West Northamptonshire Health and Wellbeing Board

A meeting of the West Northamptonshire Health and Wellbeing Board will be held at the Council Chamber, The Forum, Towcester NN12 6AF on Tuesday 23 January 2024 at 10.00 am

Agenda

1.	**Apologies for Absence and Notification of Substitute Members**
2.	**Notification of Requests to Address the Meeting** The Chairman to advise whether any requests have been received to address the meeting.
3.	**Declarations of Interest** Members are asked to declare any interest and the nature of that interest which they may have in any of the items under consideration at this meeting.
4.	**Chair's Announcements** To receive communications from the Chair.
5.	**Minutes and actions from Previous meeting 11th December** (Pages 5 - 18) To confirm the Minutes of the meeting of the Board held on 11th December 2023 – Chair To review actions from previous meeting 11th December 2023 - Chair Work Well Partnership Bid update – Toby Sanders (verbal)
6.	**West Northamptonshire Health and Wellbeing Board Terms of Reference and Election of Vice Chair** (Pages 19 - 28)

7.	**Life Your Best Life thematic session: Ambition 9 Access to health and social care when they need it** (Pages 29 - 60) • Joint Health and Wellbeing Strategy Ambition 9 Delivery Plan Metrics & LAP Delivery – Sally Burns, Karen Spellman, Julie Curtis (Presentation) • Urgent Emergency Care Strategy Engagement – Chris Pallot (Reports) • Primary Care Strategy - Julie Lemmy (presentation) • BCF/Prevention Strategy – Ashley Leduc/Michael Hurt (Presentation) • Health Inequalities and prevention – Paul Birch (presentation) • COVID Impact Assessment – Annapurna Sen (Presentation) • Dentistry – Toby Sanders (verbal)
8.	**Voluntary Sector Spotlight:** (Verbal) South Northants Volunteer Bureau – Rachael Page Broadmead Church – Adam Eakins
9.	**Local Area Partnership Terms of Reference** (Pages 61 - 68)
10.	**Any Other Business**
11.	**Close meeting**
12.	**Reports for information - Substance Misuse Needs Assessment** (Pages 69 - 192)

West Northamptonshire Health and Wellbeing Board Members:

Councillor Matt Golby (Chair)

Councillor Fiona Baker
Dr Jonathan Cox
Sally Burns
Colin Foster
Russell Rolph
Colin Smith
Dr Andy Rathbone
Professor Jacqueline Parkes
Dr Philip Stevens
Dr Santiago Dargallonieto
Heidi Smoult
Councillor Jonathan Nunn
Anna Earnshaw
Naomi Eisenstadt
Stuart Lackenby
Toby Sanders
Michael Jones
Councillor Wendy Randall
Wendy Patel
Dr David Smart
David Maher
Robin Porter

Miranda Wixon | Carella Davies

Chief Superintendent Rachel Handford

Information about this Agenda

Apologies for Absence
Apologies for absence and the appointment of substitute Members should be notified to Cheryl.bird@westnorthants.gov.uk prior to the start of the meeting.

Declarations of Interest
Members are asked to declare interests at item 2 on the agenda or if arriving after the start of the meeting, at the start of the relevant agenda item

Local Government and Finance Act 1992 – Budget Setting, Contracts & Supplementary Estimates
Members are reminded that any member who is two months in arrears with Council Tax must declare that fact and may speak but not vote on any decision which involves budget setting, extending or agreeing contracts or incurring expenditure not provided for in the agreed budget for a given year and could affect calculations on the level of Council Tax.

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Queries Regarding this Agenda
If you have any queries about this agenda please contact Cheryl Bird, Health and Wellbeing Board Business Manager via the following:

Tel: 07500 605450
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Or by writing to:

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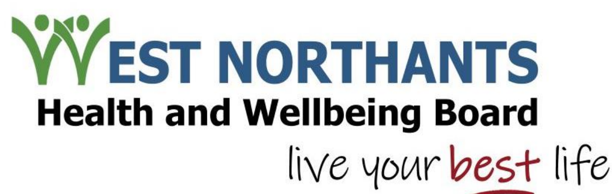

WEST NORTHAMPTONSHIRE HEALTH & WELLBEINGBOARD
Minutes of the meeting held on 11th December 2023 at 10.00 am
Venue: Jeffrey Room, Guildhall, Northampton, NN1 1DE

Present:

Councillor Matthew Golby (Chair)	Cabinet Member for Adults, Health and Wellbeing, West Northamptonshire Council
Colin Foster	Chief Executive, Northamptonshire Childrens Trust
Councillor Wendy Randall	Labour Group Leader, West Northants Council
David Maher	Deputy Chief Executive, Northamptonshire Healthcare Foundation Trust
Dr David Smart	Chair Northampton Health and wellbeing Forum
Gabriella Van Beek	Office Manager, Healthwatch Northamptonshire
Miranda Wixon	Co-Chair Daventry and South Northants Health and Wellbeing Forum
Palmer Winstanley - substitute	Chief Operating Officer, Northampton General Hospital
Professor Jacqueline Parkes	University of Northampton
Rebecca Wilshire	Director of Childrens Services, West Northants
Russell Rolph Via Teams	Chief Executive, Voluntary Impact Northamptonshire
Sadie Beishon - substitute	Public Health Principal Health Inequalities, West Northants Council
Sally Burns via Teams	Director of Public Health, West Northants Council
Stuart Lackenby	Deputy Chief Executive, West Northants Council

Also, Present

Anya Willis, Chief Executive Re:Store
Belinda Green, Assistant Director Revenue and Benefits, West Northants Council
Bonita Wallace, Senior Public Health Administrator, West Northants Council
Julie Curtis via Teams Assistant Director PLACE Development, West Northants Council
Louis Devayya, Senior Economic Growth Officer, West Northants Council
Michael Hurt, Better Care Fund Service Manager
Michelle Grimwood, LAP Project Lead
Rachael Byrne, LAP Project Lead
Racha Fayad, Public Health Principal Children and Young People, West Northants Council
Rhoda Asante, Public Health Administrator, West Northants Council

67/23 Apologies

Anna Earnshaw, Chief Executive, West Northants Council
Carella Davies, Chief Executive, Daventry Volunteer Centre
Cllr Jonathan Nunn, Leader, West Northants Council
Colin Smith, Chief Executive, LMC
David Peet, Chief Executive, Office Police, Fire Crime Commissioner
Dr Andy Rathborne, Primary Care Network
Dr Philip Stevens, GP, Chair Daventry and South Northants GP Locality
Dr Santiago Dargallonieto, Chair, Northampton GP Locality
Heidi Smoult, Chief Executive, Northampton General Hospital
Michael Jones, Divisional Director, EMAS
Robin Porter, Assistant Chief Fire Officer, Northants Fire and Rescue

68/23 Notification of requests from members of the public to address the meeting

None Received.

69/23 Declaration of members' interests

None received.

70/23 Chairs Announcements

The Chair made the following announcements:

Representatives from NHS Northamptonshire Integrated Care Board (ICB) are not able to be in attendance for this meeting. If there are decisions required by the Board at today's meeting these will be deferred until the next meeting.
Post meeting note: No decisions were required.

In November, there were two new launches from West Northants Council (WNC). Firstly, our new **Adult Social Care and Wellbeing** webpages went live. This provides residents and professionals with a single landing page for all services and information relating to adult social care and wellbeing, making this information more accessible. The launch of these new pages support our prevention workstream, putting prevention information at the forefront, ensuring residents have easy to access, helpful and informative information that will improve their customer experience to enable them to help themselves improve their health and wellbeing.

Also, our winter well public health campaign went live. The WinterWell campaign aims to help residents improve their health and wellbeing this winter, encouraging them to 'live their best life' by providing advice and tips, as well as signposting them to services when required. **WinterWell** addresses a wide range of topics, including general wellbeing, ageing well, economic wellbeing and mental health, with information being shared in a phased approach over the upcoming months.

The campaign will run across all of West Northants until March 2024 and will include a range of messaging and channels, some targeted to specific Local Area Partnerships (LAPs) where the workstream overlaps with their priorities. The team are also working closely with

Integrated Care Northamptonshire (ICN) comms team to support message sharing of the wider system pressures campaign and mental health support messages.

71/23 Minutes and actions from the previous meeting 28th September

RESOLVED that:

- **The minutes from the previous meetings held on the 28th September were agreed as an accurate record.**
- **All actions from the previous meeting held on the 28th September have been completed.**

72/23 Voluntary Sector Spotlight – Re:Store

The Chief Executive Re:Store gave an overview of their work and highlighted the following:

- The definition of poverty used by the Joseph Rowntree Foundation is 'Poverty means not being able to heat your home, pay your rent, or purchase the essentials for your children. It means waking up every day facing insecurity, uncertainty, and impossible decisions about money'.
- The definition of employment is around paid labour in exchange for paid contract, but for the VCSE sector this can also mean engaged in meaningful activity rather than direct employment.
- In Northamptonshire currently 17% of the working age population are economically inactive. Approximately 20% of the working population in Northamptonshire fall into low income households category.
- Re:Store formed 10 years ago, over these 10 years they have had contact with approximately 80k adults and children through their food banks and other emergency provision.
- Work of the charity forms part of the Anti-Poverty Strategy focusing on the first 2 priorities:
  - Supporting people who are struggling in poverty now
  - Preventing people from falling into poverty in the first place
- The most vulnerable groups in society are women, children and ethnic minorities, especially those with no recourse to public funds. Re:Store see those who are isolated with low mental health issues, experienced trauma, problematic births, homelessness financial distress or trafficking. The impact of poverty has a negative impact on mental health and wellbeing of families. Many referred to Re:Store have complex needs and need access to wider support and referral to specialist services.
- The focus of Re:Store is to bring communities to life through love and compassion. There are a wide range of projects focusing on building communities and strengthening families. In turn they hope to contribute to reducing the impact of poverty within Northampton Town and improving health and wellbeing.
- Re:Store projects are spilt into 3 areas:
  - Crisis provision
    - The food bank has been running for 14 years and distributes approximately £200k of essentials including food, cleaning products, hygiene over 6 locations with 50 volunteers. This is a referral based emergency provision on a short term basis, and forms part of the Food Aid Alliance in West Northants. Community Law Service is onsite during the food bank opening hours to provide debt/financial advice to those struggling.
    - Grow Baby provide new or pre-loved clothing, toys and essentials for families. This is referral based, but families do not have to be in crisis, they can be in low

income households or facing hardship. Many families referred to Grow Baby have no recourse to public funds.
    - Re:Store have a Christmas appeal with a Christmas grotto where parents of children under the age of 5 can choose presents or books to give their children.
- Strengthening families
    - A 6 week parenting course if offered, with a free creche, with the majority of parents accessing this service isolated with no support networks.
    - Time for Me is a 6 week wellbeing course, using techniques and resources linked to the Action for Happiness initiative, with the aim to improve the health and wellbeing of families. The majority of those attending have not had access to self-support for low level mental wellbeing and many have experienced trauma in their past.
    - CAP Money course is a free 3-week course that teaches people how to budget, save up and spend wisely.
    - Re:store Allotment is a volunteer led project, that seeks to grow skills and independence through growing fruit and vegetables, to improve mental wellbeing and reduce isolation, with most of the referrals come through Northamptonshire MIND or social prescribers. This initiative was awarded the Northamptonshire Community Foundation (NCF) Healthier and Happy Communities award for 2023.
    - There are support programmes led by an occupational therapist to build individual action plans focused on meaningful occupation, building confidence and skills.
- Building community
    - The Re-Store Hub runs alongside the food bank, this is volunteer led and welcome approximately 30 households per session.
    - The family hub runs alongside the Grow Baby session and provides free refreshments for families in attendance. The main focus is for volunteers to listen to peoples stories and help them to make positive changes.
    - Baby Nest is for under 18 months and is targeted at more vulnerable and isolated families that need quality time together, with baby massage and songtime sessions.

- The voice of Re:Store is a co-production group including service users who are involved in helping to set the future direction of the charity.
- There is a high and growing demand for Re:Store's services, with the charity constantly having to review the services they offer to meet this need. The lack of statutory services and clear pathways can mean that customers can often stay with Re:store longer rather than seeking specialist support.
- As Re:store rely on charitable funding, wages and overheads are lower, leading to less equipped and experienced staff facing complex situations. There is a constant effort to find funding and compete against other charities.

The Chief Executive of Re:Store chairs the Food Aid Alliance West Northants Forum and provided an overview of their work:

- This was established during the COVID19 pandemic, bringing together all the food aid providers across the county, to share understanding of good practice to bring uniformity into these services and avoid duplication.
- A process has been mapped for those in immediate food aid crisis in the short term, to those on low income and in hardship requiring longer support.
- The Alliance is comprised of 35 organisations.
- The collaborative has secured £600k of funding from the household support fund, for all organisations in the Alliance to purchase food. The funding has been spilt 50:50 between the food aid providers and larders.

- Organisations that are part of the alliance also face costs for hiring community rooms, heating these spaces and supporting workforce/volunteers. The food aid partners provide wrap around services alongside providing food.

The Board discussed the update and the following was noted:
- There is a need to consider how faith communities can contribute and work in partnership with the VCSE sector and how this sector can also be included when developing new pathways and training programmes.
- If the VCSE sector could access more specialist support, this could link in with the early help offer of helping families stay together when it is safe to do so. Including follow up services with social workers.
- Having no recourse to public funds can make families homeless, with the children coming into the care system.
- There needs to be a debate about how public funding is distributed amongst VCSE organisations.
- WNC have started to plan for the implications of not having a Household Support Fund 5 post April 2024, including providing free meals during schools holidays.
- Part of the work of the Anti-Poverty Steering group is to consider how strategically the demand for food bank etc can be reduced.
- Discussions are taking place between WNC and NHS Northamptonshire ICB around looking at the totality of investment from public sector organisations into West Northamptonshire to understand where there might be areas of duplication. Using the evidence base contained within the JSNA for the commissioning cycle for designing interventions.

RESOLVED that the Board noted the update.

73/23 Live your best life domains: Employment that keeps them and their families out of poverty:

The Chair advised the Live Your Best Life (LYBL) thematic theme for this meeting is Employment to keep them and their families out of poverty.

The Public Health Principal, Health Inequalities gave an overview of the health skills and employment data and highlighted the following:
- The Integrated Care Partnership (ICP) held a workshop on the 15th November to discuss the Integrated Care Systems (ICS) 4th aim to support broader social and economic development.
- The workshop looked at understanding the local need and strategies already in place, as well as the programmes of work contributing to this aim and how partners can align more.
- In 2022/23 the gap in the employment rate for those with a physical or mental long term health condition (aged 16 to 64) and the overall employment rate was 7.9% in West Northamptonshire compared to 9% for England.
- In 2022 across Northamptonshire over half of all people age 16+ (54.2%) reported having any long-term physical or mental health conditions, disabilities or illnesses, over a fifth of whom (13% of total population) reported a long term mental health condition.
- Diagnosis of a mental health disorder is the most common reason for a fit note diagnosis, with the second highest being MSK.
- Among the working age people in West Northamptonshire 79% are in employment, of those aged 16-65 not in employment:
  - 8,700 are unemployed
  - 10,400 are long-term sick

- 10,900 have caring responsibilities
    - 12,200 are studying
    - 7,800 are retired
- Of those who are unemployed, 463 (5%) have been seeking work for more than a year.
- There are higher gaps in education attainment for children who are receiving free school meals than those who are not.

The Assistant Director Revenues and Benefits provided an overview of WNC Debt and Money Advice Service and highlighted the following:

- Internal WNC Debt and Money Advice team has been operating in much the same way as prior to 1 April 2021 and offer a service for only the South Northants area. Northampton area have a service offered by Citizens Advice and Community Law Service who work on behalf of WNC.
- The internal team comprises of 2.6 Officers who offer a range of services working closely with clients, mainly for urgent cases and get referrals from food banks, libraries and focusing and once the new pathway is in place this will reach a wider cohort of people.
- It is recognised that the internal team Debt and Money Advice offer across the Authority is inconsistent and a transformation project was launched to look at the wider offer and opportunities working closely with colleagues across WNC, the VCSE sector and partner organisations.
- The project is still underway with following outcomes so far:
    - Increase in the capacity of the internal team. 2 new officers joined on September 23 and a further 4 officers to be recruited to provide services across WNC in 2024.
    - Working with the voluntary sector to agree the service offer and pathways for residents to access the services.
- This work has been closely linked with Community Training Partnership training sessions.
- As part of the transformation a pathway will be developed to look at how people can access services, what is the best method to access services and how do we make the most of the resource.
- The aim of the internal teams is to:
    - Supporting households with debt and money advice, offering a free and confidential service.
    - Provision of a good quality service tailored to the needs of individual, working alongside clients making recommendations for dealing with debt from debt management plans to IVA/bankruptcy and Debt Relief Orders.
    - Prevention work, to stop people getting into crisis situations, such as income maximisation including benefit checks, making benefit applications, support with appeals and budgeting advice.
    - Working with colleagues across WNC, Health and other organisations to deliver positive outcomes for residents including working in hubs, warm spaces, LAPs.
    - Demonstrate secondary benefits including how acutely services are accessed, health and wellbeing, promoting independent living and helping people to move out of poverty and allow them to live their best lives.
    - Prevention of homelessness – working with Housing colleagues.

The Senior Economic Growth Officer gave an overview of funding opportunities and highlighted the following:

- There is dedicated funding to support those aged 19 years and over, such as ex-offenders, parents to support children with homework and managing finances.
- There is also an implement support service, which is a 24/7 free service for West Northamptonshire residents to access mainly online, but an in person service is being piloted at Towcester as a pilot on a monthly basis

- The UK Shared Prosperity Fund has allocated £5.4 million to West Northamptonshire across 3 years ending in March 2025. The people and skills element is only funded until the next financial year with the following elements:
  - Business support to drive employment growth by looking at helping people to secure long term sustainable employment and engaging with employers. Hoping to utilise this funding to educate employers on best practice, to become disability confident, hiring young people or those from the aging population, along with workplace wellbeing.
  - Employment support for economically inactive people
  - Tailored support to enable people already in employment to access training
  - Local areas to fund local skills needs

- In January 2024 partners will be encouraged to take part in a bidding process for projects, which will be presented to panel at the end of February 2024. The bids should be for specific smaller schemes within LAP areas, be evidenced based and aligned to the community framework.
- A Work Well Partnership Programme was announced nationally in spring 2023 with the aim to better integrate local employment and health support for disabled people and those with health conditions to start, stay and succeed in work, following a place based approach in line with ICS strategic aims:
  - There is £54 million of funding available to be shared between approximately 15 ICBs to become Vanguard Sites. The amount of funding allocated will depend on the numbers of individuals that will be supported included.
  - The program will be locally led, convened by ICBs and local authorities bringing together the NHS, local authorities and other partners, in collaboration with job centers.
  - Vanguard sites will be allocated a unit cost of 800pp, £320k in 24/25 and £220k in 25/26. There will be an additional allocation made to all ICBs to fund a health and work leadership role.
  - The submission date for this bid is 22nd January 2024 with successful ICS notified in April 2024, where a more robust case of how the funding will be delivered must be developed. The initiative must start in October 2024 with the purpose of the funding aligning with 3 objectives:
    - Deliver a holistic work and health service
    - To take forward an integrated local work and health strategy
    - To be part of a national learning programme.
  - A workshop was held in September looking at the wider determinants of health and sustainable local employment and the barriers people face which identified 5 potential focus areas:
    - Areas of deprivation using the LAP profiles
    - Females over 50 years, particularly those in low income in need of ESOL
    - Economy inactive people including low term health conditions
    - Empowering employers to to deliver needs of employees
    - Care leavers and young people
  - The provision of these 5 groups was mapped and be built upon for inclusion in the bid. Existing provision has been mapped, with gaps in the provision being identified.
  - Work has been undertaken with adult learning services, DWP, Job Centre Plus to retrain targeted groups and use anchor institutions to use as case studies, along with using the LAP profile to provide employment data at a local level.
  - Next steps are is Launch a call for projects for UKSPF – Jan 2024, presented to panel end Feb 24, a bidding process for a range of applications for specific smaller schemes within lap areas responding to the need with evidence. This would be

aligned community framework and grants being delivered by the community engagement team.

The Public Health Principal, Health Inequalities advised the Adult Learning Service are looking at aligning the priorities of their services and offer to the Local Enterprise Partnership, skills improvement plan and health and wellbeing priorities.

The Public Health Principal, Health Inequalities gave an overview of Anchor Institutions Network and highlighted the following:

- The Anchor Institutions Network and agreed priorities was launched in 2023. The network seek and agree best practice, to measure impact and hold each other to account and actively commit to the following:
  - ➢ Empowering the next generation
  - ➢ Employment opportunities
  - ➢ Social value gained from local investment
  - ➢ Enhancing sustainability
- The initial focus of the network was to look at gaps in employment for care leavers, and opportunities for organisations to support care leavers, as well as representatives from Northamptonshire Childrens Trust (NCT) and the Leaving Care Team to link in with employers. A number of organisations are signatories on the care leaver covenant.

The Board discussed the update and the following was noted:

- Many MSK illnesses can be linked to mood disorder, the COVID19 pandemic and the cost of living crisis has heightened the issue.
- 25% of people who commit suicide are due to family issues. Early prevention is key to enable more focus to be given to those with higher needs.
- Families who have a member who is suffering with dementia can be affected by debt, due to not able to accessing pensions or unable to work. Not having access to transport can lead to attending medical services.
- There difficulty in accessing data from Fit Notes due to different systems used by GP Surgeries. The University of Northampton (UoN) is hoping to put forward a mental health research bid linked to employment and fit notes.
- There is West Northamptonshire Social Enterprise fund grants of up to £5k.
- VCSE should be seen as an anchor institution, and those with caring responsibilities should be recognised as well as getting volunteers back into work.
- Need to consider those who are in work with long term medical conditions and could be at a higher risk from suffering with poor mental health.

