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Healthier Communities Select Committee Supplementary Agenda

Tuesday, 28 June 2016
7.00 pm,
Civic Suite
Lewisham Town Hall
London SE6 4RU

For more information contact: John Bardens (02083149976)

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Part 1

Item		**Pages**
4.	HIV services	1 - 8
5.	Public health commissioning intentions and consultation	9 - 96

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TRANSFORMING THE UK'S RESPONSE TO HIV

25 May, 2016

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Dear Councillor Peck

Re: Lambeth, Southwark and Lewisham HIV Service User Consultation

I am writing as Chief Executive of NAT (National AIDS Trust), the UK's national HIV policy and campaigning charity, in response to the twin consultations on Public Health Services in Lambeth and on HIV support service provision in the London Boroughs of Lambeth, Southwark and Lewisham (LSL).

NAT has a strong commitment to ensure people living with HIV have the support they need. I have serious concerns about the impact the proposed changes will have on the support services that people living with HIV can access in the boroughs with the highest HIV prevalence in the country, as well as the wider effect such cuts could have on public health and HIV transmission.

I would start by pointing out an apparent discrepancy between the two consultations. The broader public health consultation states that *"We intend to reduce the funding to specialist HIV care and support services (providing advice, counselling and peer support)"*, targeting the remaining funding on maintaining a specialist service for children and families. The HIV specific consultation on the other hand states *"We intend to maintain the HIV peer support service and will work with the peer service providers on how peer support might assist service users as a result of any services changes elsewhere"* and also commits to maintain family support, with all other specialist provision (counselling, first point, advice services) ending, to be replaced by generic services.

It is crucial that interested parties are given accurate information about the changes that are being proposed. I will assume that the LSL HIV support services consultation reflects the current position and it is now agreed that peer support will continue for people with HIV in LSL (which is of course welcome).

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Kathleen Britain
Dr Valerie Delpech
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The need and demand for HIV support services

I am also concerned about apparently contradictory underlying assumptions in the HIV specific consultation around demand. The consultation document states that:

> *"While there is still no cure for HIV, there are treatments to enable most people with the virus to live a long and healthy life. The number of HIV related deaths in the UK is now very low and the number of people living with HIV has therefore grown significantly.*
>
> *There is increasing pressure on public services due to rising need and increased financial pressures within the NHS and local councils. This, coupled with the fact that many people with HIV can live a long and normal life, means continuing to provide HIV specialist support services in the same way and at the same level that we do now is not sustainable."*

This seems to imply both that demand for support services is falling due to improvements in treatment, but also that demand is unsustainably high. In fact, as I go on to show below, despite treatment improvements there is still significant psychosocial need amongst people with HIV.

Great improvements have been made in HIV treatment in recent years but there are still many people living with HIV, especially older people, who were diagnosed before treatment became available or when treatment still had very severe side-effects and who have as a result permanent impairments and support needs. About one in five people with HIV are still diagnosed very late with far greater rates of ongoing ill-health and impairment as a result. With regard to mortality, whilst rates of death have of course declined massively from the early days of the epidemic, the mortality rate of people with HIV in this era of ART in the UK is still six times higher than that of the population as a whole and still over twice as high even when AIDS-deaths are excluded.[1]

Public Health England's Positive Voices 2014 survey of a representative HIV clinic population found that 68% of people with HIV have at least one other long-term co-morbidity, the most common being depression/anxiety (30% of the whole weighted sample), high cholesterol (20%) and hypertension (14%).[2] All of these percentages are very significantly higher than that of the general population. People with HIV need holistic long-term condition management support to self-manage effectively and access appropriate healthcare.

Still others who are living well with HIV are able to do so precisely because they are able to access the support services they need. Among these, many people living with HIV need support services episodically, at particular moments in their life such as

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[1] Sara Croxford, Public Health England, Non-AIDS mortality among people diagnosed with HIV in the era of HAART compared to the general population: England and Wales, 1997-2012, BHIVA 22nd Annual Conference 2016

[2] Kall M, Shahmanesh M, Nardone A, Gilson R, Delpech V on behalf of the Positive Voices Study Group. Self-reported prevalence of co-morbidities and use of non-HIV related medications among people living with HIV in England and Wales: results from the Positive Voices survey. *15th European AIDS Conference*. Barcelona, Spain; October 21-24 2015

when they are newly diagnosed, if they lose a job, become pregnant, need to think about disclosure, or experience discrimination.

I welcome your intention to maintain peer support services on the grounds that they are recommended by BHIVA. However, peer support alone is not sufficient to provide for the service needs of people living with HIV.

For example, people with HIV experience significantly elevated levels of depression, anxiety and suicidal ideation compared with the general population.[3] As stated above, Positive Voices found that 30% of people with HIV also experience depression/anxiety. HIV support services, including counselling, can be low threshold, preventive and cost-saving interventions to avert acute ill-health and crisis.

There are also high levels of social disadvantage amongst people with HIV. There is robust evidence of the impact that such social disadvantage (for example around income, employment and housing) has, in the absence of interventions, on the ability of people with HIV to adhere to their medication and maintain the suppressed viral load necessary for good health and non-infectivity.[4]

HIV specialist support organisations provide a vital service in helping people cope with the experience of stigma. 37% of the UK's 2015 Stigma Index Survey participants who had experienced HIV-related discrimination had relied on support from a local specialist HIV organisation within the last year.

Specialist support services may be the only places where people living with HIV can be open about their status and there is a great danger that, without HIV specialist services, people living with HIV will drop out of the vital support that allow them to achieve optimal health and wellbeing.

Comprehensive HIV support services are agreed to be an essential element in the HIV care pathway

BHIVA Standard 9 recommends a number of services beyond peer support. It indicates that support and information about HIV treatment, healthy living with HIV, diet and lifestyle, and optimisation of general health; support around access to health services; and financial, housing and employment support are all necessary for effective long term condition management.[5]

Moreover, drawing on BHIVA Standards, NHS England has clearly stated in its service specification for adult HIV specialised services that 'the effectiveness of HIV specialised services depends on other elements of the HIV care pathway being in place and effectively coordinated' (NHS England HIV adult service specification 2.2). These other elements include 'Community services provided by third sector and other organisations. These services can provide important support on long-term condition management'. They are later described in the same service specification as 'third sector HIV care and support services for treatment adherence, peer support

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[3] See *Psychology, Health and Medicine* Vol 16 Number 5 October 2011

[4] See Socio-Economic Factors and Virological Rebound: a Prospective UK Cohort Study Burch *et al*, Abstract 560, CROI 2015

[5] Standards of Care for People Living with HIV, British HIV Association, 2013

and self management' as well as 'social care, mental health and community services for rehabilitation, personal care or housing' (section 2.5). In other words, these HIV support services are an integral part of the required care package available to people with HIV.

It is perverse to use good HIV clinical outcomes as an argument that HIV support services are no longer needed. It is precisely the historical combination in England of specialised clinical care and comprehensive, usually community-based, support which has secured such outcomes. Withdrawing specialist counselling, advice and needs assessment/signposting puts such outcomes at risk for a significant proportion of people with HIV.

The Public Health England Positive Voices survey in 2014 found that 35% of people with HIV had accessed HIV support services in the previous 12 months, most commonly:

- information about living with HIV
- treatment advice
- peer support or social contact with other HIV positive people, and
- counselling.

Data from the Stigma Survey UK[6] show similar results for use of HIV support services, but also indicate that certain groups of people living with HIV particularly depend on these services. Among their sample, 46% of those recently diagnosed and 43% of those feeling suicidal had accessed local HIV support organisations.

In other words, LSL are not proposing to end marginal aspects of HIV care, but rather essential elements, both in terms of national guidance and actual use.

Use of generic services

The LSL proposals rely heavily on the recommendation that for advice and counselling people with HIV access instead generic advice and talking therapy services. The public health consultation refers to 'A review of HIV care and support services undertaken by the NHS suggested that many mainstream services would be able to support people living with HIV and that this might be desirable to avoid service duplication and de-stigmatise HIV as a long term condition'. I am unsure which review is being referred to and think it poor practice for there to be no reference to allow consultees to read and assess the review for themselves.

This approach to generic services is itself too generic – there needs to be a distinction between elements of advice and counselling which intrinsically require HIV specialism and those which could be delivered by generic services if they were competent around HIV-related issues.

The consultation indicates that generic services such as Law Centres, CABs, and specialist advice agencies such as Every Pound Counts will provide advice and support around HIV-specific matters such as long term condition management, adherence support, support with disclosing status, dealing with stigma, or advice on how to have sex safely. Even stating the proposition so baldly demonstrates at once

[6] HIV in the UK: Change and Challenges; Actions and Answers, The People Living With HIV Stigma Survey UK 2015 National findings, 2016

how impossible and inappropriate that would be. More work is needed to distinguish elements of advice, information and counselling which are inherently HIV-specific and those elements which genuinely over time could possibly be delivered by generic providers. It is vital that HIV-specific advice, information and counselling remain in place.

The reason even more generally applicable advice and counselling have historically been provided by specialist providers is of course the prevalence of HIV stigma. This has not gone away. The recently published findings of the Stigma Index show that stigma and discrimination remain common and affect the ability to come to terms with a new diagnosis, contribute to feelings of social isolation (especially around fears of disclosing to friends and family who would otherwise be providing much needed social support) and to difficulties coping.

The same social stigma that increases the demand for HIV support services fuels the need for *specialist* service provision.

HIV specialist providers remain well placed to meet the needs of people living with HIV, having the nuanced and detailed understanding of the condition to deal sensitively with complex HIV issues and, most importantly, secure the trust and confidence of all people with HIV.

Any move to generic services needs to be gradual and planned – if done well it could be a model nationally of how to provide appropriate generic support for people living with HIV. I suspect, however, that these same generic services are themselves short of resources and ill-prepared for new service users and fresh competencies. It does not go down well among people with HIV for the move to generic services to be presented airily as 'de-stigmatising' when in fact it may mean nothing more than exposure to stigma.

Both consultations promise that generic services will be knowledgeable, competent and welcoming, in line with BHIVA's standard 9 on long term condition management, which states that "Services should be delivered by providers with appropriate expertise and competencies." However there is no information provided on how staff will be trained; what arrangements will be made to ensure that provision is appropriately private; or how confidentiality will be assured.

More detail and thought is needed from LSL on how generic services will be trained to support people with HIV, how access of people with HIV will be measured and monitored, what outcome measures would be agreed to demonstrate success of generic services in meeting the needs of people with HIV, and how experiences of people with HIV will be assessed.

The sudden end of key HIV services without any real vision for HIV-competent generic provision is not reassuring. And it is a missed opportunity to bring people with HIV and the HIV sector along with LSL in genuine service development and innovation.

Short term cuts do not relieve long term financial pressures

Specialised support services not only help to improve the well-being of people living with HIV, they can also promote adherence to HIV treatment and encourage partner

notification and partner testing, with consequent public health benefits and savings in relation to treatment costs.

These support services have an important role in preventing needs for more expensive assessed care and support the work of clinics in encouraging adherence to treatment which is important for people to stay well and to reduce transmission, maintaining an undetectable viral load.

NAT is very conscious of the financial pressures currently facing local authorities and know that savings are required. I do not, however, believe that the proposed cuts to key service elements of HIV support can be justified. I also strongly believe it is a false economy which will end up placing increased costs on local services. The costs of such action will be felt -

- in increased serious ill-health as people with HIV fail to engage as effectively with healthcare or adhere to medication,
- in greater local rates of HIV transmission as people with HIV remain infectious (not achieving a suppressed viral load) and have difficulty maintaining safer sex,
- in increased unemployment as they lack the support to remain in work or the expert advice to prepare for and apply for jobs,
- in poorer mental health as they lack the counselling to deal with depression and anxiety, and
- in social isolation and family/relationship breakdown as issues of stigma and disclosure remain unresolved.

Consultation process

I have significant concerns about the consultation process. In the consultation specifically dealing with HIV support services, you have asked for responses only from people who have used services provided by Metro, Positive Parenting and Children, or Terrence Higgins Trust. In so doing you have actively excluded responses from those who have as yet chosen not to use these services, or those who are not service users but whose lives may be affected by the proposed changes to services (such as a family member of an HIV specialist support service user), or indeed people who were unaware of such services but are nevertheless local residents living with HIV.

Further, the initial survey questions strongly imply that respondents should be people who have used these services within the last 12 months (if these are simply identifying questions they should be at the end of the survey along with the other identifying questions). This implication is a barrier to inclusion of people who have not accessed services within the last year. We know that many people living with HIV only need to access support services at key moments in their lives, rather than routinely.

By effectively excluding these groups from your survey you will not receive complete information on the full impact of the service cuts that you are proposing.

A consultation survey such as this (especially given the limitations I have cited) cannot substitute for the councils' legal obligation to undertake a needs assessment of local people living with HIV which can feed into, or be part of, the Joint Strategic

Needs Assessment (JSNA). I am not clear that such a needs assessment has been done. It would involve close liaison with the HIV clinics which local residents attend, both to get detailed evidence around psychosocial needs, for example, as well as appropriate means to contact the wide range of LSL residents being seen for HIV care.

Before any changes to services are made, a full evidence based assessment should be made of the needs of people living with HIV who use the services in Lambeth, Southwark and Lewisham.

Furthermore, HIV is a disability (under the Equality Act 2010) and people with HIV are disproportionately from gay and African communities. There is an equalities dimension to these services, linked to the Council's public sector equality duty, which needs to be taken into account before any decision on the future of these services is made. I am not aware whether as yet an Equality Impact Assessment has been done on these proposals, but it is vitally important that it is done and fully consulted on and discussed before any final decisions are reached.

There is no reference in either consultation to the fact that in Lewisham and Southwark the commissioner responsible for funding the HIV support services is, I understand, the local Clinical Commissioning Group. This is in my view entirely appropriate given how much of HIV support is in effect long-term condition management. I know that NHS budgets are themselves under immense strain but the argument around public health budget cuts made in the Lambeth consultation does not apply to NHS funding which is increasing in real terms. Lambeth needs to consider sharing of commissioning responsibility with Lambeth CCG as one way forward.

I am very conscious of the financial challenges facing Lambeth, Southwark and Lewisham, and I am not resisting any and every reduction in expenditure. However, the LSL proposals go beyond 'savings' to the total end of core elements of HIV support, and seem to make the case for such decommissioning on the basis that the services are either not needed or can be replicated by generic provision. I challenge both those two assumptions, and believe LSL need instead to model how, even in a time of financial strain, necessary provision can be maintained. A decision to end key HIV support services in the local authorities with the highest HIV prevalence in the country will send a profoundly harmful national message and I urge you to think again and work with people with HIV locally, clinicians and the HIV voluntary sector to achieve innovative solutions.

I look forward to hearing from you.

Yours sincerely

Deborah Gold
Chief Executive

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Healthier Communities Select Committee		
Report Title	**Public health savings consultation**	
Ward	**All**	**Item No. 5**
Contributors	**Executive director for community services**	
Class	**Part 1 (open)**	**Date: 28 June 2016**

1. **Summary and Purpose of the Report**

The purpose of this report is to ask the Healthier Communities Select Committee (The Committee) to review the report attached as Appendix 1 for Mayor & Cabinet on July 13th 2016.

The report in Appendix 1 outlines a range of consultation activity for proposals to realise savings agreed by Mayor and Cabinet on September 30th 2015, and to balance the reduction to the Public Health grant announced in the 2015 spending review.

2. Recommendations

2.1 The Committee is recommended to review, note and comment upon the consultation plans relating to health visiting and school nursing, preventative health, sexual health and substance misuse services in the report attached as Appendix 1.

3. Legal Implications

3.1 The Health and Social Care Act 2012 ("the Act") sets out the Council's statutory responsibilities for public health services. The Act conferred new duties on the Council to improve public health. The Council has a duty to take such steps as it considers appropriate for improving the health of people in its area.

3.2 Under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 ("the Regulations"), where the Council has under consideration any proposal for a substantial development of health services or substantial variation in the provision of such service the Council must consult. This applies only to the 0 – 19 services.

3.3 The Healthier Communities Select Committee has the scrutiny function under the Regulations. The Committee may review and scrutinise any matter relating to the planning, provision and operation of the health service in its area. The Committee may make reports or recommendations which must include an explanation of the matter reviewed or scrutinised, a summary of the evidence considered, a list of participants in the review and scrutiny and an explanation of any recommendations on the matter reviewed or scrutinised. Where a request for a response is required, the Council must respond within 28 days of the request.

3.4 Following consultation, the Committee may refer to the Secretary of State where it is not satisfied that consultation on a proposal has been adequate in relation to content or time allowed; where the Committee is not satisfied that the reasons given by the Council are adequate; or where the Committee considers that the proposal would not be in the interests of the health service in its area.

4. Financial Implications

4.1 The financial implications are as laid out in section 8 of the report attached as appendix 1

5. Crime and Disorder Act Implications

5.1 The Crime and Disorder act implications are as laid out in section 10 of the report attached as appendix 1

6. Equalities Implications and human rights

6.1 The equalities and human rights implications are as laid out in section 11 of the report attached as appendix 1

7. Environmental Implications

7.1 There are no environmental implications.

8. Conclusion

8.1 This report attached as Appendix 1 lays out a range of consultation activity on proposals to realise the savings agreed by Mayor & Cabinet on September 30th 2015, and to balance the reduction to the Public Health grant announced in the 2015 spending review. The report seeks Mayor & Cabinet approval to conduct this consultation activity.

8.2 The Committee is recommended to review, note and comment upon the consultation plans relating to health visiting and school nursing, preventative health, sexual health and substance misuse services in the report attached as Appendix 1.

8.2 Consultation will be carried out in the different areas as laid out in the report attached as Appendix 1, and the outcomes will be reported to the Healthier Communities Select Committee on the 13th of September 2016 before proposals are taken to Mayor & Cabinet 28th September 2016.

MAYOR AND CABINET		
Report Title	**Public health savings consultation (draft)**	
Key decision	**Yes**	**Item No.**
Ward	**All**	
Contributors	**Executive director for community services**	
Class		**Date: 13/7/16**

1. **Summary and Purpose of the Report**

The purpose of the report is to seek Mayor & Cabinet approval to consult on a range of activity to realise the savings agreed by Mayor & Cabinet on September 30th 2015, and to balance the reduction to the Public Health grant announced in the 2015 spending review

2. Structure of the Report

2.1 The report is structured as follows:
Section 3 sets out the recommendations.
Section 4 sets out the policy context
Section 5 sets out the background
Section 6 sets out the consultation areas:
6.1 preventative health services
6.2 health visiting and school nursing
6.3 sexual health services
6.4 substance misuse
Section 7 sets out procurement arrangements
Section 8 sets out the financial implications
Section 9 sets out the legal implications
Section 10 sets out the crime and disorder implications
Section 11 sets out the equalities implications
Section 12 sets out the environmental implications
Appendix 1 Lewisham's 9 health and wellbeing priorities
Appendix 2 2016-17 allocation of the Public Health grant
Appendix 3 the Public Health Outcomes Framework
Appendix 4 Public Health England's grant reduction letter to local authorities
Appendix 5 Substance misuse Joint Strategic Needs Assessment (JSNA)

3. Recommendations

3.1 Mayor and Cabinet is recommended to approve:

- The consultation activity for preventative health services outlined below following consideration by Healthier Communities Select Committee on 28th June 2016.
- The consultation activity for health visiting and school nursing services outlined below following consideration by Healthier Communities Select Committee on 28th June 2016.

- The consultation activity for substance misuse services outlined below as following consideration by Healthier Communities Select Committee on 28th June 2016.
- The consultation activity for sexual health services outlined below following consideration by Healthier Communities Select Committee on 28th June 2016.

4. Policy Context

4.1 The services within this paper meet the two key principles of the Lewisham's Sustainable Community Strategy 2008-2020:

- Reducing inequality – narrowing the gap in outcomes for citizens
- Delivering together efficiently, effectively and equitably – ensuring that all citizens have appropriate access to and choice of high-quality local services

4.2 These services also contribute to the following priority outcomes:

- Safer – where people feel safe and live free from crime, antisocial behaviour and abuse
- Empowered and responsible – where people are actively involved in their local area and contribute to supportive communities
- Healthy, active and enjoyable – where people can actively participate in maintaining and improving their health and well-being

4.3 The services in this report support the council's corporate priorities of:

- Community Leadership and empowerment- developing opportunities for the active participation and engagement of people in the life of the community
- Caring for adults and older people- working with health services to support older people and adults in need of care
- Active, healthy citizens- leisure, sporting, learning and creative activities for everyone

4.4 The Health and Well Being Strategy 2012/22 has been developed by Lewisham's Health and Wellbeing Board (HWB) and sets out the improvements and changes that the board, in partnership with others, will focus on to achieve the board's vision of achieving a healthier and happier future for all. Sexual health, preventing the uptake of smoking among children and young people and reducing the numbers of people smoking, reducing alcohol harm and promoting healthy weight are all priorities identified in the Health and Well Being Strategy.

4.5 Sexual Health is an important public health priority at both a national and local level. Lewisham continues to experience high demand and need for sexual health services reflected as high rates of teenage pregnancy, abortion and sexually transmitted infections.

4.6 Although smoking prevalence has reduced there are higher rates of smoking in Lewisham than London and England. More than 1 in 5 of the adult Lewisham

population are smokers and 1 in 4 people in routine and manual occupations still smoke. There are currently about 50,000 adult smokers in Lewisham with a high proportion who are heavily dependent, such as pregnant women, people with long term conditions and people with mental health problems. Smoking is a contributory factor to the main causes of death in Lewisham and it is the single largest factor associated with health inequalities. Smoking is responsible for half the difference in life expectancy between Lewisham's richest and poorest residents.
Forty eight percent of Lewisham school children said they lived in a household with a smoker[1] and Lewisham's asthma admission rates for children are significantly higher than England.

Lewisham has a higher proportion of smoking related hospital admissions and early deaths due to smoking. Babies and children exposed to a smoky atmosphere are more likely to need hospital care in the first year of life. Passive smoking can put children at an increased risk of sudden infant death syndrome (SIDS), developing asthma or having asthma attacks when the condition is already present, middle ear infection, and coughs and colds. In households where mothers smoke, for example, young children have a 72% increased risk of respiratory illnesses.

The estimated local societal cost of smoking for Lewisham is £73.4m each year, and passive smoking costs a further £1m annually, including £9m on healthcare and £4m on social care directly attributable to smoking.

4.6 Lewisham's Children and Young People's Strategic Partnership vision is: "Together with families, we will improve the lives and life chances of the children and young people in Lewisham". This is achieved through a focus upon closing the gaps in outcomes achieved by our children and young people and agreement to ensure that children's and families' needs are prevented from escalating and are instead lowered. The ideal is for all children and young people to require only universal services and where further support is needed this should be identified and provided as early as possible.

4.7 The National Drug Strategy 2010 puts a key focus on recovery. Whilst recognising that recovering from dependent substance misuse is an individual person-centred journey, there are high aspirations for increasing recovery outcomes. Drug and alcohol recovery systems are increasingly being geared towards the achievement of the following outcomes:

- 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
- The capacity to be an effective and caring parent

4.8 The National Alcohol Strategy sets a range of outcomes intended to:

[1] School Health Education Unit survey

- Ensure everyone is aware of the risks of excessive alcohol consumption and can make informed choices about responsible drinking; and
- Recognise that some people will need support to change their behaviour and ensuring that this is available, particularly for the most vulnerable in our communities.

