.

14.0 PARTNERSHIPS

14.1 1st April 2013 brought into being the Clinical Commissioning Groups, the drivers of new clinically-led commissioning system, whom councils have developed similar partnerships with as they did with PCTs.

14.2 Halton is the host body in a Complex Care Pooled budget from 1st April 2013 working jointly with Halton Clinical Commissioning Group (HCCG) This brings together the Integrated Community Equipment Service, Intermediate Care Services, Adult Social Community Care (including Section 117 & joint funded packages of care), HCCG Continuing Health Care, HCCG section 117 and Reablement Services.

14.3 The Council has established partnerships and shared service arrangements with a number of councils and other organisations over recent years. It will continue to develop such arrangements where it is considered beneficial both in terms of service delivery and cost reduction.

15.0 EFFICIENCY STRATEGY

15.1 In order to maintain the level of performance across services delivered by the Council, it needs to find new and innovative ways to deliver services whilst making efficiency savings. The Council is determined not to compromise on the quality of the services that are provided to the community. However, it recognises the need to look more radically at the way it does business in order to achieve the level of savings that will protect key services.

15.2 The Council has an established Efficiency Programme in place to review services in a consistent way. This enables the identification of opportunities to enhance productivity, reduce costs, explore alternative delivery mechanisms and ensure that services are configured in the most appropriate way to meet the needs of service users.

15.3 Through the Efficiency Programme the Council has achieved savings of over £12m to date, including Procurement savings

15.4 The Council has proper arrangements for challenging how it secures economy, efficiency and effectiveness. This has been much strengthened and improved by the centrally coordinated procurement arrangements established via the Procurement Division. Procurement is considered a key mechanism for delivering efficiencies across the Council.

15.5 An e-tendering system, “Due North (the Chest)”, has been introduced to advertise and manage all tender exercises and sourcing activities. It also aims to encourage transparency of opportunity with Small and Medium Enterprises (SMEs). An increase in value thresholds within the

Council's standing orders has been made in order to generate potential savings through less bureaucracy and a more streamlined approach.

15.6 The accommodation strategy aims to rationalise the Council's land and property portfolio and wherever possible to locate staff in Council owned buildings. Progress continues to be made with implementation of the strategy, which has and will continue to result in significant budget savings during the period of the forecast.

16.0 MONITORING

16.1 Spending against each Department's revenue budget and capital programme is monitored and reported to the Policy and Performance Boards, alongside service outcomes, within the quarterly performance management reports. The Council-wide position is also reported quarterly to Executive Board.

17.0 SUMMARY

17.1 As a result CSR10, CSR13 and the technical consultation to the Finance Settlement 2014/15 and 2015/16 there have been severe cuts to the Council's funding, which are expected to continue in the medium term. In addition, the Business Rate Retention Scheme, localisation of council tax support and top-slicing of New Homes Bonus, bring further risk to the funding potential of the Council over the period of the Medium Term Financial Strategy and beyond. This will mean a considerable deterioration in monies available to fund services in the Borough.

17.2 As a consequence there is a requirement to make significant budget savings. There are also spending pressures, not included in the spending forecast, which will result in the need for further savings to keep future council tax increases to reasonable levels.

17.3 Future levels of growth and savings will therefore be directly influenced by the decisions made concerning council tax increases. Council tax increases will reduce the level of savings required, although the setting of capping through council tax referendum legislation will ensure the Government keep the cost of increases to council tax to a minimum.

17.4 The Medium Term Financial Strategy has been based on information that is currently available. Revisions will need to be made as new developments take place and new information becomes available.

APPENDIX

RESERVES AND BALANCES STRATEGY

1.0 INTRODUCTION

1.1 The following sets out the Council's Strategy in respect of the level of reserves and balances it wishes to maintain, by reference to the financial needs and risks associated with the Council's activities.

1.2 The overall strategy is to provide the Council with an appropriate level of reserves and balances in relation to its day to day activities and to ensure the Council's financial standing is sound and supports the achievement of its long term objectives and corporate priorities.

1.3 The Operational Director, Finance will undertake quarterly reviews of the level of reserves and balances and take appropriate action in order to ensure the overall strategy is achieved. The outcome of the reviews will be reported to the Executive Board and will be used to inform the Medium Term Financial Strategy (MTFS), the annual budget setting process and the final accounts process.

1.4 The Strategy concentrates upon the Council's key reserves and balances, being those which may potentially have a significant affect upon the Council's financial standing and its day to day operations.

2.0 GENERAL BALANCES

2.1 It has been the Council's policy since it gained unitary status to maintain general balances at a reasonable level. Close monitoring and control of budgets since then has meant this policy has been successfully achieved. It is considered prudent to maintain general balances at a reasonable level in order to provide for any major unforeseen future events. Going into 2013/14 the level of the general reserve stood at £8.1m, this will be reduced by the close of the financial year as it was agreed £1m would be used in balancing the budget for 2013/14.

2.2 The level of revenue budget savings currently indicated by the MTFS provides increased uncertainty in terms of the Council's ability to deliver spending in line with its annual budget, which would result in a reduction in general balances. It is therefore considered prudent to maintain general balances at approximately 7% of the Council's net revenue budget in order to provide for such eventualities, as well as to minimise the financial impact of any major unforeseen future events.

3.0 BAD DEBT PROVISIONS

Sundry Debtors

3.1 The Council makes provision for bad and doubtful debts based upon an annual review of outstanding debts profiled by age and the associated risks of non-payment, depending upon the types of debt.

3.2 Past experience has shown that after 43 days the likelihood of sundry debts being paid reduces significantly and therefore the risk of them not being recovered increases greatly. Full provision will therefore be made for all sundry debts outstanding for more than 43 days.

3.3 The bad debt provisions in respect of sundry debtors currently total £4.3m.

Council Tax / Business Rates (NNDR)

3.4 Bad debt provisions are made in respect of Council Tax and National Non Domestic Rate (NNDR) debts, based on an overall 97.8% collection rate. The bad debt provisions in respect of Council Tax and NNDR debtors currently total £3.1m.

3.5 The levels of bad debt provisions held are considered prudent in relation to the current level and age profile of outstanding debts. But they will be reviewed annually, particularly in the light of the prevailing economic climate and reductions in council tax support payments and empty property discounts which may affect collection rates. Therefore appropriate provisions will be made to minimise the risk of financial loss to the Council.

4.0 INSURANCE RESERVE

4.1 The Council maintains an Insurance Reserve in order to meet the cost of current and future insurance claims which exceed the level of cover provided by the Council's insurers.