RESOLVED that:

- **The Assistant Director Revenue and Benefits to link in with the Population Health Board Prevention Subgroup.**
- **The Assistant Director Revenue and Benefits to ascertain if there is any provision currently in place to help people with offsetting debts.**
- **An update on the Work Well Partnership bid submission to be given at the next meeting.**

74/23 Better Care Fund Quarter 2 Report

The Better Care Fund (BCF) Service Manager gave an overview of the BCF Quarter 2 report and highlighted the following:

- The number of falls was higher than expected, a small working group has been created to complete further investigation into this.
- The quarter 2 submission was put forward as an exemplar by the regional team.

- Reviews have started on the schemes contained within the BCF to assess whether they meet the national objectives, and their impact versus cost effectiveness.

The Director of People advised currently we have a reactive approach to falls and this needs to be more preventative to reduce the current number. The reduction in care home placements and keeping residents at home for longer, means there will people at home with higher levels of frailty which could increase the number of falls.

RESOLVED that the Board endorsed the BCF Quarter 2 submission.

75/23 Children and Young People Needs Assessments

The Public Health Principal Children and Young People, gave an overview of the Children and Young People Needs Assessment and highlighted the following:

- The purpose of this needs assessment is to provide a snapshot of the health and wellbeing needs of children, young people aged 0-19, and up to 25 where there's a statutory responsibility for the young person and their families.
- Underpinning this needs assessment is a life-course approach which describes the importance of the best start in life and recognises the importance of prevention and early intervention to tackle any emerging issues in young person's life.
- The objectives of the needs assessment are to:
  - Review the current model of 0-19 services delivery across WNC and North Northants Council.
  - Identify opportunities to improve, integrate and re-align local provision to better meet the needs of this population.
  - Make recommendations to commissioners and policy makers based on the findings and conclusion, to develop more effective and efficient services, reduce inequalities and help meet the national targets for the Health Child programme.
- The following methods were used to inform this health needs assessment:
  - Literature Review of national and local evidence was carried out by a public health officer to inform this HNA. Findings are summarised at the beginning of each chapter.
  - Epidemiological – A wide variety of data sources have been used to inform this HNA. The Office for National Statistics (ONS) and Office for Health Improvement and Disparities (OHID) Fingertips data. Local data have also been used and supplied by our system partners where available. Limitations in finding data have also been noted.
  - Surveys - Three surveys were undertaken in March-April 2023 to gather insights into the health and wellbeing of children and young people, and their families. The surveys were targeted at parents and carers, primary and secondary school staff and stakeholders and wider partners. Which gathered more than 2700 responses.
  - Semi-structured Interviews – 32 semi-structured interviews were undertaken with stakeholders including Maternity services, ICB senior executives, Northamptonshire Children's Trust (NCT) colleagues, 0-19 service provider, Strong start, Local Authority public health and Education colleagues and Voluntary community sector organisations. The key themes were identified using a thematic analysis and are summarised in the Engagement and Insight chapter.
  - Public Engagement – WNC and NNC have commissioned Free2Talk in partnership with HomeStart Daventry and south Northants and NHFT participation to deliver a series of engagement workshops with children young people aged 0-19 and their families, as well as stakeholders and wider system partners. More than 120 children and young people, and 68 stakeholders were engaged throughout these workshops.
- The needs assessment contains the following chapters:
  - West Northamptonshire Demographic

- Maternal and infant health
    - Early years
    - Primary School Children
    - Secondary school children
    - Transition to adulthood
    - Engagement and Insights
- The key strategic findings and recommendations of this health needs assessment are:
    1. In reviewing the 0-19 service currently provided as a county-wide offer, there has been recognition of the need to develop a new service model and service specification with a greater emphasis on a whole family approach, reflecting the need of making prevention and early intervention everyone's business to support children, young people, and their families with a focus on existing universal services.
    2. There is a wide variation in the needs of children and young people across WNC and NNC as shown by the epidemiological data. The 0-19 service must ensure that resources (including workforce) are targeted to meet the needs of children and families most in need, whilst at the same time maintain universal offer. This also include working on a locality basis, aligning with local area partnerships, and restructuring the service workforce to increase capacity and meet the needs identified.
    3. Lack of early help services across WNC and NNC. This was identified as the underpinning cause of many significant gaps identified through this health needs assessment. It also means that services are being overwhelmed dealing with complex cases and crisis due to the lack of prevention and early intervention practice across the system. The need to invest in early help and preventative services was evident across the needs assessment and the stakeholder engagement to prevent the escalation of need and embed prevention and early intervention approach across our integrated way of working across the system.
    4. Improve partnership working, join up and integration across the system to meet the needs of children, young people and their families living in West Northamptonshire and North Northamptonshire. It was clear from the stakeholder consultation that partnership working across the system have improved in the last 2 years, however it still needs to be more integrated. This includes making decisions on commissioning for new services, the co-location of services, improved understanding of services, closer relationships, and information sharing.
    5. The development of clear pathways of support for services available for children, young people and families was highlighted as being unclear. It was agreed that support pathways for children and families should be accessible and easy to understand and navigate. It was also agreed that we need to map the existing service provision alongside the referral pathways to enable the workforce and frontline workers to signpost appropriately.

The Board discussed the Needs Assessment and the following was noted:

- The information contained within the needs assessment will be used proactively to address some of the daily challenges.
- Good governance is needed to drive forward any strategy resulting from the needs assessment. A Best Start in Life Board has been created which feeds into the Children and Young People work of the ICS.
- UoN will be hosting an event around children and young people in the spring and this will be linked into the Best Start in Life ambition.
- Asset mapping has been completed by the VCSE Infrastructure organisations and it would be useful if this could be mapped against needs of residents in the LAP areas.

RESOLVED that:

- **The Board endorsed the needs assessment.**

- **A workshop to be hosted to discuss the needs assessment in more detail and links to the Joint Health and Wellbeing Strategy including case studies.**

76/23 Joint Health and Wellbeing Board Strategy and Scorecards

The Director of Public Health provided an overview of the Joint Health and Wellbeing Strategy (JHWBS) and highlighted the following:

- There will be delivery plans for each of the Live Your Best Life ambitions contained within the JHWBS for the next 16 months 2023-2025.
- The JHWBS aligns with the ICN Strategy and NHS Northamptonshire 5 Year Forward Plan.
- The delivery plan will enable the Board to see progress against the metrics contained within the Strategy.
- The delivery plans align with associated strategies and boards.
- During the thematic theme for each meeting, the delivery plan will be discussed to provide an overview on progress against the ambition.
- The delivery plans will contain the 'We will statements' from the JHWBS, from which the high level objectives will break down the statements areas of work taking place. The key actions and dates will be used for RAG rating. The system outcomes measures are the indicators agreed by the ICP to focus on.
- A high level scorecard will give an overview of the ambition indicators on one page. Behind the indicators there will be other measures of progress. These delivery plans will provide a thread down into the LAPs Plan on a Page.
- Larger parish councils are starting to work on their own health and wellbeing strategies (plan on a page).

RESOLVED that the Board noted the update.

77/23 Local Area Partnership

The Assistant Director of PLACE Development gave an update on LAPs and highlighted the following:

- All 5 project leads are in post and are starting to focus on task groups set up within the LAP to work on their identified priorities.
- The aim is for each LAP to have its own Active Lives plan with support from NSport and Sport England.
- Dementia will also be a golden thread running through all the LAPs, with Rural South and Rural East LAPs piloting Robopets as a dementia aid.
- Adult Social Services are starting to align their services with the LAP footprint. Northamptonshire Police, has already its beats to LAP areas, with the VCSE and GPS aligned with the LAPs. Discussions are taking place with NHFT on how their Adult Community Mental Health Teams being aligned to the LAP footprint.
- A pilot has started in Rural East LAP to support 18-24 years get into employment.

RESOLVED that the Board noted the update.

There being no further business the meeting closed at 12.05 pm.

West Northants Health and Wellbeing Board

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West Northamptonshire Health and Wellbeing Board Action Log

Action No	Action Point	Allocated to	Progress	Status of Action
111223/01	Belinda Green to link in with the Population Health Board Prevention Subgroup.			
111223/02	Belinda Green to ascertain if there is any provision currently in place to help people with offsetting debts			

Actions completed since the 11th December 2023

Action No	Action Point	Allocated to	Progress	Status of Action
111223/03	An update on the Work Well Partnership bid submission to be given at the next meeting	Toby Saunders	On the agenda for 23rd January	Completed.

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WEST NORTHAMPTONSHIRE HEALTH AND WELLBEING BOARD

23rd January 2023

Report Title	West Northamptonshire Health and Wellbeing Board Terms of Reference
Report Author	Cheryl Bird, Health and Wellbeing Board Business Manager, West Northants Council

Contributors/Checkers/Approvers		
Other Director/SME	Stuart Lackenby, Director of People	19th January 2024

List of Appendices

Appendix A – West Northamptonshire Health and Wellbeing Board Terms of Reference

1. Purpose of Report

1.1. The purpose of the West Northamptonshire Health and Wellbeing Board report is to review the Terms of Reference, to ensure the Board remains compliant with its statutory functions, as a S102 Committee of West Northamptonshire Council and to ensure there is appropriate alignment and accountability within the Integrated Care System.

2. Executive Summary

2.1 The West Northamptonshire Health and Wellbeing Board Terms of Reference provides details on how the Board expects to conduct its business in meeting its statutory obligations and wider partnership working.

3. Recommendations

3.1 The Board are asked to review the Terms of Reference for West Northamptonshire Health and Wellbeing Board and adopt the proposed changes.

3.2 Regular review of the Terms of Reference is required for the West Northamptonshire Health and Wellbeing Board to ensure the Board conducts its business in line with specific legislative

guidance and ensure there is appropriate alignment and accountability within the Integrated Care System.

4. Report Background

4.1 The West Northamptonshire Health and Wellbeing Board requires a Terms of Reference to outline how the Board expects to conduct its business in overseeing its delegated areas of responsibilities and to ensure it is operating within the specific legislative guidance.

4.2 The Terms of Reference provides details on accountability, role of the Board, key responsibilities, appointments, membership, code of conduct, and meeting administration.

4.3 The Terms of Reference were adopted by the Board at their meeting on the 24th June 2021.

4.4 The following proposed additions are to be added to ensure the Board complies with regulations for face to face Local Authority statutory committee meetings and to outline additional procedures for when a Board member needs to join virtually:

- Paragraph 8.2 If a Board member joins the meeting virtually this will not be counted in the quorum of that meeting.
- Paragraph 9.2 If a Board member joins the meeting virtually, they will not be counted as being in attendance or be permitted to vote.

4.5 The following proposed amendment from quarterly to bimonthly meetings to clarify frequency of meeting arrangements:

- Paragraph 10.1 The Board shall meet on a bi-monthly basis, but this may need to be reviewed if there is a change in the frequency of work the Board needs to address. The date, hour and place of meetings shall be fixed by the Board.

5. Issues and Choices

5.1 The Board can either accept or recommend amendments to the draft Terms of Reference.

6. Implications (including financial implications)

6.1 **Resources and Financial**

6.1.1 There are no resource or financial implications arising from the draft Terms of Reference.

6.2 **Legal**

6.2.1 It is a statutory requirement of West Northamptonshire Council to provide a Health and Wellbeing Board, which require a Terms of Reference.

6.2.2 The legal implications for West Northamptonshire Health and Wellbeing Board not adopting a Terms of Reference is the Board may not act in accordance within statutory requirements.

6.3 **Risk**

6.3.1 Not having a Terms of Reference may disrupt operation of the Board in meeting its statutory duties.

6.4 **Consideration by Overview and Scrutiny**

6.4.1 The draft Terms of Reference have not been submitted for consideration by Overview and Scrutiny.

6.5 **Climate Impact**

6.5.1 Apart from Board members travelling to and from meetings, there is no additional climate/environmental impact arising from the draft Terms of Reference. .

6.6 **Community Impact**

6.6.1 It is expected that several Countywide organisations will have Board representation.

7. Background Papers

7.1 Health and Social Care Act 2012.
7.2 Health Care Act 2022.

WEST NORTHANTS
Health and Wellbeing Board
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West Northamptonshire Health and Wellbeing Board
Terms of Reference

1. Accountability

1.1 The West Northamptonshire Health and Wellbeing Board is a statutory committee of West Northamptonshire Council which:

a) Is established in accordance with section 194 of the Health and Social Care Act 2012.
b) Is treated as a Committee of the Council under section 102 of the Local Government Act 1972 and provisions of the Local Government and Housing Act 1989.
c) Will be subject to any amendment or replacement of regulation or guidance applicable to any legislation relevant to the functions, powers and duties of Health and Wellbeing Boards.

2. Role

2.1 The Board is a forum that enables key leaders from across West Northamptonshire and the county to secure better health and wellbeing outcomes for the local population, better quality of care for all patients and care users, better value for the taxpayer and reduce health inequalities by shaping the future of services through a more integrated approach to commissioning health and wellbeing related services.

2.2 The Board aims to achieve this by:

- Providing a strategic lead for the local health and care system, and improving the commissioning of services across the NHS, local government and its partners.
- Initiating and encouraging the integrated delivery of health, social care and other services with health and wellbeing related responsibilities (such as housing, leisure, planning community activity).
- By reviewing its terms of reference every six months to ensure appropriate and timely alignment and/or integration with the emergent governance structure of the Integrated Care System (ICS) for Northamptonshire. Reviews will take into account the national direction of travel for ICS legislation, as outlined in *Integration and Innovation: working together to improve health and social care for all (DHSC, February 2021)*, and any subsequent relevant publications and/or legislative change.
- Providing a key forum to increase democratic legitimacy in health, along with public and joint accountability of NHS, public health, social care for adults and children, and other commissioned services that the Board agrees are directly linked to health and wellbeing.

3. Key responsibilities/duties

3.1 The statutory duties of the Board are**:**

- The preparation of Joint Strategic Needs Assessments (JSNAs) which assesses the current and future health and social care needs of the local population.
- The preparation of a Joint Health and Wellbeing Strategy (JHWS), ensuring it outcomes are contained within the Integrated Care Strategy.
- To encourage the integration of health and social care services, in particular providing appropriate advice, assistance or support for the purposes of integration of services under section 75 of the National Health Service Act 2006.

- To encourage close working between commissioners of health-related services (such as housing and many other local government services) and commissioners of health and social care services.
- To endorse and oversee the successful implementation of Better Care Fund (BCF), Improved Better Care Fund (IBCF) and Disabled Facilities Grant (DFG) arrangements locally.
- To provide the Integrated Care Partnership (ICP) with oversight of the development of the place based partnerships.
- To oversee the development and implementation of West Northamptonshire Place to support the delivery of the Joint Health and Wellbeing Strategy.
- To review NHS Northamptonshire Integrated Care Board (ICB) 5 Year Plan to ensure its takes proper account of the Joint Health and Wellbeing Strategy.
- To review the ICB Joint Capital Resource Plan
- To consult with the ICB for the ICN Annual Report on performance of any steps taken by the ICB to implement the Joint Health and Wellbeing Strategy.
- To advise the Care Quality Commission, NHS England, Trust Development Authority or NHS Improvement (as appropriate), where the Board has concerns about standards of service delivery or financial probity.
- Publication of a Pharmaceutical Needs Assessment.
- To undertake any additional responsibilities as delegated by the West Northamptonshire Council.

4. Authority

4.1 The Board may seek any information it requires from any employee of a Constituent Member organisation via a Member and all Constituent Members and Members are directed to co-operate with any reasonable request made by the Board.

4.2 The Board may obtain independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. The costs, if any, of obtaining such third party advice shall be shared among the constituent organisations as agreed between them.

4.3 The Board shall receive written and oral evidence from senior staff, and other partners, as appropriate.

4.4 The Board shall seek to ensure there is an acceptable balance between the value of the information it receives and the time and other costs it takes to acquire and process it.

5. Appointments

5.1 The Chair of the Board will be nominated by the Leader of West Northamptonshire Council. The Chair can be an independent co-opted member. Vice Chairs will be appointed by the Board.

5.2 The Chair and Vice Chairs term of office shall last for a maximum of two years, where they will be re-appointed or replaced as approved by Full Council.

6. Membership

6.1 The following are statutory members of the Board as stipulated in the Health and Social Care Act 2012 section 194:

- At least one elected member of the local authority nominated by the Leader of the local authority.
- The director of adult social services for the local authority.
- The director of children's services for the local authority.
- The director of public health for the local authority.
- A representative of the Local Healthwatch organisation for the local authority.
- A representative from NHS Northamptonshire Integrated Care Board

6.2 The Board may appoint additional persons to become members of the Board as it thinks appropriate.

6.3 West Northamptonshire Council must consult the Board before appointing a non statutory member to the Board.

6.4 Members of the Board shall each name a deputy who will have the authority to make decisions in the event that they are unable to attend a meeting.

6.5 In the absence of the Chair then one of the Vice-Chairs shall preside. If all are absent the Board shall appoint, from amongst its members, an Acting Chair for the meeting in question.

6.6 Individuals may be listed under membership of the Board as Special Advisors by invitation for specific issues and expertise.

7. Code of Conduct

7.1 All members of the Board are covered by the West Northamptonshire Council's code of conduct and must adhere to that code of conduct when acting in the capacity of a Board member.

7.2 Where any Board member has a Disclosable Pecuniary Interest or Non-Statutory Disclosable Interest, which will require them to leave the meeting for the duration of discussion on that item, they must make this known at the commencement of the meeting. They may remain and address the board on the relevant matter but must leave the room prior to any debate, voting or decision-making process.

8. Quorum

8.1 A quorum for any meeting shall be one-quarter of the members of the Board including at least one Elected Member, one officer and one representative from the ICB. No business requiring a transaction shall take place where the meeting is not quorate, if this arises during a meeting the Chair must either suspend business until the meeting is again quorate or declare the meeting to be at an end.

8.2 If a Board member joins the meeting virtually this will not be counted in the quorum of that meeting.

9. Voting Arrangements

9.1 Unless the Council decides otherwise, all full members of the Health and Wellbeing Board have voting rights; only full board members (or nominated deputies in their absence) shall sit at the board room table, or join virtually so that the right to vote is obvious.

9.2 If a Board member joins the meeting virtually, they will not be counted as being in attendance or be permitted to vote.

9.3 Decisions shall be made on the basis of a show of hands of a majority of voting members present. The Chair will have a second or casting vote.

10. Meeting Frequency

10.1 The Board shall meet on a bi-monthly basis, but this may change if there is a change in the frequency of work the Board needs to address. The date, hour and place of meetings shall be fixed by the Board.

10.2 The Chair may convene an extraordinary meeting at short notice to consider matters of urgency, under Schedule 12A of the Local Government Act 1972. The notice must state the business to be transacted and no other business is to be transacted at the meeting.

10.3 The Chair will be required to consider convening a special meeting of the Board if he/she is in receipt of a written requisition to do so signed by no less than three of the Constituent Members of the Board. Such requisition shall specify the business to be transacted and no other business shall be transacted as such meeting. The meeting, if convened by the Chair, must be held within seven days of the Chair's receipt of the requisition.

10.4 The Chair of the Board, or majority of those present at a Board meeting can take the decision meetings of the Board may be adjourned at any time to be reconvened at any other day, hour and place, as the Board decides.

11. Sub Groups

11.1 The Board can establish sub groups based on the Board's priority areas which will be reviewed on an annual basis. The Sub Groups will be informal officer groups, ensuring that the views of patients and service users are included. The Sub Groups should provide an overview of work undertaken and any issues arising for discussion at alternate Health and Wellbeing Board meetings to be considered by members.

12. Visitors and Speakers

12.1 As the Board is a public meeting observers may attend and will be seated in a viewing area.

12.2 Presenters who are not full Board Members may attend the meeting and should sit in the viewing area, they will be invited to address the floor by the Chair when their agenda item arrives.

12.3 Members of the public who wish to address the Board on matters listed on the Agenda for a specific meeting may do so for a period of not exceeding 3-minutes at the commencement of that meeting, only with the agreement of the Chair, and provided they have given 48 hours' notice of the matter to be raised to the Chairman and Secretariat in writing.

13. Meeting Administration

13.1 The Board Secretariat shall give at least five clear working days' notice in writing to each member for every ordinary meeting of the Board, to include any agenda of the business to be transacted at the meeting.

13.2 Papers for each Board meeting will be sent out five clear working days in advance. Late papers will be sent out or tabled only in exceptional circumstances, and not without the prior consent of the Chairman.

13.3 The Board shall hold meetings, or parts of meetings, in private session when deemed appropriate in view of the nature of business to be discussed. The Board must first pass a resolution for the exclusion of press and public. The following must be stated at this time:

"In respect of the following items the Chairman moves that the resolution set out below, on the grounds that if the public were present it would be likely that exempt information (information regarded as private for the purposes of the Local Government Act 1972) would be disclosed to them: The Committee is requested to resolve: That under Section 100A of the Local Government Act 1972, the public be excluded from the meeting for the following item(s) of business on the grounds that if the public were present it would be likely that exempt information under Part 1 of Schedule 12A to the Act of the descriptions against each item would be disclosed to them".

Appendix A: Board Membership

Membership of West Northamptonshire Health and Wellbeing board is agreed as follows:
Certain post holders have a statutory requirement to be members of the Health and Wellbeing Board.

Statutory Board members

- One elected member as nominated by the Leader of West Northamptonshire Council - portfolio holder for Adults, Health and Wellbeing.
- The Director of Adult Social Services for West Northamptonshire Council
- The Director of Children's Services for West Northamptonshire Council
- The Director of Public Health for West Northamptonshire Council
- A representative of the Local Healthwatch organisation for Northamptonshire
- A representative from NHS Northamptonshire Integrated Care Board

The Health and Wellbeing Board may co-opt additional members to the board as it thinks appropriate.