4.9 There are an estimated 43,432 high risk & increasing risk drinkers in Lewisham. The rate of hospital admissions for alcohol related harm is higher In Lewisham than England and increasing at a faster rate.

4.10 Reported obesity rates among adults in Lewisham show a steady upward trend with 60% of adults with excess weight (obese and overweight) in 2014. This equates to 53,000 people with a BMI above 30 (obese) and 137,500 people with a BMI above 25 (excess weight). Estimated prevalence of morbid obesity (BMI above 40) is 2.5% (5000 people). Nationally obesity is projected to increase from 29% in 2015 to 32% in 2020 and 41% in 2035, with prevalence projected to rise most markedly from the lowest income groups. If current trends continue 72% of the adult population would be predicted to be overweight or obese by 2035.

4.11 In Lewisham childhood obesity rates remain significantly higher than the England rate with a quarter of children in Reception (age 4-5) and over a third of children in Year 6 (age 10-11) being overweight or obese. Maternal obesity is a risk factor for childhood obesity and nearly half of women are overweight or obese at their booking appointment. It is estimated that there are over 8,500 children at risk of obesity in Lewisham with over 900 children identified each year through the National Child Measurement programme.

4.12 Obesity prevalence is associated with socioeconomic status with a higher level of obesity found among more deprived groups.

5. Background

5.1 The Health and Social Care Act (2012) transferred the bulk of public health functions to local authorities. The Council is responsible for delivering public health outcomes through commissioning and building partnerships within the borough, region and city.

5.2 In September 2015 Mayor & Cabinet approved £2m of savings by 17/18.In the Spending Review and Autumn Statement 2015 the government announced cuts to public health services. For Lewisham this has resulted in a grant reduction of £2.7m by 2017/18. The Council therefore needs to save £4.7m by 1 April 2017.

5.3 At its meeting on 26 November 2014, Council agreed to set up a time limited Public Health Working Group to operate until the end of February 2015 to consider the proposals to change public health services being proposed as part of the Council's budget process for 2015/16. This was intended to make a contribution to the Council's debate about the future of public health services in Lewisham and reported in February 2015

5.4 This report describes the consultation activity needed to achieve the necessary level of savings.

6. Consultation areas

6.1 Preventative health services

6.1.1 The Council currently commissions a range of preventative health services to support behaviour change in residents at high risk of ill health and reduce health inequalities, including smoking, eating, physical activity and wellbeing. These are delivered in partnership with local healthcare and voluntary sector providers, and have a total value of £2.1m. These services are in addition to broader policies which promote health such as those relating to the environment and the regulation of supply.

- The Lewisham Stop Smoking service is an addiction treatment service, which assists dependent smokers to quit and is delivered by Lewisham and Greenwich Healthcare Trust for £461,000 per annum with a further £240,000 of medication costs. Last year 1297 people quit smoking through a combination of a specialist team and primary care provision though GPs and pharmacies. The primary role of the Stop Smoking Service is to deliver high quality, evidence-based stop smoking interventions to dependent smokers living in Lewisham. This includes a more intensive service for highly dependent smokers provided through group and one to one sessions, and support for moderately dependent smokers through GPs & pharmacies including a hub based model in each neighbourhood. This service is primarily targeted at heavily dependent smokers, including pregnant smokers, smokers with mental health problems and smokers with long term conditions. This service has recently been redesigned due to a 30% reduction in funding from the Council in 2015/16.

- The Community Health Improvement Service is delivered by Lewisham and Greenwich Trust for £571,518 per annum to provide a range of health promotion activities targeted at those with poorer health outcomes. It provides behaviour change and healthy lifestyle support through: a lifestyle hub delivering motivational interventions and referrals to 950 people identified as at risk following an NHS Health check; Health Trainers providing one to one and group motivational interviewing and lifestyle coach support to 300 people (over 80% of those supported by the service sustain behavioural change after 24 weeks) and the Healthy Walks programme, which trains walk leaders, develops, promotes and ensures regular health walks to increase participation and uptake of physical activity (200 new walkers per annum and just under 600 regular walkers). It also engages, develops and empowers communities through community development for health improvement and neighbourhood based activities including outreach, participatory budgeting/small grants, networks, negotiating and developing referral pathways into preventative lifestyle activities and interventions, and linking providers of preventative initiatives with community groups (reaching at least 500 people per year).

- The £400,000 per annum NHS Health Check programme is commissioned to identify 40-74 year olds with a high risk of developing cardiovascular and other conditions. This includes direct commissioning of health checks provided by GPs, pharmacies and To Health (outreach); a call/recall system (every 5 years) and IT. This is a mandatory programme, assessing risk and facilitating early intervention. More than 6,000 Health checks were conducted in Lewisham last year.

- The Breastfeeding Network project manages the community breastfeeding groups and provision of a breastfeeding peer support service for £48,895 per annum. This includes training 24 new breastfeeding peer supporters and providing on-going supervision to all active volunteer peer supporters (around 30). The peer supporters support mothers attending the community breastfeeding groups and on the postnatal ward (total 1200 hours of volunteer time per annum). The community breastfeeding groups support 900 new women a year.

- MyTime Active deliver a children's weight management programme (MEND) for £230,000 per annum. The service delivers a range of age-specific evidence-based family interventions for 375 overweight and obese children. The service includes specialist support (dietician, psychologist and physical activity specialist) for obese children with co-morbidities or with complex needs (180 children per annum). The service also delivers a range of bespoke workforce training sessions (100 staff per annum). The children's weight management service supports the mandatory National Child Measurement Programme which identifies that Lewisham has consistently high prevalence of childhood obesity.

- Weightwatchers deliver 795 adult weight management interventions at a cost of £42,930 per annum. This entitles individuals that are overweight or obese (BMI of 28 or more) to attend 12 weeks of Weight Watchers meetings and access 16 weeks online support free of charge. The service has shown successful outcomes with 54% of clients completing the programme and 91% successfully losing weight.

6.1.2 **Proposal**: The Council will consult on delivering savings of £800k, which will be achieved through a combination of re-commissioning, redesign and potential termination of some services across the areas outlined below. These proposals have been drawn up with an emphasis on effectiveness in terms of outcome and increased alignment between services and pathways to reduce costs.

1) Savings from the Stop Smoking Service:

The Council will be consulting on re-design and potential re-commissioning incorporating different delivery models including a greater use of digital and telephone support for less heavily dependent smokers; face to face support from specialists for heavily dependent smokers such as pregnant women, smokers with mental health problems and/or long term conditions and more efficient and effective prescribing of stop smoking medication. The number of smokers able to access the service is likely to reduce.

2) Savings from the Community Health Improvement Service (CHIS):

To deliver this saving the Council will be consulting on a significant reduction including potential reconfiguration or removal of the services currently delivered by CHIS:

Removal of the health trainer programme could be mitigated by the new community nutrition and physical activity service delivered by GCDA and commercial weight management (e.g. weightwatchers vouchers).

Delivering the community development element differently, for example by re-focusing the council and local voluntary sector's community development resource across all four neighbourhoods.

An alternative referral model for NHS Health checks, for example through redesign of the lifestyle hub function or potentially through re-commissioning the NHS Healthchecks programme

Priority will be given to supporting emerging neighbourhood delivery models and alignment with wellbeing community development programmes such as Well London, which is an external funding stream.

3) Savings from the children's weight management service:

The Council will consult on integrating through investment into a new contract for school nursing. This would require serving notice on the existing service.

The Council will also consult on potential removal of the specialist element of the service**:** in this scenario children with complex needs would be offered the core programme in the same way as other children. The service will provide a limited range of age-specific targeted programmes with focus on children under the age of 12 with a reach reduced to under 200 families.

4) Savings from the breastfeeding support service

To deliver this saving the Council will consult on incorporating this service within a new contract for health visiting. This would require serving notice on the existing service.

5) Savings from the NHS Healthchecks programme

The Council will consult on redesign and potential re-commissioning of the programme, including different delivery models for follow-up for those identified as at risk following an NHS Health check. We are aiming for a better integrated pathway, targeting of at risk populations and more effective follow-up for those identified as at risk.

6.1.3 **Consultation Plan:** The Council will consult with the public, service users and stakeholders from July to September on the options and priorities outlined above.

The Council will conduct online engagement through Uengage with the public and users of the different services. We propose to outline the financial challenge and need to reconfigure services differently and ask a number of questions in order to:

a) Identify service areas which are considered priorities
b) Obtain views on different ways in which services could be accessed with less or no funding for that area
c) Obtain views on how the council could facilitate this

The Council will consult with fellow health commissioners on each proposal area for savings. We propose to outline the financial challenge and ask:

1) What impact the proposals might have on the ability of partners to commission and deliver services
2) Are there any commissioning plans, service reconfigurations in partner organisations which may impact on the ability of the council to deliver the savings proposed
3) Are there any further mitigating actions which partners could suggest which may support the Council to minimise any adverse impact of the proposals without incurring additional costs.

The Council will consult healthcare partners and expert stakeholders through Uengage and an engagement event to allow them to consider-

1) What health impact will proposals have on residents and how might these be mitigated
2) What impact proposals will have on partners
3) What alternative models or proposals might allow the Council to deliver the required savings with a lesser impact

The Council proposes to work with Healthwatch Lewisham and consult existing neighbourhood health forums and other relevant organisations with a health interest.

6.1.4 Timetable

Preventative health services timetable
Consultation plans to healthier communities select committee 28/6/16
Consultation approval at Mayor & Cabinet 13/7/16
Approved further consultation starts w/b 18/7/16
Consultation outcome to healthier select 13/9/16
Mayor & Cabinet for approval to procure 28/9/16
Issue tender documentation 14/10/16
Tender evaluation w/b 21/11/16
Award Mayor & Cabinet (contracts) 7/12/16
Potential overview and scrutiny 21/12/16
Mobilisation (and any TUPE) for service start 1/4/17

6.2 Health visiting and school nursing

6.2.1 Over the last six months, Lewisham's Children and Young People joint commissioning team, in common with many other local authorities, has begun to review the services and pathways between some of the core universal and targeted services for children and families. In particular, the focus has been on a review of public health nursing functions (health visiting and school nursing) and how these align with children's centres.

6.2.2 **Overview of Current Services**:

- ***Health visiting*** - provides public health services for children aged 0 to 5, including a universal health review service in line with the Healthy Child Programme for children aged up to 2 ½ years, alongside targeted work for vulnerable families. The service costs £7.35m per annum and is provided by LGT.

- ***School nursing -*** provides support to school age children including specific support for children with particular health conditions and 1:1 support including safeguarding and early help. The service is also responsible for the delivery of the National Child Measurement Programme. The total cost of the service is £1.75m per annum and is provided by LGT.

- In addition, our ***children's centres*** provide universal and targeted services for children and families covering health and general welfare via a range of community and school based buildings. These are delivered across 16 sites in a mixed provider model and contracts cost £1.8m per annum.

6.2.3 There are already some strong links between the three services through informal co-location and, in some areas, joint delivery of children's centre services and health visiting.

6.2.4 The following factors have prompted a review of services:

- The annual spending review announcements on the public health grant mean the council will have a reduction in income of £2.7m by 17/18; Mayor and Cabinet approved £2m of savings by 17/18. Assuming pro-rating of savings, CYP will need to save £2m from health visiting and school nursing services.

- Levels of need are rising due to a sustained rise in birth rates (now c. 5,000 per year) and an increase in the number of children and families identified as vulnerable. Currently there are 2,000 children on our health visiting targeted caseload and 400 children subject to child protection plans in Lewisham.

- The Council's current contracts for school nursing, health visiting and children's centres are all due for recommissioning in April 2017.

6.2.5 There are also key opportunities for change:

- ***Changes to commissioning and statutory arrangements for health visiting*** – from 1st October 2015 responsibility for commissioning health visiting services passed from CCGs to local authorities. The transfer was made on a 'lift and shift' basis with local authorities mandated to deliver the five health child programme reviews. From April 2017, this mandation will be lifted (unless new legislation is passed) enabling authorities to review the effectiveness of current pathways and to specify a service which is relevant for their local populations.

- ***Redesign of our early help offer*** – the local authority is currently reviewing its early help pathway in line with the recommendations made by Ofsted. This includes recommissioning family support services and moving towards a single point of access model for social care referrals to allow better co-ordination of the pathways

for parents requiring additional support. There is an opportunity to consider how public health and children's centre services fit within this model.

- ***Our Healthier South East London*** – Lewisham CCG are currently reviewing the way in which they provide services to identify opportunities to deliver more health services in community settings via neighbourhood care network models. The Council has an opportunity to consider how children's centres might act as a core hub for the neighbourhood care network model.

6.2.6 Between January 2016 and June 2016 an initial review of existing health visiting and school nursing services was carried out by a project team comprising officers from CYP commissioning, Early Intervention and Public Health. The review aims were to get a clear understanding of the current service delivery models and costs including key pressures, impact and effectiveness of interventions. Officers also aimed to engage partners and service users in shaping a new model for more integrated services.

6.2.7 Between February and June 2016 the project team completed the following consultation exercises:-

- Engagement through meetings and two half-day workshops with service managers and staff from across current commissioned services on current models and opportunities for change.
- Activity Based Costing exercises across health visiting, school nursing and Children's Centres' staff
- Engagement with other London local authorities who are redesigning their health visiting and school nursing services, including visits with our existing provider to Hackney, meetings with several other London local authorities, and participation in two workshops on the future of 0 to 5 years' services organised by the London Councils.
- Engagement with key stakeholders (including members, schools, voluntary sector, LGT, and SLAM) through the CYP Strategic Partnership Board and the Joint Commissioning Group.

6.2.8 In addition, officers have undertaken direct service user consultation with parents and young people. This included a six-week online survey for parents and a six-week online survey for young people. Officers also interviewed parents in children's centres over two half days. The surveys and interviews asked questions about current services and expectations, priorities for what services should be delivering in future, and opportunities for change.

6.2.9 The surveys were distributed via health visitors and schools, as well as cascaded through local organisations such as Lewisham Youth Service; HealthWatch Lewisham; Young Mayor's and Advisors; Mummy's Gin Fund; and Voluntary Action Lewisham.

6.2.10 176 responses were received to the survey, 95% of which were from mums and 5% from dads; 13% had a child with special educational needs; 79% were white and 71% had a child aged five or younger. 19 mothers and 1 father took part in semi-structured interviews when officers attended children's centres.

6.2.11 ***Key findings from service mapping work***

All three of these core services form a critical part of our Early Help offer across the borough. Together they provide:

- Early identification of need in a range of settings: home (health visiting), community (children's centres) & school (school nursing)
- Targeted support for both children and parents, preventing poor outcomes in health and preventing the escalation of need to social care.
- The physical infrastructure for parents and children to meet and develop in a safe environment and spaces for professionals to come together to deliver services jointly.
- Universal health services – i.e. immunisations and targeted health interventions (i.e. disability care plans)
- Core safeguarding function for our most vulnerable young people.

The provision of all of these functions will continue to be a critical part of the Council's early help offer locally in the future. However, there are some opportunities/requirements for change which will influence ***HOW*** these services are delivered in the future to maximise efficiency, reduce duplication and improve pathways.

6.2.12 ***Key findings from consultation work***

- There was significant overlap between the role that parents felt health visiting and children's centres should play, with the additional emphasis on the role of children's centres in providing space for parents to meet.

Health visiting	Children's centres
• Support for mother and baby, and the family • Ensure baby and mother are healthy • Reassurance • Morale and Emotional Support • Make referrals • Health Checks • Breastfeeding support and other evidence based advice	• Pre-school activities • Parenting Advice • Support for breastfeeding and weaning • Place for carers and parents to meet, reduce isolation • Free Support • Warm and welcoming environment • Provide English support

- For school nursing, young people responding said that the key areas they wanted support on from a school nursing service were: sexual health, mental health and drugs and alcohol. For parents responding, there was a greater emphasis on the role of school nurses in supporting physical health and minor illness. Officers asked about the role of online services; whilst young people responding were positive about this, parents said they preferred a face to face service.

- Officers gave respondents an opportunity to tell officers about their priorities and opportunities for change. The majority of responses focused on health visiting and children's centres which officers expect relates to the profile of respondents. The responses included:

    - The important role of children's centres as multifunctional spaces for both the parents and child.

    - Opportunities to deliver health visiting and children's centre services together. Examples of good practice like Bellingham Children's Centre were cited.

    - Making the children's centre offer clearer to parents

    - Improving consistency of messages to parents, particularly for the health visiting service

    - Increasing the number of visits for parents who had less family or friend support in the early years.

6.2.13 **Proposals**

The following are areas identified from the work above as possible areas for redesign when services are recommissioned:

6.2.14 ***Health visiting***

- Accelerating existing integration between health visiting and children's centres so that parents in need have a single integrated core offer.

- Delivering some universal health visiting reviews in groups from children's centres for parents who are able to access services in this way.

- Reducing duplication across services (maternity, health visiting and children's centres) so that families do not receive multiple visits across service pathways.

- Remodelling our health visitor clinics to ensure that supply matches demand and delivering more of these clinics from children's centres.

- By delivering services to the universal caseload in a more streamlined way, create the capacity for a greater role for health visiting in supporting the targeted caseload.

6.2.15 *School Nursing*

- Continue with a core school nursing service to deliver safeguarding, school entry health checks, screening, and the National Child Measurement Programme. Ensure that this service is integrated with specialist weight management support.
- Consider whether there is scope for commissioning an additional specialist support service for secondary schools to enable young people to have access to areas of unmet need including support and advice on sexual health, mental health, and drug and alcohol misuse.
- Consider the use of online channels for young people to access some support services.

6.2.16 *Consultation Plan*

The consultation exercise to date has provided valuable insight into current services and opportunities for change and has enabled the project team to develop some high level options for change.

A second phase of consultation is now planned with providers, stakeholders and service users to inform the development of service specifications for the recommissioning of new services from April 2017.

The feedback from consultation so far has highlighted the importance of aligning services with children's centres. We will continue to explore this through further consultation and build this into the children's centre re-commissioning which runs to the same timescale as the health visiting and school nursing services.

6.2.17 **Proposed consultation areas**

The key focus for this phase will be based around the following questions:

- What a more integrated health visiting and children's centre offer might look like in practice
- Which services should be delivered jointly or co-located?
- How can the Council utilise groups effectively to deliver health visiting support?
- How can the Council reduce duplication across services and pathways?
- What is the role for children's centres within the neighbourhood care network model?
- What an effective single pathway for targeted 1:1 support for families should look like across children's centres and health visiting.

- How an integrated 1:1 support offer for children and young people could work in practice, including the role of online channels.

6.2.18 **Consultation timetable**

The proposed timescale for consultation activities in order to meet our April 2017 implementation date for new contracts is set out below:

Activity	Timing
Second phase of consultation to inform proposals: • CCG governing body, CCG membership forum (August) • GPs – four GP neighbourhood meetings (June and July)and online survey for GPs • Teachers - Primary and Secondary Heads strategic forums (June/July), teachers' working group, and online survey for teachers (July) • Meetings with children's centre providers, maternity service managers, and community children's services (LGT) (July) • Meeting with Healthwatch (July) • Further online surveys for parents, carers and young people (July/August)	**June to August 2016**
Development of final proposals and Equalities Analysis Assessment	**July & August 2016**
Report on consultation to healthier select committee	**13th September 2016**
Final savings and redesign proposals presented to Mayor and Cabinet	**28th September 2016**
Development of specifications and tender documentation for new service models: • Workshops with key stakeholders and providers • Market testing • Developing tender documentation	**September – October 2016**
External tender process	**October-December 2016**
Tender evaluation and contract award	**December-January 2016**

6.3 Sexual Health

6.3.1 Sexual Health commissioning moved to Local Authorities in 2013/14 following the implementation of the Health and Social Care Act. Budgets for sexual health services, were amalgamated into the public health grant and were based on previous expenditure in PCTs.

6.3.2 Genitourinary Medicine Services (GUM) and Contraception and Sexual Health services (CaSH) are statutory services. They are “open access” which means that residents are entitled to use them in any part of the country without the need for a referral from GP or other clinician. This accessibility requirement impacts on the ability of all Councils to predict service demand and manage budgets.

6.3.3 In Lewisham sexual health services are provided through:

- 4 Contraception and Sexual Health (CaSH) clinics which offer a full range of contraception and sexually transmitted infection (STI) services (2 of which are targeted at under 25s) – (46,760 attendances in 2015/16)
- A specialist GUM clinic at the Waldron (5,176 attendances in 2015/16)
- A website www.checkurself.org.uk offering chlamydia and gonorrhoea screening for 16-24 year olds (886 screens in 2015/16)
- GPs providing contraception, condoms, pregnancy testing, HIV testing and STI testing and treatment
- Pharmacies providing free emergency contraception and chlamydia and gonorrhoea screening.

6.3.4 Lewisham sexual health services are used by residents of neighbouring boroughs (with the exception of GP services which are limited to their registered patients), and Lewisham residents also access services in other boroughs.

6.3.5 Only the GUM elements of cross border flows are currently cross charged (online services are billed to the borough of residence). The CaSH contract is negotiated annually as a fixed contract value between Lewisham and Greenwich NHS Trust and the Council. The value of CaSH element of this contract in 2016/17 will be £3.2m. The value of GUM across is likely to be £2.5M, but is dependent on activity levels. In 2015/16 The Lewisham and Greenwich NHS Trust GUM element was £0.5M.

6.3.6 Case for Change

6.3.7 In London there has been significant growth in GUM activity over the last 5 years. This has been driven by a young and increasingly diverse London population, with high rates of STIs and increased demand for services. Between 2014/15 and 15/16 Lewisham saw a 22% rise in GUM activity.

6.3.8 Due to the nature of the cross charging arrangements for GUM, individual boroughs are unable to manage demand and therefore costs of sexual health services independently of other London boroughs. Lewisham residents access specialist Sexual Health (GUM) services across London including in central London clinics at Guys and St Thomas's, Kings College Hospital and Chelsea and Westminster NHS FT as well as local provision provided by Lewisham and Greenwich NHS Trust.

6.3.9 The increase in demand for services combined with the reduction in the public health grant has led to collaboration across London on sexual health commissioning and the development of the London Sexual Health Transformation Programme. The programme sets out a case for change and a new model for sexual health services. An overview of these proposals was brought to Mayor and Cabinet (contracts) on 21 October 2015.

6.3.10 Proposals

6.3.11 The key components of the new London service model are:

- Increase existing online STI testing and sexual health information offer
- Increase in primary care pharmacy and GP sexual health service provision
- Reduction in the number of highly specialised services across London achieved through improving access to STI testing for patients without symptoms
- Use of Integrated Sexual Health Tariff to finance for sexual health services.

6.3.12 One of the mechanisms to deliver savings across the sexual health system in London is the introduction of an integrated sexual health tariff (ISHT). This changes the way local authorities pay for sexual health services. It will remove the fixed contract value arrangement for CaSH services and the NHS tariff for GUM, and replace it with a sexual health tariff which can be cross charged between boroughs. The integrated sexual health tariff reflects the actual costs of delivering the patient care rather than an estimated crude average cost. This is a fairer way of paying providers for the services they deliver.

