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Cabinet Member's Decision - Health and Well-being

Thursday, 7 August 2014

Cabinet Member with Responsibility Mr M J Hart

Agenda

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Cabinet Member Decision
7 August 2014

1. RE-COMMISSIONING OF DRUG AND ALCOHOL TREATMENT AND RECOVERY SERVICES

Relevant Cabinet Member	Mr M J Hart
Relevant Officer	Director of Adult Services and Health
Recommendation	**1. Director of Adult Services and Health recommends to the Cabinet Member with Responsibility for Health and Well-being that:** **a) an integrated Drug and Alcohol Recovery Service be re-commissioned, using monies from the Public Health Ring-Fenced grant, and following County Council procurement processes;** **b) a revised Payment by Results structure be adopted to incentivise good performance and penalise poor performance;** **c) the Director of Adult Services and Health produces a service specification which will deliver new focus on integration between all parts of the current system; improve areas of below average performance; and deliver robust pathways across the system, including adults, children and young people, primary and secondary health services, criminal justice and voluntary organisations, and the Director undertakes a procurement exercise for such a service;** **d) the Cabinet Member for Health and Well-being, in consultation with the Director of Adult Services and Health, then makes the final decision to award a contract to the successful provider, following due procurement process.**
Background information	2. Drug and alcohol addiction is preventable and treatable. However, significant numbers of people in the County are addicted. Currently, 1,400 people are in treatment for opiate

and crack cocaine addiction; 200 for non-opiate addiction; and 900 for alcohol addiction. This creates significant pressures on services, linked to increased numbers of children coming into care; increased numbers of vulnerable adults with eligible social care needs; and increased levels of crime and disorder.

3. In the past, national and local policy has focussed on reducing drug related crime. This has resulted in a service emphasis on substitute prescribing, rather than on breaking the cycle of addiction to achieve recovery from drug use and full integration into society. Achieving this means a very different service response, with a far greater range of options than substitute prescribing. It also requires services to be able to reach beyond the known addict population, into the wider field of people who are developing dependence and will benefit from early intervention to stop escalation.

4. In Worcestershire, the contract for drug and alcohol services is held by an external provider, and runs to 31 March 2015. A range of specialist services are provided, including: medical assessment; substitute prescribing; psychotherapeutic interventions; needle exchange; and peer mentorship. Services are provided for adults and young people, as well as for the families of those who misuse drugs and alcohol.

5. There has been disappointing performance since the start of the contract. Performance against outcomes such as successful completions for opiate and non-opiate clients and length of time in treatment has been consistently below cluster and national average.

6. The substance misusing population is changing. For example:

- Numbers of opiate users are stable but are now ageing, and staying in treatment for longer
- Young people are engaging with 'novel psychoactive substances' (or 'legal highs'), about which little is known
- Numbers in treatment for alcohol addiction have reduced significantly, although delivery of brief interventions has increased. Estimates of alcohol dependency far exceed numbers in treatment, and are rising.

Re-commissioning and service model

7. Effective drug and alcohol services will contribute to making Worcestershire a healthier and safer place. They will specifically contribute to: meeting the Council's statutory duties to improve health, safeguard vulnerable children and adults, and contribute to preventing crime and disorder.

They will also contribute to reducing the demand for children's and adults' health and social care services.

8. However, the current service model and performance needs improvement, and it is therefore necessary to rework the service specification and proceed with a full procurement exercise. This will be based on the evidence from a full needs assessment, and from consultation with users and stakeholders. The service will focus on integration, recovery, and will have a stronger emphasis on alcohol, (which is one of the four priorities of our Health and Well-being Strategy,) and on Think Family and Children and Young People, (who are a cross-cutting theme of the Health and Well-being Strategy, as well as one of the four corporate priorities of the Council).

9. Recent widespread consultation with partner agencies, service users, families and carers, and other stakeholders has raised some specific areas for change, such as: improving accessibility to the service; extending the range of treatment options which are available; developing a response to use of New Psychoactive Substance; and strengthening links with other agencies such as criminal justice, children's services, primary and secondary health care. Positive issues such as the development of peer led recovery groups and mutual aid arrangements were also noted.

10. The revised service specification will not be over-prescriptive, but will outline the required outcomes and principles of delivery. Potential providers will use their specialist knowledge and experience to creatively develop safe and effective ways to deliver these outcomes. The service will have recovery at its core, putting more responsibility on individuals to overcome dependency and supporting clients to work productively, build strong relationships, and contribute positively to their family and community.

11. Key principles will include: flexibility to adapt to changing substance misuse; establishing robust pathways to front-line staff in other organisations; and strengthening peer support. Closer links must be built with criminal justice, acute and community health services, and children's services. It is important that substance misuse services reach effectively to the families of those who abuse drugs and alcohol, aligning closely with the Stronger Families and Early Help programmes.

12. The integrated recovery service will be procured through a single contract. However, it is intended that all services, some of which are separately commissioned, should be

brought into this contract. This will create a supply chain managed by the main contractor, and allow a clearer pathway, reducing fragmentation and enabling a flexible menu of support. This integration is increasingly seen as best practice and linked to improved outcomes.

Monitoring, outcomes and evaluation

13. A small number of Key Performance Indicators for Payment by Results will be used, including:

- Proportion of all in treatment who successfully completed treatment and did not re-present in 6 months opiates (Public Health Outcomes Framework 2.15a)
- Proportion of all in treatment who successfully completed treatment and did not re-present in 6 months non-opiates (PHOF 2.15b)
- Successful completions as a % of all in treatment for alcohol
- Numbers referred into treatment from DIP
- % of eligible new presentations who have completed a course of Hep B vaccinations
- Numbers of young people achieving a successful outcome from treatment.

14. Additional quality KPIs will be closely performance monitored including for example:

- improvement in risky behaviour
- Numbers still injecting after 6 months/12 months / 4 years in treatment
- reduced levels of alcohol/drug use
- Young people's unplanned discharges
- Indicators with regard to safeguarding to be agreed with Children's Services, to ensure that impact is made on supporting safer parenting in families where the adults abuse drugs or alcohol
- Collection of retrospective utilisation data, relating to health, social care, and crime.

15. There will be tight contract monitoring with routine quarterly review meetings held between providers and commissioners. In addition, there will be proactive management of delivery plans and audits of client records to ensure that quality outcomes are being achieved. Performance will be also be reviewed by the Director of Adult Services and Health and the Head of Public Health through the Corporate Dashboard monitoring system. Quarterly progress reports will be made to the Health Improvement Group and Health and Well-being Board.

Budget and Costs

16. The Drugs and Alcohol treatment service is funded from the Public Health Ring-Fenced Grant, and currently totals

£4m. It is recommended that a cost improvement of 7.5% be made, securing a saving of £0.3m. The overall size of the contract will, however, be increased above the current level by bringing the whole recovery pathway into scope, and this integration will make efficiency savings more straightforward. It will create opportunities to reduce duplication and review the impact of initiatives which are currently separately commissioned. This streamlining will ensure that the saving of £0.3m will not result in a reduction of overall capacity to deliver the required outcomes.

17. The current contract has a complex payment system and it is necessary to revise this and use a simpler reward and penalty system of up to 10%, in line with others in the West Midlands. For year 1, the Council will operate a shadow benchmarking system on which years 2 and 3 will be based. The 10% financial consequences for poor performance will be in addition to the usual contract management processes which will invoke financial penalties for non-deliver.

Legal, HR and Equality Implications

18. There are no particular legal implications. Due notice has been serviced on the existing provider, and the Council's procurement process will be followed. A data impact assessment will be carried out to ensure providers are handling data according to the Data Protection Act.

19. HR implications fall to the provider, not the Council which is the commissioner of the service. TUPE may apply in the event of a new provider being awarded the contract, and this will be a provider to provider issue.

20. Assessment of potential equality impact has not specifically been undertaken for these proposals, but a more wide-ranging assessment was carried out earlier this year in respect of proposals for substance misuse services, and is available as a background paper. The assessment recognised the particular importance of these services in the lives of individuals (often male) who have poor mental health. The needs of service users who have one or more of the protected characteristics are reflected in the service specification and compliance with the Public Sector Equality Duty is a requirement of the contract.

21. The Council needs to consider its approach to the retendering of Drug and Alcohol services ahead of the September meeting of Cabinet, and therefore the Leader of the Council has authorised the Cabinet Member with Responsibility to take all decisions on behalf of the Cabinet in relation to the retendering of Drug and Alcohol services and subsequent contract award.