Non-Statutory Board members

- West Northamptonshire Council - Leader
- West Northamptonshire Council – Portfolio Holder for Childrens, Families, Education and Skills
- West Northamptonshire Council – The Chief Executive
- Northamptonshire Police – One representative
- Northamptonshire Healthcare Foundation Trust – One representative
- University Hospitals Group Northamptonshire - One representative
- Northamptonshire Local Medical Committee – One representative
- Voluntary and Community Sector – One representative
- University Hospitals of Northamptonshire Group – One representative
- NHS Northamptonshire Integrated Care Board – Chief Executive
- Northamptonshire Fire and Rescue Service – One representative
- East Midlands Ambulance Service – One representative
- Northamptonshire Children's Trust – Chief Executive
- Primary Care Networks – One Representative
- West Northamptonshire Council – Opposition elected member
- BAME Representative
- Northampton GP Locality – Chair
- Daventry and South Northamptonshire GP Locality – Chair
- Northampton Health and Wellbeing Forum – Chair
- Daventry and South Northamptonshire Health and Wellbeing Forum – Chair
- Office Police Fire Crime Commissioner – one representative

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WEST NORTHAMPTONSHIRE HEALTH AND WELLBEING BOARD

23 January 2024

Report Title	**NHS Northamptonshire ICB Urgent and Emergency Care Strategy – Engagement**
Report Author	**Chris Pallot, Director of Operations and Deputy Chief Operating Officer**

Contributors/Checkers/Approvers		
Other Director/SME	Toby Sanders, CEO, NHS Northamptonshire ICB	16th January 2024

List of Appendices

Appendix A – UEC Strategy Slides HWBB

1. Purpose of Report

1.1. This presentation is made to the Health and Wellbeing Board as part of the engagement process that is being undertaken as our Urgent and Emergency Care (UEC) strategy is finalised.

2. Executive Summary

2.1 The UEC Strategy proposes six key strands of work that will deliver revised pathways for patients who access unscheduled care in Northamptonshire. This is a strategy that underpins the Five Year Forward Plan that has already been approved for NHS Northamptonshire ICB and in particular the Recovering Independence multi-impact intervention.

2.2 The initial focus of the strategy is to support patients who have been diagnosed with a long term condition to live independently for as long as possible ("Maintaining Independence"). It then describes five further pillars of work that spans the continuum of urgent care services from community, primary, secondary and rehabilitative care all of which are aimed at supporting patients through their journey.

2.3 It ends with a detailed focus on pilar 6 which is aimed solely at "Recovering Independence" for those patients who need care post-hospital.

2.4 The UEC system in Northamptonshire is under increasing pressure and it is widely acknowledged that we must find alternative methods to support patients and in so doing, to support our services to provide care who are most at need. This strategy is aimed at commencing our journey in this regard.

3. Recommendations

3.1 The Health and Wellbeing Board is invited to discuss this proposed strategy and to offer any comments as it is finalised.

4. Report Background

4.1 This document is presented to consult and engage with the HWBB on the future direction for UEC services. It supports Live Your Best Life ambition 9 and the ICBs 5-year strategy.

5. Issues and Choices

5.1 The aim is to address the current gap between demand and capacity for UEC services and in particular to support citizens to live independently where possible in their own homes and where necessary to recover their independence following a period of ill-health.

6. Implications (including financial implications)

6.1 Resources and Financial

None at this time; all proposals will be subject to business cases that will need to be supported by individual organisations. At the present time these are in development for services that are included in the strategy such as Ageing Well, Dementia and Delirium and P2 bed reprovision.

6.2 Legal

None

6.3 Risk

There are no significant risks arising from the proposed recommendations in this report.

6.4 Consultation

6.4.1 This paper is presented as part of a consultative process

6.5 **Consideration by Overview and Scrutiny**

6.5.1 To date; the Overview and Scrutiny Committee has received proposals for the reprovision of some community bed provision overseen by Northamptonshire Healthcare NHS Foundation Trust. These aims are included in the overall direction of the strategy. There a no other elements that have been before the Committee.

6.6 **Climate Impact**

6.6.1 None forseen

6.7 **Community Impact**

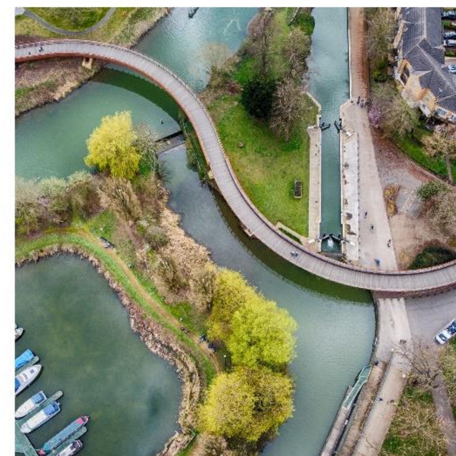
6.7.1 None foreseen other than an increase in LAP work to provide support and preventative services.

7. Background Papers

7.1 None

Integrated Care Northamptonshire

Northamptonshire Urgent & Emergency Care Strategy



Six Stages of our Northamptonshire UEC Model

Integrated Care
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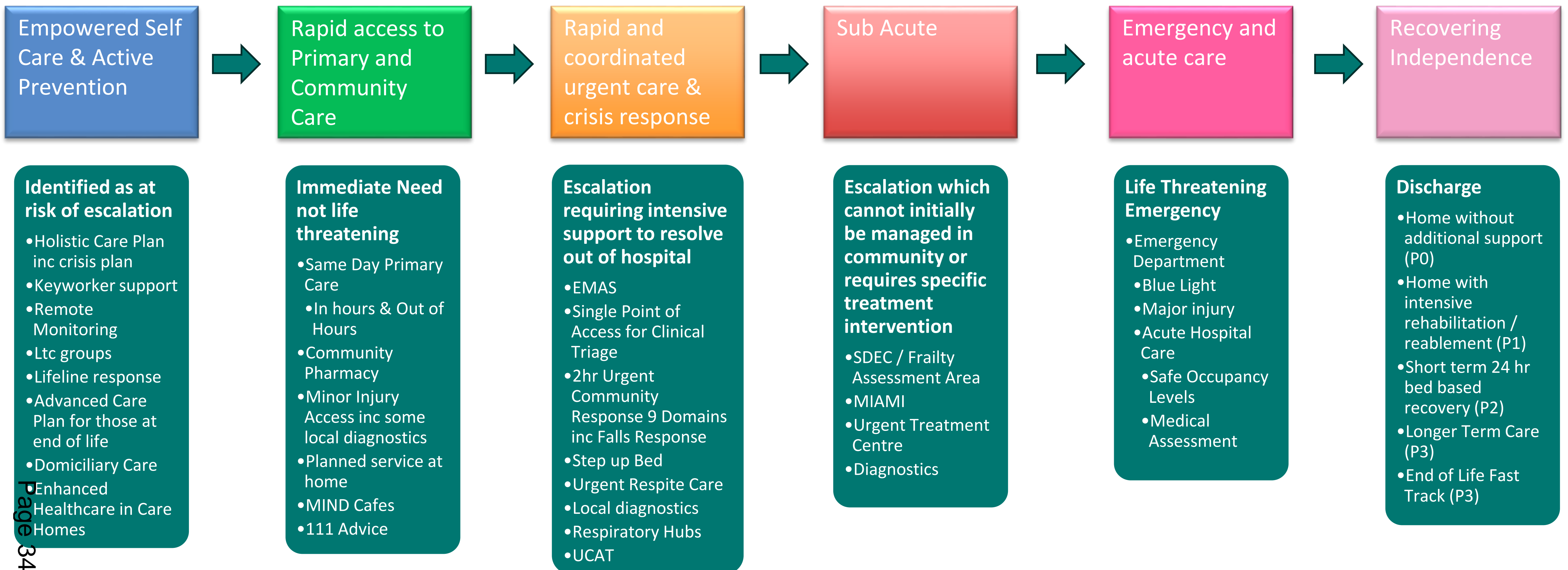
Right Care, Right Time, Right Place
An Integrated Multi Partner Approach to Mitigating and Responding to Urgent and Emergency Care Demand



Our Six Urgent Care Commitments

Integrated Care
Northamptonshire

We will ensure all those living with **multiple long term conditions** are supported to **live wel**l and thrive in their communities, supported by services delivered at **place-level**. Each will have a comprehensive holistic care plan which is visible to all partners; increased use of **remote monitoring; peer support groups and increased annual health checks**

We will ensure those with a non-emergency need but requiring same day support can access the most appropriate professional through delivering **primary care services at scale** at locations around the county.

We will expand and embed a **single point of access** to respond to escalating needs to safely avoid a conveyance or admission to hospital, enabling the person to complete their recovery in their place of usual residence. Including **24/7 Urgent Community Response**; **management of certain EMAS calls; alignment with mental health response and primary care**

Where hospital examination or diagnostic tests are required we will provide **same day access** to services where possible. Assessments and diagnostics will be undertaken locally to enable patients to stay at home overnight with **local community bed step up capacity** when 24hr observation is required. Aligned to the **community diagnostic centres** and increased **remote monitoring** with **SPOA support**

When time critical **acute or mental health** responses are required within a **hospital set**ting, **treatment will not be not delayed**. Patients will receive care specific to their presenting need with follow up treatment in the **most appropriate location**. Achieved by delivering a **primary and community-based response** to lower level attendances and **recovering independence workstreams**

To deliver periods of **intensive rehabilitation** or recovery **without delay** for those who are able to return home and support them to **remain there**. Those who transition to a permanent care setting will receive this without delay.

STAGE 1

Integrated Care Northamptonshire

Empowered Self Care & Active Prevention

Our Commitment : We will ensure all those living with **multiple long term conditions** are supported to **live well** and thrive in their communities, supported by services delivered at **place-level**. Each will have a comprehensive holistic care plan which is visible to all partners; increased use of **remote monitoring; peer support groups and increased annual health checks**

Our Progress :

- Consistent use of care plans using Ardens Templates
- 100 patients per month receiving an extended GP led review
- Northamptonshire Shared Care Record created
- Peer support groups for COPD, Diabetes, Heart Failure, Dementia
- 161 persons in their own home and 296 care home residents set up for remote monitoring

Our Intent :
We will expand our capacity so that by 2028

1. 10,000 persons with multiple long-term conditions have a care plan using consistent care plan format
2. 5,000 persons benefit from remote monitoring
3. Every Local Area Partnership will have a minimum of one peer support group per month for each of the four long term conditions prioritised for support
4. We will extend the annual health check for all persons over the age of 50 to include full blood test and an extended review with a lead clinician
5. All partner organisations involved in the support for the named person will have access to the care plan and take part in Multi Disciplinary Teams reviews

STAGE 1

Integrated Care
Northamptonshire

Empowered Self Care & Active Prevention

Our Commitment : We will ensure all those living with **multiple long term conditions** are supported to **live well** and thrive in their communities, supported by services delivered at **place-level**. Each will have a comprehensive holistic care plan which is visible to all partners; increased use of **remote monitoring; peer support groups and increased annual health checks**

How We Will Achieve This (1)

1. Expand and enhance the range of Long Term Condition support groups around the county, supporting patients to live healthier lives in the community and thus reduce readmission rates as proven via cardiac and respiratory services already in-place
2. Ensure that all unplanned hospital admissions for persons with two or more long term conditions are followed up by local place team with full clinician review where required within 72 hours
3. Create capacity across the Local Area Partnership / Primary Care Network footprints for 600 persons to be assigned a named keyworker with persons being in any one of three categories at any given time
    1. Receiving active support
    2. Receiving intermittent support and advice / guidance when needed
    3. Watchful waiting after period of support with direct access back to team should needs change
4. Scale capacity of nursing and specialist clinical response in our Remote Monitoring Hub to support safe growth in number or persons being supported
5. Identify those persons through local team reviews who would benefit from assistive technology and / or home monitoring with onboarding plan at rate of 100 new persons per month
6. Further strengthen the use of Ardens Templates with Northamptonshire Organisations and ensure this is core part of induction for all new staff and ensure key information travels between records and is visible within the Northamptonshire Shared Record

STAGE 1

Integrated Care
Northamptonshire

Empowered Self Care & Active Prevention

Our Commitment : We will ensure all those living with **multiple long term conditions** are supported to **live well** and thrive in their communities, supported by services delivered at **place-level**. Each will have a comprehensive holistic care plan which is visible to all partners; increased use of **remote monitoring; peer support groups and increased annual health checks**

How We Will Achieve This (2)

1. Increase the range and breath of services at Local Area Partnership level to support patients with Long Term Conditions, identified by primary care and supported via initiatives such as Breathing Space, Pumped-Up (cardiac) and diabetes groups.
2. Increase the team of specialist clinicians able to lead peer support groups by allocating place-based areas to Acute Consultants and factoring in one group per fortnight as PA Session in Consultant job plans for the four long term conditions prioritised for support
3. We will extend the annual health check for all persons over the age of 50 to include full blood test and an extended review with a lead clinician
4. All partner organisations involved in the support for the named person will have access to the care plan and take part in Multi Disciplinary Team reviews
5. Swift access to additional support via the Single Point of Access in the event of an exacerbation

STAGE 2

Integrated Care Northamptonshire

Rapid access to Primary and Community Care

Our Commitment : We will ensure those with a non-emergency need but requiring same day support can access the most appropriate professional through delivering **primary care services at scale** at locations around the county.

Our Progress :

- At-scale delivery of same day primary care through Federation delivered Extended Access model
- Surge solutions for Paediatric and Respiratory Hubs
- Established model of 'walk in' for MIND Cafes, Children and Young Person Cafes

Our Intent :

We will expand our capacity so that by 2028

1. We will have modelled the same day demand expected from our population
2. Embedded NHS 111, linked to the Single Point of Access as the intended first port of call
3. We will have delivered an at scale a community integrated urgent care model across local area partnership footprints.
4. 'Same Day Access hubs' which will be a key feature of our model and will be established around the county, linked to diagnostic centres.
5. Integrated with pharmacy, dental and optometrist providers where possible to provide an unscheduled care service that builds on current arrangements
6. Our models will be designed in a way that we reduce the over reliance on acute urgent care services

STAGE 2

Integrated Care Northamptonshire

Rapid access to Primary and Community Care

Our Commitment : We will ensure those with a non-emergency need but requiring same day support can access the most appropriate professional through delivering **primary care services at scale** at locations around the county.

How we will achieve this

1. We will co-produce with the primary care sector and other key stakeholders a new community urgent care model. This will be delivered as part of the Primary Care Strategy which will be published in 2024.
2. We will identify all community urgent care capacity at a local area partnership level, empowering local teams to design and implement new enhanced ways of working.
3. We will set out a plan on how we will deliver our same day access hubs across the county. Where feasible we will look for opportunities to build on existing enhanced access / respiratory hubs. But we will also look for early implementers to test out our new model of care.
4. We will review how we commission GP Out of Hours services and align to our Same Day Access Hubs.
5. We will design a community based urgent care model that seamlessly integrates with sub- acute / acute care and diagnostics and reduces the number of patients utilising our A&E services.
6. We will develop a workforce plan that supports the delivery of our new model of care.
7. We will look for innovative estate solutions to accommodate our Same Day Access Hubs.

STAGE 3

Rapid and coordinated urgent care & crisis response

Our Commitment : We will expand and embed a **single point of access** to respond to escalating needs to safely avoid a conveyance or admission to hospital, enabling the person to complete their recovery in their place of usual residence. Including **24/7 Urgent Community Response**; **management of certain EMAS calls; alignment with mental health response and primary care**

Our Progress :

- A well established SPOA / Clinician to Clinician Live Handover / 2hr Urgent Community Response model responding to circa 30 escalations per day with direct access for known patients / carers
- Ability to take referrals electronically from EMAS and 111 as well as phone
- Nationally promoted Mental Health Crisis Pathway included Home Based Urgent Response, walk in access through Mind Café's, Police and Ambulance Triage Vehicles and access to Crisis House and Section 136 Suites

Our Intent : By 2028 we will

1. Develop a fully integrated 24 hour service able to provide two hour Urgent Community Response where this would achieve our commitment and the same outcome cannot be achieved through core service provision
2. Meet national target of 80% achievement of red referrals successfully responded to by face to face clinical contact within two hours
3. Ensure that persons who can be supported by 2hr Urgent Community Response are transferred to service from EMAS dispatch desk releasing crew capacity for attends
4. Ensure that all nine domains in the 2hr Urgent Community Response model are fully delivered locally strengthening our current capacity and pathway for escalations of persons at End of Life and in situations of carer / care package breakdown
5. Further improve patient experience and outcome by expanding the point of care testing capabilities of our Urgent Community Response services
6. Avoid long waits following a fall where there is either no injury or is a clear minor injury

STAGE 3

Integrated Care
Northamptonshire

Rapid and coordinated urgent care & crisis response

Our Commitment : We will expand and embed a **single point of access** to respond to escalating needs to safely avoid a conveyance or admission to hospital, enabling the person to complete their recovery in their place of usual residence. Including **24/7 Urgent Community Response**; **management of certain EMAS calls; alignment with mental health response and primary care**

How We Will Achieve This

1. Undertake test and learn period to :
   - Provide Specialist Palliative Nurse as part of the Single Point of Access
   - Provide Voluntary Sector Coordinator as part of the Single Point of Access
   - Increase direct access to GP to support Multi-Disciplinary Team / Clinical Decision making within the 2hr Urgent Care Response model
2. Train additional partner community staff in the use of Raizer Chairs and supporting clinical decision making App to increase the pool of persons able to respond to non-injurious falls. Linked to further deployment of Raizer chairs and creation of an interactive map to show tracked location of devices available.
3. Create a new service specification which can meet needs of escalating patients between 10pm and 8am where this can be met by Urgent Community Response and would not be safe to delay until core service hour provision is available
4. Ensure that we have correctly forecasted and commissioned the volume of Urgent Community Response interventions needed to mitigate urgent care demand and attendances to inappropriate settings eg A&E
5. Align our physical and mental health urgent community response provision to ensure best patient outcomes are achieved and that persons with mental health and physical exacerbations receive a seamless integrated intervention

STAGE 4

Sub Acute

Our Commitment : Where hospital examination or diagnostic tests are required we will provide **same day access** to services where possible. Assessments and diagnostics will be undertaken locally to enable patients to stay at home overnight with **local community bed step up capacity** when 24hr observation is required. Aligned to the **community diagnostic centres** and increased **remote monitoring** with **Single Point of Access support**

Our Progress :

- Same Day Emergency Care (SDEC) units at NGH and KGH
- KGH have dedicated Frailty Assessment Area staffed to support same day turn around of patients at point of escalation
- Primary Care have piloted Point of Care (POC) testing with home visiting Paramedic Service
- Agreement on two sites at Corby and Kings Heath in Northampton as Community Diagnostic Hubs

Our Intent : We will strengthen our provision and approaches to :

Establish the two Community Diagnostic Centres delivering specialist diagnostic services in two new localities, expanding the range and volume of diagnostic tests which can be undertaken outside of traditional acute settings increasing local provision and access for populations

Deliver multiple Same Day Access centres around the county linked to the primary care strategy

Implement solutions which enable a directing clinician to book see and treat slots within Urgent Care Centre and Same Day Emergency Care facilities supporting demand and flow management

Maximise the use of technology and point of care testing to reduce waiting periods for patients

Increase the range of remote monitoring solution so patients be observed at home whilst tests are performed

STAGE 4

Integrated Care
Northamptonshire

Sub Acute

Our Commitment : Where hospital examination or diagnostic tests are required we will provide **same day access** to services where possible. Assessments and diagnostics will be undertaken locally to enable patients to stay at home overnight with **local community bed step up capacity** when 24hr observation is required. Aligned to the **community diagnostic centres** and increased **remote monitoring** with **SPOA support**

How We Will Achieve This

1. Working with Primary Care on same day delivery model agree the presenting patient conditions which cannot be managed at a neighbourhood level but do not require an Emergency Department attend
2. Ensure direct referral and access to Same Day Emergency Care and Specialist Frailty Units with real time visibility of capacity and ability to direct book patients to attend for timed appointment slots
3. Extend our Same Day Emergency Care operating models to provide a 24-hr solution for ambulatory care conditions
4. Ensure that existing on-site provision at NGH and KGH is fully integrated to provide a blueprint for on-site redesign to combine the current services (Minor Injury, Same Day Emergency Care)
5. Provide estates solutions which deliver seamless patient flow ensuring our ambition of right care, right time, right place is achieved

STAGE 4

Sub Acute

Our Commitment : Where hospital examination or diagnostic tests are required we will provide **same day access** to services where possible. Assessments and diagnostics will be undertaken locally to enable patients to stay at home overnight with **local community bed step up capacity** when 24hr observation is required. Aligned to the **community diagnostic centres** and increased **remote monitoring** with **Single Point of Access support**

How We Will Achieve This

1. Deliver the first two Community Diagnostic Hubs and review learning and outcomes to inform further planning of additional capacity for 2025/2026 and identify opportunities for wider 'one stop' shop approach within communities based on solutions implemented in Humberside and in Havering
2. Work with technology partners through framework procurement agreements to ensure that we are maximising the latest in remote diagnostic capabilities and point of care testing
3. Develop SOPs which enable clinicians working in UTC or Community Diagnostic Hubs or Extended Primary Care Same Day models to have access to local overnight bed solution to support a 24 hour monitoring period where required and unable to be delivered in patients own place of usual residence

STAGE 5

Integrated Care Northamptonshire

Emergency and acute care

Our Commitment : When time critical **acute or mental health** responses are required within a **hospital** setting, **treatment will not be not delayed**. Patients will receive care specific to their presenting need with follow up treatment in the **most appropriate location**. Achieved by delivering a **primary and community-based response** to lower level attendances and **recovering independence workstreams**

Our Progress :

- Established Same Day Emergency Care services in each hospital
- Established mental health triage car service
- Reprocured the Urgent Care Centre provider at Corby
- Outline case written to expand majors cubicles and minors capacity at NGH

Our Intent : We will strengthen our provision and approaches to :

1. Ensure our Emergency Departments are right-sized to manage demand
2. Reduce the number of patients who are fit to leave hospital – enabling bed capacity to be appropriate utilised
3. Deliver ambulance response times and ensure handovers occur without delay
4. Provide the equipment and environments which ensure timely transfer of patients arriving by ambulance – adults and children
5. Increase our workforce so that decision making is consistent across every day of the week both in receiving medical teams and specialist medical treatment staff
6. Give clinicians access to timely diagnostic results, minimising the need to refer to hospital
7. Enable receiving clinical teams to access the full patient record
8. Step patients into Virtual Ward provision

STAGE 5

Integrated Care
Northamptonshire

Emergency and acute care

Our Commitment : When time critical **acute or mental health** responses are required within a **hospital** setting, **treatment will not be not delayed**. Patients will receive care specific to their presenting need with follow up treatment in the **most appropriate location**. Achieved by delivering a **primary and community-based response** to lower level attendances and **recovering independence workstreams**

How We Will Achieve This

1. Support University Hospitals of Northamptonshire to remodel the NGH emergency department
2. Deliver the proposals listed in Stage 6 to reduce bed occupancy
3. Expand the range of point of case testing at the acute front door and reduce the time taken for test results during hospital admissions
4. Develop staffing models across Unified Acute Group which maximises the available staff skills and resources across both sites
5. Ensure our Paediatric A&E are of correct size to meet the demand from the growing population expected within this cohort

STAGE 5

Integrated Care
Northamptonshire

Emergency and acute care

Our Commitment : When time critical **acute or mental health** responses are required within a **hospital** setting, **treatment will not be not delayed**. Patients will receive care specific to their presenting need with follow up treatment in the **most appropriate location**. Achieved by delivering a **primary and community-based response** to lower level attendances and **recovering independence workstreams**

Northampton General Hospital Emergency Department redesign

- A single "front door" for walk-in patients seeking emergency care
- Subsequent separation of adult and paediatric patient flows
- Rapid assessment and triage of walk in patients
- An integrated Urgent Care Centre comprising (Adult) Minor Illness and Minor Injury (MIAMI) plus Same Day Emergency Care
- Dedicated paediatric urgent treatment facilities immediately adjacent to the Paediatric Emergency Department
- An additional 8 majors cubicles
- Remodelled (previous) ED minors waiting area to improve initial assessment and treatment
- Improved ambulance handover facilities

STAGE 6

Integrated Care
Northamptonshire

Recovering Independence
Pathway 0 Discharges

Our Commitment : To deliver periods of **intensive rehabilitation** or recovery **without delay** for those who are able to return home and support them to **remain there**. Those who transition to a permanent care setting will receive this without delay.