6.3.13 An example of how this might work is as follows:
A 20 year old female would like a chlamydia and gonorrhoea STI screen:
Currently the cost of this would vary depending where she goes to be screened:

- In a Lewisham CaSH service this would cost around £67
- In a GUM service in central London at Dean Street this would cost £157
- Online through www.checkurself.org this would cost around £16
- Under ISHT this would cost £48.57

In the first scenario Lewisham would be paying for the cost of the service regardless of whether the service user was a Lewisham resident. Under the ISHT (and the current GUM and online provision) her borough of residence would be charged for this service.

6.3.14 The 2015/16 projected spend for sexual health (GUM and CaSH) elements was £6.35M. The ISHT was modelled and showed an estimated charge for the same activity of £5.69M (10% reduction) in costs. Based on some projections and further refinement to the ISHT it has been estimated that this may save Lewisham Council

£0.5M in 2017/18. A considerable amount of due diligence and further audit has been carried out to try and ensure that the financial risk to commissioners is minimal.

6.3.15 As part of the recommissioning of sexual health services across London there is broad agreement that this (IHST) will be the payment mechanism for sexual health services from 1st April 2017. This change should have no impact on service users or service delivery. The new arrangement will be built into contracts from the 1st April 2017. This decision was delegated to officers at 21 October 2015 Mayor and Cabinet (contracts).

6.3.16 Lewisham is part of the SE London Sub region for the London Sexual Health Transformation Programme. The Lambeth Sexual Health Commissioning Team are working with existing NHS providers on the redesign of clinical services. The next step of this process is procurement of sexual health services for the SE London sub region will be undertaken over the next 6 months.

6.3.17 **Consultation to date**

6.3.18 As part of the London Sexual Health Transformation Programme a number of consultation and engagement exercises have been undertaken. These include:

- A clinic user survey across 12 London GUM clinics including the central London clinics most frequently used by Lewisham residents (Feb 2015).
- Sexual Health clinician engagement events to inform the model of service provision
- A Clinical steering group to inform the development of the service specification, which includes expert clinical input from sexual health professional bodies.

6.3.19 There has been some local engagement on likely future service models including:

- Survey of Lewisham sexual health clinic users
- Public Health attending Lewisham and Greenwich NHS Trust Sexual Health Services staff meeting to discuss London Sexual Health Transformation Programme proposals
- Local SE London provider/ commissioner transformation meetings

6.3.20 **Planned Consultation**

6.3.21 The local proposals being consulted on are:

- Increased use of home testing/self-sampling for sexually transmitted infections through an online service
- Increased and more comprehensive offer of contraception and STI testing services offered by community pharmacies and GPs
- Service user and public views on the provision of specific services for young people (under 25).

6.3.22 A 6 week public consultation on proposals for sexual health services redesign has recently concluded in Lambeth and one is currently underway in Southwark. A similar exercise is being planned for Lewisham. Activities include:

- online questionnaire
- public meetings

- service users meetings and surveys
- provider and network meetings.

6.3.22 Following this consultation, a report with options and recommendations for commissioning across SE London will be taken through the LSL Sexual Health Commissioning Board. Once the final service model is agreed across SE London, Lewisham will undertake a procurement exercise either in partnership with Lambeth and Southwark, or independently depending on the outcomes and recommendations of the final commissioning report.

6.3.23 The SE London service model will be subject to further consultation and engagement with local partners. This would include as a minimum, service users, providers, GPs and pharmacists and their representative organisations, Lewisham and other SE London CCGs.

6.3.24 The authority to award the contract for new GUM and CaSH services was delegated to the Director for Resources and Regeneration at the Mayor and Cabinet (Contracts) meeting of 21 October 2016.

6.4 **Substance Misuse**

6.4.1 Substance (drug and alcohol) misuse provision differs from other aspects of this paper in that it has been commissioned by the local authority since 2000 and did not form part of the Public Health transfer in 2012

6.4.2 The commissioning and procurement of these services has been undertaken several times during that period with Mayor and Cabinet agreeing the current contracting arrangements in 2009 and 2014

6.4.3 The Public Health grant contributes £4,402,100 to the overall treatment budget of £4,913,100 for 2016/17, with a further £511,000 coming from the Mayor’s Office for Policing and Crime (MOPAC) in recognition of the links been substance misuse and crime. At the time of writing it is unclear whether MOPAC funding will be available from 2017/18. This report therefore outlines proposals for a £500,000 saving should MOPAC funding be retained, and a £1,011,000 saving should this cease.

6.4.4 The vast majority of the services are provided by charities who work with the council to align with the ambition of Public Health England (PHE) to reduce health inequalities and the Government's Drug and Alcohol Strategies to increase the number of individuals recovering from addiction. This partnership works to reduce drug and alcohol related offending as it is well demonstrated that cessation of drug use reduces re-offending significantly. This in turn will have benefits to a range of wider services and will help reduce harm in local communities.

6.4.5 In order to develop savings proposals regarding these services officers have undertaken significant activity to ensure that the remaining resources are correctly targeted and dedicated to meeting agreed priorities.

6.4.6 This has included the development of a detailed Joint Strategic Needs Assessment (JSNA) to establish the overall trends in local and national data, as well as examining performance data which gives an up to date picture of the activity with the local services. The development of the JSNA also included consultation with local stakeholders as well as a range of service user feedback. The full substance misuse JSNA is attached as appendix 5.

6.4.7 The findings of this work formed the basis of further consultation with service users and a range of stakeholders including:

- Public Health England
- Lewisham Clinical Commissioning Group
- Police
- National Probation Service
- Community Rehabilitation Company
- Lewisham Service User Council
- LB Lewisham Departments – Customer Services/Children and Young People

6.4.8 **Proposal**:

In light of findings from the JSNA, current performance data and service user views officers are recommending two scenarios subject to available funding. Overall these scenarios are intended to protect resources within the core and complex treatment service and the primary care service for both drug and alcohol users. These core services form the backbone of treatment services and offer economies of scale as well as significant resource to provide crucial clinical governance infrastructure required for high risk treatment work and links to the broader health service. The broad assumption is that it would be more effective to bolster these services to mitigate for the loss of smaller services rather than apply salami slice reductions across all services. The details of the scenarios are explored below:

Scenario A – MOPAC funding retained:

- Reduced investment in YP services due to poor levels of engagement and value for money.
- Decommissioning the REaL service due to poor levels of engagement and the existence of a significant pattern of mutual aid provision in the borough
- Increase investment in the PCRS service to create a mutual aid coordination role
- Re-procurement of the core contract with increased investment to recognise the increased demands from 18 – 25 year olds and the need for outreach to minority communities. The service would retain an IOM element although this would be remodelled
- A reduction in the commissioning team and general staffing overheads

Scenario B – MOPAC funding withdrawn

- Reduced investment in YP services due to poor levels of engagement and value for money.
- Decommissioning the REaL service due to poor levels of engagement and the existence of a significant pattern of mutual aid provision in the borough

- Increase investment in the PCRS service to create a mutual aid coordination role
- Re-procurement of the core contract with decreased investment. The service would no longer contain an IOM element but retain the capability to support court issued treatment orders
- A reduction in the commissioning team and general staffing overheads
- A reduction in the funding available for residential rehabilitation

6.4.9 *Reduced investment in YP services due to poor levels of engagement and value for money (Scenario A and B)*

- Despite increased investment from April 2015 the Young Persons service has failed to attract significant numbers of YP into treatment with the latest performance figures confirming a long term picture highlighted in the needs assessment. Current data shows that there has been a sharp decline in young people accessing drug services nationally.
- The increase in the upper age limit to 25 has also had little effect with only 37 over 18s and 46 over 21 year olds accessing the service during 2015/16
- The majority of the clients who do access the service do so for cannabis and alcohol use and the issues are often 'broadly social' rather than linked to a physical addiction
- In order to mitigate the impact of this closure officers are recommending that £200,000 be ring-fenced for investment to enhance the specialism in a new specialist 1:1 support service for secondary school age children, to be commissioned jointly with CYP as outlined above. This would allow for greater integration of drug and alcohol treatment with other services such as sexual health in order to focus on a range of risk factors. The service will deliver a range of interventions from training to direct support and would include closer liaison with schools and other educational services.
- Due to changing nature of substance misuse for young people (New Psychoactive Substances, Club Drugs etc.) and the limited uptake of the current offer the new service will need to ensure that it is fully integrated with other service offers and develops modern and responsive engagement techniques e.g. phone apps, Whatsapp groups and video appointments. We must have a flexible community delivery model, able to deliver at a range of venues dependant on the need of the young person. This should include the YOS, schools, home and other community venues.
- A dedicated resource should be made available to particular priority groups such as the Youth Offending Service and Looked after Children with a focus on one to one psychosocial interventions
- Officers are recommending that investment in core contracts is increased to cope with any demand from the 18-25 who would become eligible for the service.

6.4.10 It is important to note that this recommendation is no reflection of the quality of the work of Lifeline, who have delivered excellent interventions since the start of the service, but mirrors national patterns of YP drug use and service engagement.

6.4.11 *Decommissioning the REaL service due to poor levels of engagement and the existence of a significant pattern of mutual aid provision in the borough (Scenario A and B):*

- The needs assessment is relatively silent on the impact of aftercare but the most recent performance data shows that despite increased investment from April 2015, only 156 clients had accessed the service during 2015/16 and at the end of April 2016 there were 54 clients actively engaged within the service, 41 for alcohol recovery and 13 for drug recovery. This is against the 2015/16 Key Performance Indicator of 350 new starts.
- Given the level of saving required the service is not considered to represent sufficient value for money.
- Officers are confident that the needs of those leaving treatment can effectively be met through the comprehensive network of mutual aid groups in the borough – see table below. Mutual aid is typically provided outside formal treatment agencies and is one of the most commonly travelled pathways to recovery. Mutual aid groups come in different types, with the most widely provided being based on 12-Step principles, for example Narcotics Anonymous and Cocaine Anonymous. Other forms include SMART Recovery and locally derived peer support networks.
- Officers are recommending increased resource be made available to the Primary Care Recovery Service (PCRS) in order to build capacity and create an environment where these mutual aid services can flourish in line with the community development charter and workstreams.

Mutual Aid currently available in Lewisham

Monday:	**NA**	**11am**	**New Direction *410 Lewisham high street SE13 6LJ***
	NA	7pm	Deptford Salvation Army *MaryAnn Gardens SE8 3DP*
	AA	**4.30pm**	**Goldsmith College *Lewisham Way SE14 6NW***
	AA	8pm	All Saints Community Centre *105 New Cross Road, SE14 5DJ*
Tuesday:	**AA**	**6pm**	**New Direction *410 Lewisham High St SE13 6LJ***
	NA	1pm	PCRS Blenheim CDP *55 Dartmouth Road, SE23 3HN*
	NA	**6pm**	**PCRS Blenheim CDP (Women's Meeting) *55 Dartmouth Road, SE23 3HN***
	AA	8pm	The Grove Centre *2 Jews Walk, SE26 6JL*
	AL-NON	**12pm**	**The Crypt, St Mary the Virgin Church *346 Lewisham High Street, SE13 6LE***
Wednesday:	NA	11am	PCRS Blenheim CDP *55 Dartmouth Road, SE23 3HN*
	NA	**7.30pm**	**Forest Hill Methodist Church *Normanton Street, SE23 2DS***
	AA	8.15pm	Telegraph Hill Centre *Kitto Rd SE14 5TY*
	AA	**12pm**	**The Crypt, St Mary the Virgin Church *346 Lewisham High St, SE13 6LE***
Thursday	SMART	7.30 pm	'Friends & Families' New Directions *410 Lewisham High St, SE13 6LJ*
	AA	**8pm**	**Trinity United Reformed Church Stanstead Road, SE6 4XE**
	AA	1pm	St Andrews United Reformed Church *Wickham RD SE4 2SA*
	AA	**7.15pm**	**Armada Court Community Hall *21 McMillan St, SE8 3EZ***
Friday	NA	6pm	New Direction *410 Lewisham high street SE13 6LJ*
	AL-NON	**8pm**	**Friends Meeting House *34 Sunderland Road, SE23 2QA***
Saturday:	NA	6pm	New Direction *410 Lewisham High St SE13 6LJ*

	AA	**9.30pm**	**New Testament Church of God *141 Newland Park SE26 5PP***
	AA	1pm	St Marys Community Centre *69 Brockley Rise SE23 1JN*
	AA	**7.45pm**	**St James Hatcham Church *St James's, London, SE14 6AD***
Sunday	CA	9am	PCRS Blenheim CDP *55 Dartmouth Road, SE23 3HN*
	AA	**6pm**	**St Saviours Church *175 Lewisham High St, London SE13 6AA***
	AA	7.30pm	Kings Church *Catford Hill, London SE6 4PS*
	AA	**11am**	**Armada Court Community Hall *21 McMillan St, SE8 3EZ***

6.4.12 As with the YP service this recommendation should not be a taken as comment on the quality of the work delivered by REaL but rather a reflection of the budgetary pressures facing the authority and the fact that the borough is fortunately very well serviced by mutual aid groups.

6.4.13 *Increase investment in the PCRS service to create a community development role.* These coordinators would be based within the existing hubs and work across all 4 neighbourhoods. Part of this work would be to coordinate community development across the borough. *(Scenario A and B):*

- NICE clearly recommends that the benefits of these groups can be further enhanced if keyworkers and other staff in services facilitate contact with them, for example by making an initial appointment, arranging transport or possibly accompanying patients to the first meeting and dealing with any subsequent concerns. These interventions can be of benefit to a wide range of people at different levels of the care and treatment system. As such officers are recommending increased investment in the PCRS to deliver this support.
- It is important that this coordination function focuses attention on the south of the borough where provision is currently limited.

6.4.14 *Re-procurement of the core contract with increased investment to recognise the increased demands from 18 – 25 year olds, the need for BME outreach and to increase the offer for women.* The re-tendering of the Core Adult Contract is necessary under procurement rules as it has not been tendered since 2010 and will be subject to a competitive tender during 2016/17 with the new contract in place by 1st April 2017. Given the complexity of the clients seen by the core service no reduction in service provision is recommended with key features such as:

- Hospital Liaison Service - due to increasing numbers of hospital related admissions, particularly due to alcohol misuse
- Outreach Team – increase investment to target hard to reach groups and improve Lewisham's low penetration rate
- Dual Diagnosis – increase investment due to the increased complexities within this cohort.
- Harm reduction links to be maintained including BBV vaccination and testing, Needle exchange provisions and the continuation with the naloxone programme (Naloxone is a medication called an "opioid antagonist" used to counter the effects of opioid overdose, for example morphine and heroin overdose)
- Increased investment is recommended to deal with the 18-25 cohort currently seen within the YP service who may need to be absorbed into the core contract

- Increased investment would also be targeted at specific outreach projects to increase the number of BME residents accessing the service
- The service would be commissioned to increase the differential in the offer for women in response to service user feedback.
- The Integrated Offender Management (IOM) service would be retained and funded via MOPAC but would be remodelled to increase its effectiveness
- The homeless pathway post retained and links to housing providers prioritised
- The service will work with sexual health service providers to understand the impact legal highs and or club drugs have on sexual health and Men who have Sex with Men (MSM), as they are more likely to use recreation drugs and participate in poly-drug use, and not access mainstream treatment provisions.
- The service will ensure that it is informed on a range of developments including models for violence prevention. Evaluation has shown that using such models enhances the effectiveness of targeted policing and local authority effort.

6.4.15 *Re-procurement of the core contract with decreased investment. The service would no longer contain an IOM element but retain the capability to support court issued treatment orders (Scenario B only)*

- The service would be re-commissioned as above but with the removal of the majority of the IOM service
- This would mean no presence in police custody suites or prison settings and only a minimal resource available for assessing for/and delivering court treatment requirements.

6.4.16 *A reduction in the commissioning team and general staffing overheads (Scenario A and B)*

- Given the level of savings required it is important that the local authority commissioning function is considered as part of the savings proposals
- Posts that are currently being held vacant will be deleted and a wider restructure will deliver further efficiencies including greater joint work with other authorities

6.4.17 *A reduction in the funding available for residential rehabilitation (Scenario B only)*

- Should MOPAC funding be withdrawn it will be necessary to reduce the level of funding available for residential rehabilitation to create the resource required to maintain core services that would otherwise be lost
- It is anticipated that this loss of capacity could be absorbed through more effective use of community detoxification for alcohol clients but this would need to be closely monitored to ensure that those that needed residential treatment were still able to access it.

6.4.18 **Consultation Plan:** given the level of consultation already undertaken regarding these changes it is not proposed that further activity is specifically focused in this area. This is due to the following factors:

- Service users views have been sought using a range of means and proposals have been endorsed by the local Service User organisation

- All relevant stakeholders have been consulted and have endorsed the proposals
- Changes to provision for young people will be covered in the consultation activity regarding the new specialist 1:1 support service for secondary school age children outlined above
- Services delivered by GPs and Pharmacies will be unaffected
- Services delivered in partnership with GPs will be unaffected
- The main health interfaces within the core service will be either unaffected or strengthened
- Overall the changes are not considered to be a substantial variation

6.4.19 **Timetable**

Substance misuse services timetable
Consultation plans to healthier communities select committee 28/6/16
Approval to tender at Mayor & Cabinet 13/7/16
Potential overview & scrutiny 26/7/16
Issue tender documentation 1/8/16
Tender evaluation w/b 24/10/16
Evaluation interviews w/b 7/11/16
Award Mayor & Cabinet (contracts) 7/12/16
Potential overview and scrutiny 21/12/16
Mobilisation (and any TUPE) for service start 1/4/17

7 Procurement Arrangements

7.1 The proposed activity on which the Council is consulting would necessitate a range of procurement activity.

7.2 Overall procurement summary timeline

	2015	2016							2017			
	Sept '15 to May '16	June	July	Aug	Sept	Oct	Nov	December	Jan	Feb	March	April 1st
Substance misuse	Consultation to date	Approval	Procurement	Procurement	Procurement	Procurement	Procurement	Approval / Award	Mobilisation	Mobilisation	Mobilisation	New services start
Sexual Health	Consultation to date	Approval	Further Consultation	Further Consultation	Approval	Procurement	Procurement	Approval / Award	Mobilisation	Mobilisation	Mobilisation	New services start
health visiting and school nursing	Consultation to date	Approval	Further Consultation	Further Consultation	Approval	Procurement	Procurement	Approval / Award	Mobilisation	Mobilisation	Mobilisation	New services start
Preventative health services		Approval	Further Consultation	Further Consultation	Approval	Procurement	Procurement	Approval / Award	Mobilisation	Mobilisation	Mobilisation	New services start

8. Financial Implications

8.1 The consultations outlined in this report are on activity to realise the savings agreed by Mayor & Cabinet on September 30th 2015 and to balance the reduction to the Public Health grant announced in the annual spending review. The proposals would

achieve a balanced budget in 2017/18 but would leave an estimated overspend of £1.5m on Public Health budgets in 2016/17.

9. Legal Implications

9.1 The Health and Social Care Act 2012 ("the Act") sets out the Council's statutory responsibilities for public health services. The Act conferred new duties on the Council to improve public health. The Council has a duty to take such steps as it considers appropriate for improving the health of people in its area.

9.2 Under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 ("the Regulations"), where the Council has under consideration any proposal for a substantial development of health services or substantial variation in the provision of such service the Council must undertake a formal consultation process, including, In Lewisham's case, the Overview and Scrutiny Committee where the statutory scrutiny role for health functions lies. Any consultation carried out by the Council must be carried out at a formative stage, with sufficient reasons to allow intelligent consideration and response, adequate time to consider and respond and responses must be given conscientious consideration when making a decision.

9.3 Since the Council has been responsible for the exercise of certain public health duties, by virtue of s242 (1B) of the NHS Act 2006, as amended by the 2007 Local Government and Public Health Act, each relevant English body responsible for Health services must make arrangements with respect for those health services for which it is responsible, to ensure that users of those services, directly or through representatives, and whether by consultation or by being provided with information, or in other ways, are involved in:-

1.The planning and provision of those services

2.The development and consideration of proposals for change in the way those services are provided and

3. Decisions to be made affecting the operation of those services.

1 and 2 must be observed when there are proposals being made which would have an impact on the manner of service delivery to users of the service, or the range of health services available to those users

Guidance on the s242 duty sets out the principles of the involvement. This must be that it is clear, open and transparent, accessible, inclusive, responsive, sustainable, proactive and focussed on improvement

Different methods of involvement are suggested, depending upon the nature of the proposal and the community affected - so this may include focus groups, interviews, questionnaires, leaflets etc and formal consultation.

The Local Authority must correctly identify the people who should be involved as this is crucial to effective engagement.

All of the guidance makes it clear that the information and engagement dialogue is and should be ongoing.

9.4 In addition, the duty to consult the community may well arise separately from the " usual conduct " of any particular Local Authority, and its usual approach to service changes. The Health consultation duties do not add any extra issues to those which must already be considered in scoping an effective consultation strategy, which should be adequate in time and content and appropriate to the scale of the issue

being considered. In Lewisham we also have a history of proper consultation when considering service changes, Recent caselaw also provides further guidance on the scope of lawful consultation and the requirements upon Local Authorities necessary to meet it.

9.5 The Equality Act 2010 (the Act) introduced a new public sector equality duty (the equality duty or the duty). It covers the following nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

9.6 In summary, the Council must, in the exercise of its functions, have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- advance equality of opportunity between people who share a protected characteristic and those who do not.
- foster good relations between people who share a protected characteristic and those who do not.
-

9.7 The duty continues to be a "have regard duty", and the weight to be attached to it is a matter for the Mayor, bearing in mind the issues of relevance and proportionality. It is not an absolute requirement to eliminate unlawful discrimination, advance equality of opportunity or foster good relations.

9.8 The Equality and Human Rights Commission has recently issued Technical Guidance on the Public Sector Equality Duty and statutory guidance entitled "Equality Act 2010 Services, Public Functions & Associations Statutory Code of Practice". The Council must have regard to the statutory code in so far as it relates to the duty and attention is drawn to Chapter 11 which deals particularly with the equality duty. The Technical Guidance also covers what public authorities should do to meet the duty. This includes steps that are legally required, as well as recommended actions. The guidance does not have statutory force but nonetheless regard should be had to it, as failure to do so without compelling reason would be of evidential value. The statutory code and the technical guidance can be found at: http://www.equalityhumanrights.com/legal-and-policy/equality-act/equality-act-codes-of-practice-and-technical-guidance/

9.9 The Equality and Human Rights Commission (EHRC) has previously issued five guides for public authorities in England giving advice on the equality duty:

1. The essential guide to the public sector equality duty
2. Meeting the equality duty in policy and decision-making
3. Engagement and the equality duty
4. Equality objectives and the equality duty
5. Equality information and the equality duty

9.10 The essential guide provides an overview of the equality duty requirements including the general equality duty, the specific duties and who they apply to. It covers what public authorities should do to meet the duty including steps that are legally required, as well as recommended actions. The other four documents provide more detailed guidance on key areas and advice on good practice. Further information and

resources are available at: http://www.equalityhumanrights.com/advice-and-guidance/public-sector-equality-duty/guidance-on-the-equality-duty/

10. Crime and Disorder Act Implications

10.1 Section 17 of the Act of the Crime and Disorder Act recognises that there are key stakeholder groups who have responsibility for the provision of a wide and varied range of support services to and within the community. In carrying out these functions, section 17 places a duty on partners to do all they can to reasonably prevent crime and disorder in their area.