Supporting Information

- Appendix 1 - Draft Strategic Drugs Plan, Worcestershire County Council
- Appendix 2 - Worcestershire Alcohol Plan
- Appendix 3 - Delegation by Leader of the Council

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Background Papers

In the opinion of the proper officer (in this case the Director of Adult Services and Health) the following are the background papers relating to the subject matter of this report:

- Worcestershire Health and Well-being Strategy
- A 5 Year Health and Care Strategy for Worcestershire
- Worcestershire County Council Equality Impact Assessment, 27 January 2014.

Worcestershire Health & Wellbeing Board

Strategic Drugs Plan

2014-17

Context

1. Drug misuse is a complex issue. Whilst the number of people with a serious problem is relatively small, someone's substance misuse and dependency affects all of those around them. Over the last few years there have been significant improvements to the drug treatment system at a local level. However ongoing improvements to the system are needed to enable drug users to work towards drug-free and productive lives

2. The approach now needs to develop to provide a focus on integration that runs throughout the treatment journey and beyond, to wider health, social care and community based support consolidating gains made through structured drug treatment

3. This strategy outlines some of the key issues for substance misuse and the action plan that will be developed to accompany it, will detail how we will work in partnership with agencies such as employment services, housing, police, communities, service users and their families in ensuring that flexible treatment and ongoing support is available to those affected by drug misuse

4. A separate Alcohol Plan has been developed as alcohol is one of the four Health & Wellbeing Board priorities.

Aims

5. The Worcestershire Health and Well-being Board vision is that

Worcestershire residents are healthier, live longer and have a better quality of life, especially those communities and groups whose health is currently poorest.

6. The Worcestershire Drug Strategy aims to:
    - Increase positive outcomes from drug treatment, enabling recovery
    - Reduce drug related deaths and ill health
    - Improve access to drug treatment and support
    - Reduce drug related crime and disorder

7. It is important that our services are based on sound evidence of local need; as such the strategy is informed by the current substance misuse needs assessment (2014), which was carried out as part of the re-commissioning process for substance misuse services in Worcestershire.

Governance

8. In order to develop and implement the aims of the strategy, a detailed action plan with clear tasks and lines of accountability will be developed.

9. Progress against the plan will be reported to the Worcestershire Health Improvement Group, Worcestershire Alcohol & Substance Misuse Strategic Commissioning Group, the Safer Communities Board and will be subject to consideration with the two Community Safety Partnerships

Enabling people in Worcestershire to live a drug free life.

10. Actions supporting the aims of the plan include:

1. Improve access to drug treatment and support

- Worcestershire County Council will strengthen a programme of prevention work
- ensure that opening hours and access to treatment services reflect the needs of clients
- raise awareness of available mutual aid and community support to professionals and those seeking help with drug issues
- provide signposting information for agencies who have contact with drug misusers
- review engagement with housing providers to ensure appropriate and safe accommodation is available at different points in a client's journey
- Link with Worcestershire Stronger Families Programme in supporting families and children who have drug issues
- maximise service user and local community involvement in service planning and review

2. Make sure early and self-help is easily accessible and effective

- prepare educational materials and promote their use in institutional settings including schools, prisons and residential care homes
- deliver targeted campaigns in the community, using a range of appropriate media to cover the full life course, to raise awareness of: harms caused by drug misuse, safety issues for drug users and the help available for those who need it.
- ensure training is available for front line staff across all appropriate settings so that they have the skills to deliver appropriate brief interventions and key messages to individuals, and thereby increase access into recovery services
- develop appropriate responses to emerging issues such as misuse of over the counter and prescription drugs and image and performance enhancing drugs
- work in partnership with primary care services specifically GP's and community pharmacists, to ensure a high quality and consistent service for problematic drug users
- Support the work of the Drug Related Deaths Group
- commission excellent recovery focussed prevention and treatment services which reach effectively to those who need them most
- encourage recovery for opiate users who have been in long term treatment
- review existing services against the Strang principles
- increase the numbers of people successfully completing treatment and not representing particularly 'low complexity' clients

- support the development of volunteering opportunities for people who have previously been drug misusers, including recovery champions
- support the development of activities that promote social capital[1] for people who have previously misused drugs, such as recovery communities
- ensure the wider determinants of health are considered for clients in treatment, and provide help for those seeking employment, housing, education and training

3. Reduce drug related crime and disorder

- work with the Police & Crime Commissioner and West Mercia Police to deliver the Warwickshire Police and West Mercia Police drug strategy 2013-16 and the Police and Crime Plan for West Mercia 2013-17
- strengthen existing links with prisons to ensure effective treatment and support for prisoners
- work with the Drug Intervention Programme to ensure opportunities to refer clients to treatment services are maximised
- ensure close working with the Safer Communities Board and Community Safety Partnerships across the county

Definition

11. For the purpose of this document the term 'drugs' is taken to mean those substances that are controlled under the Misuse of Drugs Act 1971 (MDA), and prescription and over the counter medicines, it also takes into account new psychoactive substances which may or may not be legal substances. This strategy does not include reference to alcohol or tobacco, although it is acknowledged that there should be an alignment of approaches to address all substance misuse.

The extent of the issue

National Summary

12. The number of estimated opiate and/or crack cocaine users (OCUs) has fallen steadily since 2005-06, with a 10% fall in since 2004/05 from a total of 327,662 to 298,752 in 2010/11. This can partly be attributed to the success of treatment interventions. It should also be noted that the age profile of estimated OCUs shows a growing number of those in the 35-64 age bracket, and those estimated to be aged 15-24 now make up only half the number estimated in 2004-05.

13. Data from the National Drug Treatment Monitoring System (NDTMS) on the number of adults (18 and over) in contact with drug treatment providers and GPs in England in 2012-13 shows that:

[1] The definition of social capital used by ONS, taken from the Office for Economic Co-operation and Development (OECD), is 'networks together with shared norms, values and understandings that facilitate co-operation within or among groups'.

- Of the 193,575 clients aged 18 and over in treatment during 2012-13, 181,994 were in for 12 weeks or more or completed free of dependency before 12 weeks (94%).
- 29,025 (47%) of clients exiting treatment in 2012-13 completed, defined as having overcome their dependency.
- Clients' median age at their first point of contact in their latest treatment journey in 2012-13 was 35.
- 73% of clients in treatment were male.
- Most clients were white British (83%); the next most common ethnicity was 'white – other' (4%). No other ethnic groups accounted for more than 2%.
- Most clients in treatment were using heroin (80%). Cannabis was the primary drug for 8%, and powder cocaine for 5%.
- The most common routes into treatment for clients starting in 2012-13 were self-referrals (42%) and referrals from the criminal justice system (28%). Onward referrals from other drug services together accounted for 12%.
- Where reported, 9% of clients starting new journeys had no fixed abode on presenting for treatment, and a further 15% had other housing problems.
- The majority of young people accessing specialist drug interventions have problems with alcohol (37%) and cannabis (53%), requiring psychosocial, harm reduction and family interventions, rather than treatment for addiction, which most adults but only a small minority of young people require.
- Most young people need to engage with specialist drug interventions for a short period of time, often weeks, before continuing with further support elsewhere, within an integrated young people's care plan.