4.2 In particular, this relates to claims in respect of school premises, where the Council's insurance policy has an excess of £100,000. In addition, the cost of renewal of contents etc. often exceeds the insured costs. Past experience has shown that the proportion of costs falling to be funded from the Insurance Reserve in these instances can be very significant.

4.3 The Insurance Reserve will therefore be maintained at the level of total outstanding claims, in order to provide for both the cost of uninsured claims and the potential cost of future school claims. The Insurance Reserve currently totals £4.2m.

4.4 A separate Insurance Reserve exists to meet future claims in respect of the Council's previous housing stock, which was transferred to Halton Housing Trust in 2005. This reserve is primarily intended to minimise the financial risk to the Council of potential future environmental claims relating to the period prior to the transfer. This reserve currently totals £1.3m.

5.0 CAPITAL RESERVE

5.1 The Council holds a Capital Reserve to support the financing of the Council's capital programme which currently totals £2.m. However, following the capitalisation direction received in respect of 2008/09 Mersey Gateway preparation costs, the Capital Reserve has been earmarked to meet remaining Mersey Gateway preparation costs in 2013/14 and revenue costs associated with the Mersey Gateway Crossings Board.

6.0 EQUAL PAY RESERVE

6.1 The Council has set-aside funds totalling £3.6m to assist with meeting the costs of equal pay claims. The likely cost of meeting equal pay claims is as yet unknown and whilst the level of reserves are sufficient to meet current claims, a balance should be maintained for future claims.

7.0 INVEST TO SAVE FUND

7.1 The Council has an Invest to Save Fund which currently totals £1.5m, in order to provide one-off funding for proposals which will generate efficiencies and thereby create significant, permanent, revenue budget savings, whilst also supporting the achievement of the Council's corporate objectives.

7.2 Applications for funding which meet specific criteria are considered by Executive Board and ultimately a proportion of the revenue budget savings achieved are returned in order to sustain the Fund.

8.0 TRANSFORMATION FUND

8.1 In 2010/11 the Council created a Transformation Fund to fund the costs associated with efficiency reviews and structural changes required in order to deliver a balanced budget. The fund's balance is currently £1.8m, which is considered reasonable given the financial challenges facing the Council over the coming years.

 Agenda Item 7d

REPORT TO:	Executive Board
DATE:	21 November 2013
REPORTING OFFICER:	Operational Director – Finance
SUBJECT:	Treasury Management 2013/14 2nd Quarter: July - September
PORTFOLIO:	Resources
WARDS:	All Wards

1.0 PURPOSE OF REPORT

1.1 The purpose of this report is to update the Board about activities undertaken on the money market as required by the Treasury Management Policy. Commentary regarding the UK and global economic position has been provided by Capita Asset Services (formerly known as Sector) the Council's Treasury Management advisers.

2.0 RECOMMENDED: That the report be noted.

3.0 SUPPORTING INFORMATION

3.1 During the quarter ended 30th September:-

- Indicators suggested that the economic recovery accelerated;
- Household spending growth remained robust;
- Inflation fell back towards the 2% target;
- The Bank of England introduced state-contingent forward guidance;
- 10-year gilt yields rose to 3% at their peak and the FTSE 100 fell slightly to 6460;
- The Federal Reserve decided to maintain the monthly rate of its asset purchases under Quantitative Easing 3 (QE3).

After strong growth of 0.7% in Q1, it appears that UK Gross Domestic Product (GDP) is likely to have grown at an even faster pace in Q2. On the basis of past form, the CIPS/Markit business surveys for July and August point to quarterly growth of potentially over 1.0% in the second quarter of 2013/14. Similarly, the official data have continued to improve. Admittedly, industrial production was flat in July. But even if it held steady in the rest of the quarter, it would still be 0.9% higher in Q2 than in Q1. In addition, the service sector expanded by 0.2% m/m and the construction sector grew by 2.2% m/m in July after growth of 1.8% q/q in Q1.

Consumer spending also continued to rise and may beat the increase seen in Q1. While the 1.1% monthly rise in retail sales in July was almost entirely offset by a 0.9% fall in August, the unusually warm weather in August is likely to have had a part to play in this. The retail surveys also painted a positive picture for household spending growth, with the Bank of England's Agents' Scores, BRC and CBI retail sales indicators showing stronger growth in Q3. And while growth in non-high street spending may have slowed, it probably remained robust. For example, although annual growth in new car registrations eased from the 24% rate seen in Q1, it was still a strong 15% in August.

The run of good news on the labour market continued, with the ILO unemployment rate falling to 7.7% in July from 7.8% in June. Employment rose by 80,000 in the three months to July, supported by an even bigger rise in full-time employment. This meant that the ratio of full-time to part-time workers continued to rise after it troughed last summer. The timelier claimant count measure of the unemployment rate also fell. Indeed, the cumulative fall in unemployment of 68,900 in July and August – the biggest two month fall since May and June 1997 – brought the claimant count unemployment rate down from 4.4% at the end of Q1 to 4.2% in August. Despite this, the headline (3 month average of the annual) rate of pay growth fell from 2.2% in June to just 1.1% in July. Excluding bonuses, earnings growth ticked up slightly to 1.1% y/y, but this remained well below the rate of CPI inflation at 2.7% in August, meaning real wages continued to fall.

Meanwhile, the cost of new credit has continued to fall, perhaps in response to the extension of the Bank of England's Funding for Lending Scheme (FLS) earlier this year. The quoted interest rate on a 5-year fixed mortgage at a 75% loan-to-value ratio was 3.34% in August, 7 basis points lower than in June and 77 basis points lower than when the FLS was introduced in July 2012.

Demand in the housing market continued to grow at a fast pace, supported by the FLS and the Government's Help to Buy scheme, which provide equity loans to credit-constrained borrowers. The RICS housing market survey reported that new buyer enquiries hit their highest level on record in August. Mortgage approvals for new house purchase rose to their highest level since February 2008 in August. Consequently, house prices continued to rise, with the Halifax and Nationwide measures recording 6.2% and 3.5% y/y rises in August, respectively. Office for National Statistics (ONS) data, though, shows that in real terms only London experienced y/y price rises in July. All other regions saw modest falls.

The economic recovery may finally be feeding through to the public finances. Although the government registered a surprise deficit in July (a month that normally delivers a surplus), in August net borrowing was ‘just’ £13.2bn, compared to £14.4bn in August 2012.