10.2 The purpose of section 17 is simple: the level of crime and its impact is influenced by the decisions and activities taken in the day-to-day of local bodies and organisations. The responsible authorities are required to provide a range of services in their community. Section 17 is aimed at giving the vital work of crime and disorder reduction a focus across the wide range of local services and putting it at the heart of local decision-making.

10.3 The Government's recent Modern Crime Strategy highlighted drugs and alcohol of 2 of the 6 major drivers of crime in Britain with the social and economic cost of drug use and supply to society is estimated to be £10.7billion of which about £6 billion is attributable to drug-related crime. 45% of acquisitive offences (c. 2 million offences) are thought to be committed by heroin and/or crack users. The delivery of efficient substance misuse services is key to fighting crime in the borough as services to treat addictions are widely recognised as the most effective route to tackling associated crime and disorder issues.

11. Equalities Implications and human rights

11.7 The consultations outlined in this report are designed to gather a wide range of views across the borough to inform the development of an Equalities Analysis Assessment of procurement proposals for delivery on April 1st 2017, which will be reported to Mayor & Cabinet on the 24th of September 2016.

12. Environmental Implications

12.1 There are no environmental implications.

13 Conclusion

13.1 This report lays out a range of consultation activity on proposals to realise the savings agreed by Mayor & Cabinet on September 30th 2015, and to balance the reduction to the Public Health grant announced in the 2015 spending review. The report seeks Mayor & Cabinet approval to conduct this consultation activity.

13.2 Consultation will be carried out in the different areas as laid out in section 6, and the outcomes will be reported to the Healthier Communities Select Committee on the 13th of September 2016 before proposals are taken to Mayor & Cabinet 24th September 2016.

Appendix 1: Lewisham's 9 health and wellbeing priorities

1. achieving a healthy weight
2. increasing the number of people who survive colorectal, breast and lung cancer for 1 and 5 years
3. improving immunisation uptake
4. reducing alcohol harm
5. preventing the uptake of smoking among children and young people and reducing the numbers of people smoking
6. improving mental health and wellbeing
7. improving sexual health
8. delaying and reducing the need for long term care and support.
9. reducing the number of emergency admissions for people with long-term conditions.

Appendix 2: Allocation of the Public Health grant for 2016/17

PH service area	Includes	value	grant %
CHILDREN 5-19 PUBLIC HEALTH PROGRAMMES	mental health promotion, sexual health education	£40,000	**0.2%**
HEALTH PROTECTION	immunisation, child death review	£85,992	**0.3%**
SEXUAL HEALTH	local clinics, prescribing , GUM, sexual health promotion	£6,257,270	**24.4%**
SUBSTANCE MISUSE	core & YP treatment service, rehab, medication, GPs, aftercare	£4,402,000	**17.2%**
NHS HEALTH CHECK PROGRAMME	Healthchecks, health improvement training	£420,238	**1.6%**
OBESITY	nutrition, vitamin D, breastfeeding	£463,800	**1.8%**
PHYSICAL ACTIVITY	Physical activity programmes	£70,800	**0.3%**
OTHER PUBLIC HEALTH SERVICES	CHIS, Area programmes, administration	£739,408	**2.9%**
PRESCRIBING	smoking medication, LARC, GP substance use medication	£373,256	**1.5%**
MEASUREMENT PROGRAMME	health visiting & school nursing	£8,910,238	**34.8%**
PUBLIC HEALTH ADVICE	support to CCG	£60,000	**0.2%**
PUBLIC HEALTH STAFFING TEAM	staff	£1,097,740	**4.3%**
SMOKING AND TOBACCO	smoking service, tobacco control	£473,738	**1.9%**
	total 16/17 allocated services spend	**£23,394,480**	**91%**
	Corporate Reallocations		
	LEISURE	£400,000	
	CHILDREN'S CENTRE	£550,000	
	HOMELESSNESS	£245,000	
	VAWG	£400,000	
	FOOD & SAFETY	£187,000	
	ENVIRONMENTAL PROTECTION	£77,000	
	CAMHS	£313,000	
	BENEFITS ADVICE	£200,000	
	ADULT CARE: PREVENT ISOLATION	£750,000	
	NEW 16-17 REALLOCATION	£557,000	
	Total 16/17 corporate reallocation	**£3,679,000**	**14%**
	total allocated spend against PH grant	**£27,073,480**	**106%**

Appendix 3: Public Health Outcomes Framework 2016-19

VISION

To improve and protect the nation's health and wellbeing and improve the health of the poorest fastest

Outcome measures

Outcome 1) Increased healthy life expectancy, i.e. taking account of the health quality as well as the length of life
Outcome 2) Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities)

Alignment across the Health and Care System

- * Indicator shared with the NHS Outcomes Framework.
- ** Complementary to indicators in the NHS Outcomes Framework
- † Indicator shared with the Adult Social Care Outcomes Framework
- †† Complementary to indicators in the Adult Social Care Outcomes Framework

Public Health Outcomes Framework 2016–2019
At a glance

1 Improving the wider determinants of health

Objective

Improvements against wider factors which affect health and wellbeing and health inequalities

Indicators

1.01 Children in low income families
1.02 School readiness
1.03 Pupil absence
1.04 First time entrants to the youth justice system
1.05 16-18 year olds not in education, employment or training
1.06 Adults with a learning disability / in contact with secondary mental health services who live in stable and appropriate accommodation† *(ASCOF 1G and 1H)* **(NHSOF 2.5ii)*
1.07 Proportion of people in prison aged 18 or over who have a mental illness
1.08 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services **(i-NHSOF 2.2) ††(ii-ASCOF 1E) **(iii-NHSOF 2.5i) †† (iii-ASCOF 1F)*
1.09 Sickness absence rate
1.10 Killed and seriously injured casualties on England's roads
1.11 Domestic abuse
1.12 Violent crime (including sexual violence)
1.13 Levels of offending and re-offending
1.14 The percentage of the population affected by noise
1.15 Statutory homelessness
1.16 Utilisation of outdoor space for exercise / health reasons
1.17 Fuel poverty
1.18 Social isolation † *(ASCOF 1I)*

2 Health improvement

Objective

People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

Indicators

2.01 Low birth weight of term babies
2.02 Breastfeeding
2.03 Smoking status at time of delivery
2.04 Under 18 conceptions
2.05 Child development at 2 – 2 ½ years
2.06 Child excess weight in 4-5 and 10-11 year olds
2.07 Hospital admissions caused by unintentional and deliberate injuries in children and young people under 25
2.08 Emotional well-being of looked after children
2.09 Smoking prevalence – 15 year olds
2.10 Self-harm
2.11 Diet
2.12 Excess weight in adults
2.13 Proportion of physically active and inactive adults
2.14 Smoking prevalence – adults (over 18s)
2.15 Drug and alcohol treatment completion and drug misuse deaths
2.16 Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison
2.17 Estimated diagnosis rate for people with diabetes mellitus
2.18 Alcohol-related admissions to hospital
2.19 Cancer diagnosed at stage 1 and 2***(NHSOF 1.4v 1.4vi)*
2.20 National Screening Programmes
2.22 Take up of the NHS Health Check programme – by those eligible
2.23 Self-reported well-being
2.24 Injuries due to falls in people aged 65 and over

3 Health protection

Objective

The population's health is protected from major incidents and other threats, whilst reducing health inequalities

Indicators

3.01 Fraction of mortality attributable to particulate air pollution
3.02 Chlamydia diagnoses (15-24 year olds)
3.03 Population vaccination coverage
3.04 People presenting with HIV at a late stage of infection
3.05 Treatment completion for TB
3.06 Public sector organisations with board approved sustainable development management plan
3.08 Antimicrobial Resistance

4 Healthcare public health and preventing premature mortality

Objective

Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities

Indicators

4.01 Infant mortality* *(NHSOF 1.6i)*
4.02 Proportion of five year old children free from dental decay** *(NHSOF 3.7i)*
4.03 Mortality rate from causes considered preventable ***(NHSOF 1a)*
4.04 Under 75 mortality rate from all cardiovascular diseases (including heart disease and stroke)* *(NHSOF 1.1)*
4.05 Under 75 mortality rate from cancer* *(NHSOF 1.4)*
4.06 Under 75 mortality rate from liver disease* *(NHSOF 1.3)*
4.07 Under 75 mortality rate from respiratory diseases* *(NHSOF 1.2)*
4.08 Mortality rate from a range of specified communicable diseases, including influenza
4.09 Excess under 75 mortality rate in adults with serious mental illness* *(NHSOF 1.5i)*
4.10 Suicide rate***(NHSOF 1.5iii)*
4.11 Emergency readmissions within 30 days of discharge from hospital* *(NHSOF 3b)*
4.12 Preventable sight loss
4.13 Health-related quality of life for older people
4.14 Hip fractures in people aged 65 and over
4.15 Excess winter deaths
4.16 Estimated diagnosis rate for people with dementia * *(NHSOF 2.6i)*

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Public Health
England

Protecting and improving the nation's health

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To: Local Authority Chief Executives
Cc: Directors of Public Health

PHE Gateway Number: 2015-502

27 November 2015

Dear everyone

Spending Review

I wanted to write to you following Wednesday's Spending Review announcement about the public health grant to share my thoughts on what this means for the next five years.

First, as anticipated, there will be a reduction. The Chancellor talked about savings in the public health grant, which will be an average real terms saving of 3.9% each year to 2020/21. This translates into a further cash reduction of 9.6% in addition to the £200 million of savings that were announced earlier this year. From the baseline of £3,461m (which includes 0-5 commissioning and takes account of the £200m savings) the savings will be phased in at 2.2% in 16/17, 2.5% in 17/18, 2.6% in each of the two following years, and flat cash in 20/21.

Cuts are never welcome, and this is by no means the only challenge that local authorities face. However, you and your colleagues have already proved that you are capable of managing reductions on this scale. I am confident that you will find ways of continuing the very real progress of the past three years in protecting and improving the public's health and in working to reduce health inequalities.

We do not yet know the implications for individual local authorities. This will depend on decisions about the funding formula, on which the Department of Health has consulted on behalf of ACRA and the political decision on pace of change (how fast we move from historic spend to the formula based target shares). My advice to the Government throughout has been to prioritise stability and certainty for the next two years and concentrate on getting the arrangements right for the transition to full funding through business rates. I believe this reflects what your colleagues have told me on my visits to local authorities across the country.

The Spending Review made a number of further commitments including:

- a commitment to retain the public health grant for 16/17 and 17/18 in order to complete the transition of 0-5s and to work through what we will all need in a world without a ringfence.

- a clear signal that the public health grant will be replaced as we move to a model based on retained business rates. The detail of how this will work needs to be worked through and will be subject to full consultation. We will obviously be keen to ensure that any redistribution mechanism reflects health need and does not exacerbate health inequalities.

- the Government is not proposing to change the statutory prescribed functions for local authorities for 16/17. It is right that local government is trusted to make the best decisions about how to use the resources available.

As you know, improving the public's health is about so much more than services secured through the public health grant – it is about jobs, decent housing, a safe environment and companionship. Following the Spending Review, we can work together to build a far wider programme of action on prevention and improving health and wellbeing, including:

- the settlement for the NHS fully funds the Five Year Forward View, and its commitment to getting serious about prevention.

- understanding how we can best use the additional £1.5 billion invested in the Better Care Fund to maximise system-wide efforts to prevent the preventable.

- the importance of Government action, and in particular action on childhood obesity, is signalled. As you know, PHE have provided clear evidence on how we could reduce sugar consumption. We are now working with the Department of Health to produce an effective Childhood Obesity Strategy.

- the importance of work to health. The provision of new national funds to develop approaches to help people with health problems get back to work speaks to an agenda that I know is important to all of you.

- developing a place-based approach to NHS planning; the planning round for 16/17 and beyond will move to a place-based approach and properly engage local authorities in the decisions about future health services.

- the Government's commitment to real and meaningful devolution provides opportunities for local authorities to join up public services to address the real problems in our communities.

You will be considering the impact of the Spending Review for your authority. I am clear that we have the basis for making a real difference to the public's health in the coming years. I do not underestimate the challenges, but they are nothing to what you have already shown you are capable of.

PHE stands ready to help in whatever way we can.

Best wishes

Yours sincerely

Duncan Selbie
Chief Executive

Lewisham

Adult and Young Peoples Substance Misuse Needs Assessment 2016

Completed by the Prevention, Inclusion and Public Health Team - April 2016

Contents

	WHAT DO WE KNOW?	
1.0	Introduction	
2.0	Facts and figures	
3.0	What are the key inequalities?	
4.0	Targets and performance	
5.0	National and local strategies	
6.0	What works?	
7.0	Current activities and services	
	WHAT IS THIS TELLING US?	
8.0	What are the key gaps in knowledge and/or services?	
9.0	What is coming on the horizon?	
10.0	Priorities for 2015/16	
	Appendices	

WHAT DO WE KNOW?

1.0 Introduction

This needs assessment forms part of the Lewisham Joint Strategic Needs Assessment (JSNA) and informs the implementation of the Health and Wellbeing strategy and the Drug and Alcohol delivery plans. It provides an up-to-date picture about alcohol and drug related harm in Lewisham and suggests how it can be addressed. It allows Lewisham to demonstrate the effectiveness of the existing treatment system and highlights any gaps in treatment delivery, which prevent an individual from moving through and out of treatment and on to live a substance free life in the community.

This needs assessment was conducted between October 2015 and March 2016, by the Prevention and Inclusion Team (P&I) and Public Health, drawing on a variety of data sources.

Unless otherwise stated the needs assessment examines treatment data from 2014/15. Due to changes in treatment methodology (adults only) this report does not compare adult performance in 2014/15 with previous years, but looks at progress in Q2 2015/16.

2.0 Facts and figures

Alcohol and drugs use has a major impact on health, anti-social behavior, crime and other important social issues, including the well-being and development of children and young people.

According to the findings of the Drug Misuse Crime Survey 2014/15[1]:

- Around 1 in 12 (8.6%) adults aged 16 to 59 had taken an illicit drug in the last year. This equated to around 2.8 million people.
- Around 1 in 5 (19.4%) young adults aged 16 to 24 had taken an illicit drug in the last year. This proportion was more than double that of the wider age group, and equated to around 1.2 million people.
- Just over one-third (34.7%) of adults aged 16 to 59 had taken drugs at some point during their lifetime.

There is a wealth of information available regarding the prevalence and impact of drug and alcohol use including:

- An estimated 300,000 people are dependent on crack and/or heroin in England
- There are reports of an increasing use of other psychoactive substances (‘legal highs’) and image and performance enhancing drugs and a growing concern about dependence on prescribed and over the counter medicines
- Alcohol is the leading risk factor for deaths among men and women aged 15 to 49 in the UK and alcohol impacts on other public health outcomes
- Over 9 million people in the UK drink at levels harmful to their health, with 1.9m showing some signs of dependence

[1] The Crime survey measures levels of drug use (only) in a national sample of 16 to 59 year olds. Figures refer to drug treatment in the last month and last year prior to interview, as well as drug use at any point in the respondents lifetime.

- Alcohol has been associated as a causal factor in over 60 conditions including liver disease, circulatory diseases, cancers and depression in those drinking at harmful levels and also those increasing risk drinkers
- Early deaths from liver disease are increasing. It is of concern that England has one of the highest death rates from liver disease in Western Europe and it is the only disease where the death rate among those under 65 has been rising.
- Drinking at higher risk levels increases the risk of alcohol-related disease. For example, the risk of liver disease is increased by 13 times and risk of coronary heart disease is increased by 1.7 times for men and 1.3 times for women.[2]
- An individual's drug use or dependence on drugs can significantly affect people around them including their family, friends, communities and society.
- An estimated one in three of the English treatment population has a child living with them at least some of the time.
- Presentations to treatment for opiates (all ages) have been falling over the last six years (55,494 to 44,356), reflecting the downward trend in prevalence of heroin use.
- Non-opiate-only clients had the highest rates of successful exits with almost two thirds (64%) completing treatment, followed by 61% of alcohol clients. Opiate clients had a completion rate of 30%.
- Sixty one percent of people who died while in contact with services in 2014-15 were opiate clients
- Overall numbers accessing treatment for alcohol have increased by 3% since 2009-10
- The estimated cost to the NHS of caring for an injecting drug user is £35,000 over their lifetime.
- Cannabis is the most common drug that young people, with more than four-fifths (86%) of young people in specialist services say they have a problem with this drug
- Alcohol is the next biggest problem substance with just over half the young people in treatment (51%) seeking help for its misuse during 2014-15.
- The number of deaths due to substance misuse over a seven year period from 2009 to November 2015 (latest data) was 183. Most of these (130 - 71%) were alcohol clients. Among those accessing treatment for drug use, there were 35 (19.1%) deaths, whilst deaths for substance misuser's dependant on a combination of both alcohol and drugs was 18 (9.8%) (Appendix 16).
- 34% of all drug related deaths are due to mixed drug and alcohol poisoning. 61% of all mixed drug and alcohol poisoning is due to opiates mixed with alcohol. Overall, 76% of all deaths (alcohol related and drug related and mixed drug and alcohol related) were in males. The age range all deaths related to drug and alcohol use was 20 to 93 years old. Most drug and mixed drug and alcohol deaths for men and women occurred in those younger than 60.

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[2] PHE JSNA Support Pack

Local Prevalence Estimates

Drugs

The estimated number of opiate and/or crack users (OCU) and injectors in Lewisham is set out below:

	Lewisham		London	England
	Prevalence estimate (15-64)	Rate per 1000 of population		
OCU	2438	12.41	9.55	8.40
Opiate	1875	9.54	7.63	7.32
Crack	1823	9.28	6.96	4.76
Injecting	599	3.05	1.97	2.49

Source: PHE Prevalence Estimate 2011/12

Figures suggest Lewisham has a higher prevalence of opiate and/or crack users (OCU) and injectors (per 1000 of population) compared with the region and England average.

Alcohol

Estimates of abstainers, lower risk, increasing risk and higher risk drinkers:

	Population estimate for all groups			Population estimate for drinkers only	
	Lewisham		London	Lewisham	London
	n	%	%	%	%
Abstainers	46029	22.2	24.5	-	-
Lower risk	118194	57.0	52.1	73.2	69.1
Increasing risk	31873	15.4	15.8	19.7	20.9
Higher risk	11365	5.5	7.6	7.0	10.0

Source: NW England Public Health Observatory, Topography of Drinking Behaviours in England - August 2011

Figures suggest Lewisham has a higher proportion of lower risk drinkers (Appendix 13) in both cohorts compared with the London average. Estimates of drinkers and abstainers are broadly similar compared with the London average.

In Lewisham the rate of hospital admissions for alcohol related harm have increased from 1836 to 2300, per 100,000 residents since 2008/09[3]. The upward trajectory follows a similar trend compared with other geographic, but the rate in Lewisham is higher (and rising) (Appendix 14).

[3] Public Health Lewisham

Admissions to hospital for mental and behavioural disorders due to alcohol for Lewisham was 116.5 per 100,000 population, the rate for England was 84.1 per 100,000[4].

13% of those screened for health checks have excess alcohol intake (about 90 per quarter)[5].

Young People

While the majority of young people do not use drugs nor alcohol, and most of those that do are not dependent, drug and alcohol misuse can have a major impact on young people's education, their health, their families and their long-term chances in life[6].

Despite recent declines, the proportion of children in the UK drinking alcohol remains well above the European average. We continue to rank among the countries with the highest levels of consumption among those who do drink, and British children are more likely to binge drink or get drunk compared to children in most other European countries[7].

The main prevalence data for trends in alcohol, drug and tobacco use amongst young people is the annual schools survey in England'[8].

- 46% of pupils aged 11-15 said they had drunk alcohol, smoked or tried drugs at least once.
- 38% drunk alcohol, 18% have smoked and 15% have taken drugs.
- 4% of pupils aged 11 were more likely to have sniffed volatile substances and (1%) taken cannabis

Prevalence data from other sources say:

- 11% of 15 year olds had tried cannabis at least once[9].
- The proportion of young adults aged 16 to 24 who had taken an illicit drug in the last year is similar to the findings of the 2013/14 survey, at 19.4% (around 1 in 5) from 19.0%[10].

Although the latest report shows declining trends in substance use overall, it highlights the increased risk of drug use among pupils who truant or who have been excluded from school and whose circumstances or behaviour already make them a focus of concern. The same survey also indicates that young people at risk of misusing drugs and alcohol are also likely to be smoking and that one of the factors linked to increased initiation of smoking is experimentation with drugs and alcohol[11].

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[4] Public Health Lewisham
[5] Public Health Lewisham
[6] YP JSNA Support pack Public Health England 2015/16
[7] Hibell B, Guttormson U, Ahlstrom S, et al (2012) The 2011 ESPAD report: substance use among students in 36 European countries
[8] Smoking, drinking and drug use among young people in England in 2014, Health and Social Care Information Centre
[9] What About YOUth survey
[10] www.crimesurvey.co.uk/index.html
[11] Public Health England 2014

Admissions to hospital due to substance misuse for young people aged 15 to 24 in Lewisham, was 92.3 per 100,000 population against 70.3 in London and 88.8 in England – 2012/13 to 2014/15. The confidence intervals are quite wide for this indicator as it's only looking at a small section of the population, Lewisham are therefore deemed to be statistically similar to England. [12]

Accommodation Need

In order for an individual to sustain recovery it is imperative that they are able to reintegrate into the community and one way of enabling them to achieve this is to provide them with somewhere to live.

Many homeless people have one or more support need: 41 per cent alcohol; 31 per cent drugs; 45 per cent mental health[13].

Lewisham has almost double (16%) the proportion of adults reporting an urgent housing need (those with NFA and a housing problem) at the start of treatment compared with national average (9%), the majority of this cohort are males (Appendix 7).

According to PHE there are no young people in Lewisham reporting an urgent housing need. This is in line with the national picture. The majority of young people in treatment in Lewisham year to date reported living with their parents, other relatives or independent settled accommodation (85%), this is similar to the national average 82%.

Ensuring access to housing and housing related support services at the different stages of recovery can present a number of challenges for local partners as people may have a range of complex housing-related needs and therefore require a wide range of responses.

An individual may find it difficult to become stable in their treatment programme without access to suitable housing or housing support. They may also find it difficult to sustain their recovery post treatment, without a stable place to live[14]

Single Homeless Intervention Programme (SHIP)

Most of the housing stock and supported housing for homeless people comes under the umbrella of the Single Homelessness Intervention Programme (SHIP). Any homeless clients requiring 'supported' or other accommodation must apply through SHIP.

In 2015/16 there were a total of 535 units[15] in the Lewisham housing pathway. A snapshot exercise of 169 service users from the above cohort highlighted:

- 33 (20%) had a primary alcohol need
- 33 (20%) had a primary drugs need

Employment, Training & Education

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[12] Public Health Lewisham
[13] http://www.crisis.org.uk/pages/rough-sleeping.html
[14] Public Health England

[15] Accommodation spaces

The Department of Work and Pensions (DWP) reports 1 in 15 benefit claimants has a drug or substance misuse problem. 1 in 25 benefit claimants has an alcohol misuse problem. Employment is a key component to establishing a stable life and allowing people to live independently.