Our Progress :

- Expanded remote and virtual monitoring services
- Voluntary sector partners to make follow up welfare call checks on discharged patients
- Where family or carer are not able to support we ensure the home is ready to receive the returning person eg warm, essential food in place, any equipment needed has been delivered
- Patients on discharge have emergency contact numbers for first 24 hours

Our Intent : We will strengthen our provision and approaches to :

1. Discharge notes are immediately visible in the patient record through the Northamptonshire Shared Care Record
2. Each GP practice will receive a same day electronic advice to state patient discharge completed
3. The needs of patients identified for P0 discharge are identified early in the stay enabling the Voluntary Sector to schedule pre return visits to the home and post return home calls
4. Maximise the number of discharges completed by midday by ensuring transport solutions are in place and take home medication is with the ward or discharge lounge before 11
5. We will ensure that all discharged patients are contacted within 72 hours of leaving hospital to ensure planned actions have happened and have direct access to either the Hospital Team or their GP if they have concerns immediately following return home.

STAGE 6

Integrated Care
Northamptonshire

Recovering Independence
Pathway 0 Discharges

Our Commitment : Whilst most people will leave hospital and return directly home without ongoing intensive interventions we recognise that within this cohort there may be anxiety and requirement for planned follow up actions eg a wound dressing. We will ensure that all discharged patients are contacted within 72 hours of leaving hospital to ensure planned actions have happened and have direct access to either the Hospital Team or their GP if they have concerns immediately following return home.

How We Will Achieve This

1. Build a digital solution which is triggered to primary care when patient leaves the ward / discharge lounge
2. Contract with the voluntary sector to include transportation for those who require getting home support
3. Ensure the Single Point of Access and EMAS are aware of all patients discharged each day to be aware of potential re-escalation
4. Ensure Patients / Carers have access to advice / guidance in the 72 hours immediately following discharge
5. Set clear Expected Date of Discharge for patients to ensue families can prepare for return home

STAGE 6

Recovering Independence
Pathway 1 Discharges

Our Commitment : To deliver periods of **intensive rehabilitation** or recovery **without delay** for those who are able to return home and support them to **remain there**. Those who transition to a permanent care setting will receive this without delay.

Our Progress :

- Dedicated staff within Community Health and Council Reablement Services currently supporting 10 patients home each day 5 of which will be jointly delivered
- Changes made to Frameworks operated by Local Authorities to bring Domiciliary Care Providers into place based planning and delivery
- Commissioned provider by NNC to provide additional P1 recovery capacity
- Introduced improved tracking and monitoring of demand, capacity, delays and outcomes through shared dashboards

Our Intent : We will strengthen our provision and approaches to :

1. Ensure that patients do not wait for more than 48 hours in hospital from being ready for discharge to being at home
2. Provide longer term therapy where required through local community therapy services
3. Ensure any equipment or minor home adaptations required to support maximum independence of person are identified early in the patient journey and implemented to avoid delays
4. Utilise short term alternative (non 24 hr staffed) accommodation for persons to commence their out of hospital recovery if their own home is not yet available for them to return to
5. Maximise the use of Virtual Ward to enable the patient to return home for further recovery where they would otherwise have occupied a hospital bed where they are supported through outreach monitoring

STAGE 6

Integrated Care Northamptonshire

Recovering Independence
Pathway 1 Discharges

Our Commitment : To deliver periods of **intensive rehabilitation** or recovery **without delay** for those who are able to return home and support them to **remain there**. Those who transition to a permanent care setting will receive this without delay.

How We Will Achieve This

1. Utilising our future Single Point of Access to ensure we have resource to support and track seven day discharges increasing the number of supported weekend discharges by 50% and smoothing current mid / late week peaks
2. Recruit to the staffing establishments required to meet forecast demand
3. Review our existing contractual arrangements to maximise the use of available resource by creating an outcome based approach for identified presenting patient need including those who need intensive health input beyond seven days including collarcare, non weight bearing and short term specialist feeding support
4. Develop a partnership approach with domiciliary care sector organisations to skill up workforce able to deliver reablement interventions
5. Establish agreements with Housing partners for access to suitable short term use accommodation
6. Review our capacity within community therapy and identify solutions to remove current waits so that there are no gaps in continuity of care
7. Maximise the use of Disability Living Grant provision for home adaptations and modifications, working with partner building companies to reducing delays in assessment, decision making and implementation

STAGE 6

Integrated Care
Northamptonshire

Recovering Independence
Pathway 2 Discharges

Our Commitment : Those persons who require a period of intensive rehabilitation or recovery before being able to return home or transition safely to next care setting and require a bedded solution to achieve this will transfer to an appropriate facility within five days of becoming medically fit following an Acute managed escalation

Our Progress :

- Analysed use of and demand for current pathway
- Introduced additional board round approach to improve discharge planning
- Reduced days lost in P2 facilities for persons who no longer have reason to reside
- Created a new Recovering Independence Bedded Unit (RIBU) model of one facilities jointly operated by health, social care and primary care.
- Prepared high level model plan showing how we will deliver a 230 bed model to meet local demand whilst retaining small elements of surge capacity

Our Intent : We will reprofile to ensure that by 2025

1. Any person requiring general rehabilitation / reablement in a bedded unit will be able to access this provision within ten miles of their home
2. We will have a single specialist facility giving correct provision of specialist stroke recovery beds to meet demand and ensure patients do not remain in Acute bed for longer than benefits their recovery plan
3. For persons who require a bedded pathway to manage unresolved delirium or challenges from behaviour related to dementia before they can progress to next part of their recovery journey we will provide beds within one of our units with additional on site, in and out-reach staff to support successful outcomes
4. We have achieved full approval for our plans from stakeholders including HOSC North and West
5. We have maximised the use of our best estate and reduced future estate liability costs
6. No more than 5% of recovery beds are occupied on any given day by a person who no longer has reason to reside

STAGE 6

Integrated Care
Northamptonshire

Recovering Independence
Pathway 2 Discharges

Our Commitment : To deliver periods of **intensive rehabilitation** or recovery **without delay** for those who are able to return home and support them to **remain there**. Those who transition to a permanent care setting will receive this without delay.

How We Will Achieve This

1. Continue to test and learn from the RIBU approaches at Turn Furlong and Thackley Green to inform future model
2. Develop individual business cases for each of the steps towards delivering our overall vision with the first element being an affordable solution for the re-use of Spinneyfield facility in Rushden, East Northants.
3. Increase our current stroke bedded rehab capacity by further four beds to reduce waits in transfers from NGH
4. Work with the Community Stroke Team to ensure a consistent and cohesive recovery pathway after stroke decreasing the length of stay required in bedded element of the pathway and maximising those who can return home including consideration of respite and step up within the bedded unit
5. Develop primary care led medical models which enhance continuity and ensure patient is supported by their PCN Neighbourhood team throughout their recovery journey
6. Invest in our estate to ensure that the environments support recovery as applicable to each patient cohort to include use of technology to mitigate falls risks and coproduced and designed day spaces (internally and externally) which support engagement activities and provide safe wandering and sensory experiences
7. Ensure that we have correctly forecasted and commissioned the volume of packages of care for the next stages of the patient journey

STAGE 6

Integrated Care Northamptonshire

Recovering Independence **Pathway 3 Discharges**

Our Commitment : To deliver periods of **intensive rehabilitation** or recovery **without delay** for those who are able to return home and support them to **remain there**. Those who transition to a permanent care setting will receive this without delay.

Our Progress :

- Established Discharge Hubs in both NGH and KGH and Discharge Coordinators in Community Bedded Units
- Daily reporting processes and dashboards showing pathways assigned
- Established an Integrated Brokerage Team to source places on behalf of ASC and ICB CHC
- Thematic analysis of the challenges and causes of current delays and backlog

Our Intent : We will strengthen our provision and approaches to :

1. Fully implement trusted assessor model across statutory and commissioned providers
2. Provide appropriate bridging care environments for persons whose onward package of care is not immediately available to free beds to support safe patient flow
3. Have a robust market of providers working to a partnership model who are able to accept and meet the needs of an increasingly frail patient cohort
4. Ensure appropriate community wrap around support for our long term care providers
5. Meet patient and family choice whilst ensuring that additional harm does not occur from extended hospital stays
6. Implement recommendations of the End of Life workstream to increase the number of persons able to die with privacy, dignity and respect in the place of their choice
7. Implement solutions which are able to resolve escalations through commissioning of bespoke care packages where these fall between business as usual provision

STAGE 6

Integrated Care
Northamptonshire

Recovering Independence
Pathway 3 Discharges

Our Commitment : To deliver periods of **intensive rehabilitation** or recovery **without delay** for those who are able to return home and support them to **remain there**. Those who transition to a permanent care setting will receive this without delay.

How We Will Achieve This

1. Utilising our future Single Point of Access to ensure we have resource to support and track seven day discharges increasing the number of supported weekend discharges and smoothing current mid / late week peaks
2. Design and commission capacity for complex Dementia Care Packages having taken steps to mitigate demand through our P2 improved Dementia and Delirium recovery provision
3. Refine our daily reporting to ensure visibility of total demand, current Medically For Discharge and time waiting for packages to commence
4. Strengthen our escalation and resolution process empowering decision makers with the resources to create and implement bespoke packages when required. To note in time escalation will be through our Single Point of Access / Oversight.
5. Engage with our market providers to identify support required to meet P3 demand in timely manner building on our ambition that our Domiciliary Care Providers and Care Home Providers become key partners in our local integrated place based teams
6. Maximise the use of provided technology for persons receiving long term care to reduce frequency of escalations and to ensure timely support to clinical advice and guidance from those providing the ongoing care
7. Ensure that we have correctly forecasted and commissioned the volume of packages of care for the next stages of the patient journey

Listening to our patients….

Integrated Care Northamptonshire

Challenges identified through previous engagement

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what would you do?
It's your NHS. Have your say.

Maintaining and caring for the whole person to ensure continuity within their long-term care and ensuring all have access to patient records through a 'patient passport' were also felt to be important

"A closer to home hospital or support system in my locality." (Age 35-44 carer)

difficulties around discharge from hospital, where carers felt they were not fully involved in decisions and where family members were discharged from hospital without proper assessment of their needs or adequate notice to carers of the arrangements: "Professionals need to understand the family dynamics when the patient is considered vulnerable",

don't want to be seen as a condition or a diagnosis; they want to be treated in a holistic way, with a focus on their overall wellbeing and with respect for individual choice

a lack of communication and coordination between services. Information about a person and their needs is not always transferred in a timely and accurate manner, particularly when treatment involves admission to hospital. Problems with the flow of information had contributed to delays in treatment, an inability to deal with people's multiple conditions and prescribing difficulties (including incorrect medication being prescribed and instructions being incorrect or misunderstood). Such problems can lead to a person's condition deteriorating and considerable distress for patients and their carers.

Throughout the development of this strategy, as well as previous service developments such as Ageing Well, we have engaged with service users and providers to seek their views on services within Northamptonshire.

Previous Engagement Comments

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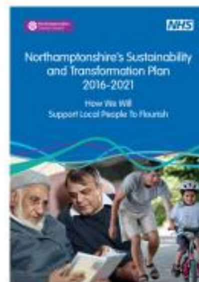

respondents mentioned needing sufficient care staff who are properly trained and funded and the need for continuity of healthcare professionals"

respondents said they want to be involved in decisions about their treatment, receive timely communications and have easier and quicker access to services.

difficulties with understanding clinical language and the process of diagnosis, treatment and care (not everyone understands the term 'pathway'), including what choices are available

There continues to be national issue needing resolution in terms of health and care support to overcome the issues arising from the current structure of separate heath and care services and geographical differences."

"I want an end to initiatives which promise all these things yet only do so on paper. Don't put them in place unless they are meaningful. Don't tell me I can see a healthcare professional when I need to, then not allow me to do so because of underfunding. Don't tell me I will get the treatment I need, then deny it me because you won't fund it. Don't keep passing all my problems back to me, my friends and family."

There are a number of consistent themes that have arisen in the course of our patient discussions which are summarised below; for every proposed service development we will ensure that this feedback is built-in to the design process to ensure that the views of those who experience and deliver our services are heard.

Listening to our patients….

Integrated Care Northamptonshire

Timely access to primary care – ensuring that patients can access their GP in the most appropriate clinical timescale. Our plan is to support this via the establishment of same day access hubs; meaning that more appointments are freed-up in mainstream General Practice.

Patient record visible to support good decision making and avoid retelling of story at each touch point. This is a common theme across the entire healthcare sector which will be addressed considerably by the Northamptonshire Care Record.

Being kept updated, patients tend to be more amenable to a wait in their journey if kept informed as to the reasons and how to access support in the meantime. We will do this via the Single Point of Access development

Better coordination for End of Life care especially at crisis points. This is another piece of consistent feedback, Many families will have experienced caring for a loved one at the end of their lives and when the person deteriorates it is a stressful and distressing time. Care needs to be provided swiftly and in the preferred place of a persons death. This will also be delivered via the Single Point of Access service.

Escalations don't all happen Monday to Friday between 9 and 5 – access to specialist knowledge and response support should be available as minimum 8am to 10pm every day which will be delivered via our proposed Same Day Access Hubs and co-ordinated by the Single Point of Access.

Simple communication, our service users ask for us to speak in lay persons terms and in clear language. Not using abbreviations or complicated medical terms. This is a task that all members of the health service should adopt whether working in Emergency Care or another sector.

Clear expectation of what needs to be achieved for safe discharge the vast majority of patients do not want to be in hospital and their relatives would rather they were in their usual place of residence. However, we don't always plan accordingly and involve patients and relatives appropriately. We don't explain what to expect, recovery expectations, how to use equipment or the types of care packages as well as we could. This will be delivered in our plans to redesign services for patients leaving hospital and who need extra support from health or social care.

Co-production & Engagement

Integrated Care Northamptonshire

As we implement this strategy we will engage and listen to members of our community at every step of the way.

Our UEC model has developed over several years reflecting best practice, locally, nationally and internationally and building on the success of innovation and transformation achieved within Northamptonshire.

Over the coming months we will continue to work with our patients, carers and staff to further evolve and refine our plans utilising existing forums eg Health and Wellbeing Boards, Primary Care Patient Participation Groups, Users of our LTC Condition Groups, Persons receiving Care Packages including Lifeline help, Governor and Elected Member meetings, Community Champion led events as well as facilitating on-line and in person bespoke events.

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WEST NORTHANTS
Health and Wellbeing Board
live your best life

WEST NORTHAMPTONSHIRE HEALTH AND WELLBEING BOARD
23rd January 2024

Report Title	Local Area Partnerships (LAPs) Terms of Reference (ToRs)
Report Author	**Julie Curtis** **AD for Place Development, West Northants Council**

Contributors/Checkers/Approvers		
West Northants Executive Place Delivery (EPD) Board	All Partners/Members Representation from: • WNC Officers (Adult Social Care, Communities & Opportunities, Public Health, Education) • Integrated Care Board • Northamptonshire Police Service • Fire & Safety Service • East Midlands Ambulance Service • GPs • Northamptonshire Childrens Trust • Northamptonshire Healthcare Foundation Trust • Northampton General Hospital • VCSE • Public Health • Healthwatch • Town & Parish Councils	V1.0 26th July 2023 Board V4.0 5th December 2023 Board – Recommendation to WN Health & Wellbeing Board 23/01/23
Northampton Health & Wellbeing (HWB) Forum	All Partners/Members	V3.0 20th November 2023 (For discussion and recommendation to EPD Board)
Daventry & South Northants Health & Wellbeing Forum	All Partners/Members	V3.0 18th August 2023 (For discussion and recommendation to EPD Board)

Contributors/Checkers/Approvers		
All 9 LAPs across West Northants	All Partners/Members: Circa 150 members across 9 LAPs	LAP Meetings August 2023 to October 2023 (for discussion and recommendation to HWB Forums)

List of Appendices

Appendix A – Local Area Partnership Terms of Reference

1. Purpose of Report

1.1. The West Northants Health & Wellbeing Board are asked to consider and approve the recommendation from the Executive Place Delivery Board to adopt the Local Area Partnership Terms of Reference (Appendix A).

2. Executive Summary

2.1 It is important that our LAPs work to a set of standardised ToRs to ensure all members understand their role in the development and delivery of the West Northants Place Operating Model.

2.2 The first iteration of the LAP ToRs was produced in July 2023. The first draft was taken to the WN Executive Place Delivery Board for feedback and guidance from its membership. Subsequently the LAP ToRs was shared with members of the two Health & Wellbeing Forums and the membership of all 9 LAPs (~150 members) between August and October 2023 for feedback and comments.

2.3 All feedback and comments from the 2 Forums and 9 LAPs were considered and culminated in the draft ToRs include in Appendix A. On 5th December 2023 the WN Executive Place Delivery Board agreed to make a recommendation to the WN Health & Wellbeing Board for approval and adoption of the final draft LAP ToRs as shown below. This is in line with the governance and decision-making arrangements agreed for the LAPs.

2.4 The LAP ToRs are included in the report below. In summary the ToRs include details on the following:

- The purpose of the LAP
- LAP Objectives
- The function of the LAP
- The membership of the LAP
- Meeting arrangements
- Governance and reporting structure
- ToRs Review period

2.5 The ToRs included in this report are purposefully generic and once they are approved by the WN Health & Wellbeing Board each LAP will adopt their own version of the ToRs. The ToRs will be

populated with individual LAP personalised information regarding LAP area and membership (sections 1 and 5).

3. Recommendations

3.1 To consider and approve the recommendation from the Executive Place Delivery Board to adopt the Local Area Partnership Terms of Reference as included in Appendix A.

4. Implications (including financial implications)

4.1 **Resources and Financial**

4.1.1 There are no resources or financial implications arising from the proposals.

4.2 **Legal**

4.2.1 **T**here are no legal implications arising from the proposals.

4.3 **Risk**

4.3.1 There are no significant risks arising from the proposed recommendations in this report.

4.4 **Consultation**

4.4.1 Engagement undertaken with a wide range of stakeholders including:

- WNC Officers (Adult Social Care, Communities & Opportunities, Public Health, Education)
- WNC Elected Members (LAP Members)
- Integrated Care Board
- Northamptonshire Police Service
- Fire & Safety Service
- East Midlands Ambulance Service
- GPs
- Northamptonshire Childrens Trust
- Northamptonshire Healthcare Foundation Trust
- Northampton General Hospital
- VCSE
- Public Health
- Healthwatch
- Town & Parish Councils

4.5 **Consideration by Overview and Scrutiny**

4.5.1 None required

5. Background Papers

- ICN Strategy
- WN Health & Wellbeing Board Strategy
- ICB 5 Year Forward Plan

LAP LOGO

[NAME] Local Area Partnership

Terms of Reference

DRAFT V4.0 for Approval by the West Northants Health & Wellbeing Board

1) Introduction

There are nine Local Area Partnerships, also known as LAPs in West Northants. Each of the LAPs cover communities of between 30,000 and 50,000 people with the aim to work together to ensure health, care and wider determinants of health services are better co-ordinated and focused on the needs of each community. LAPs are the focus of how local communities can design activities and services to improve outcomes, reduce health inequalities and contribute to the 10 Live Your Best Life ambitions.

[NAME] LAP covers the communities of [LIST OF WARDS]

2) Purpose

The purpose of the LAP is:

2.1 To represent local areas and give a voice to residents, translating strategy into local action.

2.2 To empower residents to co-produce new services and solutions for their local area.

2.3 To identify where the alignment of local services is appropriate and delivered in a way that will meet the needs of the community.

2.4 To contribute to system-wide priorities by utilising strong evidence-based information and deep local insight from frontline services and communities.

2.5 To empower local leaders to take accountability for local action.

3) Objectives

The objectives for the Local Area Partnership are as follows:

3.1 To promote partnership working at a community level to reduce inequalities and improve public health and wellbeing outcomes for local residents.

3.2 To promote the integration of Health services, care services and wider determinates of health services at a local level to reduce duplication and drive efficiencies.

3.3 To engage and coproduce services with local people based on community areas collaborating across organisational barriers.

4) Function

The main functions of the LAP are:

4.1 Agree the core leadership team to include members from: elected members; Local GPs; VCSE; Public Health; WNC; Police; NCT; ASC; C&O leads; Fire & Safety

4.2 Adopt an intelligence and data led approach to identify areas experiencing high levels of inequality that would benefit from redesign and integration of service provision.