The new Governor of the Bank of England, Mark Carney, took office in July. Alongside the August Quarterly Inflation Report, the Bank introduced its new policy of forward guidance in which the Monetary Policy Committee (MPC) pledged not to raise official interest rates, or reduce the size of the asset purchase facility, until the ILO unemployment rate falls to 7%. At this point, the MPC would discuss whether or not to alter official policy. This guidance was subject to three ‘knockouts’ which, if breached, would invalidate the guidance. These are that the MPC forecasts inflation at or above 2.5% in 18-24 months' time, inflation expectations are no longer sufficiently well anchored or financial stability is threatened by the stance of monetary policy. On the MPC's current forecasts, the unemployment rate is most likely to reach 7% in late 2016.

However, financial markets continued to price in increases in Bank Rate by mid-2015, with overnight index swap rates and gilt yields rising after the announcement of forward guidance. Members of the MPC subsequently appeared at the Treasury Select Committee and three gave further speeches to clarify the guidance, but there was little market impact. However, the Bank of England's surveys suggest the message may have got through to the public as the balance of people expecting interest rates to rise over the next 12 months fell from 29% in May to 24% in August.

Meanwhile, Consumer Prices Index (CPI) inflation fell from a 2013 peak of 2.9% in June to 2.7% in August. The fall was primarily the result of a drop in the contribution from petrol prices and a reduction in core inflation from 2.3% in June to 2% in August. CPI inflation looks likely to have edged down again in September, perhaps to about 2.5%, reflecting a further fading of both energy prices and core inflation.

The big news in financial markets was that the Federal Reserve unexpectedly decided not to taper its asset purchases in September. In announcing its decision to maintain monthly purchases at $85bn, the Fed explained that it wanted to *“await more evidence that [the economic recovery] will be sustained before adjusting the pace of its purchases.”* This came despite previous hints of tapering from the Fed and the fall in the unemployment rate in both July and August. It currently stands at 7.3%.

Across the quarter as a whole, advanced economy bond markets sold off, suggesting the rise in UK gilt yields was not solely down to markets'

scepticism about domestic forward guidance. Gilt yields tracked US Treasury yields up, with ten-year gilts rising by around 60 basis points to reach 3% in early September for the first time since mid-2011. After the Fed's decision not to taper, gilt yields fell back, although not enough to offset the previous rise. Ten-year gilts finished the quarter at 2.7%. Equity markets stayed relatively flat over the quarter. While the FTSE 100 rose from 6470 to 6620 over the first few weeks of June, the index closed the quarter at 6462.

Meanwhile, Eurozone business surveys suggested that the economy continued to expand in Q2, albeit at a moderate pace. There was also a general election in Germany in which the incumbent Chancellor, Angela Merkel, performed better than expected by winning 41.5% of the vote. She is now likely to form a coalition, but it remains to be seen what form this will take.

3.2 Interest Rate Forecast

The following forecast has been provided by Capita Asset Services:

	Dec-13	Mar-14	Jun-14	Sep-14	Dec-14	Mar-15	Jun-15
Bank rate	0.50%	0.50%	0.50%	0.50%	0.50%	0.50%	0.50%
5yr PWLB rate	2.50%	2.50%	2.60%	2.70%	2.70%	2.60%	2.80%
10yr PWLB rate	3.70%	3.70%	3.70%	3.80%	3.80%	3.90%	4.00%
25yr PWLB rate	4.40%	4.40%	4.40%	4.50%	4.50%	4.60%	4.70%
50yr PWLB rate	4.40%	4.40%	4.40%	4.50%	4.60%	4.70%	4.80%

Capita Asset Services undertook a review of its interest rate forecasts in late September as a result of an increase in confidence in economic recovery, chiefly in the US, but more recently, also in the UK and Eurozone. The latest forecast now includes a first increase in Bank Rate in quarter 3 of 2016 (previously quarter 4).

SUMMARY OUTLOOK

UK economy
After the previous Inflation Report included a somewhat encouraging shift towards optimism in terms of a marginal upgrading of growth forecasts, the August Inflation Report occurred in the midst of a welter of economic statistics which have left economists and forecasters speechless in terms of finding suitable words to describe a major simultaneous shift up in gear of the economy in all of the three sectors of services, manufacturing / industrial and construction! It is therefore not surprising that the Report upgraded growth

forecasts for 2013 from 1.2% to 1.4% and for 2014 from 1.7% to 2.5%. However, Bank Governor Mark Carney put this into perspective by describing this welcome increase as not yet being “escape velocity” to ensure we return to strong AND sustainable growth, after what has been the weakest recovery on record after a recession. So very encouraging - yes, but, still a long way to go! As for inflation, it was forecast to be little changed from the previous Report – falling back to 2% within two years and staying there during year three.

In addition to the stimulus provided by quantitative easing (QE), the Funding for Lending Scheme (FLS), is aimed at encouraging banks to expand lending to small and medium size enterprises. The FLS certainly seems to be having a positive effect in terms of encouraging house purchases (though levels are still far below the pre-crisis level), and causing a significant increase in house prices – but only in London and the south east. FLS is also due to be bolstered by the second phase of Help to Buy aimed to support purchasing of second hand properties, which started in October.

Forward guidance caveats

The Bank of England also issued forward guidance with the Inflation Report which said that the Bank will not start to consider raising interest rates until the jobless rate (Labour Force Survey / ILO i.e. not the claimant count measure) has fallen to 7% or below. This would require the creation of about 750,000 jobs and was forecast to take three years. The UK unemployment rate currently stands at 2.5 million i.e. 7.7 % on the LFS / ILO measure. The Bank's guidance is subject to three provisos, mainly around inflation; breaching any of them would sever the link between interest rates and unemployment levels. This actually makes forecasting Bank Rate much more complex given the lack of available reliable forecasts by economists over a three year plus horizon. The Capita Asset Services view is that the recession since 2007 was notable for how unemployment did NOT rise to the levels that would normally be expected in a major recession. The latest Inflation Report noted that productivity has sunk to 2005 levels. Capita Asset Services are therefore, concerned that there has been a significant level of retention of labour, which will mean that a significant amount of GDP growth can be accommodated without a major reduction in unemployment.

In summary, Capita Asset Services current views are centred around the following: -

UK

- Growth has been on an upward trend – 0.3% in Q1; 0.7% in Q2 and likely to be much stronger in Q3. The so called double dip recession at the beginning of 2012 was erased by the latest revision of statistics.
- Business surveys, consumer confidence, consumer borrowing and house prices are all on the up and may help to create a wide spread feel good factor. However, this is still a long way away from the UK getting back to sustainable strong growth.