NOMS Labour Market Profile for Lewisham[16]:

In 2014/15 the unemployment/economically inactive[17] rate for clients in treatment mirrored the national average (47%). Of this cohort, Lewisham has a higher proportion of individuals who are long term sick or disabled, at 29% against a national average of 21%.

Those in regular employment are lower, at 14% against 19% nationally. Being in work or accessing education and training is linked to better treatment outcomes (Appendix 7).

Jobcentreplus (JCP)

2014-2015 saw the success of partnership working between treatment agency and JCP partners seeing an increase of Treatment Provider Referral (TPR2)[18], Key Performance Indicators (KPI) being set for treatment providers to increase Employment Training and Education (ETE) activity and outcomes.

The drug strategy recognises ETE as a key indicator to successful outcomes and sustained recovery, recent work has seen an improved relationship between JCP Partnerships. The government has implemented a number of significant welfare reforms affecting every significant working age benefit claimant.

There are two key reforms, impacting a large percentage of service users locally:

- the transfer of claimants from Incapacity Benefit (IB) to either Employment & Support Allowance (ESA) or Jobseeker's Allowance (often referred to as 'ESA migration')
- the staged introduction of Universal Credit Start in February 2016

NOMS Labour Market Profile for Lewisham[19]:

On the 31st March 2012 Lewisham had a similar proportion of individuals in treatment on benefits, at 65% (561/862), against a national average of 61%. The majority were Employment Support Allowance, Incapacity Benefit and Income Support.

Employment, Education and Training at Start of Treatment (ETE - Young People under 18)

Over half (51%) of young people in treatment year to date are in school or further education college, this is similar to the national average (52%). A further (24%) are receiving education in a pupil referral unit or at home, again similar to the national average (20%).

Lewisham has a lower proportion of young people NEET, at 10% against 15% nationally.

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[16] Lewisham Employed (74% in Employment, 64% employees & 10% self-employed) 6% Unemployed https://www.nomisweb.co.uk/reports/lmp/la/1946157254/report.aspx
[17] Not in employment or unemployed
[18] Form used by the treatment provider to share information with JCP
[19] https://www.nomisweb.co.uk/reports/lmp/la/1946157254/report.aspx

Young people are 2.1[20] times more likely to become NEET (six months or more) if they are using substances.

Local views - Service User & Carer Involvement

The prevention and Inclusion team remains committed to meaningful service user and carer involvement, working in partnership to build a robust, service user driven, recovery community that is valued and normalised practice.

In 2014-15 Lewisham established a growing recovery community, with the reach of involvement from SU from diverse backgrounds increasing, complex care, shared care, aftercare, YP and supported housing services. SU's were involved in co-production, engagement, development and commissioning activities.

A local pharmacy audit conducted in 2015 showed, service user where positive about their experiences of supervised consumption and OST pick up's.

Mutual Aid partners continue to be a valued partner in delivering recovery peer lead focus to the local drug and alcohol population. Mutual aid is bridging the gap for treatment naïve and offering an out of hour's service which creates recovery community opportunities. Local attendance has increased averaging 20-30 attendees per meeting.

Feedback from SU has highlighted the following gaps in treatment: lack of women's provision's and early opportunity to engage in treatment, financial hardship as a result sanctions introduced with changes to the benefit system, skills gap - lack of computer skills/ literacy.

[20] http://researchbriefings.files.parliament.uk/documents/SN06705/SN06705.pdf

3.0 What are the key inequalities?

Socio-economic status

Drug and alcohol related harms fall disproportionately on the poorest in society.

On the 31st March 2012 Lewisham had a higher proportion of individuals in treatment on benefits, at 65% against a national average of 61%. The majority were Employment Support Allowance, Incapacity Benefit and Income Support.

For the most deprived tenth of the population, hospital admissions, where the main reason for admission is alcohol, are 55% higher and alcohol related deaths 53% higher than the least deprived tenth of the population.

In 2014/15 the unemployment/economically inactive[21] rate for clients in treatment mirrored the national average (47%). Of this cohort, Lewisham has a higher proportion of individuals who are long term sick or disabled, at 29% against a national average of 21%.

Lewisham had almost double (16%) the proportion of adults reporting an urgent housing need at the start of treatment compared with national average (9%). The majority of this cohort were male.

An individual may find it difficult to become stable in their treatment programme without access to suitable housing or housing support. They may also find it difficult to sustain their recovery post treatment, without a stable place to live[22]

Sexual orientation

Lesbian, Gay, Bisexual, Transgender, Transsexual & Questioning (LGBTQ) clients

0.4%[23] of Lewisham households are made up of same sex couples in civil partnerships (Census 2011). This is more than double the average for England.

Gay or bisexual adults were more likely to have taken any illicit drug in the last year than heterosexual adults. In particular, gay or bisexual men were the group most likely to have taken any illicit drug in the last year (33.0 per cent had taken drugs in the last year), with higher levels of illicit drug use than gay or bisexual women (22.9 per cent) and heterosexual men (11.1 per cent)[24].

Local intelligence confirm the proportion of individuals from LGBTQ communities accessing specialist treatment services in Lewisham remains low 5%, similar to the previous year.

[25]There is a substantial body of evidence demonstrating that LGBT people experience significant health inequalities, which impact both their health outcomes and their experiences

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[21] Not in employment or unemployed
[22] Public Health England
[23] http://www.lewishamjsna.org.uk/a-profile-of-lewisham/social-and-environmental-context/sexual-orientation
[24] Health & Social Care Information Centre (hscic) – Statistics on Drug Misuse – 2014
[25] Williams et al (2013) The LGB&T Public Health Outcomes Framework Companion Document

of the healthcare system. [26] Has substance misuse been considered as part of a wider investigation into the health inequalities affecting LGBT people?

Gender

Men are more likely to take drugs than women. Around one in eight (11.9%) men aged 16 to 59 had taken an illicit drug in the last year, compared with around one in eighteen (5.4%) women[27].

In Lewisham, in 2014/15, the ratio of adult males to females in the treatment population was 74% to 31%[28] . Males remain significantly over-represented in treatment compared with the national (70%) and population average[29]. The three groups - opiate, non-opiate and non-opiate and alcohol have a very similar distribution with just under three quarters of each group being male. It appears that the gap between men and women in treatment is widening as in Q2 2015/16 proportions increased to 79%, whilst females have decreased to 21% (Appendix 1).

In 2014/15 the ratio of male to female YP (aged 10-25) in the treatment population was 57% to 43%. Males made up the majority young people in treatment, higher than the general population in Lewisham in this age group (49%), but lower than the national average (65%). In Q2 2015/16 proportions have decreased for both cohorts to 53% and 21% respectively (Appendix 9).

Men (67%) are twice as likely to attend A&E due to an alcohol and violence incident than women, who make up just a third of attendances.

Vulnerabilities and gender differences

Self-harm[30] and sexual exploitation[31] are specific issues facing females in Young People's drug treatment in Lewisham, at 43% and 15%, against 5% and 0% respectively males. Nationally proportions for females are 33% and 12% respectively (Appendix 12).

Based on the national prevalence of 7%, an estimated 1,302 children in Lewisham self harm between the ages of 11-16[32]. [33]As with all types of abuse, it can have a devastating impact on the child or young person who is being exploited. A number of reports have highlighted that substance misuse could be an indicator of child sexual exploitation and abuse.

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[26] . The Lesbian and Gay Foundation www.lgf.org.uk/policy-research/the-lgbt-public-health-outcomes-framework-companion-document
16 www.lgf.org.uk/policy-research/JSNA
[27] Drug Misuse Crime Survey For England & Wales 2014/15
[28] PHE NDTMS statistics report
[29] Lewisham, Male 49% Female 51%
[30] Self-harm refers to the deliberate self-infliction of damage to body tissue. Association of YP Health – Adolescent Self Harm - 2013
[31] The sexual exploitation of children and young people is a form of child sexual abuse – HM Gov Safeguarding Children & YP from Sexual Exploitation
[32] Public Health Lewisham
[33] Public Health England 2014/15

Age

Younger people are more likely to take drugs than older people. The level of any drug use in the last year was highest among 16 to 19 year olds (18.8%) and 20 to 24 year olds (19.8%). The level of drug use was much lower in the oldest age group (2.4% of 55 to 59 year olds)[34]. Those who use other substances tend to be younger, as can be seen in the 20/14/15 Crime Survey for England and Wales. This survey shows that cannabis, ecstasy and powder cocaine are more commonly used by 16-24, with 16.3% using in the last year (compared with 6.7% for the general population aged 16-9).

According to PHE individuals are more likely to start using drugs in their late teens and early twenties and, seek treatment within eight years of first use. Non-opiate clients and Non-opiate and alcohol rend to be younger than clients who present for opiate use. A larger proportion will have started their heroin/opiate use in the 80's and 90s and are now in their 40s[35]. The number aged 40 and over accessing services in England has risen by 21% and the number aged 50 and over by 44%.

The median age of Opiate clients is 41 (38 national), slightly younger than non-opiates clients at 43 years of age (29 national) and alcohol & non-opiate clients at 44 years of age (34 national). Clients presenting with problematic alcohol use are the oldest with a median age of 45, in-line with the national average. The majority of clients in treatment 2014/15 were between the ages of 30 and 49 (Appendix 1). This compares with 35%[36] of the population.

However, the pattern of young people engaging in drug and alcohol use does not translate into numbers into treatment. The current young person's service works with 11-25 year olds and only 52% of the current clients are under 18 and the overall number in treatment is very small. Lewisham young people aged 16-17 represent the age group with the highest reported substance misuse need (40%) (Appendix 9).

Ethnicity

According to a substance misuse report from the Health and Social Care Information Centre – 2014, the prevalence of drug dependence varies with ethnicity. Black men are more likely (12.4%) and South Asian men are least likely (1.5%) than men from other ethnic groups surveyed, to report symptoms of dependence. In women this ranged from 4.8% of Black women to 0.2% of South Asian women[37].

Individuals recorded as white British made up the largest ethnic group in treatment (60%, 690) in Lewisham with a further 11% (130) from other white groups. This compares with a general population of 42% and 12% respectively.

In Lewisham Black African (11.6%) residents are now more numerous than Black Caribbean (11.2%) and Black Other have also seen a sizable increase from 2.1% to 4.1%. Yet Black African and Black Caribbean residents appear to be less well represented in treatment at 2.9%, 6.1% respectively (Appendix 2).

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[34] Drug Misuse Crime Survey For England & Wales 2014/15
[35] Adult substance misuse statistics from NDTMS 2014/15
[36] ONS 2014
[37] Health & Social Care Information Centre (hscic) – Statistics on Drug Misuse – 2014

Borough Comparisons – Proportion in treatment:

	Lewisham	London
	Black African	Black Caribbean
Greenwich	1.8%	1.9%
Lambeth	1.6%	6.6%
Lewisham	2.9%	6.1%
Southwark	2.6%	6.1%

Source: NDTMS PHE

These figures (when taken in conjunction with the report from the Health and Social Care Information Centre) suggests that Lewisham is not alone in failing to engage Black Communities in treatment but that this represents a key inequality.

The majority of young people in treatment under the age of 18 are Black Caribbean, at 30% (24/79) against 6% of under 18's in general population. White British are second, at 22% against 15% of under 18's in general population and Black African third, at 10% against 8% of under 18's in general population. There are currently zero Mixed Asian, Indian or Bangladeshi young people in treatment (Appendix 10).

Clients in contact with the Criminal Justice System (CJS)

Lewisham has a significantly lower proportion of clients in treatment with an offending history, at 16% drugs and 4% alcohol only, against 58% and 6% nationally (Appendix 6).

These figures should be viewed with an air of caution due to organisational changes at the National Probation Service (NPS) and the Community Rehabilitation Company (CRC) which may be impacting on figures.

[38]The relationship between problem drug use and crime is complex. Even so, all the evidence indicates that problem drug users are responsible for a large percentage of acquisitive crime, such as shoplifting and burglary

4. Targets and Performance

Specialist treatment service - Adults

Individuals achieving the Public Health Outcome indicator 2.15 for Opiate and Non-opiate users demonstrate a significant improvement in health and well-being in terms of increased longevity, reduced blood-borne virus transmission, improved parenting skills and improved physical and psychological health. Successful completions are a key measure of a recovery focussed treatment system.

In Lewisham this remains similar to the national average, with 7.3% (58/791) Opiate users and 39.7% (160/403) Non-opiate users successfully completing[39] treatment in the twelve months up to 31st March 2015, against 7.2% and 38.5% respectively nationally.

[38] Public health England
[39] Free from substance misuse dependency or substance misuse is no longer problematic (the latter does not apply to heroin or crack)

Recent data covering the twelve month period to 30th September 2015 shows a decline in the numbers of adults successfully completing their treatment since the baseline, with only Non-opiates remaining in the top quartile at 47.4% (93/196). Alcohol only users successfully completing have fallen below the national average at 31.1% against 39.1% (Appendix 3).

Re-presentation[40] rates are relatively high in Lewisham compared with top quartile range, particularly for poly substance users and dependent drinkers. With 9/41 (22%) and 11/61 (18%), returning to treatment having successfully completed (Appendix 3).

[41] Individuals who re-present (i.e. those who have had many goes round the system) are less likely to complete treatment successfully. Circumstances can change, as does the ability to cope. Re-presentation is not necessarily a failure, individuals should be quickly re-assessed and a new care plan prepared to addresses changed needs.

Overall penetration rates for opiate and/or crack use in Lewisham are lower than the national average, with 34.4% of the estimated number of opiate and/or crack users in treatment compared with 52.1% nationally.

Treatment outcomes

Treatment outcome data in Lewisham shows that with exception of crack users, all other cohorts stop using in the first six months of treatment. 84 Lewisham clients reported using crack at treatment start and 24 (29%) were no longer using by 6 month review. This is just under the lower expected range 31% to 52%. Alcohol abstinence is within expected range.
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[42]Evidence suggests that clients who stop using opiates in the first 6 months of treatment are 4.3 times more likely to complete successfully than those that continue to use.

Employment and housing outcomes (treatment exit) have improved in the latest period but remain lower than national average for all adults (Appendix 4).

Access to suitable stable housing and housing related services contributes to a successful completion and sustained recovery. In addition, being in work or accessing education and training is linked to better treatment outcomes.

Further investigation is needed to understand why Lewisham has a larger proportion of opiate users still using at six month review, also with the following complexity factors that negatively impact on successful completions: using on top, injecting, unemployment and a housing problems, compared with the national average (Appendix 4). In addition, we need to address the large number using the substance longer than 21 years (career length), at 48% compared with a cluster average of 31% (Appendix 5).

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[40] Individuals who have returned to treatment after completing treatment successfully
[41] Public Health England
[42] Public Health England

Harm Reduction

Blood Bourn Virus (BBV) testing presents an excellent opportunity to reduce long term harm to individuals in this high risk group through providing a pathway to treatment for those who carry a BBV, in addition to reducing long-term costs to health services.

Data on harm reduction initiatives around hepatitis in Lewisham shows that the rate of acceptance of HBV vaccination is above the national average (32.9% compared to 21.9%) with 30 starting and 35 completing a course of the 115 who accepted the offer. HCV testing rates for injecting drug users exceed national rates at 90% against 71%.

Clients in contact with the Criminal Justice System (CJS)

Lewisham have seen a considerable increase in referrals of offending clients from criminal justice services in the community to community treatment this quarter (from 12% to 45%), an indication that pathways between criminal justice and treatment agencies and are improving. However, there is still work to be done to increase numbers in treatment as Lewisham has a significantly lower proportion of clients in treatment with an offending history 47%, against 64% nationally (Appendix 5).

These figures should be viewed with an air of caution due to organisational changes at the National Probation Service (NPS) and the Community Rehabilitation Company (CRC) which may be impacting on figures.

Drugs & Alcohol – Lewisham Police Intelligence - 2012 to 2016

Under the Misuse of Drugs Act 1971 it is an offence to:[43]

- possess a controlled substance
- possess a controlled substance with the intent to supply
- unlawfully supply a controlled drug (even when there's no charge made for the drug)
- allow premises you occupy or manage to be used for the purpose of drug taking

The total number of drugs recovered by Lewisham Police under the Misuse of Drugs Act has increased from 1394 to 1706 (22%) since 2014.

As in previous years, cannabis was the most commonly recovered drug, at 80% (1367/1706) of all possessions recorded, second was cocaine at 10% (165/1706) and third heroin at 5% (79/1706). Proportions are similar to 2014, at 84%, 7% and 4% respectively.

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[43] Police UK

Referral Sources into Drug & Alcohol Treatment in Lewisham in 2014/15

The most common referral route into treatment in 2014/15 was self for all individuals across all substance groups. This is consistent with the national picture. Opiate referrals from this source were highest at 65% against 47% nationally. In Q2 2015/16 referrals from this source have fallen to 53%.

These figures should be viewed with an air of caution as individuals may not disclose the correct referral route at assessment, and will therefore be recorded on NDTMS as a self-referral.

For alcohol only clients, the next common referral from this source was through health services 19% (GP 12%, Hospital & A&E 3% and other Health 4%). This compares with 33% nationally. In Q2 2015/16 referrals from this source have grown to 26%.

In contrast, health services accounted for 6% of opiate client referrals against 10% nationally. The criminal justice system was the second most common referrals source for opiate clients (22%). This compares with 9% of referrals coming from the criminal justice system for alcohol only clients. Overall 4% of referrals came from substance misuse services, against 9% nationally (Appendix 6).

Prescription Only Medication and Over the Counter Medication (POM/OTC)

The 2010 Drug Strategy[44] covers dependence on all drugs, including addiction to medicines (ATM), individual's dependant on prescription only medicines (POM) or over-the-counter (OTC) medicines.
According to the Addiction to Medicine (ATM)[45] report published in 2011, between 1991 and 2009, community prescribing of Opioid medicines, has increased from 228.3 million to 1384.6 million items.

In 2014/15 147 (12%) of clients in treatment reported an addiction to medicines (ATM). Including 130 dependant on a combination of illicit drugs and POM and OTC, and an additional 17 whose primary substance of choice is POM and OTC - only. The majority are Male at 69%. The proportion in Lewisham is generally similar to the national average (Appendix 6).

Given the changing trends in substance misuse and the increase in dependence on medicines (ATM), it is important that commissioners of substance misuse treatment in Lewisham have an understanding of not only illicit drug use, but also addiction to medicines, in order to ensure services have the capacity to support local needs.

Young People (young people under 18)

Lewisham has seen the number of YP receiving specialist treatment fall by 18 % from 199 to 163 (12 month rolling). The direction of travel in Lewisham is three times the national (-6%),

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[44] http://www.nta.nhs.uk/search.aspx?query=Drug+Strategy+2010

[45] http://www.nta.nhs.uk/uploads/addictiontomedicinesmay2011a.pdf

although other like boroughs have also experienced significant decline (Southwark -50% and Greenwich -27%).

This could be for a number of reasons including, the reduction of YP in alcohol and drug treatment across all geographic has fallen to 18,349 from 19,126 since 2013/14, it is also suggested that the pull on resources and closure of YP provisions may have impacted on referral pathways into treatment and the reconfiguration of the treatment system in Lewisham.

Treatment Exit

Planned exits remain above baseline and national average, at 86% (44 out of 51 young people exiting the treatment system successfully), against 80% nationally. This suggests that services are responding to the needs of YP and helping them to overcome dependency.

Referral Source

Referrals to services in Lewisham are widely spread from a variety of sources, with 33% of referrals from 'self, family and friends' against a national average of 12%. The biggest increase in referrals came from Youth Justice Service, at 22% from 9% in previous quarter. Referrals from A&E remain low, similar to the national picture (appendix 11).

Effective partnership working will help to unblock referral pathways and increase numbers in treatment.

Vulnerabilities of YP in treatment

The majority of YP who present to substance misuse treatment in Lewisham have at least one vulnerability, which together reduces the social tools most YP would be able to draw upon to help them overcome difficult periods.

The proportion of YP in Lewisham who began using problem substances before the age of 15 has reduced from 99% to 84% (93% nationally) and those not in education, employment or training (NEET) from 18% to 14% (18% nationally) since 2014/15.

Those involved in offending/ anti-social behaviour has increased from 36% to 54% in the same period (33% nationally) (Appendix12).

Gender differences

In 2014/15 self harm and sexual exploitation are highlighted as specific issues facing females in YP treatment in Lewisham, at 43% and 15% (5% and 0% males). Nationally proportions are 33% and 12% respectively (Appendix 11).

Based on the national prevalence of 7%, an estimated 1,302 children in Lewisham self harm between the ages of 11-16[46].

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[46] Public Health - Lewisham 2015

Child sexual exploitation is a form of child sexual abuse. As with all types of abuse, it can have a devastating impact on the child or young person who is being exploited. A number of reports have highlighted that substance misuse could be an indicator of child sexual exploitation and abuse[47].

Although these figures suggest a large difference between sexual exploitation experienced by boys and girls, research from Barnardo's has highlighted difficulties in identifying sexual exploitation of boys and young men because they often do not disclose abuse.

Substance misuse services need to consider gender specific treatment interventions where the need is highlighted.

Youth Offending

The majority of young people who present to Lewisham's treatment services have at least one aggravating factor to their personal circumstances which increases their likelihood of substance misuse and reduces the social tools that most young people would be able to draw upon to help them overcome difficult periods such as addiction.

In 2014/15 the proportion of YP in substance misuse treatment involved in offending/antisocial was similar to the national average, at 36% against 32% nationally (Appendix 14).

Alcohol

The overall proportion of clients in treatment with problematic alcohol use in 2014/15 mirrors the national average (51%), 287 of these individuals presented with alcohol alone, with the other 454 individuals reported use of other substances. In Q2 2015/16 presentations have fallen to 45%[48].

Lewisham had a significantly higher proportion of clients in treatment drinking at higher risk levels at treatment start, compared with the national average, at 81% against 75% nationally (Appendix 14)[49].

Lewisham had a higher proportion of individuals in alcohol treatment consuming 1000+ units at treatment start, at 27%, against 19% nationally (Appendix 14)[50].

Lewisham had a significantly higher proportion of adults attending residential rehabilitation for alcohol treatment compared with the national average, at 11% against 3% nationally (Appendix 14)[51].

Lewisham had higher proportion of opiate clients new to treatment, reporting problematic drinking 9 days or more (26%), compared with the national average 21% (Appendix 15)[52].

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[47] Public Health England 2014/15
[48] PHE Recovery Diagnostic Tool 2014/15
[49] PHE Alcohol JSNA Support Pack
[50] PHE Alcohol JSNA Support Pack
[51] PHE Alcohol JSNA Support Pack
[52] PHE Alcohol JSNA Support Pack

Admission to hospital for mental and behavioural disorders due to alcohol for Lewisham was 116.5 per 100,000 of the population, the rate for England was 84.1 per 100,000 of the population [53].

Lewisham have seen the number of alcohol and violence related attendances at Lewisham A&E, fall from 108 to 60 (44%) since records started in July 2010 (appendix 16)[54].

Men (67%) are twice as likely to attend A&E due to an alcohol and violence incident than women, who make up just a third of attendances. Those aged 16-35 are over represented in such A&E attendances, contributing over half of the total number of attendances, despite comprising only a third of the total population.