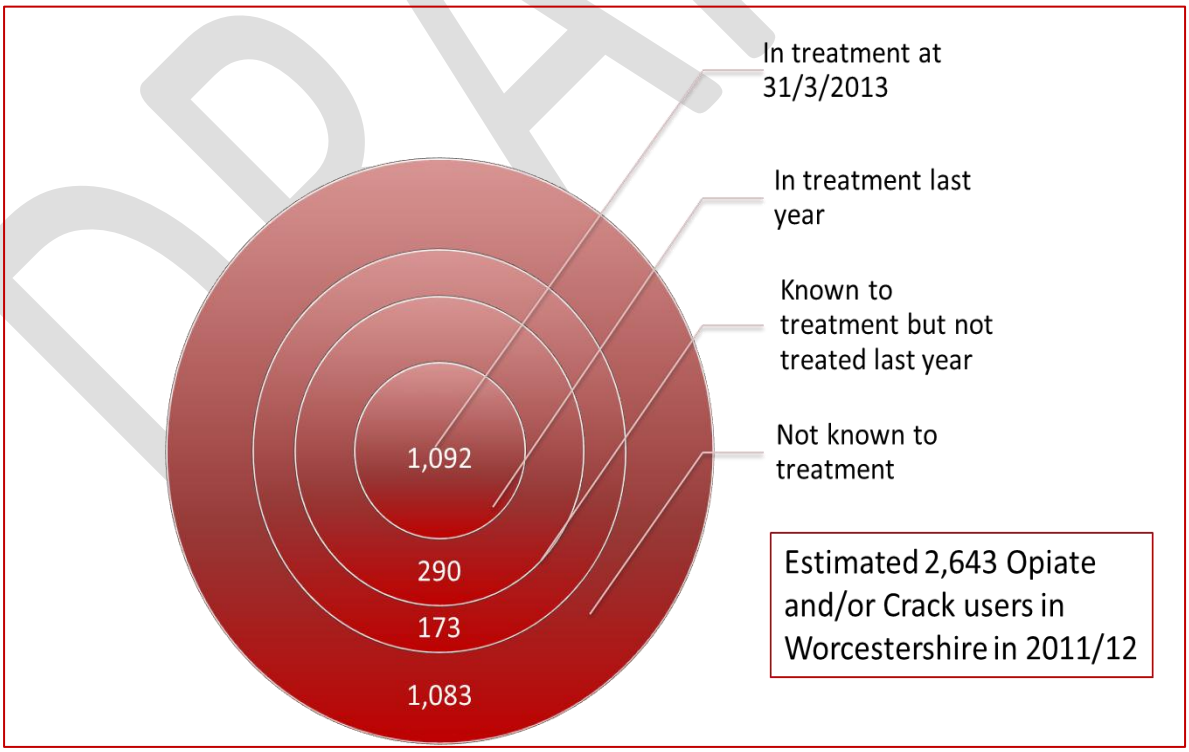
14. Despite the promising trend in the falling numbers of drug abusers, we should not be complacent. The pattern of drug use is constantly changing and there are new issues to consider. New psychoactive substances (legal highs) have become a particular concern in recent years with supply and demand increasing. The availability of these substances, especially over the internet and in 'head shops', has radically changed the nature of the drugs market (Department of Health, Home Office 2013). There is also concern about the misuse of prescription and over the counter drugs particularly amongst older people (RCP 2011) and the use of performance and image enhancing drugs (PHE 2013).

Worcestershire summary

15. A substance misuse needs assessment was recently undertaken to support the re-commissioning of substance misuse services. Some of the key issues from the needs assessment include:
    a) A large static population of people in treatment for opiate and/or crack cocaine usage
    b) Whilst numbers of young people accessing treatment services is falling, there a growing population of older drug users
    c) lack of information on new and emerging issues i.e. novel psychoactive substances
    d) lack of awareness amongst young people of the potential harms caused by cannabis use

16. Key issues for drug services;

- Latest synthetic estimates (see table below) based on information from the Glasgow Prevalence Estimates and information from the National Drug Treatment Service, show that there are 2,643 opiate and/or cocaine users (OCU's) in Worcestershire. This is an increase on the previous estimate of 2,218 in 2009/10, but below the 2008/09 estimate of 2,757.
- The number of opiate users in treatment has remained fairly stable, whilst the number of non-opiate users has fallen significantly since 2010-11.
- The percentage of clients referred into treatment from the Criminal Justice System is significantly lower than national average.
- There is an ageing population of drug users in treatment, with those from the 30-49 age groups accounting for over 70% of the treatment population in 2012/13 compared to around 45% in 2005/06.
- The percentage of opiate clients successfully completing treatment and not re-presenting is falling, and is now below national average and comparators.
- The percentage of non-opiate clients successfully completing treatment and not re-presenting has fallen significantly since 2010. It is now around half the national average and below that of Worcestershire's comparators.
- There were 83 young people in substance misuse treatment services during the 12-month period of April 2012 to March 2013. This is an increase on 72 clients in YP services for the 12-month period of April 2011 to March 2012. Latest figures for the second quarter of 2013-14 show 41 young people in treatment services in the first 6 months, although only 16 of these are new presentations to treatment.



Source: NDTMS figures and Glasgow Prevalence Estimates

What do Stakeholders in Worcestershire Think?

17. Consultation was carried out across the county to inform the substance misuse needs assessment 2014. Groups consulted included service providers, stakeholders such as housing associations, mutual aid groups, YMCA, support groups, service users, young people and the 'hidden population' i.e. substance misusers who may not be in treatment.

18. Key themes resulting from the consultation include:
    - Need for greater choice in the range of treatment options available and a greater focus on recovery
    - Lack of information available for young people on harms caused by drug usage
    - Need for greater partnership working looking at wider health determinants for complex substance misusers i.e. education, employment and housing
    - Lack of co-ordination and joint working between drug services and mental health
    - Access to treatment services is inconsistent with requirements of clients i.e. those who work and/or are in education

    The full report on this consultation is available in Worcestershire Substance Misuse Needs Assessment (2014).

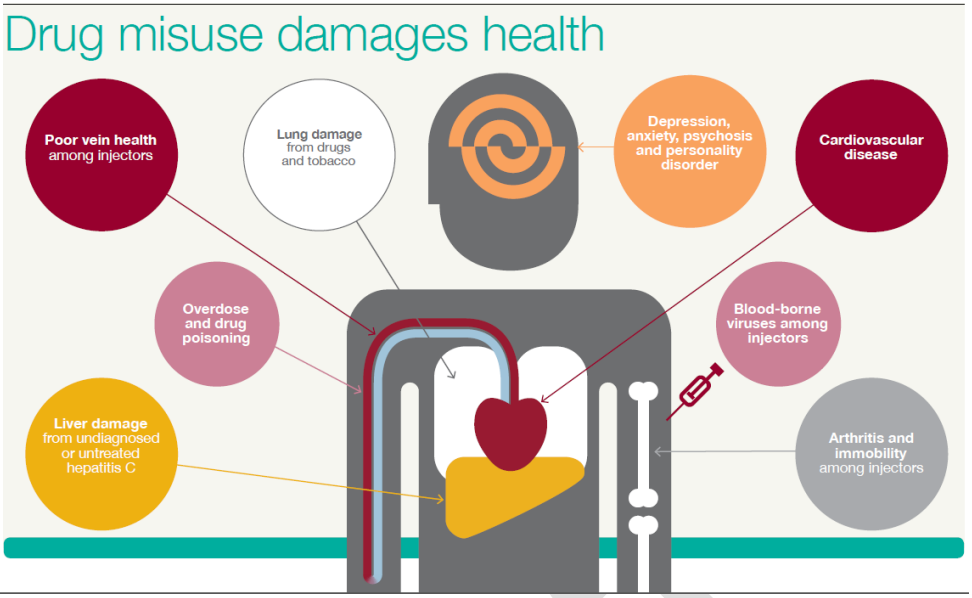
What impact does drug misuse have on health?

19. There are a number of public health harms associated with drug use, including overdose or unintentional injury, which might lead to premature drug-related death; and the spread of blood-borne viruses via injecting or sexual activity.

20. Prolonged use of cocaine can lead to mental health problems; crack cocaine users can experience high levels of anxiety, depression and paranoid ideation. Other symptoms, such as aggression and violence, are also associated with crack cocaine. Along with poor mortality rates and its relationship with blood borne viruses, heroin injection is associated with poor psychosocial functioning.

21. Prolonged cannabis use has been linked to psychosis, and studies have shown a link between use of marijuana and depression (NTA 2012). There is also an emerging concern that habitual smoking of cannabis may contribute to the development of chronic obstructive pulmonary disease, pneumothorax and respiratory infections, including tuberculosis and lung cancer (Royal College of Physicians, Edinburgh 2014).

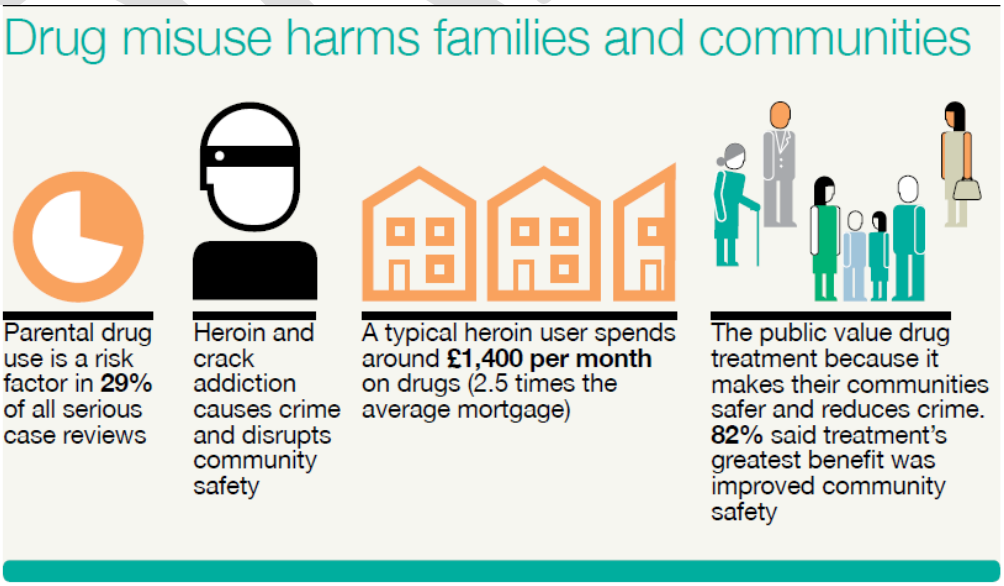
22. Many drug users are older, have entrenched problems and have failing health (PHE 2013). A recent study found that the lifetime use of cannabis, amphetamine, cocaine and LSD in 50-64 year olds has significantly increased since 1993 and is much higher than lifetime use in adults aged over 65, highlighting that prevalence may rise as populations for whom illicit drug use has been more common and acceptable become older (Institute of Psychiatry, Kings College, London 2012).