- A fair proportion of UK GDP is dependent on overseas trade; the high correlation of UK growth to US and EU GDP growth means that the UK economy is still vulnerable to what happens in overseas markets.
- Consumer expenditure is likely to remain suppressed by inflation being higher than increases in average earnings i.e. disposable income will continue to be eroded.
- The coalition government is hampered in promoting growth by the need to tackle the budget deficit. However, the March Budget did contain measures to boost house building and the supply of mortgages, and brought forward, by one year to April 2014, the start of a £10,000 tax free allowance for incomes.
- There is little sign of a co-ordinated strategy for the private sector to finance a major expansion of infrastructure investment to boost UK growth.
- Government inspired measures to increase the supply of credit to small and medium enterprises (which are key to achieving stronger growth) by banks are not succeeding.
- Gilt yields remain vulnerable to pressures to rise, especially as they are powerfully influenced by US treasury yields and American investors have been spooked by Chairman Bernanke's comments on tapering QE. The Fed's reluctance to start tapering in September has, potentially, only delayed a trend for gilt yields to rise.

Eurozone

- Most Eurozone countries are now starting to see a return to growth after a prolonged recession. The prospects for growth, at least in the short term, have also improved. However, for some countries, austerity programmes could prove to be a self-defeating spiral of falling demand, tax receipts, and GDP, leading to a rise, not fall, in debt to GDP ratios. Debt ratios in excess of 90% will cause market concern as beyond this level, the costs of servicing such debt becomes oppressive and growth inhibiting. This could, therefore, lead to an inevitable end game during the next few years of withdrawal from the Eurozone bloc in order to regain national control of a currency, government debt, monetary policy and, therefore, of setting national interest rates. The European Central Bank's pledge to provide unlimited bond buying support for countries that request an official bailout means that market anxiety about these countries is likely to be subdued in the near term. However, the poor economic fundamentals and outlook for some economies could well mean that an eventual storm in financial markets has only been delayed, not cancelled.
- The European Central Bank maintained its central policy rate at 0.5% in this quarter.
- The Eurozone remains particularly vulnerable to investor fears of contagion if one country gets into major difficulty.

US

- There has been a marked improvement in consumer, investor and business confidence this year.

- Unemployment has continued on a steady, but unspectacular decline to 7.3%, but is still a long way from the target rate of 6.5% for an increase in the Fed policy rate.
- The housing market has turned a corner, both in terms of rising prices and in increases in the volume of house sales. More householders are, therefore, escaping from negative equity.
- US equities have reached all-time highs.
- The package of tax increases and cuts in Government expenditure starting in 2013 does not appear to be having a major impact on depressing growth.
- GDP in Q1 was disappointingly downgraded from +2.4% to a sub-par +1.8% before rising to 2.5% in Q2.

Capita's forward view

Economic forecasting remains difficult with so many external influences weighing on the UK. Major volatility in bond yields is likely during the remainder of 2013/14 as investor fears and confidence ebb and flow between favouring more risky assets i.e., equities, and safer bonds.

Near-term, there is some residual risk of further QE - if there is a dip in strong growth or if the MPC takes action to do more QE in order to reverse the rapid increase in market rates, especially in gilt yields and interest rates up to 10 years. This could cause shorter-dated gilt yields and PWLB rates over the next year or two to significantly undershoot the forecasts in the table below. The failure in the US, over passing a Federal budget for the new financial year starting on 1 October, and the tension over raising the debt ceiling in mid-October, could also see bond yields temporarily dip until any binding agreement is reached between the opposing Republican and Democrat sides. Conversely, the eventual start of tapering by the Fed could cause bond yields to rise.

The longer run trend is for gilt yields and PWLB rates to rise, due to the high volume of gilt issuance in the UK, and of bond issuance in other major western countries. Increasing investor confidence in economic recovery is also likely to compound this effect as a continuation of recovery will further encourage investors to switch back from bonds to equities.

The overall balance of risks to economic recovery in the UK is currently weighted to the upside after five months of robust good news on the economy. However, only time will tell just how long this period of strong economic growth will last; it also remains exposed to vulnerabilities in a number of key areas.

Downside risks currently include:

- The conflict in the UK between market expectations of how quickly unemployment will fall as opposed to the Bank of England's forecasts

- Prolonged political disagreement over the US Federal Budget and raising the debt ceiling
- A return to weak economic growth in the US, UK and China causing major disappointment to investor and market expectations.
- The potential for a significant increase in negative reactions of populaces in Eurozone countries against austerity programmes, especially in countries with very high unemployment rates e.g. Greece and Spain, which face huge challenges in engineering economic growth to correct their budget deficits on a sustainable basis.
- The Italian political situation is frail and unstable.
- Problems in other Eurozone heavily indebted countries (e.g. Cyprus and Portugal) which could also generate safe haven flows into UK gilts.
- Monetary policy action failing to stimulate sustainable growth in western economies, especially the Eurozone and Japan.
- Weak growth or recession in the UK's main trading partners - the EU and US, depressing economic recovery in the UK.
- Geopolitical risks e.g. Syria, Iran, North Korea, which could trigger safe haven flows back into bonds

The potential for upside risks to UK gilt yields and PWLB rates, especially for longer term PWLB rates include: -

- A sharp upturn in investor confidence that sustainable robust world economic growth is firmly expected, causing a surge in the flow of funds out of bonds into equities.
- A reversal of Sterling's safe-haven status on a sustainable improvement in financial stresses in the Eurozone.
- Further downgrading by credit rating agencies of the creditworthiness and credit rating of UK Government debt, consequent upon repeated failure to achieve fiscal correction targets and sustained recovery of economic growth which could result in the ratio of total government debt to GDP to rise to levels that undermine investor confidence in the UK and UK debt.
- UK inflation being significantly higher than in the wider EU and US, causing an increase in the inflation premium inherent to gilt yields.
- In the longer term – an earlier than currently expected reversal of QE in the UK; this could initially be implemented by allowing gilts held by the Bank to mature without reinvesting in new purchases, followed later by outright sale of gilts currently held.

3.3 Short Term Borrowing Rates

The bank base rate remained at 0.50% throughout the quarter.

	Start	July		Aug		Sept	
		Mid	End	Mid	End	Mid	End
	%	%	%	%	%	%	%
Call Money (Market)	0.49	0.48	0.49	0.48	0.48	0.48	0.48
1 Month (Market)	0.49	0.49	0.49	0.49	0.49	0.49	0.49
3 Month (Market)	0.51	0.51	0.51	0.51	0.52	0.52	0.52

3.4 Longer Term Borrowing Rates

	Start	July		Aug		Sept	
		Mid	End	Mid	End	Mid	End
	%	%	%	%	%	%	%
1 Year (Market)	0.90	0.88	0.86	0.88	0.88	0.89	0.87
10 Year (PWLB)	3.57	3.49	3.51	3.88	3.81	3.98	3.73
25 Year (PWLB)	4.45	4.42	4.44	4.63	4.51	4.63	4.46

Market rates are based on LIBOR rates published at the middle and end of each month. PWLB rates are for new loans based on principal repayable at maturity.