Saturdays and Sundays have the most number of attendances throughout the whole period analysed. Attendances tend to be clustered between 5-7pm, 10-11pm and 12-1am. After 4am, attendances are lower and gradually increase after 10am towards lunch time.

5.0 National and local strategies

National Drug Strategy 2010[55]

The National Drug Strategy, 2010 puts a key focus on recovery. Whilst recognising that recovering from dependent substance misuse is an individual person-centred journey, there are high aspirations for increasing recovery outcomes. Drug and alcohol recovery systems are increasingly being geared towards the achievement of the outcomes highlighted;

- 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
- The capacity to be an effective and caring parent

The Home Office is currently consulting on the development of the new 2016 Drug Strategy; where it is assumed that the focus will continue to remain on abstinence and recovery but with an emphasis on providing holistic interventions and treatment services with less financial resources.

Public Health Outcomes Framework (PHOF)[56]

The Public Health Outcomes Framework Healthy lives, healthy people: Part 1 'Improving Outcomes and Supporting Transparency sets the overall context. There are two high-level outcomes, linked to further indicators four 'domains' across public health. The specific outcomes which relate to drugs and alcohol include:

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[53] Public Health Lewisham
[54] Public Health Lewisham
[55] Drug Strategy 2010 – Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life
[56] http://www.phoutcomes.info/

1) 2.15: Successful completion of drug treatment – Individuals achieving this outcome demonstrate a significant improvement in health and well being in terms of increased longevity, reduced blood-borne virus transmission, improved parenting skills and improved physical and psychological health.

2) 2.16: People entering prison with substance dependence issues who are previously not known to community treatment - There is significant evidence that treatment interventions for the management of substance misuse can help to reduce re-offending'

3) 2.18: Alcohol related hospital admissions – This indicator measures progress made in reducing alcohol-related accidents, injuries, assaults and self-harm.

4) 4.06: Under 75 mortality rate from liver disease.

Lewisham Health and Well Being Strategy - "Health and Wellbeing for all Lewisham residents by 2013"

Over the next three years (2015-18): the overall priorities for action are:

- to accelerate the integration of adult, children's and young people's care;
- to shift the focus of action and resources to preventing ill health and promoting independence;
- supporting our communities and families to become healthier and more resilient, which will include addressing the wider determinants of health.

Collective and concerted action on these three priorities, working with local communities, could bring about significant population level improvements. These priorities align with, and support delivery of, key national and local policies and programmes. These include the NHS five year Forward View, the Care Act, the Our Healthier South East London Consolidated Strategy, Lewisham's Adult Integrated Care Programme, and Lewisham's new Children & Young People's Plan. All these policies and programmes prioritise integration, prevention, collective action and stronger communities.

Reducing Alcohol Harm from is one of the key priorities in the ten year Lewisham Health and Well Being Strategy. The key actions to be delivered from 2015-18 on Reducing Alcohol Harm are:

- Practitioners to be skilled in identifying those at risk from alcohol harm and in delivering brief interventions
- Fewer drinkers at increased or higher risk of harm from alcohol and a decrease in the number of alcohol-related hospital admissions
- More people accessing and completing alcohol treatment services.
- Young people successfully exiting treatment in a planned way.
- A decrease in alcohol use by adults and young people across the borough
- Stabilise the number of early deaths from liver disease in Lewisham and, to achieve the same or lower levels as England

An Alcohol Delivery Group meets on a quarterly basis to develop, refine and monitor these actions. Progress to date is as follows:

- There has been a continued focus on enforcement regarding the availability and supply of alcohol and the Licensing Policy has been reviewed
- Increase in numbers screened for alcohol: All pregnant women are now screened for alcohol. Proportion of those having NHS Health checks screened for alcohol has increased significantly to almost 100% and is now embedded in programme.
- Increase in the number of front line workers trained to identify alcohol misuse and deliver brief interventions
- The Specialist alcohol care team at Lewisham hospital has become increasingly effective at reaching dependent drinkers in A & E and as inpatients, although their capacity is stretched and below the national average
- From April 2015 Specialist services for young people and shared care with GPs were re-commissioned from new providers

An Alcohol Harm performance Dashboard is used by the group to measure success and there are a number of indicators which are reported to the Health and Well Being Board on a regular basis:

- Alcohol related admissions rate
- Number of practitioners skilled in identifying those at risk from alcohol harm and delivering brief interventions
- Mortality from liver disease in males under 75

Health and Wellbeing Strategy Delivery Plan 2015-18:

Performance measure	Current performance	Comparator performance	Target 2017/18	Who is monitoring this?
Alcohol related admissions (ASR per 100,000 pop)	606	645	N/A	Alcohol Delivery Group
Number of practitioners skilled in identifying those at risk from alcohol harm and delivering brief interventions (Local source)	500	N/A	1000	Alcohol Delivery Group
Mortality from liver disease in males under 75 (DSR per 100,000)	31.3	23.4	N/A	Alcohol Delivery Group
Mortality from liver disease in females under 75 (DSR per 100,000)	13.2	12.4	N/A	Alcohol Delivery Group

Source: Public Health Lewisham

The Safer Lewisham Partnership (SLP)[57]

The Safer Lewisham Partnership is the statutory crime and disorder partnership for Lewisham. The Partnership has a duty to conduct an audit of crime, disorder, anti-social behaviour and drug misuse in Lewisham, to consult widely on the findings and set strategies to tackle the issues identified. The Partnership meets quarterly and is chaired by the Mayor of Lewisham.

[57] http://www.lewishamstrategicpartnership.org.uk/partnership_safer.asp

Lewisham Children and Young People Plan (CYP) – 2015/2018[58]

The Lewisham's Children and Young People's Plan 2015 – 2018 sets out the aims and priorities for all agencies working with children and young people across the borough. The specific outcome area which relate to drugs and alcohol is Be Healthy & Active' – HA5: which aims to reduce the prevalence and impact of alcohol, smoking and substance misuse.

Success is measured by the following performance indicators:

Performance measure	2014/15 baseline	Comparator baseline	Target 2017/18
5 Lewisham 15 year olds classified as smokers (regular & occasional)	8%	8% (national)	7%
No. of young people under 18 in substance misuse services	127	N/A	
% of Lewisham children accessing substance misuse services with positive outcomes	62%	80%	90%

Source: 'It's Everybody's Business' Lewisham's Children & Young People's Plan 2015 – 2018

6. What works?

Investing in effective prevention, treatment and recovery interventions is essential for tackling the harm that drugs and alcohol can cause, helping users overcome their addiction, reducing involvement in crime, sustaining their recovery, and enabling them to make a positive contribution to their family and community.

Treatment works. [59]The link between crime and drug and alcohol misuse is well established. There is significant evidence that treatment interventions for the management of substance misuse can help to reduce re-offending[60]. For every pound spent on treatment there is a saving of £3 pounds on crime. As well as saving on costs associated with social problems and poor health. Specialist interventions for young people's substance misuse are effective and provide value for money. A Department for Education cost-benefit analysis found that every £1 invested saved £1.93 within two years and up to £8.38 in the long term. Specialist services engage young people quickly, the majority of whom leave in a planned way and do not return to treatment services[61].

[62]Effective health and public-health commissioning of specialist treatment that achieves positive outcomes for individuals, families and communities by:

[58] http://www.lewisham.gov.uk
[59] Public Health England
[60] http://www.nta.nhs.uk/prison-based.aspx
[61] Public Health England 2014
[62] PHE Adult Drug and Alcohol Prevention and Treatment – Good Practice 2015/16

- Effective partnership working between local authority-led public health, the NHS (clinical commissioning groups and NHS England local area teams), mental health services, Jobcentre Plus, Work Programme providers, adult social care, children's services and criminal justice agencies
- Drugs misuse and dependence are prevented through early identification and interventions
- There is prompt access to effective treatment
- Operating transparently according to assessed need
- Bringing providers and mutual aid together
- Service user and local communities involvement, including through Healthwatch
- Access to suitable accommodation
- Support into work
- Integrated recovery support around training, education, voluntary work and general improvement of skills and work experience

Alcohol

Evidence points to a multi faceted and integrated response aimed at individual drinkers, at risk groups and whole populations and best practice includes the following:

a) Effective population level approaches are in place which will reduce the aggregate level of alcohol consumed and therefore lower the whole population's risk of alcohol related harm.
b) Large scale delivery of identification and brief advice (IBA) to those at the most risk of alcohol related ill-health. Early interventions aimed at individuals in at risk groups can make people aware of the harm they may be doing and prevent extensive damage to health and well-being.
c) Specialist alcohol care services for people in hospital.
d) Prompt access to effective alcohol treatment. There are packages of psycho social support, pharmaco-therapeutic and recovery interventions that are accessed by target populations and deliver sustained recovery from alcohol dependency

Young People

Intervening early works and saves money:[63]

- Young people's drug and alcohol interventions result in £4.3m health savings and £100m crime savings per year
- Drug and alcohol interventions can help young people get into education, employment and training, bringing a total lifetime benefit of up to £159m
- Every £1 spent on young people's drug and alcohol interventions brings a benefit of £5-£8
- [64]Patterns of young people's drug and alcohol use often change, so services need to be flexible and respond effectively to changing needs. Cannabis and alcohol are the most common substances that young people say they have a problem with when they present to specialist substance misuse services. However, organisations working with young people should be prepared to deal with all substances, including tobacco and novel psychoactive substances. A small minority will present with class A drug problems (such as heroin and cocaine).

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[63] PHE Alcohol and drugs prevention, treatment and recovery: why invest?
[64] PHE YP Drug and Alcohol Prevention and Treatment – Good Practice 2015/16

Whilst not all young people's substance misuse is problematic, and not all of those who do have problematic use go on to become entrenched addicts, there is clearly a need to provide exceptional interventions providing both prevention and specialist treatment to reduce harm and to ensure young people who have problematic substance misuse overcome this.

There are a number of specific issues facing girls; including increased citation of alcohol as a problematic substance, involvement in self-harm, being affected by domestic violence, and involvement in sexual exploitation. Services available need to be tailored to the specific needs of girls and boys within these services and ensure that young people with multiple vulnerabilities or a high risk of substance misuse-related harm get extra support with clear referral pathways and joint working protocols[65].

Evidence suggests that specialist substance misuse interventions contribute to improved health and wellbeing, better educational attendance and achievement, reductions in the numbers of young people not in education, employment or training and reduced risk taking behaviour, such as offending, smoking and unprotected sex[66].

A good public health approach should however consider the needs of developing young adults up to the age of 24, a period which includes heightened stages of exposure to health and wellbeing risks. Clear transitions and joint care plans with adult services will help under 18s who require on-going support beyond their 18th birthday[67].

7 Current activities and services

Lewisham actively seeks to meet the changing needs of Lewisham residents in relation to those seeking help and treatment to address substance misuse issues.

In February 2014 the DAAT Board agreed that the system be re-designed in order to better meet the needs of the following groups:

- Alcohol users
- Young people under the age of 25
- People who wish to access services in primary care settings
- People who come into contact with the criminal justice service
- Minority groups who do not wish to access a mainstream integrated drug service

This redesign led to the creation of the following commissioned services in Lewisham:

- Core Adult Treatment Service
- Community based/shared care service for people with drug and alcohol problems
- Reintegration & Aftercare Service

[65] Public Health England 2014
[66] The Health of Lewisham Children and Young People, The Annual Report of the DPH of Lewisham 2015
[67] Public Health England 2014

- Drug and alcohol treatment service for young people under 25

Core Adult Treatment Service

The treatment system had at its heart a large integrated service delivering interventions for adults aged 18 and over (those aged under 25 can also access the young person's service described below) provided by CRI (now known as CGL)[68]. The service delivers support, treatment and rehabilitation interventions to promote recovery and encourage individuals to maintain their recovery through engagement in positive activities such as employment and training.

The service provides prescriptions for substitute medications such as methadone as well as community alcohol detoxification and managing the interface with the Criminal Justice System and all health services including GPs, hospitals, and pharmacies. CGL provide a lead nurse to work with the Liaison Antenatal Drug Service (LANDS) midwife, a consultant addictions psychiatrist in the women's health clinic, Midwifery department at University Hospital Lewisham. Social workers and health visitors also work with patients to address some of their wider support needs, i.e. child protection issues, parenting issues and financial support and advice.

CGL also delivers a needle exchange programme throughout the borough. The service comprises of 7 pharmacies and 5 non-pharmacy sites, including CGL's treatment base in Lewisham High Street.

In accordance with NICE guidelines, all sites offer a range of disposable equipment including needles and sharps bins and advice about safe injecting practice[17]. At each contact, clients are advised about how to minimise the risk of infection and arrangements for testing can be made.

Primary Care Recovery Service (PSRS)

The Lewisham Primary Care Recovery Service is a community based treatment service for people with drug and alcohol problems, working alongside GPs, Pharmacists, Nurse and Health Care Workers to deliver shared care.

Services include: assessment, titration, alcohol screening, brief/extended interventions nurse led community detoxifications, Intensive key-working, pre and post detox support, group work peer support and BBV screening.

Reintegration & Aftercare Service (ReAL)

ReAL is an abstinence-based service offering support and advice to people working on their recovery from drugs and/or alcohol, by building resilience and relapse prevention; alongside opportunities to gain and build skills to move on and out of treatment. The service also provides support and opportunities to access employment, training and education.

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[68] CRI changed their name from Crime Reduction Initiatives (CRI) to 'change, grow, live'(cgl) w.e.f 1st April 2016

Drug and alcohol treatment service for young people under 25

Lifeline – The Hub is a drug and alcohol service for young people up to the age of 25. There is a specialist transition worker and an agreement to use a common triage assessment with adult services for 18-25 year olds.

Much of the work is carried out in satellite sites across the borough including youth centres, YOS, Probation, housing providers and Lewisham Hospital.

In addition to these commissioned services the council also provides a range of services and interventions via other means:

Detoxification and rehabilitation

Residential detoxification is delivered via core contracts with 3 providers while rehabilitation provision is procured on a needs led basis via a framework agreement.

Hidden Harm Service

It is important to provide smooth pathways into specialist treatment for possible hidden harm population(s) of alcohol-dependent parents, or those with childcare responsibilities. [69]Over a quarter of the English treatment population has a child living with them at least some of the time. The overall number of substance using parents or those with childcare responsibilities in treatment in Lewisham is lower than the national average (Appendix 8).

The Hidden Harm Service[70] was created in 2010 in response to the rising issue of parental substance misuse. In Lewisham this service effectively links adult services with children and family services ensuring that the family receives a holistic, co-coordinated and comprehensive approach with easy access to appropriate services to address their needs.

28%-33% of all Children's Social Care cases involve parental substance abuse, each case has an average of 2 children affected and 57% of the cases are Child protection. 18% of all children's social care cases have parental mental health and substance misuse. Children's social care caseloads show that in 29% of cases parental mental health is a significant problem, in each case an average 1.4 children is effected and 61% of these cases are child protection, if there is parental substance misuse as well this child protection figure rises to 90%.

The Hidden Harm service has worked with 73 parents in 2014/15 and supported them to access drug or alcohol treatment within the borough. In 42.3% of all referrals to Hidden Harm, alcohol is the primary substance; it plays a part in 57.6% of the total referrals.

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[69] PHE JSNA Support Pack
[70] The service works with all children and young people from ages 0-18

There are a number of effective population level approaches in place which reduce the aggregate level of alcohol consumed and therefore lower the whole population's risk of alcohol related harm:

Crime, Enforcement & Regulation (CER) Service

The new service, which commenced in August 2015, sits within the Crime Reduction Service and works to deliver strategic objectives set by the Safer Lewisham Partnership. It amalgamates four previously existing service areas within the council and their related functions, including trading standards, licensing, community safety and public health and nuisance. The CER service is responsible for responding to complaints and meeting statutory requirements and responsibilities across these thematic areas. It has four teams of officers who have delegated authority to enforce relevant legislation across those areas.

The service also acts as the licensing authority for the London borough of Lewisham and is responsible for delivering all licensing functions of the council. This involves, processing applications to statutory deadlines, supporting the licensing committee in its duties and enforcing and where necessary prosecuting against breaches of licensing conditions.
A new Statement of Licensing Policy has recently been agreed, which includes a review of the Cumulative Impact Zones, with a view to extending or increasing the number in Lewisham.

The Director of Public Health is now a Responsible Authority under the Licensing Act and utilises intelligence about alcohol harm to different population groups, including geographical areas within Lewisham to make representations to the Licensing Committee and to inform the future development of Cumulative Impact Zones.

Schools

Lewisham Public Health provide a whole school and wider community approach to drug and alcohol education, within Primary and Secondary Schools for a fee. Along with workshops to help parents/carers gain accurate information and dispel the myths around drugs and alcohol under a Service Level Agreement with each school.

Alcohol Identification Brief Advice Training programme

A training programme to enable large scale delivery of identification and brief advice (IBA) to those at the most risk of alcohol related ill-health contributes to the Health and Well Being board's plan to increase the number of brief interventions delivered in a range of lifestyle areas. It started in July 2013 and has trained over 750 front line staff so far and offered briefing sessions to managers. The aim of IBA is to introduce the concepts of alcohol related harm and how to deliver an evidence based intervention. The training explores the learning and provides participants with practical skills needed to deliver alcohol IBA with their everyday work routine.

The IBA training is delivered by the Alcohol Academy aimed at non – specialist workers (i.e. not alcohol workers) to a wide range of groups and settings, who have face to face contact with the public. The training includes post training evaluation to monitor outcomes.

WHAT IS THIS TELLING US?

8.0 What are the key gaps in knowledge and/or services?

(Percentages may equal more than 100% due to rounding)

The ratio of adult Males to Females in treatment population was 74% to 31%.

The ratio of Males to Females (aged 10-25) in the treatment population was 57% to 43%.

Lewisham has a significantly lower proportion of under 18's in treatment at 52% against 83% nationally. Young people aged 16-17 represent the age group with the highest reported substance misuse need (40% - 107/270) in Lewisham.

African (11.6%) adult residents are now also more numerous than Caribbean (11.2%), yet these client groups appear to be less well represented in treatment at 2.9% (33/1155) and 6.1% (71/1155) respectively.
The majority of young people in treatment under the age of 18 are Black Caribbean, at 30% (24/79) against 6% of under 18's in general population. White British are second, at 22% against 15% of under 18's in general population and Black African third, at 10% against 8% of under 18's in general population. There are currently zero Mixed Asian, Indian or Bangladeshi young people in treatment.

Recent data covering the twelve month period to 30th September 2015 shows a decline in the numbers of adults successfully completing their treatment since the baseline. Alcohol only users successfully completing have fallen below the national average at 31.1% against 39.1%.

Re-presentation rates are relatively high in Lewisham compared with top quartile range, particularly for poly substance users and dependent drinkers. With 9/41 (22%) and 11/61 (18%), returning to treatment having successfully completed.

The number of YP receiving specialist treatment has fallen by 18 % from 199 to 163 (12 month rolling).

Self-harm and sexual exploitation are specific issues facing females in YP treatment in Lewisham, at 43% (20/46) and 15% (7/46), against 5% (5/97) and 0% (0/97) respectively males. Nationally proportions are 33% and 12% respectively

Lewisham had a large proportion of opiate clients using the substance longer than 21 years (48% - 372/780), compared with a cluster average of 31%

Lewisham has a significantly lower proportion of clients in treatment with an offending history, at 16% (191/1193) drugs and 4% (11/286) alcohol only, against 58% and 6% nationally.

Lewisham had a significantly higher proportion of clients in treatment drinking at higher risk levels at treatment start, compared with the national average, at 81% (234/289) against 75% nationally.

Lewisham had a higher proportion of individuals in alcohol treatment consuming 1000+ units at treatment start, at 27% (78/289), against 19% nationally.

Lewisham had a significantly higher proportion of adults attending Resi Rehab for alcohol treatment compared with the national average, at 11% (31/294) against 3% nationally.

Lewisham had higher proportion of opiate clients new to treatment, reporting problematic drinking 9 days or more (26% -101/387), compared with the national average 21%.

Admission to hospital for mental and behavioural disorders due to alcohol for Lewisham was 116.5 per 100,000 population, the rate for England was 84.1 per 100,000.

Lewisham had almost double (16% - 87/533) the proportion of individuals reporting an urgent housing need (those with NFA and a housing problem) at the start of treatment compared with national average (9%).

Lewisham had a higher proportion of individuals were long term sick or disabled, at 29% (154/533) against a national average of 21%.

Those in regular employment are lower, at 14% (73/533) against 19% nationally. Being in work or accessing education and training is linked to better treatment outcomes.

On the 31st March 2012 Lewisham had a similar proportion of individuals in treatment on benefits, at 65% (561/862), against a national average of 61%.

Lewisham had a larger proportion of opiate users still using at six month review, also with the following complexity factors that negatively impact on successful completions: using on top, injecting, unemployment and a housing problems, compared with the national average.

The overall number of substance using parents or those with childcare responsibilities in treatment in Lewisham is lower than the national average.

It is of concern that deaths from liver disease among people under 75 are increasing in Lewisham as in England. Most of these deaths are due to alcohol misuse. Deaths among under 75s for all other causes are decreasing.

The proportion of individuals from LGBTQ communities accessing specialist treatment services in Lewisham remains low, similar to the previous year.

Given the changing trends in substance misuse and the increase in dependence on medicines (ATM), it is important that commissioners of substance misuse treatment in Lewisham have an understanding of not only illicit drug use, but also addiction to medicines, in order to ensure services have the capacity to support local needs.

Feedback from service user has highlighted the following gaps in treatment delivery:

- lack of women’s provision’s and early opportunity to engage in treatment
- financial hardship as a result sanctions introduced with changes to the benefit system
- skills gap - lack of computer skills/ literacy.

9.0 What is coming on the horizon?

The Home Office is currently consulting on the development of the new 2016 Drug Strategy; where it is assumed that the focus will continue to remain on abstinence and recovery but with an emphasis on providing holistic interventions and treatment services with less financial resources.

At the time of writing the New Psychoactive Substances (NPS) Bill had just been delayed and it is unclear when this will return to Parliament but it seems clear that this area of substance misuse is likely to increase over the coming years.

Given the changing trends in substance misuse and the increase in dependence on medicines (ATM), it is important that commissioners of substance misuse treatment in Lewisham have an understanding of not only illicit drug use, but also addiction to medicines, in order to ensure services have the capacity to support local needs.

Pregabalin misuse

Local intelligence has highlighted an increase in the misuse of pregabalin[71], which has resulted in an increase in issues with local treatment providers and other partnership agencies. A Pregabalin Dependency Pathway has been developed in Lewisham to ensure a consistent approach to prescribing, especially where patients are requesting increasing doses, younger male patients are presenting with vague symptoms of nerve pain/anxiety or newly registered patients are specifically requesting pregabalin.

Understanding the interdependency of sex and substance misuse

There is a changing demographic profile of Lewisham and increasing number of men who have sex with men living in Lewisham. Understanding the interdependency of sex and substance misuse, including chemsex and risks associated with each will be required in addition to ensuring that any commissioning of specialist services ensures effective working with sexual health services.