4.3 Review evidence on local health needs, social and economic determinants of health and collectively determine two to three priorities that need addressing. Utilising evidence from the LAP Local Area Profile; local insights Intelligence; local partner Intelligence and community Intelligence.

4.4 Identify connections with wider system and place-based activities and ensure duplication and inefficiencies are avoided. The activity of the LAP should complement and support wider system strategies wherever possible.

4.4 Oversee the development of the LAP core products and approve the following:

- LAP Delivery Plan; LAP Project Brief, case for change, priorities, outcomes, milestones, actions etc
- LAP Communications Plan
- LAP Engagement Plan; Ensure methodologies and processes are developed to capture community feedback and insights
- LAP Individual Website content
- LAP LYBL Branding

4.5 Ensure the continuous review and update of the core products including agreeing the regular content of the website news page.

4.6 Where appropriate agree the set-up of any task and finish groups to support the LAP to deliver the identified priorities.

4.7 Identify the services / organisations that will form the local multi-agency team to support the delivery of the new Target Operating Model.

4.8 Validate that all LAP activities contribute to the West Northants Health & Wellbeing Strategy 10 Live Your Best Life ambitions.

4.9 Escalate any areas of concern to the local Health & Wellbeing Forum.

5) Membership (To be completed for each LAP)

Member	Representing
	Elected members
	GPs

Member	Representing
	Police
	VCSE
	NCT
	WNC Executive Director
	Community Development Workers / Community Safety Officers
	Public Health
	Adult Social Care
	LAP Project Lead
	Town & Parish Councils as appropriate

6) Meeting Arrangements

6.1 **Chairing**

The meeting will be chaired by the AD of Place Development and substituted with the LAP Project Lead once available.

6.2 **Frequency**

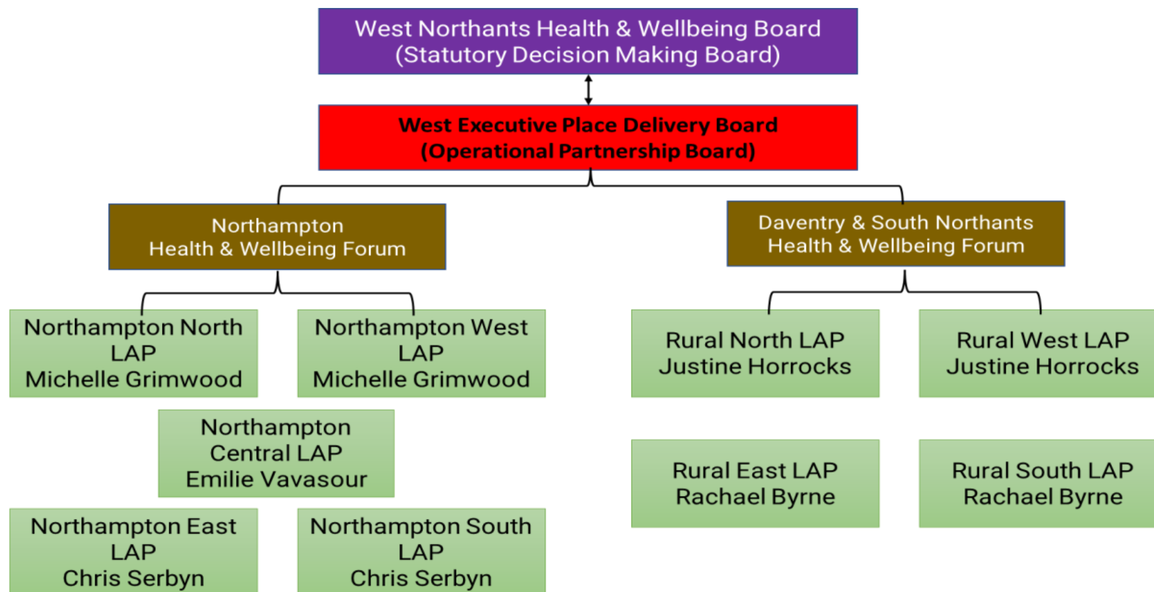
Monthly

6.3 **Administration**

Administration support for the meeting will be provided by WNC. This will include keeping the action log up to date and in real time for each meeting; producing agendas; action notes; arranging meetings; extending invitations to external experts; booking rooms (when necessary); all administration tasks to support the meeting.

7) Governance and Reporting Arrangements

7.1 The LAP governance structure is illustrated below together with the assigned LAP Project Leads:



7.2 The LAP will report to the local Health & Wellbeing Forum on a bi-monthly basis. The LAP Project Lead will represent the LAP on the local Health & Wellbeing Forum. The local Health & Wellbeing Forum will report feedback to the LAP.

7.3 The LAP will escalate any areas of challenge or barriers they are unable to resolve to the local Health & Wellbeing Forum for discussion and potential resolution.

7.4 The LAP will oversee the activities and delivery of priorities led by the Task & Finish Groups. Members of the LAP will assist with identifying the appropriate and necessary people with the skills and expertise to attend any Task & Finish Groups.

7.5 The LAP will provide leadership and strategic direction to the Multi-agency Partnership Team and assist with unblocking any challenges.

7.6 Members of the LAP will represent their local area on behalf of their sector and routinely disseminate information from the LAP to their respective organisations and / or their sector.

8) Review

The Terms of Reference will be reviewed annually unless internal or external factors impact on the work of the LAP.

WEST NORTHAMPTONSHIRE HEALTH AND WELLBEING BOARD

23rd January 2024

Reports for information

Reports Titles	Substance Misuse Needs Assessment – Rhosyn Harris

List of Appendices

Appendix A – Substance Misuse Needs Assessment

1. Purpose of Report

1.1. The attached report is for Board members to review and will not be discussed during the Board meeting.

2. Executive Summary

2.1 In September 2022, Northamptonshire established its Combating Drugs Partnership involving a wide range of local organisations. National guidance states that Combating Drugs Partnerships should produce a needs assessment in 2022 to inform their local delivery plan, addressing the three objectives.

2.2 The overall aim of the Substance Misuse Needs Assessment is to provide information to the Combating Drugs Partnership and organisations involved in the commissioning of services with information about health needs of the Northamptonshire population to inform the future delivery of services for children, young people and adults.

2.3 Specific objectives are to

- Establish the prevalence of alcohol and drug misuse in Northamptonshire.
- Identify groups at high risk of poor health from substance misuse.
- Describe the impact on substance misuse on health and wider societal outcomes.
- Identify the organisations involved in substance misuse and their interactions as a system.
- Understand the views of professionals working in services related to substance misuses.
- Understand the experience of those with lived experience, their family and carers.
- To identify the gaps and commissioning priorities.

2 Recommendations

3.1 Board members are asked to note the report.

Northamptonshire
Drug and Alcohol Needs Assessment
2023

Contents

Section 1: Background 6
National Policy 6
Aims and Objectives 7
Approach 7
Acknowledgements 8
Section 2: Prevalence of substance misuse 10
Section summary - Children and Young People 10
Children and Young People 11
Drug misuse 15
Adults 19
Section summary - Adults 19
Alcohol consumption 20
Drug misuse 22
Parents 24
Section summary - parents 24
Substance misuse in pregnancy 25
Parental substance misuse 25
Adverse Childhood Experiences 26
Section 3: Groups at high risk of substance misuse 27
Groups at high risk – section summary 27
Deprivation 29
Ethnicity 29
Mental health / dual diagnosis 29
Learning Disabilities 29
Section 4: Impact of substance misuse on children and young people 30
Section summary – impact on children and young people 30
Substance misuse and newborns 32
Children's social care 32
Looked after children 33
Young carers 34
Education 34
Crime and young offenders 35
NHS treatment 36
Section 5: Impact of substance misuse on adults 37

Section summary – Impact of substance misuse on adults ... 37
Hospital admissions ... 40
Urgent care ... 44
Deaths ... 49
Sexual health ... 51
Physical health ... 52
Mental health ... 52
Smoking ... 52
Housing and homelessness ... 54
Carers ... 55
Employment ... 55
Crime ... 56
Economic impact ... 56
Section 6: Impact of the pandemic ... 58
Section summary – impact of the pandemic ... 58
Drugs ... 58
Alcohol ... 59
Section 7: What do we currently do to prevent and reduce harm from drugs and alcohol ... 60
Systems map ... 60
Drug treatment services ... 60
Section 8: Treatment services – Children and Young People ... 63
Section summary : Treatment services – Children and young people ... 63
Numbers accessing treatment ... 65
Source of referrals ... 65
Demographics ... 67
Substance use ... 68
Mental health ... 68
Smoking ... 69
Treatment outcomes ... 69
Section 9: Treatment services – adults ... 71
Section summary: treatment services – adults ... 71
Numbers accessing treatment ... 74
Estimates of unmet need ... 74
Source of referrals & waiting times ... 75
Criminal Justice System ... 75
Demographics ... 77

Age and sex 77
Ethnicity 79
Disability and sexuality 80
Profile of substances used 80
Treatment length and outcomes 83
Length of time in treatment 83
In treatment – abstinence and reduction 84
Exit outcomes 85
Dropout rates 87
Harm reduction 89
Blood-borne viruses 89
Naloxone 90
Smoking 90
Housing and homelessness 90
Employment 91
Section 10: Qualitative – focus groups and interviews 92
Section summary – focus groups and interview 92
Study participants 93
Emerging themes 94
Harm reduction 94
Structured treatment 95
Key workers and staff 96
Treatment and care planning 97
Safety and wellbeing 98
Joining up drug treatment with other services 98
Gap in treatment services 100
Section 11: Qualitative work - system mapping with professionals and service users 102
Session 1: Understanding the system 102
Stakeholder map 102
Factors affecting harm reduction 103
Using the outputs 103
Session 2: Opportunities for improvement 107
Improving service delivery for clients with complex needs/ trauma 107
Funding & resource needs 107
Improve equitability of harm reduction provision across the county 107
Increasing prioritisation & awareness of harm reduction 108

Engaging with client groups who are less engaged currently 108
Improving information & data sharing 109
Supporting joined up working 109
Section 12: What works to prevent or treat substance misuse 110
Overview 110
Alcohol 110
Drugs Misuse 111
Substance misuse and mental health 111
Parents with substance misuse 111
Adverse Childhood Experiences 112
Substance misuse in pregnancy 112
Housing and homelessness 112
Prisons and secure settings 113
Social work 113
Section 13: Recommendations 114
Breaking drug supply chains 114
Delivering world class treatment and recovery services 115
Achieving the shift in generational demand for drugs 118
Cross cutting recommendations 119
Intelligence Gaps 120

Section 1: Background

National Policy

The December 2021, a new national strategy for drugs 'From Harm to Hope: A 10-year drugs plan to cut crime and save lives' was launched. [1] The strategy aimed to address the issues identified in Dame Carol Black's independent review of drugs, the first published in 2000 focused on the supply of drugs, trends in drug use and the health and societal outcomes resulting from use, including serious violence, harm to children, homelessness and deaths.[2] The second part published in 2021 focused on prevention, treatment and recovery. This report acknowledged the impact of disinvestment in treatment and recovery services and the need to build up capacity.[3]

The 'Harm to Hope' strategy has three main priorities:

1. Breaking drug supply chains,
2. Delivering a world-class treatment and recovery system, and
3. Achieving a shift in the demand for drugs.

The strategy recognises the importance of a system wide approach and strong partnerships in tackling substance misuse at national and local levels. Local government and delivery partners are viewed as the foundations of this strategy, supported by clear national strategic objectives and additional investment.

In June 2022, the Government issued guidance for the development of local Combating Drugs Partnerships to manage and oversee local delivery of the national strategy.[4] The guidance sets out the nature of the partnership, geographical scope and leadership. Working in partnership is seen as essential to effectively delivering on the 3 priorities. All three priorities are in scope of a Combating Drugs Partnership. Each partnership will provide a single setting for understanding and addressing shared challenges related to drug-related harm, based on the local context and need.

Local context

In September 2022, Northamptonshire established its Combating Drugs Partnership involving a wide range of local organisations. National guidance states that Combating Drugs Partnerships should produce a needs assessment in 2022 to inform their local delivery plan, addressing the three objectives. A needs assessment led by the Public Health department had commenced earlier in 2022 to inform the department's commissioning priorities. This work was formally brought under the remit of the Northamptonshire Combating Drugs Partnership when it was established.

The output is designed to meet the requirements of the national strategy and to inform commissioning intentions of individual organisations. This includes commissioning of substance misuse treatment services, a responsibility of public health departments in councils, and plans for the Office for Health Improvement and Disparities (OHID) substance misuse grants. Therefore, it has deliberately taken a broad approach, focusing on both alcohol and drugs, and the impact of the

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[1] HM Government (2021) From harm to hope: A 10-year drugs plan to cut crime and save lives

[2] Dame Carol Black (2020) Review of Drugs Part One

[3] Dame Carol Black (2021) Review of Drugs Part Two

[4] HM Government Home Office (2022). Drugs strategy guidance for local delivery partners

many factors contributing to increased risk of ill health from substance misuse. The output of this work will contribute to the delivery of objectives in many local strategies and plans, including:

- Integrated Care Northamptonshire's 10 years strategy 'Live your best life'
- North and West Northamptonshire Council corporate plans
- North and West Community Safety Partnerships
- Reducing Reoffending Board
- Adult and Children's Safeguarding Board.

Aims and Objectives

The overall aim of the needs assessment is to provide information to the Combating Drugs Partnership and organisations involved in the commissioning of services with information about health needs of the Northamptonshire population to inform the future delivery of services for children, young people and adults.

Specific objectives are to

- Establish the prevalence of alcohol and drug misuse in Northamptonshire.
- Identify groups at high risk of poor health from substance misuse.
- Describe the impact on substance misuse on health and wider societal outcomes.
- Identify the organisations involved in substance misuse and their interactions as a system.
- Understand the views of professionals working in services related to substance misuses.
- Understand the experience of those with lived experience, their family and carers.
- To identify the gaps and commissioning priorities.

Approach

The data and intelligence presented in this report and the resulting recommendations in this report are based on the intelligence from four work streams:

1. **Northamptonshire Police Supply report**. This report contains intelligence related to drug supply in Northamptonshire and recent trends. The findings were presented at a Combating Drugs Partnership workshop in December 2022. The findings are not included in this report however the resulting recommendations are included in the first section on breaking drug supply chains to provide all recommendations relevant to the work of the Combating Drugs Partnership in one report.

2. **Health needs assessment – identifying health needs**. Led by the Public Health departments and supported by a multiagency steering group, this work analyses routinely collected data to identify the needs of the local population, groups at high risk, access to substance misuse treatment services and outcomes. A comparative approach was used where possible, comparing Northamptonshire to England and other similar geographical areas. Data from a wide variety of national and local sources were used, including routine public health datasets on risk factors, deaths and use of treatment services; social care on assessment; health data on attendance at the emergency department and hospital admissions and Criminal Justice System data on young offenders. Where local data was not available, national reports and research articles were used to identify likely patterns.

3. **Health needs assessment – system mapping.** Understanding local assets and building on these strengths (or addressing deficits) is an important part of determining priorities within a local strategy. Many organisations in Northamptonshire are involved in responding to issues related to substance misuse and together they form an interconnected system. Funded by Public Health and commissioned by the adult treatment provider Change Grow Live (CGL), the University of Bath and Manchester Metropolitan University undertook systems mapping for harm reduction in Northamptonshire. Workshops were held over 2 days in July and August 2022, attended by over 70 stakeholders. Those working at operational and strategic level attended the event along with individuals with lived experience. The workshops were used to map the local system, and identify the main themes related to harm reduction and to identify the main priorities for addressing local challenges.

4. **Health needs assessment – qualitative research.** Understanding the experience of those with problematic substance misuse and their family /carers is an important part of identifying gaps in the system and priorities. Public Health commissioned a qualitative study to understand this experience, using a mix of focus groups and semi-structured 1:1 interviews with adults and parents of those in substance misuse services. Thematic analysis of the discussions over the 4 days identified the main areas of concern and suggested recommendations for addressing these areas. This work was undertaken in November 2022.

The recommendations for 'delivering a world-class treatment and recovery system' and 'achieving a shift in the demand for drugs' are based on the findings of workstreams 2-4. A brief review of the main evidence-based guidelines also contributed to development of the recommendations.
This report is a summary of the findings of a full report that will be available in 2023.

This report required the input of many individuals and organisations.

Acknowledgements

We would like to thank all those involved in the development of this report. This report would not have been possible without the contributions of many individuals and organisations.

We would like to thank the Substance Misuse Health Needs Assessment Steering Group, with representation from

- Northamptonshire Integrated Care Board
- Northamptonshire Probation Service
- Northamptonshire Police, Fire and Crime Commissioner
- West and North Northamptonshire Council
    - Housing
    - Adult Social Care
    - Children Trust
    - Public Health

We would also like to thank the CGL, University of Bath and Manchester Metropolitan University for conducting the work on system mapping and all those who contributed to the workshops.

Our thanks go to Tony Margetts and April Wareham for leading the qualitative study and conducting the 1:1s and focus groups. This work would not have been possible without the support of the

treatment and recovery services – CGL, Aquarius, the Bridge, Family Support Link and the Hope Centre. We would like to thank the staff of the treatment services for their help in facilitating the focus groups, extending invitations, and finding rooms and hospitality.

This work would not have been possible without the contribution of those with lived experience. We thank you for your time and feedback on current services and areas for development.

And finally, we would like to thank the members of the Northamptonshire Combating Drugs Partnership Board for their support and input into the development of the report and resulting recommendations.

Section 2: Prevalence of substance misuse

Section summary - Children and Young People

Substance misuse in children and adolescence can lead to physical and mental health problems, often lifelong. This includes impact on education, relationships, impaired brain development, violence, injuries, unsafe sex and sexual exploitation, criminal activity and self-harm or suicidal thoughts. Drug increases the risk of mental ill health, including suicide, depression and psychosis.

Surveys provide details of substance misuse in children and factors influencing uptake.
In 2021, 40% of pupils (mostly aged 11 – 15) in England said they had ever had an alcoholic drink with 6% of pupils drinking once a week. White pupils were more likely to have drunk than other ethnic groups (11% vs 4%) and more girls than boys had ever drug alcohol. Affluent children were more likely to get drunk. The 3 factors most strongly associated with drinking are parents don't discourage alcohol, being older, and recent drug use. Nationally, alcohol consumption in young people has fallen over the last decade.

In 2022, a similar survey was undertaken in Northamptonshire among pupils in Years 8 (age 12-13) and 10 (age 14-15). There has been a reduction in alcohol consumption locally, with 40% of secondary school children drinking alcoholic drinks (more than just a sip) in 2022 compared to 45% in 2019. The most common source of alcohol was family and friends. This survey found there a significant increase in children reporting they needed help with their family drinking – 32% in 2022 compared with 16% in 2019.

Rates of hospital admission for the under 18's for alcohol specific conditions have fallen over the last decade. In the most recent period till 2020-21, rates in West and North Northamptonshire were statistically similar to the England average.

In England, young adults aged 16-24 had the lowest levels of alcohol consumption of all adults, with 31% reporting drinking at least once a week compared to 49% for adults of all ages. This age group is also the least likely to drink over the recommended 14 units per week. Trends indicate that over time this age group has reduced levels of consumption. Local survey data on alcohol consumption in Northamptonshire currently not collected.

A national survey found that 18% of secondary pupils aged 15 and under had reported ever taking drugs in 2021, a decline from 24% in 2018. Rates have been declining since 2016. Rates are slightly higher in girls (19%) than boys (17%). Cannabis is the drug most likely to have been taken in the last year. Use of class A drugs have remained around 2-3% since 2010. The 3 factors most strongly associated with drug use were smoking, being older pupil and drinking.

Young adults aged 16-25 have the highest levels of drug consumption in any group. In a survey in England and Wales, 1 in 5 in this age group reported use in the last year. Class A drug use in this age group was 4.7%. There has been a decline in consumption since the previous survey in 2000, both in overall consumption and use of Class A drugs. This contrasts with the previously observed trend of increased use since 2013. This may reflect the impact of the pandemic, with fewer opportunities for social events where drug consumption is higher. A notable reduction in consumption was particularly seen in the 16-19 age group.

Over the last decade, rates of hospital admission due to substance misuse in those aged 15-24 have been significantly higher in Northamptonshire than England. In the most recent year that data is available, 2018-19 – 2020-21, rates were significantly higher in both North and West Northamptonshire.

Children and Young People

This section provides an overview of patterns of consumption in children and young people. There are negative, often lifelong, consequences of using drugs and alcohol in before adulthood. Adolescence is a critical age for initiation of substance misuse that then peaks for drugs in the 18-25 age group. Adolescents are most inclined to experiment, influenced by a range of factors including curiosity, susceptibility to peer pressure, rebellion against authority and low self-worth.[5]

Alcohol consumption in adolescence can negatively impact educational performance; relationships with carers, family and peers; impaired brain development; and increase the risk of alcohol misuse or abuse in later life.[6] Young people are more likely to binge drink, increasing risk of violence and injuries, unsafe sex and sexual exploitation, criminal activity, and self-harm or suicidal thoughts.[7] Adverse outcomes related to drugs misuse are similar with additional risk factors related to mental health, in particular increased risk of suicide, depression, psychosis and disruptive behaviour.[8]

Alcohol consumption

National trends – school aged children

Since 2003, national survey data published by NHS Digital has shown that the level of alcohol consumption among school aged children in England has fallen considerably.[9] Consumption is also low in young adults and in 16–24-year-olds it is the lowest of any adult age groups, although consumption on their heaviest day is higher than other age groups.[10]

In 2021, the NHS Digital survey reported that 40% of secondary school children in England aged 15 and under said they had ever had a drink. This was a decline since the previous survey in 2018 where the 44% of pupils reported drinking. In the last week, 9% of pupils reported they had drunk with no significant change since the last survey. 8% of pupils reported having been drunk in the last 4 weeks.

Rates are highest in

- **Girls**: with 42% saying they had ever had a drink compared with 39% for boys, although this difference was not statistically different.
- **Older children**: with 65% of 15-year-olds saying they had ever drink alcohol, compared to 13% of 11-year-olds.