The table above outlines the key health problems experienced by people who misuse drugs (PHE 2013)

What impact does drug misuse have on families and communities?

23. Parental or carer drug use can reduce the capacity for effective parenting. In particular the children of parents or carers who are dependent on drugs are more likely to develop behaviour problems, experience low educational attainment, and be vulnerable to developing substance misuse problems themselves. This will potentially raise safeguarding issues, and some children's health or development may be impaired to the extent that they are suffering or likely to suffer significant harm (PHE 2103).



The diagram above shows the effect on families and communities of drug misuse. Source PHE (2013)

What impact does drug misuse have on Crime?

24. Drug use does not necessarily result in crime, some drug users committed crime prior to their drug use, some clients will commit crime which isn't a result of drug use, and others do not commit crime at all. However, the Home Office estimates that drug related crime at a national level costs £13.9bn per year and that offenders who use heroin, cocaine or crack cocaine commit between a third and a half of all acquisitive crimes (National Treatment Agency (NTA) 2012. The NTA estimates that, for every £1m taken out of the system there could be an increase of approximately 9,860 drug-related crimes per year at an estimated cost to society of over £1.8m (NTA 2012). The Government's Drug Strategy (2010) recognises the value of treatment for offenders, and aims to ensure that offenders are encouraged to seek help for their dependence both in prison and in the community (HM Gvt. 2010). In Worcestershire there is a key role for strategic working between the community safety partnership agencies and the Police and Crime Commissioner to tackle the impact and harm of drugs

The above diagram outlines the cost of drug addiction and crime Source: PHE (2013)

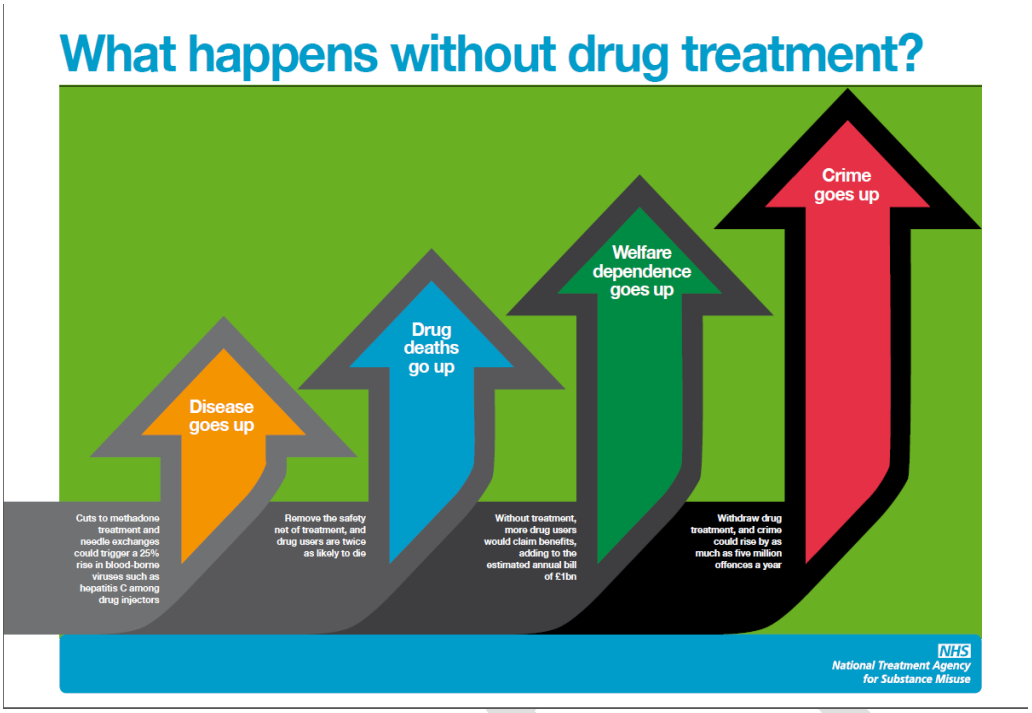
(Please note that this tool is based on a number of assumptions. This means that many of the figures produced by the tool are estimates and are indicative only. Local areas should use this information with caution and use it as a rough guide only).

Why Spend on Drug Treatment?

25. The diagram above highlights that money spent on Drug treatment benefits not only the person involved but their families, children and communities. It also benefits society as a whole in terms of fear of drug related crime and anti-social behaviour increasing confidence that these issues are effectively managed[2].

26. Without drug treatment there is greater risk of infection from blood borne viruses and death from overdose, more cost to the benefit system from addicts who cannot work and higher crime rates caused by those committing crime to fund their addiction.

[2] Warwickshire and west Mercia Police 2013-2016 Drug Strategy



Tacking the problem nationally – what does the evidence say?

27. In order to meet the ambition of the Drug Strategy 2010 'to help more heroin users to recover and break free from dependence', Professor John Strang's report, Medications in recovery, re-orienting drug dependence treatment (2012) outlines principles and features of recovery orientated drug treatment and how to test whether they are being achieved. This includes recommendations that treatment should:

    - incorporate wider social interventions as well as medication to support recovery outcomes
    - include considered provision of medications including opiate substitution treatment to gain maximum benefit
    - guard against incorrect provision or unnecessary drift into long-term maintenance on substitute prescriptions
    - regularly review care plans in order to measure and evaluate progress towards treatment goals and set new goals to move individuals along their recovery journey

28. **Putting Full Recovery first** (Home Office, updated March 2013) outlines key considerations for reducing the number of people misusing illegal drugs and other harmful drugs and increasing the number of people who successfully recover from dependence on these drugs.

    Key policy areas are:

    - Preventing young people from becoming drug misusers - It is important that we encourage young people to live healthy lives and that they know the dangers of misusing drugs. We also need drug services to help young people as soon as possible if they have a problem
    - Helping people recover from drug dependence **-** We want people who are dependent on drugs to be free of drugs for good. We also want treatment to include help with problems that might encourage people to start misusing drugs again after they are drug free.

- Helping offenders who misuse drugs get treatment **-** Prison isn't always the best place for offenders who misuse drugs. The Drugs Intervention Programme refers offenders to treatment services as early as possible in their contact with the criminal justice system.
- Providing information on what works best **-** local councils, supported by Public Health England (PHE), have responsibility for helping people to live a drug-free life. They are able to create information, support and treatment services that meet the needs of their local communities**.**
- Restricting the supply of illegal drugs **-** Restrict the supply of illegal drugs by classifying and controlling drugs, including new psychoactive substances (known as 'legal highs'), (DoH, HO 2013).

29. **Public Health England** recommends the following key things to be done to reduce drug-related harm:
    - Encourage protective factors that support young people's resilience
    - Provide packages of support – treatment, housing, employment, positive social networks – to help people recover and rebuild families and communities
    - Treat the growing numbers of older drug users, many of whom have serious addiction and health problems
    - Develop effective interventions for the harms of emerging drugs such as new psychoactive substances or so-called "legal highs"
    - Help people who are addicted to medicines (i.e. prescription only and over the counter medicines)

30. **NICE clinical guidelines** (CG51) make recommendations for the use of psychosocial interventions for people who misuse opioids, stimulants and cannabis in the healthcare and criminal justice systems. The guidance advises that care planning for individuals should consider the following when any treatment or management plan is developed:
    - type and pattern of use
    - level of dependence
    - comorbid mental and physical health problems
    - setting
    - age and gender
    - service users aspirations and expectations.