Updated alcohol consumption guidelines

The Department of Health has released updated alcohol consumption guidelines that will take effect immediately (although the wording is being consulted on until April 1st 2016). The new guidelines state that:

- There should be single guideline for men and women: This will now be 14 units a week for both men and women.
- There is an additional recommendation not to ‘save up’ 14 units for one or two days - but instead to spread them over three or more days
- A ‘protective effect’ is less significant than it was - i.e. one or two glasses of red wine does not prevent you from getting heart disease, as is often reported
- Alcohol and pregnancy: The previous line ‘If pregnant women choose to drink they should limit their drinking to one or two units once or twice a week’ will be removed to remove the current ambiguity around drinking in pregnancy

[71] Pregabalin was first developed as an anticonvulsant drug but is now mainly used for neuropathic pain and as an adjunct therapy for partial seizures

- The new guidelines will present new evidence about the clear links between alcohol consumption and cancer

Licensing

Lewisham Council has recently published a new Statement of Licensing Policy and will be reviewing the number and extent of the Cumulative Impact Zones within the policy, drawing on local intelligence about alcohol related violence and alcohol related harm.

Public Health allocation

The reduced Public Health allocation to local authorities is likely to have an impact on the resource available to fund preventive and specialist services.

Welfare Reforms

The Welfare Reforms which are currently being implemented are likely to lead to reduced disposable income for many people misusing substances and may affect recovery rates.

Substance misuse service 2016

The core specialist substance misuse service will be re-tendered in 2016, with a view to commissioning a new service from April 2017.

10.0 What should we do next?

Priorities for 2016/17:

- Investigate the under-represented groups in treatment i.e. older adults, women & certain BAME groups; with the aim to increase active participation for underrepresented groups in the Borough

- Work with JCP to investigate benefits profile of clients in treatment

- Investigate the increasing number of adults in treatment for 6 years or more; in addition to the examining the growing number of service users receiving treatment for Opiate use 21 years or more.

- Utilise ‘phasing and layering’ approach recommended by ‘Medications in Recovery’ and target treatment according to need.

- Minimise/reduce using on top as a recognised risk factor in DRD and also unsuccessful treatment, continue to provide Naloxone provision for those at risk of overdose.

- Review primary care services & pathways in order to work more collaboratively with GPs. i.e. to review opioid substitution therapy management with the view to improve the number of service users successfully completing treatment.

- Investigate what may be contributing to the reduction of treatment naïve clients and improve engagement.

- Establish the number of individuals who may be using and not accessing treatment, in order to ensure services can adapt to meet the needs of the community.

- Develop and implement a partnership marketing and communications plan/strategy that enables access to clear understandable information about services available and how to access

- Gather intelligence on new drugs/new psychoactive substances and develop effective responses to deal with the need.

- Explore how we might work with Sexual Health to understand the impact legal highs and or club drugs have on sexual health and Men who have Sex with Men (MSM), as they are more likely to use recreation drugs and participate in poly-drug use, and not access mainstream treatment provisions.

- Establish electronic recording for all needle exchange services in Lewisham.

- Investigate Tier 4 activity with regard to high numbers of alcohol clients accessing tier 4 treatment. .

- Improve referral pathways and expand interventions to support those most at risk through: identification; early intervention and brief advice by key professionals; interventions through the criminal justice system; primary care/pharmacist helping people onto treatment pathways; accessible levels of treatment.

- Make treatment providers aware of low penetration rate figures, and ensure they roll out an advertising campaign to expand awareness of treatment and to increase referrals from all sectors, specifically A&E and to consider placing a worker in A&E over weekend evenings

- Investigate the increase in older adults in alcohol treatment and Improve alcohol provision for this cohort and those who are increasing risk and higher risk drinkers in Lewisham.

- Consult with service users to improve and develop future service provision.

- Review pharmacy-based services and evaluate current activity.

- Increase number of individuals accessing BBV testing in order to: Maximise identification of BBV and facilitate treatment to enhance awareness and prevent BBV transmission. Explore testing for Hepatitis A, HIV, tuberculosis and other communicable diseases.

- Developing integrated pathways for family services as it is apparent that family services need to be central to Lewisham's treatment system in order to help overcome the wider harms caused by substance misuse.

- With the reduction in overall funding investigate structures for early interventions to reduce the long-term demand for treatment.

- Improve recording of users' recovery capital

- Continue to have multi-faceted approach to alcohol with a focus on population level enforcement regarding supply of alcohol, targeted scaled delivery of brief interventions and a specialist service with an increased focus on alcohol treatment, recovery and treatment completion in addition to completion of treatment for long term drug users.

- Continue to protect children and young people by reducing the supply of illegal alcohol and underage sales through a sustained focus on the enforcement of statutory regulations

- Selling alcohol to under age consumers must be identified and appropriate legal action taken to help reduce under age alcohol consumption.

- Optimise the use of social media, working in partnership with young people, to get key messages across to young people about smoking, drinking alcohol and using drugs

- Making it less easy to buy alcohol, by reducing the number of outlets selling it in a given area & the day and hours when it can be sold, is an effective way of reducing alcohol-related harm.

- Effective partnership working will help to unblock referral pathways and increase numbers in treatment.

- Decrease the number of referrals into treatment for alcohol at an earlier stage through increasing number of very brief interventions delivered and refining care pathways.

- Given the low numbers in the criminal justice system cohort, increase the number of referrals through improving the referral pathway

- Ensure services address the high rates of tobacco use among users and staff through referrals to the Stop Smoking Service and robust smoke free policies. Develop referral pathways into cessation services.

- Ensure service users access other lifestyle interventions such as health checks, health trainers, healthy walks and healthy eating & cookery classes

- Improve treatment completion rates for alcohol

- Reduce numbers of re-presentations via Mutual Aid support.

- Explore additional treatment pathways for service users i.e. access to Mutual Aid groups

- Given the changing trends in substance misuse and the increase in dependence on medicines (ATM), it is important that commissioners in Lewisham have an understanding of not only illicit drug use, but also addiction to medicines, in order to ensure services have the capacity to support local needs.

- Ensure service users access other lifestyle interventions such as health checks, health trainers, healthy walks and healthy eating & cookery classes.

Appendices

Appendix 1

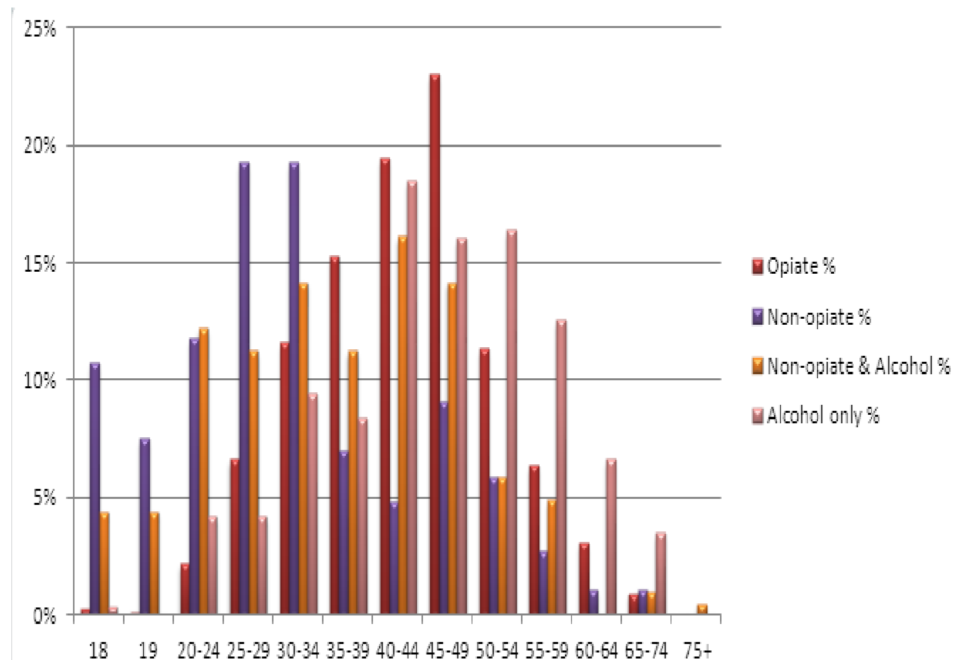
Adults

The table shows gender distribution of clients in treatment 2014/15 by four substance types (with a year to date update at quarter 2 2015/16):

	2014/15							Q2 2015/16				
	Male		Nat	Female		Nat	All	Male		Female		All
	n	%	%	n	%	%	n	n	%	n	%	n
Opiate	579	74	73	208	26	27	797	489	73	45	27	534
Non-opiate only	127	68	75	60	32	25	187	86	66	45	34	131
Non-opiate & alcohol	138	67	74	67	33	26	205	98	68	47	32	145
Alcohol only	185	65	62	102	35	38	207	132	63	76	37	208
Total	1029	74%	70%	437	31%	30%	1396	805	79%	213	21%	1018

Source: PHE Adult Partnership Activity Report & National Stats

The table shows age distribution of clients in treatment 2014/15 by four substance types:



Source: PHE Adult Partnership Activity Report & National Stats (Percentages may equal 0% or >100% due to rounding)

The table shows ethnic distribution of clients in treatment 2014/15 (with a year to date update at quarter 2 2015/16):

	In treatment in Lewisham				Lewisham Borough Profile			
	2014/15		Q2 2015/16		2011 Census		2001 Census	
All	1466		1155		275,885		248,922	
	n	%	n.	%	No.	%	No.	%
White - British	840	57.356	690	59.7	114,446	41.5	141,814	56.9
White - Irish	58	4.0	43	3.7	5,206	1.9	6,990	2.8
White - Gypsy or Irish Traveller	-	-	-		208	0.1	-	-
White - Other	129	8.8	87	7.5	27,826	10.1	15,294	6.1
White and Black Caribbean	49	3.3	46	4.0	8,539	3.1	4,760	1.9
White and Black African	8	0.5	7	0.6	3,559	1.3	1,599	0.6
White and Asian	4	0.3	5	0.4	3,045	1.1	1,565	0.6
Other mixed	25	1.7	18	1.6	5,329	1.9	2,475	1.0
Indian	4	0.3	6	0.5	4,600	1.7	3,487	1.4
Pakistani	1	0.1	1	0.1	1,596	0.6	1,090	0.4
Bangladeshi	1	0.1	1	0.1	1,388	0.5	1,229	0.5
Chinese	1	0.1	0	0.0	6,164	2.2	3,431	1.4
Other Asian	21	1.4	13	1.1	11,786	4.3	3,644	1.5
African	38	2.6	33	2.9	32,025	11.6	22,571	9.0
Caribbean	101	6.9	71	6.1	30,854	11.2	30,543	12.3
Black - Other	120	8.2	73	6.3	12,063	4.4	5,146	2.1
Arab	-	-	-	-	1,456	0.5	-	-
Other Ethnic Group	35	2.4	27	2.3	5,795	2.1	3,284	1.3
Not stated/missing	31	2.1	33	3	-	-	-	-

Source: PHE Adult Partnership Activity Report and Local Census data (percentages may equal 0% or >100% due to rounding)

The table shows latest successful completions covering a 12 month period:

	Baseline period		D.O.T		Latest period		Top Quartile range for Comparator LAs	Range to achieve Top Quartile
	(%)	(n)	B	LQ	(%)	(n)	* National average	
Opiate	7.2%	57 / 787	▼	▼	5.9%	46 / 777	10.07% - 13.59%	79 to 105
Non-opiate	48.1%	90 / 187	▼	▼	47.4%	93 / 196	44.44% - 58.28%	88 to 114
Alcohol	43.6%	125 / 287	▼	▼	31.1%	89 / 286	39.12%*	-
Alcohol and non-opiate	36.1%	74 / 205	▼	▼	33.2%	73 / 220	42.47% - 56.52%	94 to 124

Source: PHE DOMES

The table shows latest successful completions who have returned to treatment within 6 months:

	Baseline period		D.O.T		Latest period		Top Quartile range for Comparator LAs	Range to achieve Top Quartile
	(%)	(n)	B	LQ	(%)	(n)	* National average	
Opiate	8.3%	3 / 36	▼	▼	13.8%	4 / 29	11.54% - 0.00%	3 to 0
Non-opiate	2.5%	1 / 40	▲	–	0.0%	0 / 51	0.00% - 0.00%	0 to 0
Alcohol	11.8%	9 / 76	▼	▼	18.0%	11 / 61	10.73%*	-
Alcohol and non-opiate	2.7%	1 / 37	▼	▼	22.0%	9 / 41	4.26% - 0.00%	1 to 0

Source – PHE DOMES

Appendix 4

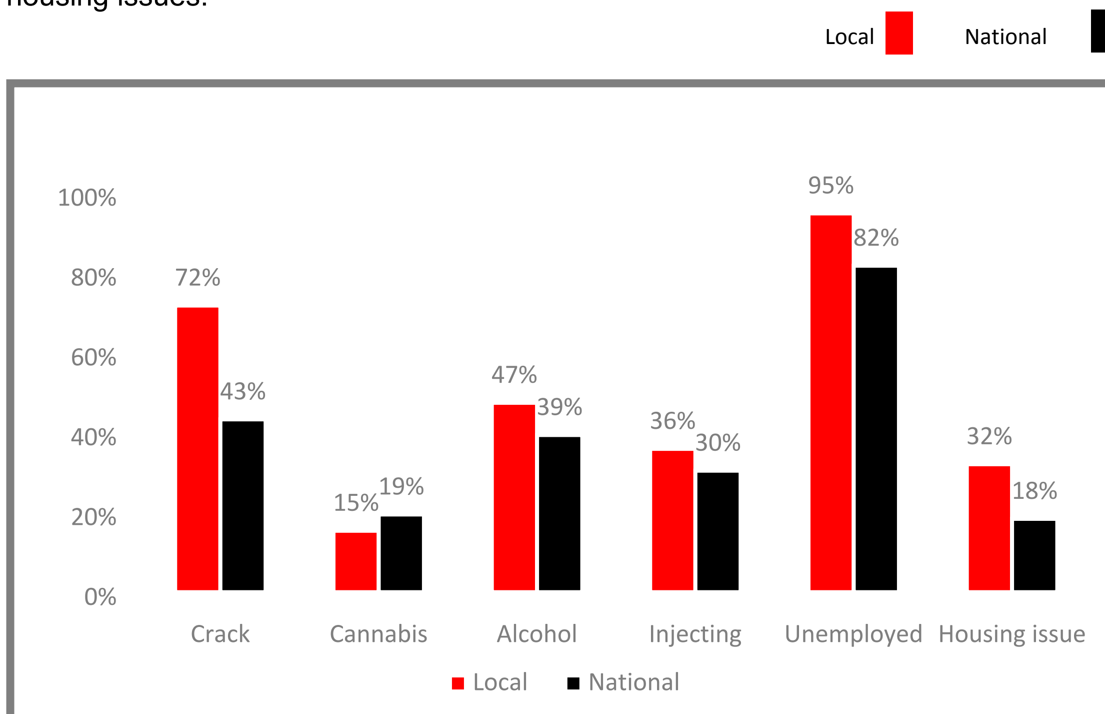
The table shows latest treatment outcomes at 6 month review:

1.4 Abstinence and reliably improved rates at 6 months review in the last 12 months	Abstinence rates		Expected range for your clients	Reliably improved
	(%)	(n)		(%)
Opiate abstinence and reliably improved rates	30.8%	33 / 107	24.1% - 41.9%	29.0%
Crack abstinence and reliably improved rates	28.6%	24 / 84	31.0% - 52.0%	16.7%
Cocaine abstinence and reliably improved rates	47.8%	11 / 23	35.8% - 76.3%	17.4%
Alcohol abstinence and reliably improved rates	16.0%	24 / 150	15.8% - 29.1%	23.3%
1.5 No longer injecting: 6 month review in last 12 months	48.8%	20 / 41	47.3% - 77.0%	14.6%

1.6 Housing and employment outcomes at successful completion of treatment	(%)	(n)	National average
Opiate Clients			
Clients with no reported housing need (Exit TOP)	86.5%	32 / 37	96.0%
Clients working >= 10 days in last 28 at exit	23.1%	9 / 39	24.3%
Non-Opiate Clients			
Clients with no reported housing need (Exit TOP)	90.3%	121 / 134	96.3%
Clients working >= 10 days in last 28 at exit	22.3%	29 / 130	32.9%

Source: PHE DOMES

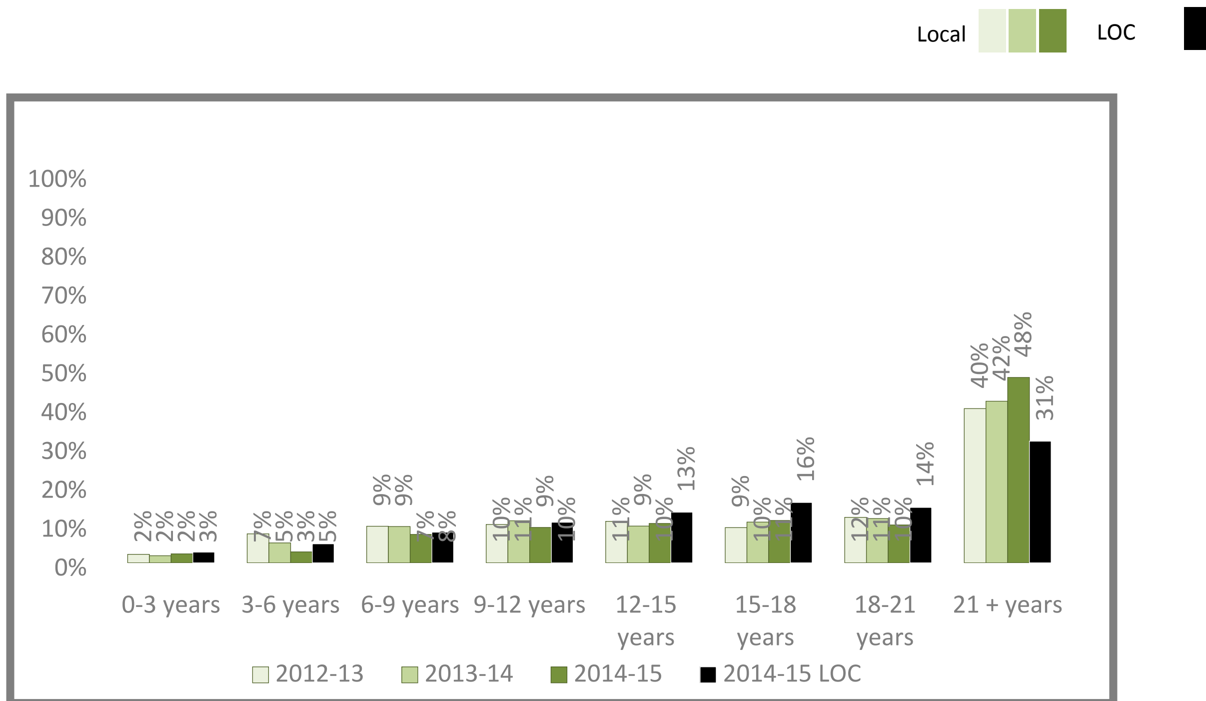
The graph below gives the percentage of opiate clients in Lewisham who are still using opiates at six month review and also using other drugs, injecting, are unemployed or having housing issues:



Source: PHE Recovery Diagnostic Tool (RDT)

Appendix 5

This chart shows the drug-using career length of opiate clients in treatment:



Source: PHE Recovery Diagnostic Tool 2014/15

The table shows the proportion of the treatment population in with an offending history:

	Latest period		National average
	(%)	(n)	(%)
Opiate	**18.9%**	147 / 777	**23.0%**
Non-opiate	**14.3%**	28 / 196	**20.5%**
Alcohol	**3.8%**	11 / 286	**6.3%**
Alcohol and non-opiate	**7.3%**	16 / 220	**14.6%**

Source: PHE DOMES

The table shows routes taken by drug and alcohol users to access structured treatment, by four substance groups:

Referral Source	Alcohol & Non-opiate		Non-opiate (only)		Alcohol (only)		Opiate		Total		
									LBL		Nat
Self, family & friends	83	60%	76	52%	138	60%	152	65%	449	60%	47%
GP	12	9%	7	5%	28	12%	4	2%	51	7%	13%
Hospital (including A&E)	1	1%	0	0%	7	3%	4	2%	12	2%	3%
Health (other)	15	11%	16	11%	9	4%	4	2%	44	6%	6%
Substance misuse service	6	4%	1	1%	12	5%	13	6%	32	4%	9%
CJS	16	12%	35	24%	21	9%	52	22%	124	17%	17%
Other	5	4%	10	7%	16	7%	5	2%	36	5%	5%
Subtotal Total	138	100%	145	100%	231	100%	234	100%	748	100%	100%
Missing or unknown	1		0		0		0		1		
Total	139		145		231		234		749		14646

Source: PHE Adult Partnership Activity Report & Adult substance misuse from NDTMS

This table shows the number of clients in treatment who cited prescription-only or over-the-counter medicine use at any point in latest treatment journey - 2014/15:

		Local n	Proportion of treatment population	Numerical split by gender M	F	National n	Proportion of treatment population
Number of adults citing POM/OTC use:	Illicit use	130	11%	90	40	26,266	13%
	No illicit use	17	1%	12	5	6,173	3%
	Total	147	12%	102	45	32,439	16%

Source: PHE Drug JSNA Support Pack

The table shows individuals with an accommodation need (new treatment journeys) – 2014/15:

Accommodation status at the start of treatment	Local	Proportion of new presentations	Proportion by gender		National	Proportion of new presentations
	n		M	F	n	
Urgent problem (NFA)	87	16%	19%	9%	7,188	9%
Housing problem	84	16%	14%	20%	10,973	14%
No housing problem	328	62%	63%	59%	58,801	73%
Other	33	6%	4%	12%	1,467	2%
Not stated/Missing	1	0%	0%	0%	1,813	2%

Source: PHE Drug JSNA Support Pack

The table shows employment status for individuals in treatment (start of treatment) – 2014/15:

Employment status at the start of treatment	Local n	Proportion of new presentations	National n	Proportion of new presentations
Regular employment	73	14%	15,080	19%
Unemployed/Economically inactive	252	47%	37,893	47%
Unpaid voluntary work	3	1%	197	0%
Long term sick or disabled	154	29%	17,135	21%
In education	18	3%	1,181	1%
Other	13	2%	2,062	3%
Not stated/Missing	20	4%	6,694	8%

Source: PHE Drug JSNA Support Pack

The table shows the benefits profile of individuals in treatment – 31st March 12:

Benefit profile of treatment population	Local n	Proportion of all in treatment on 31/03/2012	National n	Proportion of all in treatment on 31/03/2012
Number of individuals in drug treatment on 31/03/2012	862		134,090	
Number of individuals in drug treatment on 31/03/2012 recorded as being on benefits (of any type) on the 31/03/2012	561	65%	82,347	61%
Number of individuals in treatment recorded as being on benefits on the 31/03/2012 (by type)*:				
Jobseekers Allowance (JSA)	78	9%	19,178	14%
Employment Support Allowance (ESA)	216	25%	28,378	21%
Incapacity Benefit (IB)	212	25%	25,552	19%
Income Support (IS)	217	25%	26,315	20%
Disability Living Allowance (DLA)	148	17%	19,167	14%
Other	22	3%	4,308	3%