[5] Degenhardt L, Stockings E, Patton G, Hall WD, Lynskey M. The increasing global health priority of substance use in young people. Lancet Psychiatry. 2016;3(3):251–64.
[6] Public Health England. Data intelligence summary: alcohol consumption and harm among under 18 year olds. July 2016.
[7] Lees et al. (2018) Binge drinking in young people: protocol for a systematic review of neuropsychological, neurophysiological and neuroimaging studies. BMJ Open, Vol 8 (7).
[8] Nawi, A.M., Ismail, R., Ibrahim, F. *et al.* Risk and protective factors of drug abuse among adolescents: a systematic review. *BMC Public Health* **21**, 2088 (2021).
[9] NHS Digital. Smoking, drinking and drug use among young people in England, 2021.
[10] ONS. Adult drinking habits in Great Britain: 2017.

- **White ethnic groups**: with 11% of children having drunk in the last week, compared to less than 4% for other ethnic groups.

- **More affluent households**: with young people in more affluent households more likely to drink and to drink regularly compared with the most deprived households.

Local trends - school aged children

Local data on the drinking habits of Northamptonshire's children is collected in a school survey. The Northamptonshire Young People's Health and Wellbeing Survey was developed by the Schools Health Education Unit (SHEU) in partnership with the Northamptonshire Public Health Departments. The purpose of the survey was to obtain pupils' views regarding healthy eating, safety, emotional wellbeing and leisure time. The last survey was undertaken in the summer term of 2022.

A total of 5338 pupils took part in 26 primary schools and 10 secondary schools in Northamptonshire. There was a reasonable mixture of boys and girls across the specified year groups. 66% of the pupils surveyed described themselves as White British.

The secondary school survey was undertaken in Year 8 and 10 (ages 11 – 15). 68% of pupils described themselves as White British. 10% described themselves having another white background. 9% were Asian, 7% said they were black and 4% described themselves as mixed background.

In **primary school children in Year 6** (age 10-11), the responses to the questions were:

- 74% of Year 6 pupils reported that they have never had an alcoholic drink.

- 13% of Year 6 pupils said that they have drunk alcohol 'a long time ago'. 9% said they have drunk alcohol in the last year. When asked if their parents knew about it, 12% said yes, 1% weren't sure

- 3% of pupils (4% of boys and 2% of girls) in Year 6 said that they drank alcohol (more than just a sip) in the last week.

In **secondary school children in Years 8 and 10** (age 11 – 15) the responses to the questions were:

- 60% of pupils said that they don't drink alcohol.

- 14% have tried alcohol a couple of times, 24% said that they do sometimes drink alcohol.

- The most common source of alcohol is from family/friends. 2% said that they had bought the alcohol themselves from a local shop the last time they had an alcoholic drink.

- 7% were given it by a friend, 6% said someone bought it for me.

- 15% of pupils said they were given alcohol by a relative last time they had an alcoholic drink.

It should be noted that there was a **decline in alcohol consumption** in secondary school children Northamptonshire, with 40% stating they drink alcoholic drinks (more than just a sip) in 2022 compared with 45% in 2019. This follows the national trend in reduced consumption.

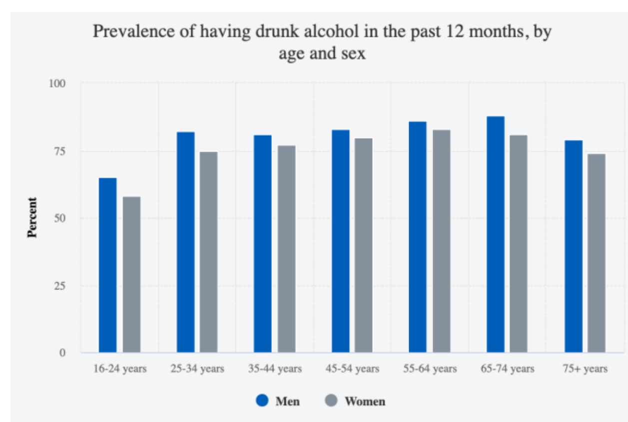
Children were also asked about their family drinking, there has been a significant increase in relation to the concern for family drinking with

- 32% think they need help or information about their family drinking alcohol compared with 16% in 2019.

National trends – young people

Young people are the group least likely to drink. In 2021, a survey in England found that 65% of men and 58% of women aged 16-24 drank in the last year – lower than any other age group (Figure 1). 31% reported drinking at least once a week. This contrasts with the average for all age groups of 79% reporting drinking in the last year and 49% reporting drinking at least once a week.

Figure 1



Source: NHS Digital. Health Survey for England 2021

For both men and women, the younger age groups were the least likely to consume alcohol above the recommended 14 units per week (Figure 2 and 3).

Figure 2

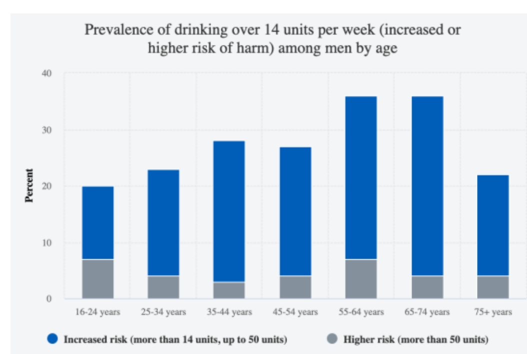
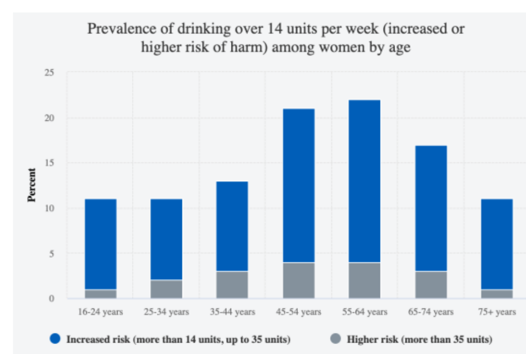


Figure 3



Source: NHS Digital. Health Survey for England 2021

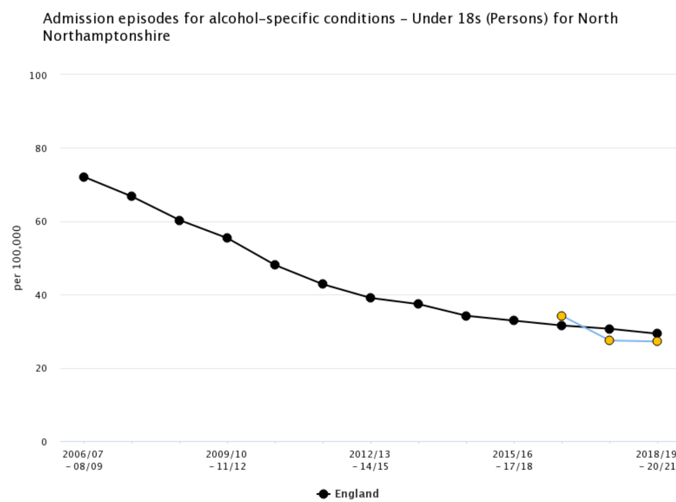
The proportions in this age group who said they did not drink in the last 12 month increased from

28% in 2019 to 38% in 2021. There were changes in the way the survey was administered over this period so trends should be viewed with caution.

Local trends – hospital admissions under 18's

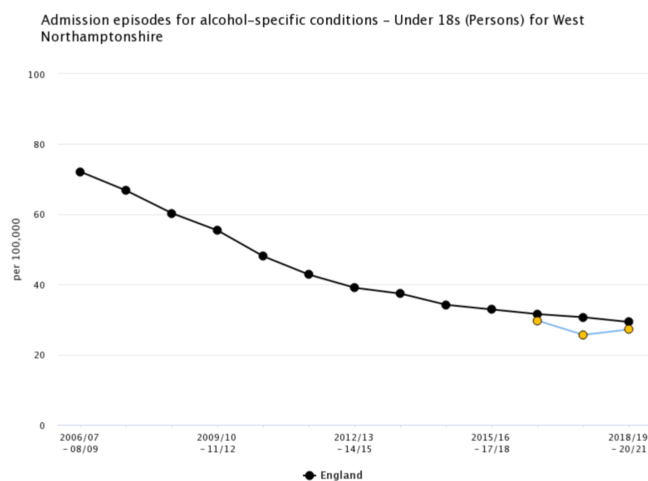
Nationally, alcohol related hospital admissions for those aged under 18 have fallen over the last decade. The same pattern has been seen in Northamptonshire. Both North and West had rates that were similar rates to England in the latest 3-year period, 2018/19 – 2020/21 (Figure 4 and 5). There is a difference in gender, with around three quarters of admissions occurring in females.

Figure 4: Hospital admissions for alcohol-specific conditions in North Northamptonshire



Source [OHID Fingertips]

Figure 5: Hospital admissions for alcohol-specific conditions in West Northamptonshire



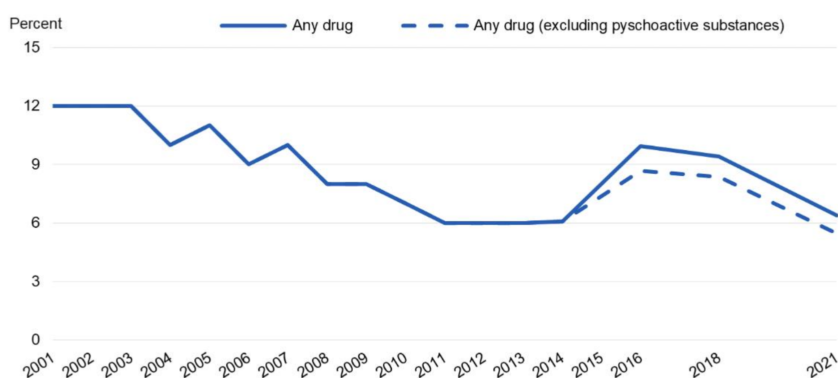
Source [OHID Fingertips]

Drug misuse

National trends – school age

In 2021, the NHS Digital survey reported that 18% of secondary school children in England aged 15 and under said they had ever taken drugs. [11] This has declined in recent years, in 2018 it was 24%. Within the last year, 12% of pupils said they had taken drugs, down from 17% in 2018. 6% of pupils said they had taken drugs in the last month, a decline from 9% in 2018 (Figure 6)

Figure 6: Pupils who have taken drugs in the last month in England



Source: NHS Digital

Rates are highest in

- **Girls**: 19% of girls reported having ever taken drugs compared with 17% of boys (not statistically significant)
- **Older age groups**: with 32% of 15-year-olds having ever taken drugs compared to 7% of 11-year-olds.

In terms of the types of drugs taken, the most common is cannabis with 6% reporting taking this in 2021. This is a reduction from 8% in 2018 and 13% in 2003. Falls were also seen in other substances including nitrous oxide, volatile substances, cocaine and crack cocaine. Use of class A drugs in this group have remained around 2-3% since 2010. Most pupils only took 1 drug in the last year – 66%.

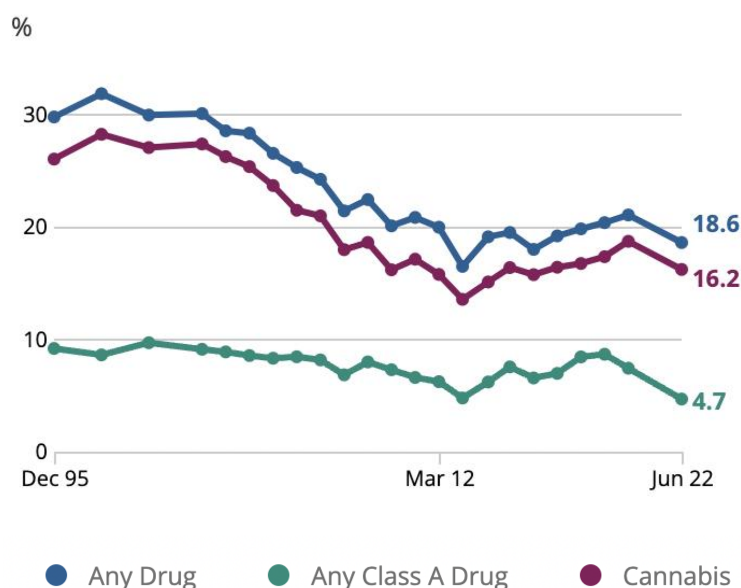
The patterns use for those consuming class A drugs was different from those taking only cannabis or volatile substances. Those taking class A drugs were more likely to have used drugs on more than 10 occasions (55%) compared to 17% using only volatile substances and 21% using only cannabis.

[11] NHS Digital. Smoking, drinking and drug use among young people in England, 2021.

National trends – young people

Young adults have the highest rates of drug consumption of any age group. In the year ending June 2022, 1 in 5 young adults aged 16-24 in England and Wales reported drug use in the last year.[12] The rate in all adults aged 16-64 was 1 in 11. Prevalence of class A drug use in young adults was aged 16-24 was 4.7%, a significant decrease from the previous survey in the year ending March 2020 when use was 7.4%. This contrasts with the previous few years, where a trend of increased consumption had been observed since 2013 (Figure 7). The impact of the pandemic, with fewer opportunities for social events where class A drugs, may be a contributing factor to the recent decline.

Figure 7: Class A drug use in the last year in England and Wales in 16–24-year-olds



Source: ONS. Drug misuse in England and Wales: year ending June 2022

The survey contains further breakdowns of age groups. Use remains highest in those aged 20 -24 with 23.3% taking drugs in the last year. However, there was a notable reduction in consumption in those aged 16-19 compared with the year ending March 2022. In particular,

- Any drug use decreased from 21.1% to 12.2%
- Any class A drug decreased from 5.8% to 2.0%
- Cannabis decreased from 19.2% to 11.3%.

Drug use in adults more generally was higher in those visiting nightclubs and pubs, with younger people more likely to visit these venues.

[12] ONS. Drug misuse in England and Wales year ending June 2022.

Local trends – school aged children

Local data on drug use of Northamptonshire's children is collected in the Northamptonshire Young People's Health and Wellbeing Survey was developed by the Schools Health Education Unit (SHEU) in partnership with the Northamptonshire Public Health Departments. The last survey was undertaken in the summer term of 2022. Key findings from this survey were

Primary school

- 43% of Year 6 pupils said that their parents/carers have talked with them about illegal drugs.
- 68% of Year 6 pupils said that someone in school had talked with them about illegal drugs.
- 2% of pupils in Year 6 pupils have been offered illegal drugs, 7% weren't sure if they have.

Secondary school

- 7% of Year 10 pupils said that they have used cannabis.
- 2% of boys and 1% of girls in Year 10 have used solvents as drugs.
- 3% of boys and 1% of girls said that they have used nitrous oxide.
- When asked where they got the drugs from, 4% of boys and 2% of girls in Year 10 said they were bought them from a dealer. 4% of Year 10 pupils said they were given them by a friend.

Factors associated with substance misuse

Surveys in school aged children have identified factors associated with increasing the risk of substance misuse. In relation to alcohol, the strongest factors are parents who don't discourage drinking, older pupils, and recent drug use (Figure 8). In relation to drugs, the strong factors were smoking, families who don't discourage drug use and drinking (Figure 9).

Figure 8: Factors associated with alcohol consumption in the last month

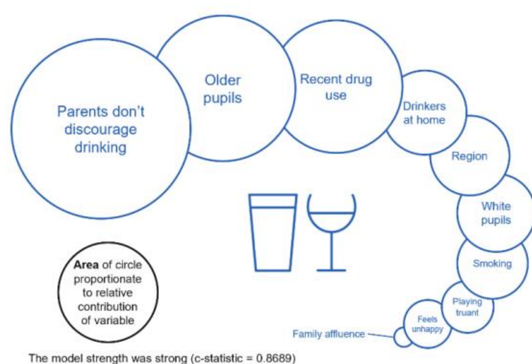
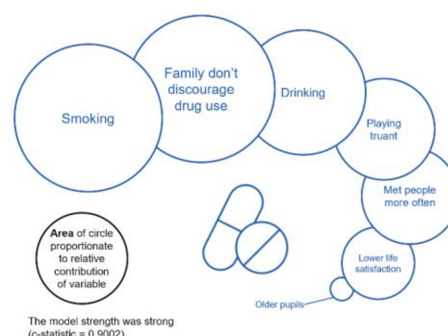


Figure 9: Factors associated with drug consumption in the last month



Source: NHS Digital. Smoking, drinking and drug use among young people in England, 2021

Local trends – hospital admissions

Local data measuring drug consumption in young adults is not available in Northamptonshire. Hospital admission data provide some indication of trends in the wider community. Over the last decade, rates of hospital admission due to substance misuse in those aged 15-24 have been significantly higher in Northamptonshire than England (Figure 10). Rates are significantly higher than the England average in both North and West Northamptonshire (Figure 11 and 12).

Figure 10: Hospital admissions due to substance misuse (15-24 years): Northamptonshire

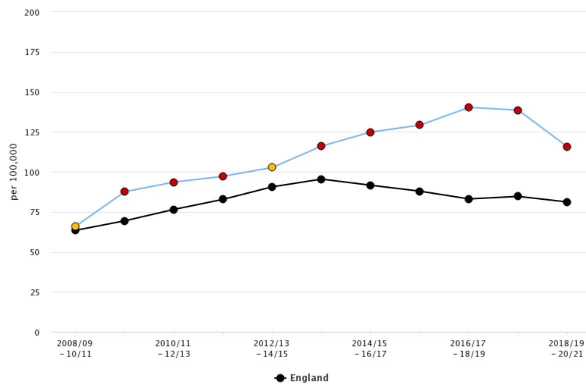


Figure 11: Hospital admissions due to substance misuse (15-24 years): West Northamptonshire

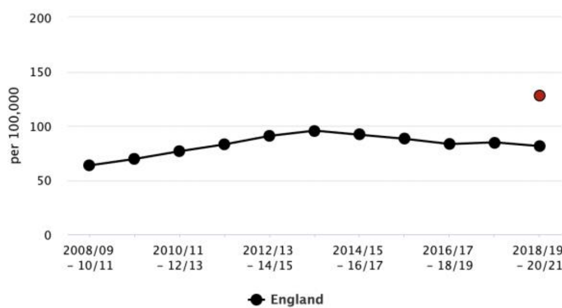
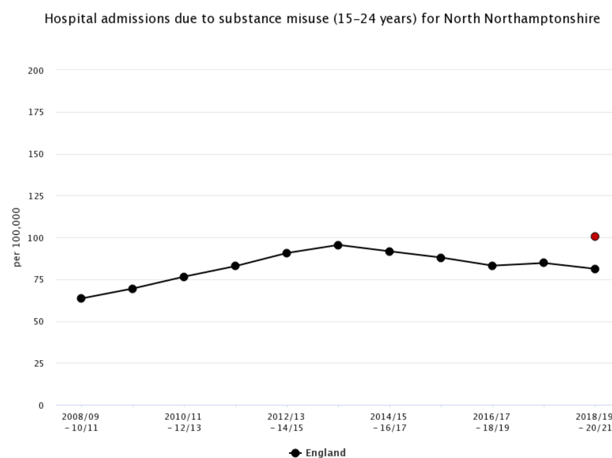


Figure 12: Hospital admissions due to substance misuse (15-24 years): North Northamptonshire



Source: OHID Fingertips

Adults

Section summary - Adults

Nationally, there has been a downward trend in the proportion of adults who drink, both in men and women. This decline is particularly the case in young people aged <25. Men continue to drink more than women, with those aged 45-64 having the highest levels of consumption. Drinking more than the recommended 14 units per week increases the risk of alcohol related harm. Rates were highest in more affluent households, men and those aged 55 to 64.

It is estimated that 7,000 adults in Northamptonshire are dependent on alcohol and potentially in need of specialist treatment. Prevalence estimates are statistically similar to the England average.

- Alcohol: 12.1 per 1,000 in Northamptonshire; 13.7 per 1,000 in England.

Around 21% of adults in Northamptonshire drink more than the recommended 14 units per week, similar to the England average of 22.8%. Fewer people locally abstain from drinking – 12.9% in Northamptonshire and 16.2% in England.

Following a period of decline, the prevalence of reported drug use in adults aged 16-69 in England and Wales increased 15% between 2013 and 2020. There was no change in overall drug use in most recent period, from March 2020 till June 2022. Approximately 1 in 11 adults, or 9.2%, reported taking drugs. Use is highest among young people aged 16-24. However, there was a decline in class A drug use between 2020 and 2022, falling from 3.4% to 2.7%. Use of ecstasy and nitrous oxide. The impact of the pandemic, fewer social events, may be a contributing factor.

Cannabis is the most commonly taken drug among adults and use at 7.8% is much higher than the next most common drug, powder cocaine (2.6%). Young adults are the group with the highest use.

Local estimates of drug use are provided by OHID based on estimates in 2016-17. This is the latest available estimate for local councils. These estimates suggest in 2016-17 there were around 1,600 crack users, 2,600 opiate users and 3,200 Opiate and Crack Users (OCUs) in Northamptonshire. Prevalence estimates were lower than the England average for all drugs at this time:

- Crack: 3.5 per 1,000 population in Northamptonshire; 5.1% in England
- Opiates: 3.9 per 1,000 population in Northamptonshire; 7.3% in England
- Opiate and/or crack use: 7.1 per 1,000 in Northamptonshire; 8.9% in England.

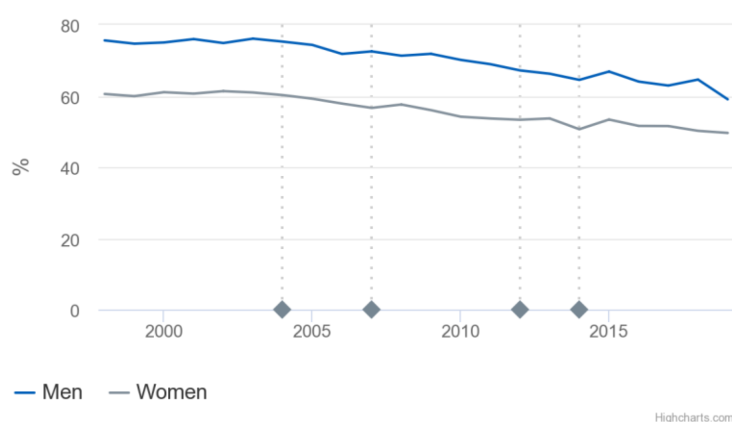
It should be noted that local figures are estimates based on the best available evidence at that time. The actual prevalence of substance misuse, for both alcohol and drugs in Northamptonshire is unknown.