    The guidance stresses that no single treatment is appropriate for all individuals; treatments should be readily available and begin when the service user presents, and there should be the capacity to address multiple needs. For most people in long-term treatment, that is those with opioid dependence, substitute medications, such as methadone and buprenorphine, are important elements of care. Services also need to address coexisting problems, such as mental health and physical health problems, alongside the drug misuse. (NICE 2008)

National Policy Framework

31. Healthy Lives, Healthy People: Our plan for public health in England. (Department of Health 2010) sets out the new framework for public health, which gives local government the freedom, responsibility and funding to innovate and develop their own ways of improving public health in their area. This approach reaches across and reaches out – addressing the root causes of poor health and wellbeing, reaching out to the individuals and families who need the most support – and be:

    - **responsive** – owned by communities and shaped by their needs;
    - **resourced** – with ring-fenced funding and incentives to improve;
    - **rigorous** – professionally-led and focused on evidence; efficient and effective;
    - **Resilient** – strengthening protection against current and future threats to health.

32. The government's Drug Strategy (2010), 'Reducing Demand, Restricting Supply and Building Recovery: Supporting People to Live a Drug Free Life', aims to restrict the supply of illegal drugs and reduce the demand for them. It focuses on protecting families and strengthening communities and emphasizes supporting people, building recovery to lead drug free lives.

33. The three strands of work within the strategy are:
    - Restricting Supply
    - Reducing Demand
    - Building Recovery in Communities

34. In May 2012 the Government reviewed its progress in meeting its commitments and established its priority to ensure existing public health and criminal justice reforms deliver the envisaged benefits, and that the needs of drug users are embedded in transformational reforms of the probation and employment landscapes.

Local Policy framework

Worcestershire Joint Health & Wellbeing Strategy 2013-16

35. The key principles of the Strategy are:

    i. Partnership. We will facilitate partnership and ensure that organisations work together across the public, voluntary and private sectors to maximise their contribution to health and well-being.

    ii. Empowerment. We will encourage and enable individuals and families to take responsibility and improve their own health and well-being. We will also ensure that targeted support is available where necessary to increase individual, family and community resilience and self-reliance.

    iii. Local action. We will recognise local assets and strengthen the ability of communities to develop local solutions to local issues.

    iv. Rigour. We will draw on the evidence of what works when developing strategies and plans for action.

v. Involvement: We will respect the views of the public, patients, service users and carers and ensure that they have an opportunity to shape how services are organised and provided.

vi. Transparency and accountability. We will be clear about the impact we expect from investment and action to improve health and well-being, and open about the progress we are making.

What services are available in Worcestershire?

36. County-wide, a range of initiatives and services to prevent and treat substance abuse are in place, and a number of different agencies contribute to this. Examples of providers and interventions include:

Commissioner	Agency	Intervention
Worcestershire County Council	CRI Pathways to Recovery	Specialist drug community treatment service offering specialist advice and information, medical and psychological treatment and access to residential rehabilitation. Drug Intervention Programme, Encouraging offenders to seek treatment and access recovery focussed services SPACE provide targeted bespoke training for those services working with Children and young people who are deemed vulnerable to substance misuse, with the aim of improving targeted support and early intervention.
NHS England	Pharmacies	Awareness raising, harm reduction, dispensing
WCC, CCG	Hospital services	Hospital treatment for drug related conditions is provided by the Acute Hospitals NHS Trust
WCC NHS England	GPs	Screening, brief interventions, referral to specialist treatment services, supervision of community detoxification and prescription of alternative medication for Heroin users
	Youth offending services	Interventions to address offending related to substance misuse
District Councils	Regulatory services	Licensing and enforcement to support responsible trading i.e. 'Head Shops'
WCC on behalf of NHS England	Worcestershire Health & Care NHS Trust	Recovery and outcome focused substance misuse service Service HMP Hewell & HMP Long Lartin
	Probation Service	Probation supervision, offending behaviour programmes and specialist support services

WCC	Worcestershire County Council, Public Health	Specialist training front line staff, campaigns, commissioning and performance management of community adult and young person's drug treatment services, interventions and projects to address drug related harm, service user engagement
PCC	Warwickshire and West Mercia Police	Police and Crime Plan - Objective 4 - 'To reduce the harm caused by drugs with a focus on treatment, and targeting those that cause the most harm'.
WCC, District Councils	Community Safety Partnerships	Working in partnership reduce the harm that drugs cause to individuals, families and communities in Worcestershire
CCG	Worcestershire Acute Hospitals Trust	Training for front line staff, social marketing, Specialist Midwives tasked with working with vulnerable women including those that misuse drugs, brief interventions delivered through the NHS health checks programme
Various	VCS organisations	Self-help support groups, advocacy, crisis and supported housing for people who misuse drugs

Key Performance Indications

37. The Public Health Outcomes Framework (PHOF) concentrates on:

- increased healthy life expectancy
- reduced differences in life expectancy
- healthy life expectancy between communities

38. The PHOF key performance indicator for drugs is:

2.15 - Number of drug users that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within six months as a proportion of the total number in treatment, presented for all adults and further segmented by opiate and non-opiate users

Next Steps

39. An action plan will be developed with partners outlining milestones to be achieved over the next three years. This plan will be reviewed on an annual basis and updated according to any new evidence, policy developments or changes in legislation

40. The financial position of the council and the current economic climate, will be taken into account when drafting and implementing the action plan

Appendix 1

Legislation

Misuse of Drugs Act 1971 - The Misuse of Drugs Act 1971 is the main law to control and classify drugs that are 'dangerous or otherwise harmful' when misused.

The act lists all illegal (or controlled) drugs in the UK and divides them into one of 3 'classes' – A, B and C – based on the harm they cause to individuals and society. Class A drugs are considered the most harmful.

The act and its associated regulations also enable organisations to carry out legitimate activities involving controlled (illegal) drugs, many of which are used in healthcare.

Since 2010, the Misuse of Drugs Act 1971 has been amended to control new drugs, including a number of new psychoactive substances. On 10 June 2013, a temporary class drug order was made on two groups of new psychoactive substances (or 'legal highs') - NBOMe and benzofuran compounds, making them illegal for 12 months.

Misuse of Drugs Regulations 2001 - The Misuse of Drugs Regulations 2001 allow for the lawful possession and supply of controlled (illegal) drugs for legitimate purposes. They cover prescribing, administering, safe custody, dispensing, record keeping, destruction and disposal of controlled drugs to prevent diversion for misuse.

The Localism Act (2011) encourages local authorities to use the new freedoms in the act to target social housing on those who genuinely need it most for as long as they need it, the Chartered Institute of Housing has also produced a guide for landlords, helping them to support tenants in recovery (Chartered Institute of Housing 2013)

The forthcoming **Care Bill** and **Children and Families Bill** will expand and make concrete the rights of carers living in Great Britain. This will include the 1.5million people who are '*significantly affected*' by a relative's drug use, and who subsequently assume caring roles. Carers of drug users will have the same rights to a needs-assessment and access to support (if appropriate) as, for example, carers for those with mental illnesses, disabilities and the elderly (Adfam 2014)

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Worcestershire Health & Wellbeing Alcohol Plan 2013-16

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worcestershire county council

Worcestershire
Health and Well-being Board

Alcohol Plan

2013-16

NHS
Wyre Forest Clinical Commissioning Group

NHS
South Worcestershire Clinical Commissioning Group

NHS
Redditch and Bromsgrove Clinical Commissioning Group

Context

1. The Worcestershire Health and Well-being Board has agreed that its vision is that ***Worcestershire residents are healthier, live longer and have a better quality of life, especially those communities and groups whose health is currently poorest.***

2. The Worcestershire Health and Well-being Strategy 2013-16 has identified alcohol as one of the four priorities. This Plan signals the intention of the Board and its member organisations to scale up our efforts to reduce harm from excessive alcohol consumption, and will shape our work over the next three years.

3. In preparing the Plan, the six key principles of the Health and Well-being Board have been important. These are:

   i. **Partnership**. We will facilitate partnership and ensure that organisations work together across the public, voluntary and private sectors to maximise their contribution to health and well-being.

   ii. **Empowerment**. We will encourage and enable individuals and families to take responsibility and improve their own health and well-being. We will also ensure that targeted support is available where necessary to increase individual, family and community resilience and self-reliance.

   iii. **Local action**. We will recognise local assets and strengthen the ability of communities to develop local solutions to local issues.

   iv. **Rigour.** We will draw on the evidence of what works when developing strategies and plans for action.

   v. **Involvement**: We will respect the views of the public, patients, service users and carers and ensure that they have an opportunity to shape how services are organised and provided.

   vi. **Transparency and accountability.** We will be clear about the impact we expect from investment and action to improve health and well-being, and open about the progress we are making.