3.5 Borrowing/Investments

Turnover during period

	No. Of Deals Struck	Turnover £m
New Borrowing	8	19.5
New Investments	3	9.0

Note that New Investments excludes investment in National Westminster call account which is re-invested on a daily basis.

Position at Month End

	July £m	August £m	September £m
Total Borrowing	75.00	73.00	74.50
Total Investments	53.45	55.00	52.65

Investment Income Forecast

The forecast income and outturn for the quarter is as follows:

	Cumulative	Cumulative	Cumulative	Cumulative

	Budget £'000	Actual £'000	Target Rate %	Actual Rate %
Quarter 1	107	170	0.26	1.12
Quarter 2	190	302	0.36	1.04
Quarter 3	235			
Quarter 4	257			

The actual rate exceeds the benchmark rate. This is due to the management of cash deposits around the planned delivery of the capital programme and most notably the acquisition of land for the Mersey Gateway project.

The target rate is based on the 7-day LIBID rate. For comparison purposes the 1 month average rate was 0.36%, 3 month rate was 0.39% and the 6 month rate was 0.47%.

3.6 New Long Term Borrowing

No new long term borrowing was taken during the quarter.

3.7 Policy Guidelines

The Treasury Management Strategy Statement (TMSS) for 2013/14, which includes the Annual Investment Strategy, was approved by the Council on 6th March 2013. It sets out the Council's investment priorities as being:

- Security of capital;
- Liquidity; and
- Yield

The Council will also aim to achieve the optimum return (yield) on investments commensurate with proper levels of security and liquidity. In the current economic climate and the heightened credit concerns it is considered appropriate to keep investments short term with a maximum duration of 12 months in accordance with Capita's credit rating methodology.

3.8 Treasury Management Indicators

It is a statutory duty for the Council to determine and keep under review the affordable borrowing limits. The Council's approved Treasury and Prudential Indicators are included in the approved Treasury Management Strategy Statement.

4.0 DEBT RESCHEDULING

4.1 No debt rescheduling was undertaken during the quarter.

5.0 POLICY IMPLICATIONS

5.1 None

6.0 OTHER/FINANCIAL IMPLICATIONS

6.1 Funding for the capital programme is dependent on the activities undertaken to support the programme being affordable and within the approved prudential indicators set out in the Treasury Management Strategy Statement

7.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

7.1 There are no direct implications, however, the revenue budget and capital programme support the delivery and achievement of all the Council's priorities.

8.0 RISK ANALYSIS

8.1 The main risks with Treasury Management are security of investment and volatility of return. To combat this, the Authority operates within a clearly defined Treasury Management Policy and annual borrowing and investment strategy, which sets out the control framework

9.0 EQUALITY AND DIVERSITY ISSUES

9.1 There are no issues under this heading.

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

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

Agenda Item 7e

REPORT TO:	Executive Board
DATE:	21 November 2013
REPORTING OFFICER:	Operational Director – Finance
PORTFOLIO:	Resources
SUBJECT:	Budget Proposals 2014/15
WARD(S):	Borough-wide

1.0 PURPOSE OF REPORT

1.1 To recommend to Council initial revenue budget proposals for 2014/15.

2.0 RECOMMENDED: That Council approve the initial budget proposals for 2014/15 set out in Appendix 1.

3.0 SUPPORTING INFORMATION

3.1 The Medium Term Financial Strategy elsewhere on this Agenda forecasts a potential revenue budget funding gap for the Council of around £15m in 2014/15, £17m in 2015/16 and £14m in 2016/17.

3.2 Budget saving proposals for 2014/15 are currently being developed by the Budget Working Group. A number of these proposals, listed in Appendix 1, can be implemented immediately. It is proposed that this is done in order to achieve a part-year saving in 2013/14 which will assist in keeping the Council's overall spending in line with budget. In addition, a number of the proposals will take time to implement and therefore commencing the process as soon as possible will assist in ensuring they are fully implemented by 1st April 2014.

3.3 The Government will announce its Grant Settlement for Local Government in late December, at which point the Council's actual funding gap will be identified. Further savings proposals to enable the Council to deliver a balanced budget will be recommended to Council on 5th March 2014.

4.0 POLICY AND OTHER IMPLICATIONS

4.1 The revenue budget supports the Council in achieving the aims and objectives set out in the Community Strategy for Halton and the Council's Corporate Plan.

5.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

5.1 The revenue budget supports the delivery and achievement of all the Council's priorities. The budget proposals listed in Appendix 1 have been prepared in consideration of all the Council's priorities.

6.0 RISK ANALYSIS

6.1 Failure to set a balanced budget would put the Council in breach of statutory requirements. The budget is prepared in accordance with detailed guidance and a timetable to ensure statutory requirements are met and a balanced budget is prepared that aligns resources with corporate objectives.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None.

8.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1072

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

APPENDIX 1

COMMUNITIES DIRECTORATE
2014/15 Budget Savings Proposals

Item	Budget Proposal	2014/15 £000
1.	Learning Disabilities: A grant for learning disabilities has now been mainstreamed into the Council's core budget.	96
2.	Complex Care Pool: Savings include some additional (beds) income generated based upon care services, a review of reablement and intermediate care and a reform grant which has been mainstreamed into the Council's budget. Certain expenditure will be met from the pooled budget providing a one-off saving.	330 1,600 (1 year only)
3.	Independent Living: Savings from a combination of funds which have led to the reconfiguration of the home improvement agency service, improvements to the Property Pool Plus and a review of the approach to the Mental Capacity Act Co-ordination which has absorbed roles into teams.	100
4.	Community Involvement Team: Increased income generated at Community Centres.	20
5.	Open Spaces: Restructure of Street Cleansing without reducing service delivery (£40,000); additional income from Registration Services (£10,000) and the Brindley (£40,000).	90
6.	Sport and Recreation: Re-negotiation of Leisure Management contract (ends January 2016).	100
7.	Stadium and Catering: Various efficiencies in School Meals (£50,000) and Community Meals (£25,000) in order to reduce the cost of provision without affecting service delivery.	75
8.	Waste and Recycling: Budget savings to be achieved from redesigning the recycling reward scheme (£100,000) and a review of household waste centres (£150,000).	250
9.	Commissioning: Cessation of the YMCA Nightstop contract. Managed underspends in 2013/14 on social care contracts and the social care reform grant carried forward to provide a one-off saving.	 46 300 (1 year only)