Alcohol consumption

National trends

Nationally there has been a downward trend in the proportion of adults who drink alcohol in the last week, this has fallen from 67% in 1998 to 54% in 2019 (Figure 13).[13] The decline in drinking in the last week has been seen in both men and women, although men continue to drink more than women – 59% and 50% respectively in 2019. Women are also more likely not to drink at all.

Figure 13



Source: NHS Digital: Alcohol

The Health Survey for England in 2021 identified groups with different drinking patterns.[14] In relation to drinking at levels that put an individual at increased risk of alcohol related harm (>14 units per week), key finding included:

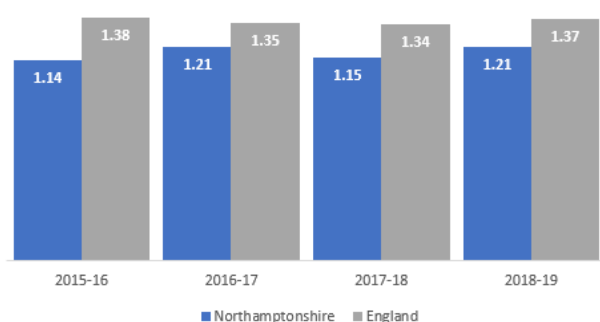
- A higher proportion of men (28%) than women (15%) drank at increasing or higher risk levels (over 14 units) in the last week for both men and women.
- Men were more likely than women to drink at increasing risk levels (23% and 13% respectively).
- 5% of men drank over 50 units a week and 2% of women usually drank over 35 units a week (higher risk levels) in a week.
- The proportions of men and women who usually drank more than 14 units in a week varied across age groups, increasing up to the age of 55 to 64 (28% of all adults, 36% and 21% of men and women respectively)
- Higher rates in the least deprived geographical areas for both men and women
- Higher rates in the most affluent households, with the highest household income.

[13] NHS Digital. Alcohol. Accessed 23rd November 2022.
[14] NHS Digital. Health Survey for England, 2021 part 1. Published 15th Dec 2022

Local trends

It is estimated that almost 7,000 adults in Northamptonshire are dependent on alcohol and potentially in need of specialist treatment (2018-19).[15] That number could be as high as 9,000, considering the margin of error. Figure 14 below compares the rate per 100 population of these alcohol dependent adults with the national average. The Northamptonshire rate is consistently below the national average across the four years, but statistically the rate is similar England.

Figure 14: Estimates of the number of adults in Northamptonshire with an alcohol dependency potentially in need of specialist treatment, rate per 100 population



Source: Public Health England

An estimated 21.4% of adults in Northamptonshire drink more than the recommended 14 units per week, slightly lower than the England average of 22.8%.[16] A lower proportion of adults in Northamptonshire abstain from alcohol than the England average – 12.9% vs 16.2%.

Table 1: Patterns of alcohol consumption for Northamptonshire **and** England

Indicator	Local (%)	LCL	UCL	England (%)	LCL	UCL
Proportion of adults who abstain from drinking alcohol	12.9	10.1	16.3	16.2	15.8	16.6
Proportion of adults drinking over 14 units of alcohol a week	21.4	17.7	25.7	22.8	22.4	23.3

Source: OHID Alcohol Commissioning Packs 2022-23.

[15] Public Health England. Alcohol dependence prevalence in the England. Updated 18 March 2021
[16] OHID Commissioning pack: 2022-23. Data is estimated for 2015-18 based on data from the Health Survey for England.

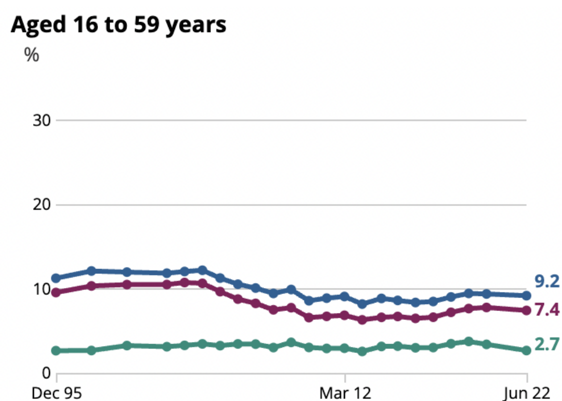
Drug misuse

National trends

The overall prevalence of drug use reported in England and Wales declined from 2003 for the next 10 years.[17] After this point, the rate of drug use started to increase. Between 2013 and 2020, the proportion of adults reporting any form of drugs increased by 15% and for young adults aged 16-24 the increase was 28%. In 2020, 9.4% of adults had taken a drug in the last year and in young adults the rate was 21%. The most used drugs have not changed over time. Cannabis is the most prevalent, followed by powder cocaine, MDMA, ketamine and amphetamine.

A different patter has been seen in the last 2 years during the pandemic, with no overall change in drug use in the last year between March 2020 and June 2020.[18] During this time, there was a decline in use of class A drugs, falling from 3.4% to 2.7% in this time period. Use of ecstasy and nitrous oxide also fell during this period. The impact of the pandemic, with fewer social events, may be contributing factor.

Figure 15: Proportion of adults reporting use of any drugs in the last year, England and Wales, ending Dec 1995 to year ending June 2022.



Source: ONS

Local trends

Local estimates of drug use are provided by OHID based on estimates in 2016/17. This is the latest available estimate for local council areas. These estimates suggest in 2016/17 there were around 1,600 crack users, 2,600 opiate users and 3,200 Opiate and Crack Users (OCUs) in Northamptonshire. Prevalence estimates were lower than the England average for all drug types (see tables 2 and 3).

[17] ONS. Drug misuse in England and Wales: year ending 2020.
[18] ONS. Drug misuse in England and Wales: year ending June 2022

Table 2: Prevalence estimates and rates per 100,000 for Northamptonshire **in** 2016-17**.**

Drug groups	Local estimate	LCL	UCL	Rate per 1,000*	LCL	UCL
Crack	1,625	1,388	1,958	3.5	3.0	4.2
Opiates	2,658	1,830	3,518	3.9	5.7	7.6
OCU	3,281	1,955	4,611	7.1	4.2	9.9

Note:
*Prevalence estimates 2016-17, rate per 1,000 of the population aged 15-64.

Table 3: Prevalence estimates and rates per 100,000 for Northamptonshire **in** 2016-17**.**

Drug groups	England estimate	LCL	UCL	Rate per 1,000*	LCL	UCL
Crack	180,748	176,583	188,066	5.1	5.0	5.3
Opiates	261,294	259,018	271,403	7.3	7.4	7.7
OCU	313,971	309,242	327,196	8.9	8.7	9.2

Note:
*Prevalence estimates 2016-17, rate per 1,000 of the population aged 15-64.

Source: OHID Commissioning support packs

Parents

Section summary - parents

The impact of substance misuse starts before birth, with consumption in pregnancy impacting the development of the unborn baby. Risks include miscarriage, premature birth, impact on growth, learning, speech, emotional and social skills. These impacts are lifelong. It is estimated that 3.2% of UK children born in the UK will be affected by Foetal Alcohol Spectrum Disorders.

Parental substance misuse has a significant impact on the physical, psychological and social outcomes of children. This includes increased risk of accidental injury, poor dental health, poisoning, conduct disorders, attention difficulties, and violent and rebellious behaviour. Educational performance is lower in these children. Children of parents with problematic substance misuse are 9 times more likely to be in care by their 7th birthday than those who do not.

The most recent estimates for opiate use in parents was produced in 2014-15 and for alcohol 2018-19. At this time, 1,457 alcohol dependent and 876 opiate dependent adults were living with children locally. Around two thirds of these were men. The estimated rate of parental alcohol misuse in Northamptonshire (3 per 1,000 population) was the same as the average for England but higher than other similar geographical areas known as CIPFA neighbours (2 per 1,000). The parental opiate dependence rate (2 per 1,000) was the same as England and CIPFA neighbours.

An estimated 6,500 children in Northamptonshire were living in households where the parent was suffering from drug or alcohol dependency in 2019-20. Of these, around 700 were aged under 1, and 1,900 were aged 1-4. The rate of 38 per 1,000 children aged 1–17 is slightly lower than the England rate of 40 per 1,000. It should be noted that estimates for adults and affected children are based on modelled data, drawing on several data sources. The exact numbers are not known.

Substance misuse is one of a range of adverse factors impacting childhood outcomes – these are known as Adverse Childhood Experiences (ACEs). Adults who have had 4 or more ACEs are 11 times more likely to have used crack cocaine or heroin. Children experiencing multiple ACEs are more likely to become dependent drinkers. In 2019-20, an estimated 1,700 children in Northamptonshire living in households affected by three ACEs in 20, the ‘toxic trio’ – substance misuse, severe mental ill health and domestic abuse. The ‘toxic trio’ rate of 10 per 1,000 in Northamptonshire was slightly higher than the England and CIPFA rate of 9 per 1,000.

Parental substance misuse has a significant impact on the health and development of children.[19] Harm can start before birth with substance misuse in pregnancy impacting on development of the unborn child. Parental substance misuse can significantly impact on their ability to meet children's physical, social and emotional needs particularly when combined with other adverse experiences such as domestic abuse and mental ill health. This section details the number of children and young people impacted by substance misuse in Northamptonshire and the related consequences.

Substance misuse in pregnancy

Risks of alcohol use in pregnancy include miscarriage, premature birth, low birth weight, impact on growth, neurodevelopmental birth defects known as Foetal Alcohol Spectrum Disorders.[20] Longer term, this can result in behavioural challenges, impact on speech and language, and psychosocial consequences that last into adulthood.[21], [22] Modelled estimates indicate that around 3.2% of children in the UK may have Foetal Alcohol Spectrum Disorders.[23] Babies born to mothers using illicit drugs experience similar adverse outcomes to those with alcohol and can suffer withdrawal symptoms.

Parental substance misuse

Parental substance misuse often results in significant physical health, psychological and social outcomes children. The impact of the resulting failure to address children's physical emotional and practical neglect and developmental wide ranging. This includes increased risk of abuse (physical, emotional, sexual), poor education outcomes, criminal activity, and psychological effects.[24],[i]

Table 4 provides estimates of the number of adults living with children in Northamptonshire with substance misuse. Around two thirds of adults who are dependent are men.

The Children's Commissioner estimated that in 2019-20, there were **6,500 children** in Northamptonshire living with adults dependent on alcohol or drugs.[ii] Of these, 700 were infants under the age of 1 and 1,900 were aged 0-4.

The number of children living in Northamptonshire with alcohol dependent adults was estimated to be between 2,230 - 2,457 in 2018-19. This equates to 1.3-1.4% of all children.

Table 4: Estimated number of adults living with children in Northamptonshire

	Alcohol (dependent)*	Alcohol Rate per 1000 population	Drugs (opiate dependent)**	Rate per 1000 population
Total	1,457	3	876	2
Male	968	3	577	3
Female	489	2	299	1

*estimate for 2018-19; ** estimate for 2014-15.

[19] SCIE. Research Briefing 6: Parenting capacity and substance misuse August 2005.
[20] IAS. Alcohol guidelines for pregnant women. Barriers and enablers for midwives to deliver advice. Aug 2019.
[21] Forray A. Substance use during pregnancy. F1000Res. 2016 May 13;5:F1000 Faculty Rev-887.
[22] Popova,S., Lange,S., Probst,C., Gmel,G., and Rehm,J., 2017. Estimation of national, regional, and global prevalence of alcohol use during pregnancy and fetal alcohol syndrome: a systematic review and meta-analysis. The Lancet Global Health.
[23] Prevalence of foetal alcohol spectrum disorder in Greater Manchester, UK: An active case ascertainment study - McCarthy - 2021 - Alcoholism: Clinical and Experimental Research - Wiley Online Library
[24] Parental substance misuse | NSPCC Learning

Adverse Childhood Experiences

Substance misuse in parents often occurs alongside other experiences determinantal to a child's health and wellbeing. These experiences are known as Adverse Childhood Experiences (ACE) - highly stressful events where a child is directly harmed, or indirectly harmed from the environment they live in.[iii] Harm can be physical abuse, sexual abuse, emotional abuse, domestic violence, losing a parent and living with someone with severe mental illness, in prison or abusing alcohol or drugs.

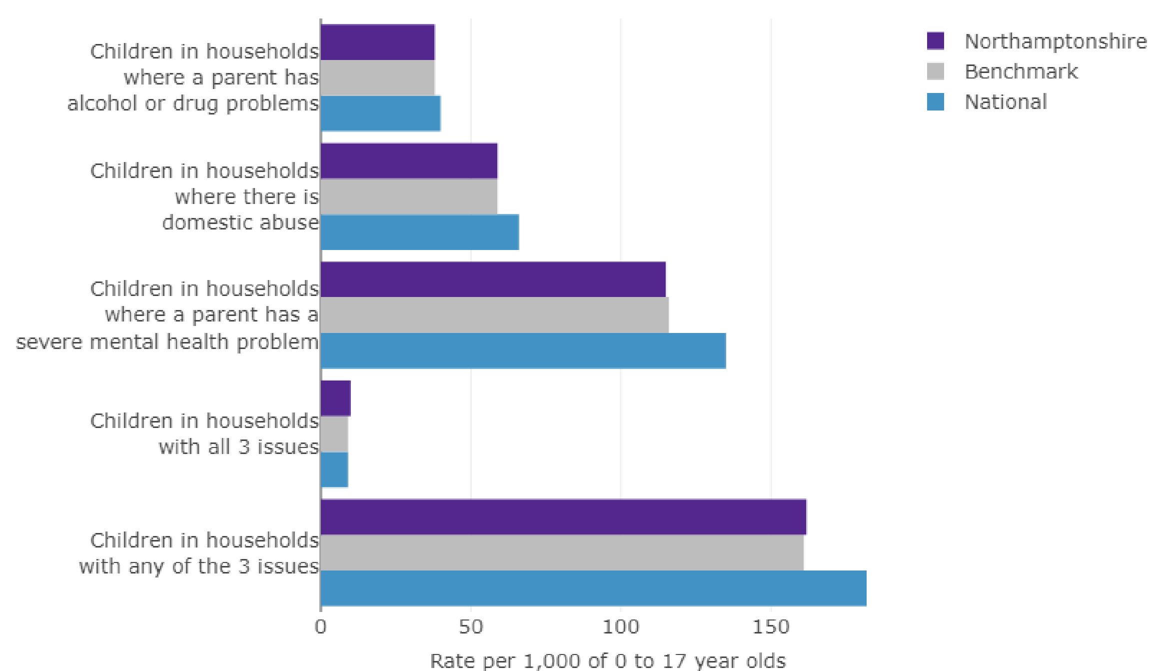
Children affected by ACEs are at significantly increased risk of substance misuse in adolescence and adulthood. The greater the number of ACEs experienced throughout childhood, the greater the risk of poor health and wellbeing immediate and long term.[iv]

Adults who have experience four of more ACESs in childhood are 11 times more likely to have used crack cocaine or heroin.[v] It is estimated in England ACES around 53% of drug misuse is attributable to ACEs.[vi] Those suffering multiple ACEs are also more likely to be heavier users of alcohol.[vii] This is especially the case for males, this combination results in substantially increased risk of violence.

National policy has emphasised the increased risk of three of ACEs have on children – these being substance misuse, domestic abuse and severe mental health – known as the toxic trio.[viii] Data issued by the Children's Commissioner estimate that 1,700 children in Northamptonshire are living in a household with all three ACEs. A breakdown is shown in figure 16.

In 2020-21, 15% of young people presented to substance misuse services in Northamptonshire reported being affected by domestic abuse and 26% were affected by others substance misuse. The England figures were 15% and 14% respectively.

Figure 16: Co-occurring parental substance misuse, mental ill health and domestic abuse (2019-20)



Source: OHID: Commissioning packs

Section 3: Groups at high risk of substance misuse

Groups at high risk – section summary

Adults

The vast majority of people who use alcohol and drugs do not develop problematic alcohol and drug dependencies, resulting in harms. This harm is associated with several risk factors and vulnerabilities. The risk can be at an individual level (e.g., experience of mental ill health), environmental / contextual level (e.g., the neighbourhood environment, relationships and social networks); and structural level (e.g., political decision, deprivation). These risk factors are interrelated and interact with one another.

Groups known to be at higher risk of problematic substance misuse include those who are:

- Experiencing mental ill health
- Being sexually exploited or sexually assaulted
- Commercial sex workers
- Homeless
- Not in employment, education and training
- Lesbian, gay, bisexual and transgender
- In the Criminal Justice System
- Experienced trauma during childhood (adverse childhood experiences – ACEs)
- Involved in smoking, gambling and risky sexual behaviour
- Attenders of festivals and nightclubs
- White British ethnicity.

Although levels of drinking are higher in more affluent, educated groups, most of the burden of ill health is experienced by the most deprived. This reflects the increased exposure to other risk factors such as smoking, mental ill health and poor living environment.

Children

The risk factors for problematic substance misuse in young people are similar to those in adults. Children at particularly high risk of substance misuse are:

- Children in care
- Care leavers
- Young offenders
- Those experiencing mental ill health
- Gang members or involved in county lines
- In families who don't discourage substance misuse
- Children in families who are using alcohol or drugs
- White British ethnicity
- Those experiencing ACEs.
- Children who truant
- Those involved in other risky behaviours.

The risks associated with using and consuming illegal drugs or an unhealthy relationship with alcohol can affect all members of society, however there are some groups that are particularly vulnerable.

The risk can be at an individual level (e.g., experience of mental ill health), environmental or contextual level (e.g., the neighbourhood environment, relationships and social networks); and structural level (e.g., political decision, deprivation). These risk factors are interrelated and interact with one another.

Issues related to age and sex have been identified in the previous sections. This section provides additional details on some of the other individual characteristics and risk factors related to problematic substance use.

The National Institute for Health and Care Excellence (NICE) suggest the following groups as being particularly vulnerable to drug misuse.[25]

- people who have mental health problems
- people who are being sexually exploited or sexually assaulted
- people involved in commercial sex work
- people who are lesbian, gay, bisexual or transgender
- people not in employment, education or training (including children and young people who are excluded from school or who truant regularly)
- children and young people whose carers or families use drugs
- children and young people who are looked after or care leavers
- children and young people who are in contact with young offender teams but not in secure environments (prisons and young offender institutions)
- people who are considered homeless
- people who attend nightclubs and festivals
- people who are known to use drugs occasionally or recreationally.

Reviews of substance misuse in adolescence have identified the following risk factor.[26],[27]

- Childhood maltreatment
  - Physical or sexual abuse: this is particularly a trigger for early onset of substance misuse
  - Emotional abuse, including witnessing violence
  - Neglect

- Social risk factors
  - Deviant peer relationships
  - Peer pressure and popularity
  - Bullying
  - Gang affiliation

- Family
  - Structure: higher in single parent and stepparent families.

[25] NICE guideline NG64. Drug misuse prevention. Targeted intervention. Published 22nd February 2017.
[26] Scottish Government. Young people experiencing harms from alcohol and drugs: literature and evidence review. November 2021
[27] Whitesell M, Bachand A, Peel J, Brown M. Familial, social, and individual factors contributing to risk for adolescent substance use. J Addict. 2013;2013:579310

        - Caring responsibility: those with caring responsibilities

    - Individual risk factors
        - ADHD
        - Depression

Deprivation

It should be noted that those from more affluent groups are most likely to consume high levels of alcohol although the health impact in terms of hospital admissions and deaths are significantly higher in more deprived communities. Other factors impact on health outcomes, including co-morbidities, lifestyle risk factors, living conditions and access to services.[28] In relation to drugs, those in the most deprived areas experience the worse health outcome (see sections below on mortality).

Ethnicity

The Adult Psychiatric Morbidity Survey looked at the proportion of the population consuming alcohol by ethnicity and gender. This survey found that men are usually more likely to drink alcohol than women regardless of ethnicity, but with one exception. Black women are more likely to drink at harmful, hazardous or dependent levels (**7.4%**) than their male counterparts (**6.6%**).

White British people are most likely (**22.6%**) to drink alcohol at harmful, hazardous or dependent levels. People from other White backgrounds were **14.8%**, mixed ethnicities **9.9%**. Black ethnicities were 7.1% likely to consume alcohol at this level. Asian ethnicities were **3.7%**.

Mental health / dual diagnosis

Alcohol and drug misuse is common among people with mental health problems and the relationship between the two is complex. It can be a vicious circle, people who drink lots of alcohol or consume illegal drugs are more likely to develop mental health issues, and those with severe mental health issues are more likely to have problems with alcohol or drugs.
Up to 70% of clients in drug services and 86% of alcohol services have mental health problems.
Alcohol and drug use can cause mental health problems such as anxiety, depression, psychosis, personality disorder and could potentially lead to suicide.

Learning Disabilities

Public Health England published guidance in 2016 summarising what is known about the prevalence of substance misuse among people with learning disability, and the implications for services. This guidance notes that although research studies are limited, overall the evidence indicates that people with learning disabilities are less likely to misuse substances than the general population.
This is particularly likely to be the case for those people who have severe or profound learning disability. However, people with mild learning disability living in the community - especially those who are young and male, with mental health problems - are likely to be at increased risk of substance misuse. There is limited evidence of the extent of this risk, and the prevalence of substance misuse, as the various studies and research available rely on self-reporting or people known to Learning Disability services, resulting in a likely underestimation.

[28] Alcohol Change UK. Alcohol and inequalities.

Section 4: Impact of substance misuse on children and young people

Section summary – impact on children and young people

The health, social and economic impacts of substance misuse are substantial. Data from a range of organisations provides an indication of the impacts experienced locally.

Parental Substance Misuse

In the year till July 2022, 27 maternities in Northamptonshire were recorded as being impacted by substance misuse. This includes babies born with withdrawal symptoms and affected by Foetal Alcohol Syndrome. Many other babies will have been affected. Trends are unknown.