4. The Plan also takes into account the Board commitment to work to ensure that where relevant the priorities are addressed for the whole population, and especially for the following groups:

   - **Children and young people.**
   - **Communities and groups with poor health outcomes.**
   - **People with learning disabilities.**

Aims

5. The Plan has three aims – some of the actions against them are set out below:
   A. Empowering individuals to take responsibility for their own and their families' drinking habits;
   B. Creating a community environment where sensible drinking is the norm;
   C. Improving treatment and rehabilitation services.

A. Empowering individuals to take responsibility for their own and their families' drinking habits
▪ Prepare educational materials and promote their use in institutional settings including schools, prisons and residential care homes; ▪ Deliver a planned programme of targeted campaigns in the community, using a range of appropriate media to cover the full life course, to raise awareness of: safe levels of drinking; the consequences of not drinking safely; and the help that is available for those who need it. Actively involve the local community in the delivery of these campaigns; ▪ Scale up training for front line staff across all appropriate settings so that they have the skills to deliver appropriate brief interventions and key messages to individuals and will increase access into recovery services; ▪ Supporting a range of volunteering activities for those who have been problematic drinkers in the past, including work as champions of safe drinking.

B. Creating a community environment where sensible drinking is the norm
▪ Engage robustly in the national consultation on minimum pricing; ▪ Maximise the new opportunity of health bodies becoming responsible authorities under the Licensing Act 2003. This will include fuller data sharing by health organisations; ▪ Support local licensing authorities to make full use of their new powers and duties including to: make it easier to refuse, revoke or impose conditions on a license; develop Cumulative Impact Policies with regard to both the on-trade and the off-trade; make it easier for local people to make representation about licensing applications and the conduct of license holders; ▪ Develop a Health Impact Assessment process, with alcohol related harm as one element, for use in all appropriate Council decision-making, at all tiers of local government; ▪ Maximise the consideration of alcohol impact in the planning process; ▪ Support the development of opportunities for alcohol-free public activities and venues; ▪ Ensure that the most is made of the renewal process of 6,000 personal licenses in Worcestershire in 2015, so that license holders are empowered to actively create a safe drinking environment on their premises; ▪ Work with local organisations who have signed up to the national Responsibility Deal to support them in adhering locally to the agreed standards, and encourage new businesses to sign up; ▪ Develop accreditation schemes such as 'STAR', Pubwatch, and Purple Flag, across the County, building on local pilot evidence on what will work best for Worcestershire.

C.	Improving treatment and rehabilitation services
▪	Review key clinical and non-clinical pathways to ensure that there is joined up working between key agencies and clients do not fall through the gaps;
▪	Maximise service user and local community involvement in service planning and review;
▪	Ensure routine health interventions, such as the health checks programme; elective and emergency hospital services robustly address alcohol intake through screening, delivery of a brief intervention, and sign-posting into specialist service where appropriate. This will include a review of the role of the Alcohol Liaison Nurses in the Acute Trust;
▪	Review engagement with housing providers to ensure appropriate and safe accommodation is available at different points in a client's journey;
▪	Review the intervention pathways for offenders at all levels of the criminal justice system, to ensure that a full and supported route into sensible drinking is promoted for all those who need it, with the full involvement of the recently elected Police and Crime Commissioner.

Implementation and governance

6. An Alcohol Action Group will be formed to develop and implement a more detailed operational plan to secure early progress on aims and actions. The operational plan will pick up some more of the detail from the consultation events and give a clear line of accountability for leading on each of the actions, with a timescale for implementation.

7. Progress against the Plan will be reported to the Board on a regular basis, including progress against a range of alcohol related outcome indicators, and including the two indicators included in the Joint Health and Well-being Strategy – for example:
   - Numbers of alcohol-related crime and anti-social behaviour;
   - Numbers of domestic abuse incidents in which alcohol was a factor;
   - Numbers of alcohol related hospital admissions.

Background: the extent of the problem

How much is too much?

8. There is some confusion among the general public and some professionals about the definition of a unit of alcohol, and about the exact definition of 'safe' levels of drinking. In response to this, the Government's 2012 Alcohol Strategy (DH 2012) commits to review the alcohol guidelines for adults.

9. A unit of alcohol is the amount of pure alcohol in a 25ml single measure of spirits (ABV 40%), a third of a pint of beer (ABV 5 to 6%) or half a 175ml 'standard' glass of red wine (ABV 12). Definitions of types of drinking are set out below:

Drinking category	**Definitions**
Abstainers	A person whose weekly alcohol consumption was reported in the General Lifestyle Survey (GLS) as 0 units over the previous 12 months
Lower risk	Men: who regularly drink no more than 3 – 4 units per day or up to 21 units a week. Women: who regularly drink no more than 2 – 3 units per day or up to 14 units a week.
Increasing risk	Men: who regularly drink over 3 -4 units per day or up to 50 units a week. Women: who regularly drink over 2 – 3 units per day or up to 35 units a week.
Higher risk	Men: who regularly drink over 8 units a day or over 50 units a week; Women: who regularly drink over 6 units a day, or 35 units a week.
Binge drinking	Those who consume at least twice the daily recommended amount of alcohol in a single drinking session (that is, 8 or more units for men and 6 or more units for women.)

10. However, the issue of risk is complex, and the figures above are based on averages. It is known that issues such as age, ethnicity, and Body Mass Index all affect the relationship between alcohol intake and health harm for the individual.

11. Safe levels of drinking for children and young people are very different. The Chief Medical Officer (DH 2009) has made the following recommendations:

    - An alcohol free childhood is the healthiest and best option. However, if children drink alcohol, it should not be until at least the age of 15 years;

- If young people aged 15 to 17 years consume alcohol, it should always be with the guidance of a parent or carer or in a supervised environment;
- If 15 to 17 year olds do consume alcohol, they should do so infrequently and certainly on no more than one day a week. Young people aged 15 – 17 years should never exceed recommended adults daily limits and, on days when they do drink, consumption should usually be below such levels.

12. Safe levels of drinking for older people are different too. The Royal College of Psychiatrists have recommended that daily alcohol units for those aged 65 and over should be revised as follows:
    - For men aged 65 and over, the upper 'safe limit' is 1.5 units per day or 11 units per week;
    - For women aged 65 and over, the upper 'safe' limits is 1 unit per day or 7 units per week;
    - Binge drinking in older people should be defined as more than 4.5 units in a single session for men and more than 3 units for women.

What harm does it do?

13. Alcohol is one of the major causes of avoidable ill-health in the UK. The health burden of alcohol misuse is massive, accounting for about 1 in 8 of all NHS bed days. Drinking too much increases the risk of (DH 2005):
    - Serious mental health problems including: clinical depression, deliberate self-harm, and suicide (65% of suicide attempts are linked to alcoholism);
    - Serious physical conditions including: circulatory disease; vascular dementia; cancers of mouth, pharynx, larynx, oesophagus, liver; liver disease (3.5% of all cancer deaths are attributable to alcohol);
    - Accidental death (20-30% of all accidents have alcohol as a factor).

14. Drinking too much as a child has serious consequences and impacts can be seen into adulthood. These include:
    - Structural deficits in brain development;
    - Reduced brain functioning during adulthood;
    - Adverse effects on liver, bone, growth and endocrine development;
    - Heavy drinking as an adult;
    - Sexual risk-taking behaviour;
    - Drink-driving as an adult;
    - Reduced educational attainment;
    - Mental health problems including depression and stress and anxiety based conditions.

15. Drinking too much alcohol has consequences other than 'just' health consequences. It is linked to adult and youth crime, including (DH 2005):

- Driving offences, leading to death or serious injury;
- Violent crime (about half is linked to alcohol);
- Anti-social behaviour;
- Deliberate fires;
- Sexual offences (about 30% are linked to alcohol);
- Street crime (about 50% is linked to alcohol).

16. Drinking too much has a significant impact on the family of the drinker as well as on the individual drinker. Consequences include (DH 2005):
    - Foetal alcohol syndrome;
    - Domestic abuse (about a third of incidents of domestic violence are linked to alcohol misuse);
    - The increased risk that the children in the family will drink too much themselves as older children and as adults;
    - Increased risk of neglect and child protection arrangements being needed for children in the families of those who misuse alcohol.

What is the scale of the problem in Worcestershire?

17. In Worcestershire, as nationally, many adults do not drink alcohol at all. About 13% of adults are abstainers. Of those that do drink, most drink responsibly, with nearly three-quarters of drinkers (73%) drinking at lower risk levels.