Item	Budget Proposal	2014/15 £000
10.	Community Services: Additional income generation from Community Day Services businesses.	120 (1 year only)
11.	Carers: A combination of savings from the Carers Centre following their successful lottery bid and the Carers Centre taking over some of the functions of the Carer Development role.	48
12.	Commissioning & Complex Care: The Operational Director has moved to part-time working.	50
	Permanent Savings	**1,205**
	One-year Savings	**2,020**
	TOTAL	**3,225**

CHILDREN & ENTERPRISE DIRECTORATE
2014/15 Budget Savings Proposals

Item	Budget Proposal	2014/15 £000
1.	Team Around the Family - Children's Centres: • Reduction in various supplies and services budgets (£50,000) • Income generation from room hire, charging for services, increasing current charges (£25,000) • Reduce marketing budget to a minimum and use electronic systems/ social media systems that are significantly lower costs (£1,000)	76
2.	Team Around the Family - Family Support; Intensive Support; Integrated Working Support Team; Short Breaks for Disabled Children: • Reduction of a Family Support Worker post (£30,000) • Cease the counselling contract as the service is duplicated within another contract (£13,000) • Review of financial support to disabled children and families (£30,000)	73
Item	**Budget Proposal**	**2014/15 £000**
3.	0 – 19 (School and Setting Improvement) Division: • Efficiency savings in portage (£10,000) • Reduction in the early years foundation stage (EYFS) training budget in private and voluntary settings (£20,000) • Reduction in the graduate leader fund budget in private and voluntary settings (£90,000) • Reduction in the EYFS workforce development training budget in private and voluntary settings (£30,000)	150
4.	Inclusion and Special Educational Needs (SEN) Division: • Education & Child Psychology Service and Attendance & Behaviour Service – additional income generation through traded services	70
5.	Children's Organisation and Provision: • Reviewed and restructured support which provides Careers Information, Advice and Guidance for young people (£100,000) • Restructure and deletion of two vacant support staff posts (£53,000)	153
6.	The Education Business Partnership (EBP):	85

	• Income generation through commissioning EBP to delivery employer mentoring and ambassador elements of the Information, Advice and Guidance strategy for an initial 12 months contract (£30,000) 14-19 Entitlement: • Income generation through a shared service arrangement with Cheshire West & Chester Council for 14-19 provision, initially for one year (£40,000) • Income generation through the sale of a "Raising the Participation Age Data Tracking Service" to other councils for an initial one year contract (£15,000)	(1 year only)
7.	Place Planning & Provision Division: • Reduce various supplies and services budgets (£7,000) • Reduce Childminder Start Up and Sustainability budgets to provide a net saving (£5,000). • Reduction in the operational budget for the Family Information Service (£16,000) • Service restructure and reduction of a Divisional Manager post (£70,000) • One-off contribution of £250,000 from the Building Schools for the Future Licence Fund	98 250 (1 year only)
Item	**Budget Proposal**	**2014/15 £000**
8.	Asset Management Division - Reductions in premises costs from reducing the industrial and commercial estate portfolio e.g. Waterloo Centre and Moor Lane (net of lost income)	75
9.	Development & Investment Services Division: • One-off fee income generated through charging in relation to Regional Growth Funded schemes • Reduction in marketing, promotions and maintenance at Widnes Market Hall	 20 (1 year only) 25
10.	Operations Division - Restructuring of the Operations Team with a resulting reduction of 2 fte posts	90
	Permanent Savings **One-year Savings**	**810** **355**
	TOTAL	**1,165**

POLICY & RESOURCES DIRECTORATE
2014/15 Budget Savings Proposals

Item	Budget Proposal	2014/15 £000
1.	Procurement Division: Income generation from the delivery of procurement related services to external organisations including CCGS and councils.	200
2.	Revenues & Benefits Division: Housing Benefits Section - One off underspend in 2013/14 from holding a number of posts vacant. It is anticipated that given the impact of the Welfare Reforms these posts will need to be filled in 2014/15.	70 (1 year only)
3.	Revenues & Benefits Division: HDL Shops - Changes to rating valuations were made by the VOA from 1/4/13, the cost of which is provided for within the HDL budget. Implementation was expected from 1/4/12 and therefore financial provision was made which is no longer required and will provide a one-off saving.	125 (1 year only)
Item	**Budget Proposal**	**2013/14 £000**
4.	Financial Management Division: Net reduction in the staffing budget following a major restructure of the Division and resultant deletion of vacant posts.	50
5.	Concessionary travel passenger numbers are lower than anticipated and therefore it is anticipated that there will be an underspend in 2013/14 which will be carried forward to provide a one-off saving for 2014/15.	50 (1 year only)
6.	Audit & Operational Finance Division: Direct Payments Team - Reduction in the staffing budget from a voluntary reduction in hours for one postholder.	7
7.	Audit & Operational Finance Division: Insurance Section - Reduction in insurance premium costs from adopting an increased level of self-insurance for motor vehicle cover.	20
8.	Audit & Operational Finance Division: Finance Support Team - Savings from bringing invoice scanning arrangements back in-house (£8,000), additional income generated from SLA with schools (£2,000) and introduction of the Early Payment Discount Scheme (£20,000).	30
9.	Audit & Operational Finance Division: Cashiers Section - Reduction in the contract cost for cash kiosk support and maintenance (£5,000) and increased income from cashiers services provided under contract to HHT	10

	(£5,000).	
10.	Audit & Operational Finance Division: Internal Audit - Income generation from external contracts to provide internal audit services to Cheshire Police and Manchester Port Health Authority.	6
11.	Audit & Operational Finance Division: Client Finance Section - Realignment of the income budget following the previous year's introduction of charges for appointeeship / deputyship clients, due to the number of clients being higher than anticipated. This will not alter the level of charges to clients.	10
12.	HR Learning & Development Division: A staffing restructure during 2013/14 will generate a one-off saving from an underspend in 2013/14 and an on-going annual saving from 2014/15 onwards.	156 39 (1 year only)
13.	Marketing, Design and Communications: Ceasing the contract for the provision of external press cuttings.	2
Item	**Budget Proposal**	**2013/14 £000**
14.	Legal Services: Reduction in legal books and publications budget (£10,000), full year balance of previous year's savings already achieved (£53,000) and reduction in the staffing budget following a change in grading of Legal Assistant posts (£10,000).	73
15.	Democratic Services Division: Reduction in staffing budget following the deletion of a vacant Member Services and Electoral Officer post (£28,000) and the full year balance of previous year savings already achieved (£5,000).	33
16.	Customer Intelligence Unit: Reduction in the staffing budget through deletion of a vacant Complaints Officer post.	27
17.	Traffic, Risk & Emergency Planning, Health & Safety Division: • Improved street lighting efficiency through use of long life lamps (£51,000) • Increased income from charges for street works inspections/defects (£10,000)	61
18.	Councilwide Procurement Savings - Target for achievement of reductions in contract prices across the Council from improved procurement.	700
19.	Salary Sacrifice Car Scheme - Estimated savings in employee oncosts from the introduction of a salary	40