PHE Drug JSNA Support Pack

Proportion of adults in treatment living with children under the age of 18 - Q2 2015/16:

	Latest period (%)	Latest period (n)	National average (%)
Opiate	19.7%	153 / 777	30.1%
Non-opiate	13.8%	27 / 196	24.2%
Alcohol	21.3%	61 / 286	25.2%
Alcohol and non-opiate	20.0%	44 / 220	23.7%

Source: PHE DOMES

Young People

The table shows YP (up to age 25) gender distribution of clients in treatment 2013/14 - 2014/15 (with a year to date update at quarter 2 2015/16):

	2013/14		2014/15		Q2 2015/16		National
	no.	%	no.	%	no.	%	%
Male	158	58%	153	57%	80	53%	65%
Female	114	42%	116	43%	70	47%	35%
All	272	100%	269	100%	150	100%	100%

Source: PHE YP Activity Report

The table shows YP (up to age 25) age distribution of clients in treatment 2013/14 - 2014/15 (with a year to date update at quarter 2 2015/16):

	2013/14		2014/15		Q2 2015/16		National
	no.	%	no.	%	no.	%	%
Under 13	0	0%	0	0%	1	1%	1%
13-14	43	16%	47	17%	12	8%	16%
15	67	25%	44	16%	25	17%	21%
16	54	20%	57	21%	17	11%	23%
17	46	17%	50	19%	23	15%	22%
18	32	12%	30	11%	15	10%	9%
19	14	5%	20	7%	9	6%	3%
20-21	15	6%	19	7%	28	19%	3%
22-24	1	0%	2	1%	18	12%	3%
25	0	0%	0	0%	2	1%	0%
All	272	100%	269	100%	150	100%	100%

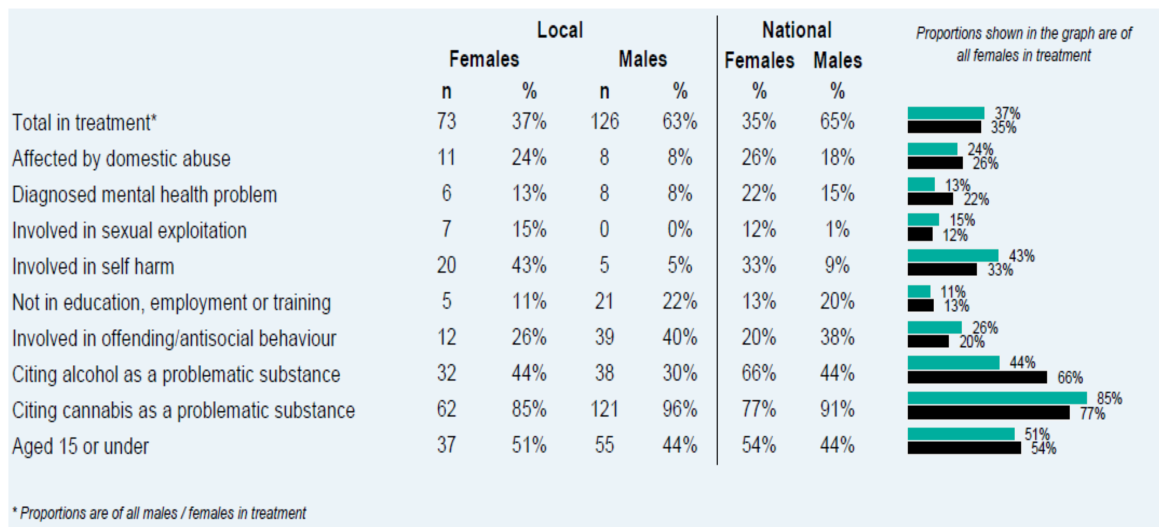
Source: PHE YP Activity Report

The table shows ethnicity (young people up to age 17)

	In treatment						Lewisham Borough Profile
	2013/14		2014/15		Q2 2015/16		2011 Census
	n	%	n	%	n	%	
White British	73	35%	57	29%	17	22%	14.8%
White Irish	3	1%	2	1%	1	1%	0.2%
White Gypsy or Irish Traveller							0.0%
White Other	10	5%	7	4%	4	5%	2.9%
White & Black Caribbean	24	11%	19	10%	6	8%	3.3%
White & Black African	2	1%	4	2%	1	1%	1.4%
White & Asian	0	0%	1	1%	0	0%	1.2%
Other Mixed	12	6%	16	8%	3	4%	2.3%
Indian	0	0%	0	0%	0	0%	0.6%
Pakistani	1	0%	1	1%	1	1%	0.4%
Bangladeshi	0	0%	0	0%	0	0%	0.3%
Chinese	1	0%	0	0%	1	1%	0.8%
Other Asian	4	2%	3	2%	2	3%	2.4%
Black African	14	7%	19	10%	8	10%	8.0%
Black Caribbean	40	19%	45	23%	24	30%	5.8%
Black Other	25	12%	21	11%	7	9%	4.3%
Arab							0.3%
Other ethnic group	0	0%	0	0%	2	3%	1.1%
Not stated	1	0%	4	2%	1	1%	
Missing/inconsistent	0	0%	0	0%	1	1%	
All Ethnic groups	210		199		79		

Source: PHE YP Activity Report

This table shows some areas where the presenting needs of young females differs from young males in treatment:



	Local				National	
	Females		Males		Females	Males
	n	%	n	%	%	%
Total in treatment*	73	37%	126	63%	35%	65%
Affected by domestic abuse	11	24%	8	8%	26%	18%
Diagnosed mental health problem	6	13%	8	8%	22%	15%
Involved in sexual exploitation	7	15%	0	0%	12%	1%
Involved in self harm	20	43%	5	5%	33%	9%
Not in education, employment or training	5	11%	21	22%	13%	20%
Involved in offending/antisocial behaviour	12	26%	39	40%	20%	38%
Citing alcohol as a problematic substance	32	44%	38	30%	66%	44%
Citing cannabis as a problematic substance	62	85%	121	96%	77%	91%
Aged 15 or under	37	51%	55	44%	54%	44%

* Proportions are of all males / females in treatment

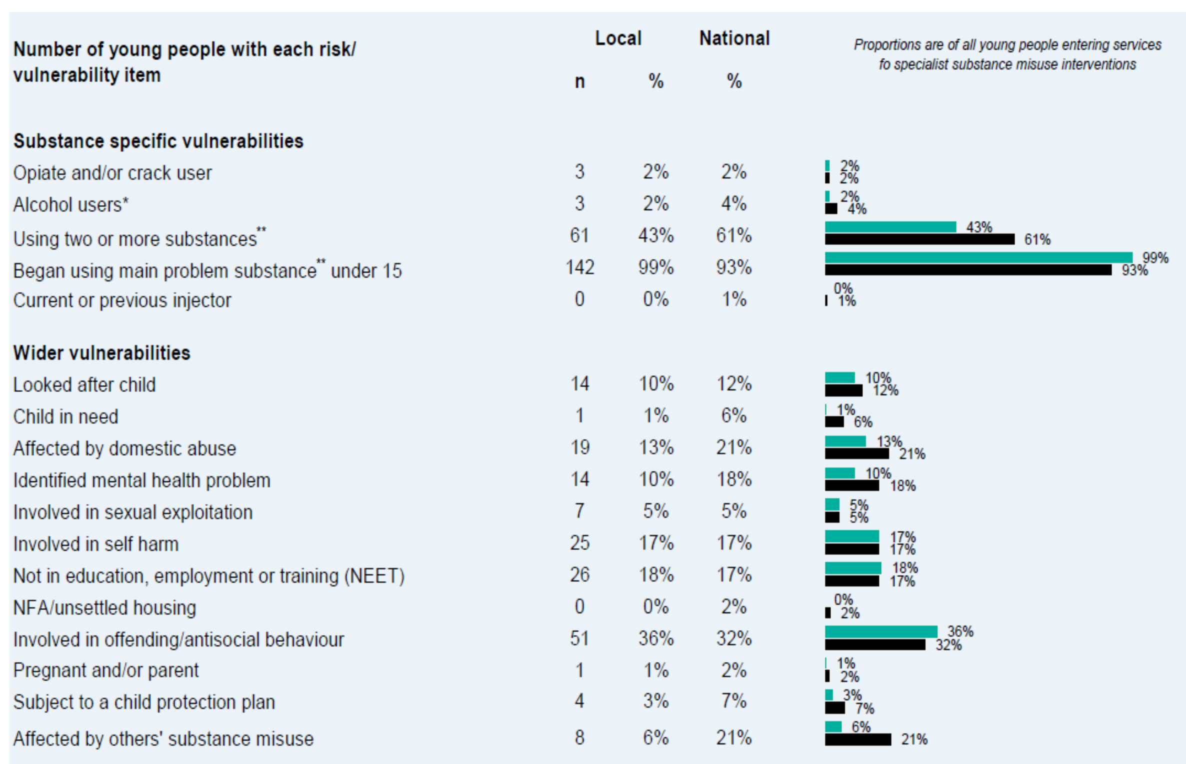
Source: Source: PHE YP JSNA Support Pack (a YP may report more than one vulnerability therefore the % may be >100%)

The table shows referral routes into treatment for YP under 18 YTD (new presentations):

Referral Source	Lewisham				National
	Baseline 2014/15	Q1	Q2		
Children & family Services	10%	15%	12/79	15%	20%
Education Services	22%	19%	16/79	20%	22%
Health & Mental Health	7%	6%	4/79	5%	8%
Accident & emergency	1%	1%	1/79	1%	2%
Substance Misuse Services	1%	0%	1/79	1%	3%
Youth Justice Service	50%	9%	17/79	22%	29%
Self, family & Friends	4%	47%	26/79	33%	12%
Other (inc blank)	4%	3%	2/79	3%	4%

Source: PHE YP Partnership Activity Report (by age)

The table shows the range of vulnerabilities of YP in substance misuse treatment in Lewisham 2014/15:



Number of young people with each risk/ vulnerability item	Local		National	*Proportions are of all young people entering services fo specialist substance misuse interventions*
	n	%	%	
Substance specific vulnerabilities				
Opiate and/or crack user	3	2%	2%	2% 2%
Alcohol users*	3	2%	4%	2% 4%
Using two or more substances**	61	43%	61%	43% 61%
Began using main problem substance** under 15	142	99%	93%	99% 93%
Current or previous injector	0	0%	1%	0% 1%
Wider vulnerabilities				
Looked after child	14	10%	12%	10% 12%
Child in need	1	1%	6%	1% 6%
Affected by domestic abuse	19	13%	21%	13% 21%
Identified mental health problem	14	10%	18%	10% 18%
Involved in sexual exploitation	7	5%	5%	5% 5%
Involved in self harm	25	17%	17%	17% 17%
Not in education, employment or training (NEET)	26	18%	17%	18% 17%
NFA/unsettled housing	0	0%	2%	0% 2%
Involved in offending/antisocial behaviour	51	36%	32%	36% 32%
Pregnant and/or parent	1	1%	2%	1% 2%
Subject to a child protection plan	4	3%	7%	3% 7%
Affected by others' substance misuse	8	6%	21%	6% 21%

Source: PHE YP JSNA Support Pack (YP may report more than one vulnerability therefore the % may be >100%)

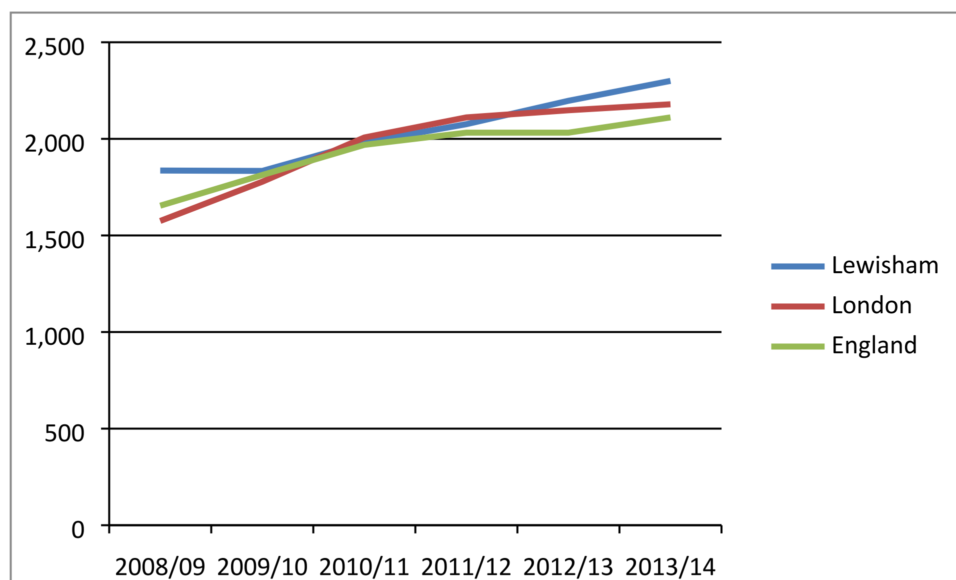
Alcohol

Alcohol drinking categorisation and definitions

Drinking Category	Government definition	Operational definition
Abstainers	No Government definition for abstinence exists.	A person whose weekly alcohol consumption was reported in the General Lifestyle Survey as 0 units over the previous 12 months.
Lower risk	Men who regularly drink no more than 3 to 4 units per day and women who regularly drink no more than 2 to 3 units per day.* Weekly limits are no more than 21 units per week for a man and 14 units per week for a woman .**	A man whose average weekly alcohol consumption was reported in the General Lifestyle Survey as >0 and <=21 units in the previous 12 months. A woman whose average weekly alcohol consumption was reported in the General Lifestyle Survey as >0 and <=14 units in the previous 12 months.
Increasing risk	Men who regularly drink over 3 to 4 units per day and women who regularly drink over 2 to 3 units per day.* Weekly limits are more than 21units to 50 units for a man and more than 14 units to 35 units for a women.**	A man whose average weekly alcohol consumption was reported in the General Lifestyle Survey as being >21 units to <=50 units in the previous 12 months. A woman whose average weekly alcohol consumption was reported in the General Lifestyle Survey as >14 units to <=35 units in the previous 12 months.
Higher risk	Men who regularly drink over 8 units per day or over 50 units per week and women who regularly drink over 6 units per day and over 35 units per week.*	A man whose average weekly alcohol consumption was reported in the General Lifestyle Survey as >50 units in the previous 12 months. A woman whose average weekly alcohol consumption was reported in the General Lifestyle Survey as >35 units in the previous 12 months.

Source: NW England Public Health Observatory, Topography of Drinking Behaviours in England - August 2011

The figure below shows hospital admissions where the primary diagnosis or any of the secondary diagnoses are an alcohol-attributable 2008/09 to 2013/14:



Source: Public Health Lewisham

The table show the number in treatment drinking at higher risk levels and units consumed at start of treatment 2014/15

	Local	% all in treatment	Proportion by gender		National	% all in treatment	Proportion by gender		% drinking at higher risk levels
	n		M	F	n		M	F	
Drinking at higher risk levels in the 28 days prior to entering treatment	234	81%	82%	79%	65,180	75%	75%	75%	

Units consumed in the 28 days prior to entering treatment:	Male	Female	0 units		1-199		200-399		400-599		600-799		800-999		1000+	
	n	n	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Local	190	99	3%	3%	15%	26%	16%	24%	19%	23%	15%	7%	12%	8%	19%	8%
National	53,656	33,238	7%	7%	18%	25%	19%	25%	20%	22%	13%	10%	10%	6%	13%	6%

Proportion by gender

Individuals with missing units data are not included in this section

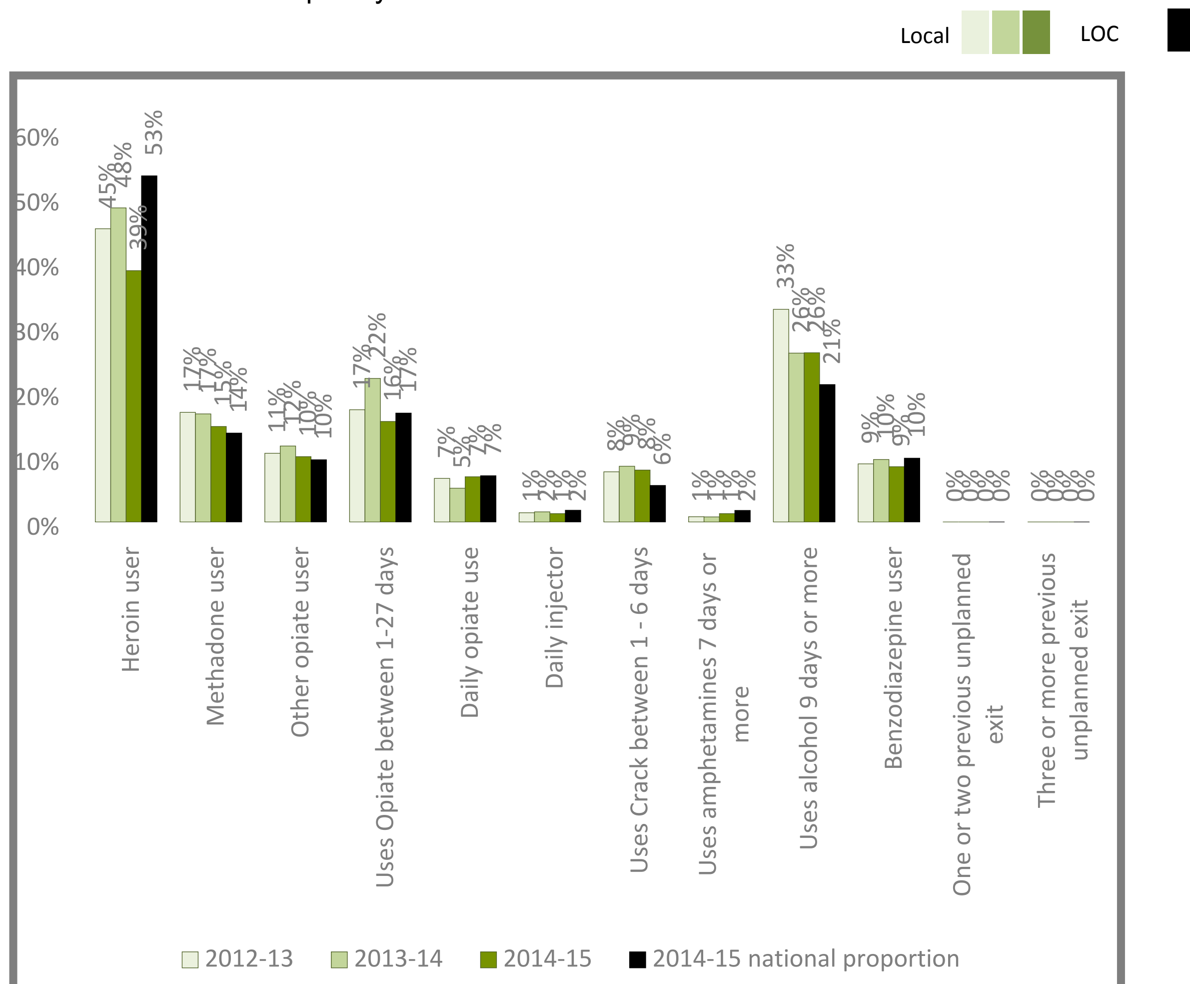
Source: PHE Alcohol JSNA Support Pack

The table show the number dependant drinkers who have been to residential rehabilitation 2014/15:

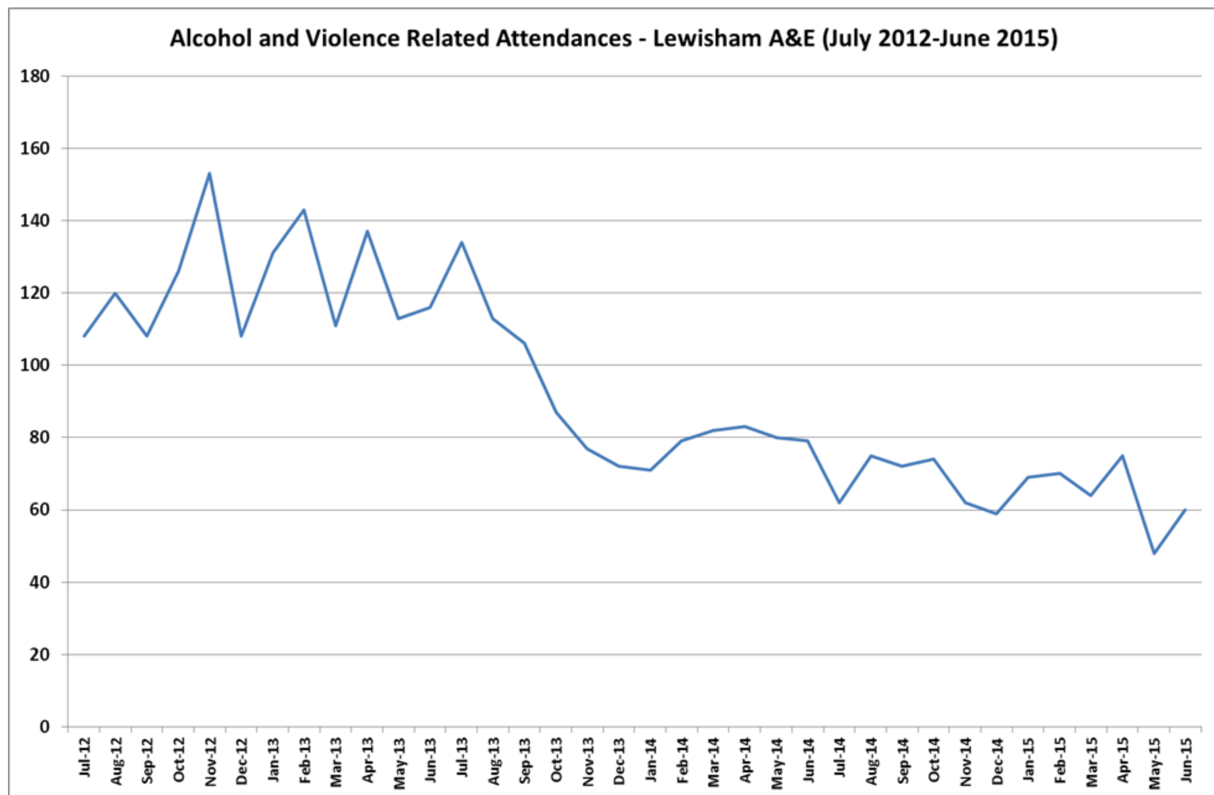
	Local n	% of all in treatment	National n	% of all in treatment
Number of adults who attended residential rehabilitation	31	11%	2,630	3%

Source: PHE Alcohol JSNA Support Pack

This chart shows the proportion of treatment naïve clients, who reported each of the factors that increase their complexity:



Source: PHE Recovery Diagnostic Tool 2014/15



Source: Public Health Lewisham

This table death due to drugs and alcohol in Lewisham – 2009 to November:

Year	Alcohol	Drugs	Mixed	Total
2015 (to Nov)	33	5	0	34
2014	17	3	2	21
2013	17	0	2	19
2012	16	5	0	21
2011	15	8	5	28
2010	16	7	1	24
2009	16	7	8	31
Total	130	35	18	183

Source: Primary Care Mortality Database, ONS (local analysis)

Key contact: Lorna Thomas

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