18. However, about a fifth of drinkers (21%) drink at 'increasing risk' levels, and about six in every hundred (5.7%) drink at 'higher risk' levels. It should be noted that these figures are taken from self-reported drinking behaviour, which is reported in the General Lifestyle Survey. Research comparing taxation data and reported drinking habits suggests that people significantly under-report their actual drinking.

19. The latest estimated numbers of drinkers among the local population aged 16 years and over are shown in Table 1 (NWPHO 2011). These estimates use modelling techniques to generate local authority level data based on the General Lifestyle Survey (2008); population demographics (age, sex, ethnicity and levels of deprivation); hospital admissions and deaths related to alcohol consumption.

20. Drinking among children and young people is recorded by the school based survey 'Young People in Worcestershire 2009', completed by pupils aged 12 – 15 years and conducted by the Schools Health Education Unit (WCC 2009). This is again subject to the inaccuracies of self-reporting. However, results show that in Worcestershire, 36% of young people surveyed had at least one alcohol drink in the last week. 3% of pupils drank over the advised weekly limit for adult females of 14 units. SHEU data from across the country show that the home is the largest single source of alcohol up to the age of 16.

Table 1: estimate number of drinkers age 16 and over

Geographical area	Abstainers	Drinkers at lower risk	Drinkers at increasing risk	Drinkers at higher risk
Bromsgrove	18,778	46,511	13,808	6,119
Malvern Hills	6,994	39,513	11,067	3,360
Redditch	9,749	42,008	9,808	2,216
Worcester City	10,132	47,986	14,688	2,963
Wychavon	12,242	61,529	17,314	4,987
Wyre Forest	10,961	51,671	15,627	3,165
Worcestershire	**68,856**	**289,218**	**82,312**	**22,810**

21. There are differences between communities in terms of rates of drinking and the known links between alcohol abuse and social deprivation are evident in Worcestershire as they are elsewhere. Those living in the most deprived communities are more likely to drink problematically. The most deprived quintile of the UK population experience 2-3 times the risk of the least deprived quintile in terms of loss of life attributable to alcohol; death from alcohol specific causes and alcohol related hospital admissions, and this is true in Worcestershire as it is in the UK as a whole (DH 2005).

22. The Worcestershire profile of alcohol related outcome indicators is set out in Figure 1. The chart shows Worcestershire's measure for each indicator, as well as the regional and England averages and range of all local authority values for comparison purposes. Although Worcestershire is about the same as the national average in many respects, it is significantly worse than the national average in respect of:
    - Alcohol specific hospital admissions for those aged 18 years and under;
    - Mortality due to alcohol related land transport accidents;
    - Employees in bars (this simply means that the number of employees as a % of all employees is particularly high in Worcestershire).

23. Figures from the 2006-2011 period show that there are some causes for optimism, with alcohol related crime overall showing a reduction, and some slowing of the rate of increase for alcohol-attributable hospital admissions. There is, of course, no room for complacency. The direction of travel during this period is, in many areas, disappointing. Alcohol attributable hospital admission rates for both men and women show an upward trend, as well as alcohol related sexual offences, although both trends are in line with national figures.

24. The county picture masks significant differences between Districts. The profile in Malvern Hills, Wychavon, and Bromsgrove compares favourably to the national average. However, in the other three Districts, alcohol indicators are significantly worse than the national average in a number of respects, and are shown in Table 2.

Figure 1: Worcestershire profile of alcohol related outcome indicators

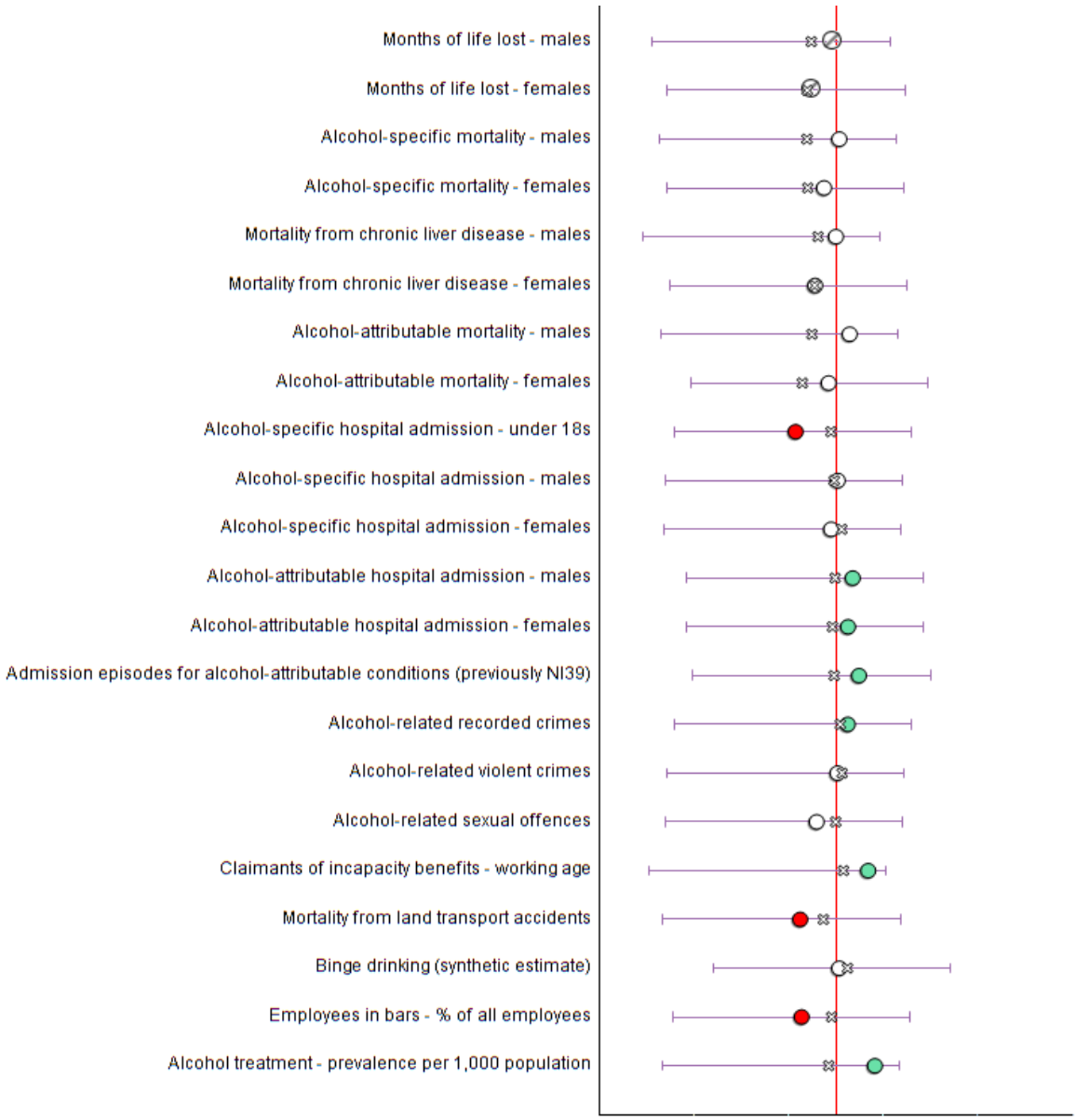

Table 2: Districts and alcohol indicators significantly worse than the national average

Indicator	Redditch	Wyre Forest	Worcester City
Alcohol specific hospital admissions under 18 years	Yes	No	Yes
Alcohol specific hospital admissions for males	Yes	Yes – with record high rates in 2011/12.	Yes
Alcohol attributable hospital admissions	For men and women - with record high rates 2011/12		
Alcohol related recorded crime	Yes - with record high rates of alcohol related sexual offences 2011/12	Yes	Yes - with record high rates of alcohol related sexual offences 2011/12
Alcohol related violent crime	Yes	Yes	Yes
Alcohol attributable mortality from land transport accidents	No	Yes	No

Tackling the problem

What does the evidence say?

25. There is extensive evidence as to what works in terms of both preventing and treating alcohol abuse. Guidance from the National Institute for Health and Clinical Excellence (NICE) about prevention (NICE 2010a) highlights three broad areas:
    - Price (introducing a minimum price);
    - Availability (making it less easy to buy alcohol);
    - Marketing (protecting children and young people from alcohol advertising).