	sacrifice car scheme. The annual saving will increase as take-up of the new scheme increases.	
20.	Reductions in United Utility charges following a review of the basis for charges for surface water drainage at various Council owned car parks. This will provide a one-off saving from repayment of arrears and an on-going permanent budget saving.	8 30 (1 year only)
21.	Carbon Reduction Commitment - The threshold for inclusion within the national carbon reduction scheme has been raised such that the Council no longer falls within the scheme. This will provide a one-off saving from the underspend in 2013/14 and an on-going permanent saving from 2014/15.	200 200 (1 year only)
	Permanent Savings **One-year Savings**	**1,633** **514**
	TOTAL	**2,147**

REPORT TO:	Executive Board
DATE:	21 November 2013
REPORTING OFFICER:	Strategic Director – Policy & Resources
SUBJECT:	Income Management System – Online Payments
PORTFOLIO:	Resources
WARD(S):	Borough-wide

1.0 PURPOSE OF REPORT

1.1 To seek waiver approval in accordance with Procurement Standing Order 1.8.3(a) where compliance with Standing Orders is not possible due to there being only one possible contractor.

2.0 RECOMMENDATION: That the competition requirements of Procurement Standing Order 4.1 be waived to facilitate the upgrade of the Council's online payment engine with Capita Paye.net portal and Internet Payments portal.

3.0 SUPPORTING INFORMATION

3.1 The Council is in the process of replacing its website to facilitate a larger number of transactional services. As part of that process it is necessary for the payment engine to be upgraded in order to allow ease of use for the customer as well as integration with our current financial management system, Agresso, our existing Cash Receipting system AIMS (used for telephone payments) and our Customer Relationship Management system (CSD) used by our Contact Centre and One Stop Shops.

3.2 The integration necessitates the purchase of two Capita products called 'Paye.net portal' and 'Internet Payments portal'. These products ensure that both internal departments and external customers are able to make secure credit and debit card payments via the web. As stated previously, these products integrate with our existing financial management and payment systems, and together will provide a seamless payment service for our customers.

3.3 Capita is the only provider of 'Paye.net' and 'Internet Payments' portals that will integrate easily with our current Capita telephone payment and Agresso financial management systems. It is therefore not possible to undertake a competitive procurement exercise.

3.4 The cost of purchasing and installing ‘Paye.net’ and ‘Internet Payments’ portals is as follows:

*If ordered **before** 30st November 2013*		
Product Name	**One-Time Cost**	**Annual Support Cost**
Paye.net	£9,995	£1,000
Internet Payments	£9,995	£1,000
Total	**£19,990**	**£2,000**

*If ordered **after** 30st November 2013*		
Product Name	**One-Time Cost**	**Annual Support Cost**
Paye.net	£11,995	£1,199
Internet Payments	£11,995	£2,399
Total	**£23,990**	**£3,598**

A waiver is sought as this cost exceeds the £1,000 competition requirement threshold set in Procurement Standing Order 4.1.

4.0 POLICY, FINANCIAL AND OTHER IMPLICATIONS

4.1 There are no policy implications.

4.2 The cost of the upgrade and support will be met from the ICT Capital Programme. It will allow for greater and improved transactional services to be delivered via the web and mean the people can make payments at times when it suits them. The Capita system supports and improves the delivery of these services and will relieve pressures in the back office, reducing time currently spent on taking payments. For some services, this will reduce the amount of cash taken on site and will allow for cash collections to be reduced, offering an additional financial saving.

5.0 IMPLICATIONS FOR THE COUNCIL’S PRIORITIES

5.1 A system to manage customer payments is central to good financial management, which underpins the Council’s ability to deliver all its priorities.

6.0 RISK ANALYSIS

6.1 An upgrade to the existing software is required to improve ease of use for the customer and thereby increase the number of online and telephone payments. Failure to implement this solution would significantly reduce the efficiency of taking payments via the web. It would also have a detrimental effect on the development of the new website and its transactional features.

7.0 EQUALITY AND DIVERSITY ISSUES

7.1 None

8.0 LIST OF BACKGROUND PAPERS

None under the meaning of the Act

REPORT TO: Executive Board

DATE: 21 November 2013

REPORTING OFFICER: Strategic Director, Communities

PORTFOLIO: Physical Environment

SUBJECT: Re-tendering of Adult Domestic Abuse Services

WARD(S) Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 The report seeks approval to extend incrementally by up to four months the existing contract with Halton and District Women's Aid Association (HADWAA) for the provision of domestic abuse services. The existing contract is due to terminate on the 31st March 2014.

2.0 RECOMMENDATION: That acting in accordance with Procurement Standing Order 1.8.4(a), Executive Board agrees to waive Procurement Standing Orders Part 4.1 to enable an extension of up to four months, on a month by month basis, to the HADWAA contract for domestic abuse services.

3.0 SUPPORTING INFORMATION

3.1 At its meeting on the 5th September 2013 the Board received a report on homelessness services and, in respect of the domestic abuse service currently being delivered by HADWAA, agreed to retendering with a view to having a new contract in place by April 2014.

3.2 It was also reported that Riverside/ECHG had agreed a refurbishment scheme for the Refuge building**,** which was to be implemented during the second half of 2013/14. These plans have now been firmed up and at the time of drafting this report, works were due to commence on the 11th November with completion during April 2014. This programme may overrun by a few weeks depending on the complexity of the decanting arrangements.

3.3 It had always been the intention to align the start of the new contract to the completion of the refurbishment works, because if a different Provider were to win the contract, it would be undesirable to have a service handover in the midst of a comprehensive refurbishment project.

4.0 POLICY IMPLICATIONS

4.1 There are no policy implications arising from this report.

5.0 FINANCIAL IMPLICATIONS

5.1 Given the slippage of the planned works into the early part of 2014/15 it is proposed that the existing HADWAA contract be extended on a month by month basis, up to a maximum of 4 months, with the intention of commencing the new contract as soon as possible after the refurbishment works are complete. This will require the Board to agree to waive Procurement Standing Orders so that the contract extension can be awarded without competition. The value of the extension would be £19,292 per month. There is currently the budget to fund this extension.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

None identified.