26. NICE recommendations for professionals from health, regulatory services, and criminal justice agencies include:
    - Extensive screening for alcohol use at the front-line, so that all those who drink too much are identified by use of a validated screening tool;
    - Delivery by the front line professionals of brief interventions where indicated by the screening tool, giving brief, structured and motivational advice, and referral on to specialist services where needed (this can reduce weekly drinking by between 13 and 34%, with 8 interventions being needed to secure one effective outcome;
    - Development of cumulative impact policies by licensing professionals where an area is saturated with licensed premises;
    - Effective enforcement by regulatory professionals of underage drinking legislation.

27. Treatment models too are founded in a clear evidence base (NICE 2010b, Raistrick 2006) with a number of key themes:
    - A 'stages of change' approach is recommended, where the place of the service user on the stages of change is identified so that the most appropriate treatment is delivered. The four stages are pre-contemplation (including relapse), contemplation, action, and maintenance;
    - A stepped care model is recommended, whereby drinkers are initially offered the least intrusive and least expensive intervention that is likely to be effective - the first treatment of stepped care should be motivational enhancement therapy, with effective treatment being often only a few sessions;
    - Brief interventions in a range of settings are effective in reducing consumption for non-dependent drinkers, and effects persist for up to 2 years, with later booster sessions being needed;
    - The strongest evidence is for cognitive behavioural treatments, and involving friends or family in treatment is helpful.
    - Self-help and mutual aid, often based on 12 step principles, are also effective both during treatment and in aftercare.
    - Medical detoxification is usually straightforward and effective;

28. The strength of this evidence for the effectiveness of treatment interventions is strong enough to allow cost-benefit analysis that estimates that for every £1 spent on treatment, a further £5 is saved elsewhere in the system (UKATT 2005).

What does national policy say?

29. The current policy context for addressing alcohol abuse has been framed by influential reports over the last decade, which have highlighted the long term unaffordability of health and social care if the burden of avoidable, lifestyle related disease continues to rise unchecked (Wanless 2002), and the persistence of the health gap between rich and poor, despite many efforts to narrow this gap (DH 2010a).

30. This Government is leading large scale reform of health and social care, and one part of this was set out in the Public Health White Paper 'Healthy Lives, Healthy People' (DH 2010b). This calls for a radical shift in the way that public health challenges are tackled. It focuses particularly on:

- Empowering individuals to make health choices;
- Giving communities the tools to address their own particular needs;
- Widening responsibility for health across society.

31. The White Paper reflects the Government's core values of freedom, fairness and responsibility by strengthening self-esteem, confidence and personal responsibility; positively promoting healthy behaviours and lifestyles; and adapting the environment to make healthy choices easier. It seeks to balance the freedoms of individuals and organisations with the need to avoid harm to others, use a 'ladder' of interventions to determine the least intrusive approach necessary to achieve the desired effect and aim to make voluntary approaches work before resorting to regulation. It calls for services to be:

- Responsive – owned by communities and shaped by their needs;
- Resourced – with ring-fenced funding and incentives to improve;
- Rigorous – professionally led, focussed on evidence, efficient and effective;
- Resilient – strengthening protection against current and future threats to health.

32. The call for a wider responsibility across society was actioned by Government through its Public Health Responsibility Deal (DH, 2011). This gives a framework for collaborative working on health improvement with the business and voluntary sector and sets out a number of pledges to which organisations outside health can commit. There are five networks to support this policy, and one of these is on alcohol. There are ambitious plans for collaboration with the industry on issues such as better information about units at the point of sale and on products; promotion of socially responsible retailing of alcohol; promotion of sensible drinking; and collaborative working.

33. More recently, Government has produced a new Alcohol Strategy (Home Office 2012). This is based around the key policy principles of working with the wider business sector; empowering and supporting individuals to change through making informed decisions; and

enabling local areas to define and implement what needs doing locally. Some examples of more specific commitments include national action to:

- Tackle the availability of cheap alcohol through introduction of a minimum price and consultation on multi-buy promotions;
- Make marketing more socially responsible through a review of the Mandatory Code for Alcohol; limiting adverts shown during programmes of high appeal to young people; and finding ways to ensure that social media marketing adheres to under age sales legislation;
- Give local communities more powers such as through extending powers to introduce Early Morning Restriction Orders; the power to introduce a new late night levy; strengthen local powers to control the density of premises licensed to sell alcohol; giving licensing authorities greater freedom to take decisions;
- Work with industry of areas such as calorie labelling, not serving people when drunk, and a renewed commitment to Drinkaware;
- Improve information and support for people to change their behaviour, for example by: reviewing the alcohol guidelines; integrating alcohol into the change4Life brand; commit to an on-going social marketing campaign; develop a model pathway for under 18s; increase the flexibility of the Alcohol Treatment Requirement imposed by the court as part of a community sentence.

What is Worcestershire doing now?

34. Countywide, a range of initiatives and services to prevent and treat alcohol abuse are in place, and a number of different agencies contribute to this. About £526,356 is spent on treatment services, with about another £200,000 spent on initiatives including alcohol liaison nurses; work with those who are homeless alcohol misusers; victims of domestic abuse; targeted youth support; and family training. Examples of providers and interventions include:

Agency	**Interventions**
CRI	Specialist drug and alcohol community treatment service offering specialist advice and information, medical and psychological treatment and access to residential rehabilitation.
Hospital services	Alcohol liaison nurses; specialist treatment for alcohol specific harm, such as treatment of liver cirrhosis;
GPs	Screening, brief alcohol interventions, referral to specialist treatment services, supervision of community detoxification and prescription of relapse prevention medication
Youth offending services	Interventions to address offending related to substance misuse
Regulatory services	Licensing and enforcement to support responsible trading
Community policing	Licensing enforcement and safety night-time economy

Worcestershire County Council	Specialist training front line staff, campaigns, commissioning and performance management of community adult and young person's drug and alcohol treatment services, interventions and projects to address alcohol related harm, service user engagement
NHS Worcestershire	Generalist training for front line staff, social marketing, Specialist Midwives tasked with working with vulnerable women including those that misuse alcohol, alcohol brief interventions delivered through the NHS health checks programme
VCS organisations	Self-help support groups, advocacy, crisis and supported housing for people who misuse alcohol

35. The current programme of work is overseen by a Strategic Alcohol Group which monitors the implementation of an action plan. This group includes members from all the agencies who contribute to the delivery of the plan, such as criminal justice, regulatory services, housing, health, and fire and rescue. The group currently reports into the Community Safety Partnership Board, the Drug and Alcohol Action Team (DAAT) Board and the Health and Well-being Group of the Worcestershire Partnership (which is now under review). Services are routinely monitored and key outcomes measured on a quarterly basis.

What do local people think?

36. This Plan was drawn up following a consultation exercise that was launched during national Alcohol Awareness week (19–25 November 2012). A range of consultation methods were used, including a 'Big Drink debate' which used radio and newsprint media, an on-line questionnaire, street surveys, and graffiti boards in community settings; as well as a Health and Well-being Board Stakeholder event with 45 attendees from a range of organisations across the county. In all, over 400 views were heard.

37. There was a marked consensus in the views expressed, with key themes being
    - Improving education about alcohol, especially for young people who were seen as drinking more heavily than in the past, and causing much of the alcohol related public nuisance, which was felt to be concentrated in the town centres rather than in local communities;
    - Encouraging personal responsibility for individuals and their families;
    - Making sure that licensing is managed in a drink-aware way, both in premises and in the licensing process;
    - Making sure that as people have access to treatment as appropriate, with particular attention paid to mental health issues;
    - Training for front-line staff from all agencies, including criminal justice, who often find it difficult to raise a discussion about alcohol with their clients.

38. Fuller findings from this consultation are available separately on the Health and Well-being Board pages of the Worcestershire County Council website.

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RE-COMMISSIONING OF DRUG AND ALCOHOL TREATMENT AND RECOVERY SERVICES – DELEGATION TO CABINET MEMBER

The Council needs to consider its approach to the retendering of Drug and Alcohol services ahead of the September meeting of Cabinet.

I therefore authorise Marcus Hart, as Cabinet Member with Responsibility for Health and Wellbeing, to take all decisions on behalf of the Cabinet in relation to the retendering of Drug and Alcohol services.

This delegation includes (but is not limited to) deciding:

- whether to retender these services, using monies from the Public Health ring-fenced grant
- whether to implement a revised payment by results structure for new Drug and Alcohol services
- the final development of the service specification and whether to ask the Director of Adult Services and Health to conduct the procurement exercise; and
- any eventual contract award/s for these services, in consultation with the Director of Adult Services and Health, following due procurement process.

Dated

Signed

A I Hardman

Leader of the Council

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