6.2 Employment, Learning and Skills in Halton

None identified.

6.3 A Healthy Halton

None identified.

6.4 A Safer Halton

None identified.

6.5 Halton's Urban Renewal

None identified.

7.0 RISK ANALYSIS

7.1 Service handovers can be difficult and complex at the best of times. Undertaking a service handover in the midst of a building project would increase the potential risk for things not to go well, disrupting continuity of service for the clients. Whilst it would be possible to seek to mitigate this risk, on balance the most sensible approach is to avoid the problem given there is no detriment to the Council in delaying a new contract.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None identified.

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

Document	Place of Inspection	Contact Officer
Homeless Accommodation Update Executive Board Report 05/09/13	Municipal Building	Strategic Director Communities

Agenda Item 8b

REPORT TO:	Executive Board
DATE:	21 November 2013
REPORTING OFFICER:	Strategic Director – Children & Enterprise
PORTFOLIO:	Physical Environment
SUBJECT:	Widnes Waterfront Infrastructure Funding
WARD(S)	Borough-wide

1.0 PURPOSE OF THE REPORT

1.1 The purpose of this report is to provide an update on regeneration projects in relation to the Widnes Waterfront sites G Park (former Bayer Cropscience) and Johnson's Lane.

The report requests approval from the Executive Board to vary the capital programme to allow these projects to proceed prior to impending written offers from the Liverpool City Region Local Enterprise Partnership expected in the new year.

2.0 **RECOMMENDATION: That Council be requested to include the £0.52m remediation costs of the former Bayer site and £0.5m for the provision of infrastructure at Johnson's Lane, Widnes within the capital programme, to initially be funded from Growing Places Fund (GPF) loans (subject to successful bids) which will thereafter be repaid from the capital receipts generated from sale of the respective sites.**

3.0 SUPPORTING INFORMATION

3.1 Former Bayer Crop Science Site – G Park, Gazeley

A report recommending the disposal of approximately 40 acres of land to Gazeley UK Ltd by a development agreement was agreed at the 5th Sepetmber 2013 Executive Board.

The Council owns approximately 40 acres of land at Gorsey Lane. This land was a former chemical manufacturing plant for Bayer. The land was purchased by the Council in 2009 for the sum of £5.5M with the acquisition price fully funded by a grant from NWDA. There was known ground contamination at the time of the purchase with an estimated liability of £500K. The terms of the grant condition were that the Council would be responsible for ground contamination; the Council could recover its

reasonable costs of managing the site from future land sales; otherwise 100% of sale proceeds would be recoverable by NWDA.

With the demise of NWDA eventually it emerged that NWDA's interests in this site had passed to BIS. Council officers have been working with BIS and the LEP and have agreed a strategy for the site, subject to Planning.

Further ground investigations since purchase have provided an increased estimate of dealing with the ground contamination of £1.6M. This is approximately £1.0m for groundwater remediation and £0.6m for asbestos contaminated soils and 'hotspots'. Remediation can be phased, enabling the programme to be accelerated for any plot to facilitate the earliest possible development. Groundwater treatment is the priority long lead item which needs to be resolved for early remediation to unlock the site. Officers consider that an early commitment to commence work on dealing with the ground contamination will bring forward the development and encourage occupier interest.

The Council requires £1m towards dealing with the ground contamination, of which there is already £0.48m in the capital programme. This can be repaid (subject to agreement with BIS) on sale of the first parcel of land.

3.2 **Johnson's Lane - Ballast Phoenix Ltd**

The Executive Board approved, on 11th July 2013, the disposal of c. 6.7 acres of land at Johnson's Lane to Ballast Phoenix Ltd subject to detailed Planning Permission and subject to contract.

The Council owns c20 acres of land at Johnson's Lane. This land has never been developed and does not benefit from access or services infrastructure beyond the edge of Johnson's Lane. The Council placed the whole site on the open market through property agents CBRE in November 2010. There have been a number of inquiries from potential occupiers, but all previous inquirers have been deterred by the amount of work and investment required to bring the site forward for development.

The capital funds will fund the advanced highway works required to access all the plots at Johnson's Lane. This will enhance the marketing of the remaining sites as well as help secure Ballast Phoenix Ltd by removing any uncertainties associated with road construction.

It is anticipated that subject to contract the land receipt from Ballast Phoenix Ltd will be used to repay the HBC capital.

4.0 POLICY IMPLICATIONS

4.1 Approval of the capital allocations outlined in this report would present an excellent opportunity to accelerate further developments at the Widnes Waterfront.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 The Council have applied for a Growing Places Fund loan for both G- Park and Johnson's Lane. It likely the outcome of these applications will be made public in the new year.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton

They are no implications associated with this report.

6.2 Employment, Learning & Skills in Halton

Overall the Widnes Waterfront programme will assist in providing job opportunities for local people and will go some way in addressing the level of unemployment in Halton.

6.3 A Healthy Halton

Overall the Widnes Waterfront programme has provided new walking and cycling routes as well as a bus service, which offer safe and affordable means of accessing the Waterfront and thereby can overcome many of the transport barriers often faced by people who do not own or have access to a car.

6.4 A Safer Halton

The projects will provide much needed environmental improvements to the immediate areas, reducing the amount of brownfield land open to abuse by illegal off road motorbikes.

6.5 Halton's Urban Renewal

The Widnes Waterfront programme is acting as a catalyst to attract developers, new businesses and leisure uses to the area by creating an attractive, well-accessed and serviced area, which provides a safe and attractive environment for employees and visitors.

7.0 RISK ANALYSIS

7.1 There are risks to the Council in altering the capital programme to accommodate these projects.

For the former Bayer site the true net value of the purchase price offer cannot be determined at this stage. Final costs and detailed agreement of recovery from BIS will require more detailed investigations. Therefore, at this stage the Council may be liable to repay the full £1.0m remediation costs.

For Johnson's Lane it is anticipated that income from future land transactions will be used to pay the HBC capital.

8.0 EQUALITY AND DIVERSITY ISSUES

Not applicable.

9.0 REASON(S) FOR DECISION

The Council to alter the capital programme to allow funding to be made available to bring forward the former Bayer site and Johnson's Lane specifically for the provision of remediation and infrastructure.

10.0 ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

The do nothing option would mean that the former Bayer Cropscience site and Johnson's Lane sites would remain unused for a further period of time, which potentially would result in further security and maintenance costs to the Council.

11.0 IMPLEMENTATION DATE

Once approval is received recommendations will immediately be acted upon

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

None under the meaning of the Act.