In Northamptonshire, 20% of parent assessments and 8% child social care assessments contained a flag relating to substance misuse in 2020-21. A higher proportion of parental assessments locally flag alcohol or drugs as a concern compared to England and similar geographical areas. The proportion of assessment involving drug and alcohol has fallen over time.

The profile of parents entering services provides an indication of some of the wider factors related to the risk of substance misuse. More parents living with children were either in employment, education or training (53%) than in similar geographical areas (48%) – the CIPFA benchmark. Rates were much lower for parents not living with children – 24% locally and 25% in England in 2019-20. In relation to housing, very few parents living with children had an urgent housing need (1% in Northamptonshire, 2% in benchmark areas) although urgent housing needs of parents not living with children were higher locally (16% in Northamptonshire vs 12% in benchmark areas).

A total of 10 young carers are registered where the primary disability is listed as substance misuse. The number is likely to be much higher as children affected by parental substance misuse are likely to be recorded under another primary disability such as mental health.

Children and Young People's Substance Misuse

There were 134 fixed term suspensions and 18 permanent exclusions related to substance misuse in Northamptonshire state schools in 2019-20, accounting for 3% and 14% of all cases. Rates of fixed term suspensions have increased over time and are slightly higher than the England average. In 2020-21, 8% of people in the youth justice system in Northamptonshire had offences related to drugs which was in line with the England average of 10%. Substance misuse may have been a factor in other offences. Although the number of first-time offenders in the youth justice system has fallen, the proportion of cases related to drugs has remained relatively unchanged in 10 years.

Children who are in local authority care are assessed for substance misuse needs as part of their annual health check. In 2020-21, 850 children were in care for at least 12 months in Northamptonshire but unfortunately data on health checks is not available for this period. We do know, however, that 16% of young people entering drug and alcohol treatment in this year were child in need, looked after child, or subject to a child protection plan. We also know that nationally 3% of young people in England who are looked after are identified as having a substance misuse need and if this national rate was applied to the local population, we would expect around 25 of our children in care to have substance misuse needs.

Very few children aged under 15 are seen in the emergency department, however attendances related to drugs and alcohol peak in those aged 15-24. Two thirds are women. Hospital admissions specific to alcohol in those under 18 have declined over the last decade and are similar to the England average. In contrast, admissions due to substance misuse in 15–24-year-olds have increased with local rates for both councils significantly higher than the national average.

Information collected on young people entering specialist treatment services provides an indication of the impact of, and risk factors for, substance misuse. The main vulnerabilities identified in 2020-21 in Northamptonshire were:

- anti-social behaviour (13%),
- self-harm (14%),
- domestic abuse (15%),
- impact of other's substance misuse (26%).

Levels of vulnerabilities locally were similar to England, with the exception of anti-social behaviour where levels in England were higher (27%) and impact of other's substance misuse where levels were lower (14%). The proportion of children living in care in local treatment clinics was 13%, compared to 7% in England.

Smoking levels locally were recorded as lower (8% compared to 27% in England). This is likely to reflect a gap in recording. A high proportion had a mental health treatment need – 43% locally and 42% in England.

Among children and young people entering specialist treatment services in Northamptonshire in 2020-21, most were in mainstream education – 64% locally compared to 56% in England. Fewer were in alternative education – 9% locally compared to 18% in England and a lower proportion of young people locally were not in education, employment or training – 8% compared to 16% in England.

This section outlines the impact of substance misuse on children and young people where known. This includes requirements related to social care, disruption to education, and hospital admissions where data is available. It should be noted that the available data only capture a small component of the overall impact and at a local level it is difficult to quantify the wider impact in areas including social relationships, mental health, educational attainment, and uptake of preventative services.

Substance misuse and newborns

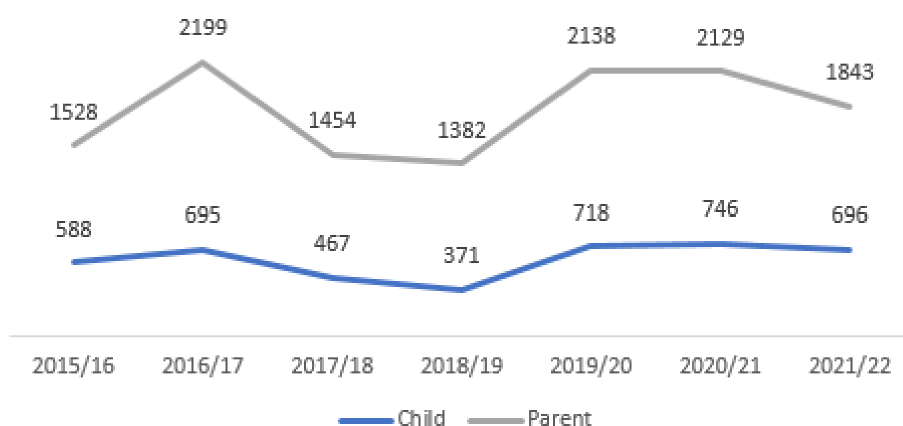
In Northamptonshire in the period August 2021-July 2022, 27 maternities were recorded as being impacted by substance misuse. Around 20% of involved Foetal Alcohol Syndrome and 80% related to newborns who were either affected by maternal drug addiction or showing signs of withdrawl symptoms. This represents around 0.5% of maternities in Northamptonshire and the most severe cases. Many other babies will be affected but not need immediate treatment. It is likely that many will require additional health, social and psychological support in childhood and into adulthood.

Children's social care

Children who have parents with substance misuse problems are 9 times more likely to be placed in care than those who do not misuse substances.[ix] Children taken into care are themselves at increased risk of substance misuse.[x] In those aged 11-19 studies estimate that there is a fourfold increase in risk for substance misuse compared to children not in care.

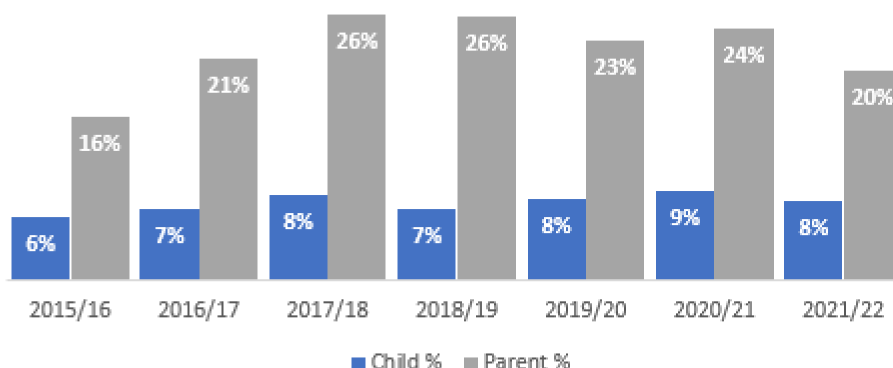
It's not possible to determine the number of children taken into the care of the Northamptonshire Local Authorities due to the adverse impacts of drugs and/or alcohol although substance misuse is recorded as a factor in assessments. In Northamptonshire, around 1 in 5 parent assessments contain a flag relating to substance misuse (figure 17). Over the last 5 years, the proportion involving drugs and alcohol has fallen slightly from a high of 1 in 4 in 2019 – 2019 although the numbers remain high – 1,843 in 2021/22 (figure 18).

Figure 17: Northamptonshire Children's Trust assessments with a drug and/or alcohol flag for either the parent or the child - number



Source: Northamptonshire Children's Trust

Figure 18: Northamptonshire Children's Trust assessments with a drug and/or alcohol flag for either the parent or the child - percentage



Assessments with drugs or alcohol flags - % of assessments

Source: Northamptonshire Children's Trust

Northamptonshire has had a higher proportion of parental assessments identifying alcohol and drugs as a factor for several years. This may be due to a higher rate of substance misuse in parents, or better detection during the assessment process. In 2019-20,

- 24.0% of parental assessment identified drug misuse as a factor in Northamptonshire, higher than similar geographical areas (19.9%) and England (17.0%).
- 20.8% of parental assessments identify alcohol misuse as a factor in Northamptonshire, slightly higher than similar geographical areas (19.0%) and England (16.3%)

Looked after children

Looked after children have an increased risk of substance misuse compared to their other children who are not looked after.[xi] They are also around 5 times more likely to have a diagnosed mental health condition compared to their peers, increasing the complexity of cases.

Substance misuse is identified as part of the health checks undertaken in this group. In 2021, 3% of looked after children in the East Midland and England, 3% were identified as having a substance misuse needs. This proportion has remained unchanged since 2018. Data reporting issues mean that no data has been available to share with the national team in Northamptonshire since 2018 and so the national figure reported for Northamptonshire in 2021 is, misleadingly, 0%.

We know, however, that there are looked after children with substance misuse needs in the county as in 2020-21, 16% of young people entering treatment for substance misuse either were identified as a child in need, looked after child, or subject to a child protection plan. This was slightly lower than the England average of 23% for this time period.

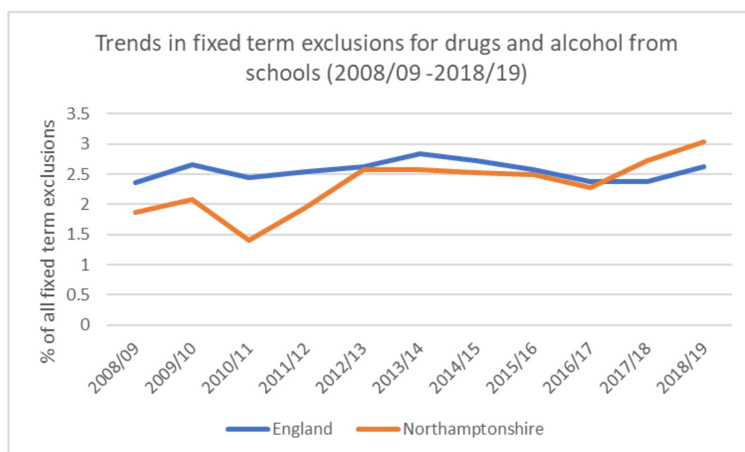
Young carers

A total of 10 young carers are registered where the primary disability is listed as substance misuse. The number is likely to be much higher as children affected by parental substance misuse are likely to be recorded under another primary disability such as mental health.

Education

In Northamptonshire in 2019-20, there were 134 suspensions (fixed term) and 18 permanent exclusions related to drugs and alcohol in state schools, accounting for 3.1% and 13.9% of all cases. Over time, a higher proportion of suspensions in Northamptonshire related to drugs and alcohol have increased, with rates now higher than the England average (figure 19).

Figure 19

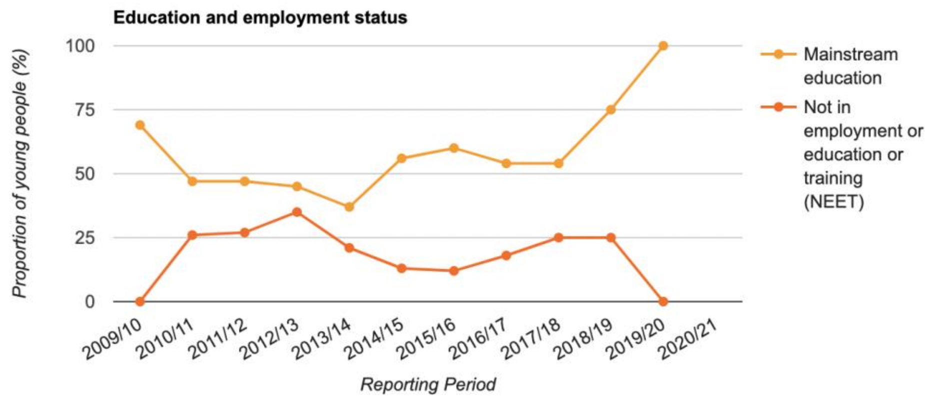


Source: [Education statistic gov.uk]

NDTMS data records the education status of those entering treatment. In 2020-21, 64% were in mainstream education at the start of their treatment in Northamptonshire, higher than the national average of 56%. Comparatively fewer were not in education, employment or training (NEETs) in Northamptonshire 8% compared to the England average of 18%. Trend data shows an increase in the proportion in mainstream education in Northamptonshire and a decline in NEETs (figure 20).

Substance misuse will impact on educational attainment and uptake of further education resulting in lifelong disadvantage. Data is not available to determine the extent of this impact at a local level.

Figure 20

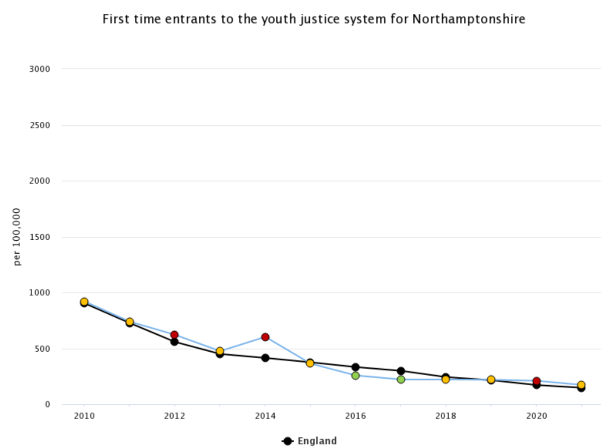


Source: OHID NDTMS

Crime and young offenders

Nationally, 13% of children aged 10-17 who receive their first caution or court offence committed a drug offence. Substance misuse may be involved in other offences leading to entrance into the criminal justice system. In 2021, 131 young people in Northamptonshire entered the criminal justice system for the first time. Local and national rates have fallen over the last decade, with the Northamptonshire rate mirroring the national rate for most of this period (figure 21).

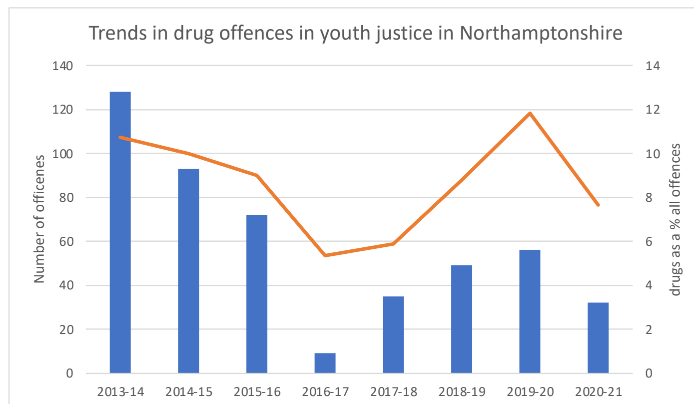
Figure 21



Source: OHID Public Health Outcomes Framework

In 2020/21, 8% of all offences recorded in children in Northamptonshire related to drugs, similar to the England average of 10%. Reflecting the reduction in numbers entering youth justice, the actual number of children with an offence related to drugs has declined over time. In 2013/14, 128 offences related to drugs in children in Northamptonshire were recorded, by 2020/21, this had fallen to 32 (figure 22). The reduction in number of recorded drug related offences is likely to reflect changes in sentencing practice, and creation of alternative provision for young people.

Figure 22

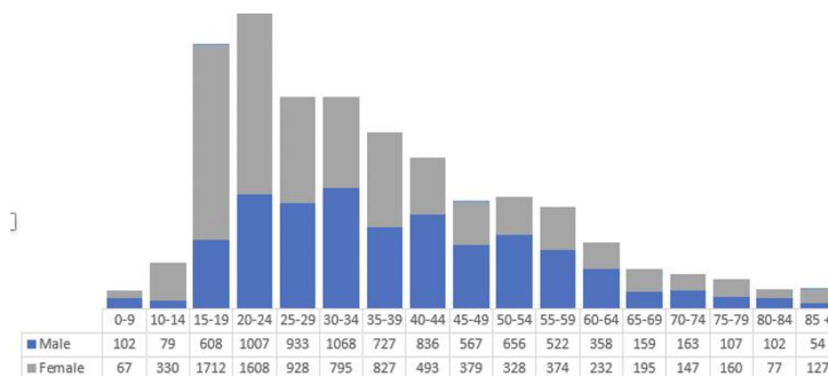


Source: [Youth Justice Board for England and Wales]

NHS treatment

While very few children aged 15 are taken to the emergency department for conditions involving drugs and alcohol in Northamptonshire, this pattern changes considerably for young people. Attendances peak in the 15–24-year-old groups and are particularly high for women – 66% of attenders (figure 23).

Figure 23: Emergency Department attendances involving drugs and alcohol in Northamptonshire, August 2021-July 2022



	0-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85 +
Male	102	79	608	1007	933	1068	727	836	567	656	522	358	159	163	107	102	54
Female	67	330	1712	1608	928	795	827	493	379	328	374	232	195	147	160	77	127

Source: NHS Northamptonshire

Details of hospital admissions for drugs and alcohol are contained in section 2.

Section 5: Impact of substance misuse on adults

Section summary – Impact of substance misuse on adults

NHS services

Routine data related to substance misuse is available for hospital and urgent care (A&E) settings. The impact on other services, particularly ambulance services, mental health services and primary care, is likely to be considerable but could not be quantified in this needs assessment.

In Northamptonshire, there were 3,455 individuals admitted to hospital as a result of drug or alcohol use in the year to July 22. Admissions peaked in the 50-54 age group. In this period there were 19,846 attendances at urgent care locally involving 6,156 individuals. On average these individuals had 2.7 attendances in that year. The cost of urgent care attendances was £3 million.

Urgent care attendances peak in the 15–24-year age group. Many of those in urgent care had an injury. Over half (56%) were accidental, with 1 in 4 involving self-harm and 15% alleged assaults. Northamptonshire had a significantly higher rate of hospital admissions for poisoning by drug misuse (43 per 100,000) than the East Midlands and England (both 31 per 100,000) in 2019-20. This rate has been higher since 2013-14. The rate of admissions where mental and behavioural disorders were a factor has been lower in Northamptonshire than in England and the East Midlands. However, this rate has risen considerably – more than doubling in the 5 years to 2019-20.

There are many measures of alcohol admissions, some looking broadly at conditions related to alcohol, others more narrowly focused on those conditions more attributable to alcohol, and others specifically reviewing alcoholic liver disease. Alcohol admission rates in the North are generally lower than England and in the West mostly similar. In both areas, there has been little change in recent years. In the measure often used to assess alcohol admissions, admission episodes for alcohol specific conditions, the rates are statistically lower in both North and West compared to England. Rates in North have not changed significantly while rates in West have increased. Alcoholic liver disease is the most common long-term effect of those admitted to hospital with an alcohol related condition, accounting for 85% of admissions. More of these admissions are in men – 64% in 2020-21.

Deaths

Death rates nationally have been rising since 1993 and were the highest in 2021. The increase is thought to be attributable to increased availability and purity of heroin and ageing heroin users. Other contributing factors include increased suicides, deaths in women, increased prescription drugs and potentially polydrug use and coroner reporting.

In line with the national trend, the death rate from drug misuse has risen every year since 2011-13. Rates are statistically similar to the England average. Local analysis of deaths provides more detail on those who have died in recent years. In the period Jan 2019 – June 2022, 134 deaths from drugs were registered in Northamptonshire. Key findings from analysis of these deaths are:

- Most deaths were in men (71%).
- 40-49 was the single most common age group.
- The mean age of death in men was 44.3 years, in women 41.3 years.
- Deaths were concentrated in the most deprived areas: 63% of illicit drug deaths occurred in the 30% most deprived areas in Northamptonshire.
- Most deaths from illicit drug use occurred in Northampton (35%), Kettering (19%) and Corby (15%).
- However, death rates (taking into account the size of the population) from illicit drug use were highest in Kettering, followed by Northampton and Corby.

In terms of alcohol, there has been no significant change in the death rate for either North or West in recent years. In 2000, there were 54 deaths specifically related to alcohol and 148 attributable to alcohol in West Northamptonshire. In North Northamptonshire, 38 deaths were specifically related to alcohol and 133 attributable. Approximately 65% of these deaths in both areas occurred in men.

Death rates from alcohol in North Northamptonshire are statistically similar to the England average and have remained unchanged on all measure of mortality related to alcohol in recent years. In West Northamptonshire morality rates are either statistically similar to or better than the England average, however no indicator has changed significantly in recent years. It should be noted that these figures do not reflect the impact of the pandemic.

Mental and physical ill health

The large rise in the deaths from drug misuse in the UK are only in part related to drugs. Increasingly, these are related to non-communicable diseases, particularly liver disease, respiratory disease (COPD), and suicide.

Recent data for an audit of suicide deaths in Northamptonshire has identified whether drugs or alcohol were involved. Alcohol was recorded in around 60% of deaths from suicide between 2017 and January 2021. Dependent and harmful drinking was identified in 23% of suicide deaths in both North and West Northamptonshire. Drugs were recorded in around 40% of suicide deaths in this time period, with 1 in 5 recording dependent or harmful use.

In those entering specialist drug treatment services in Northamptonshire, 64% were identified as having a mental health treatment need in 2020-21. This is similar to the England rate of 63%. Treatment needs were higher in women (76%) than men (59%), and in the group using alcohol and non-opiates (74%). For those entering treatment for alcohol only, 66% had a mental health treatment need, similar to the England average of 64%.

No local data was available to assess the physical needs of those with substance misuse.

Housing

The lack of stable accommodation can be a factor leading to problematic substance misuses. A safe, stable home will support recovery. At the time of entering treatment services, 10% of adults in Northamptonshire had an urgent housing need. Since 2012-13, urgent housing needs locally have been consistently higher than England. Younger people and opiate users are most affected.

Sexual health

Sexual health and substance misuse are closely linked, with studies showing evidence of consumption of alcohol and drugs associated with a higher risk of unplanned pregnancy, sexually transmitted infection and sexual assault. In young people aged 16-24, frequent binge drinking and recent drug use were associated with poor sexual health outcomes. While local data on sexual health outcomes is available, the proportion attributable to substance misuse is unknown.

Smoking

Smoking rates in adults is now below 14% but rates in adults with substance misuse are much higher. In England, 60% of those entering treatment were recorded as a smoker in 2020-21. In Northamptonshire, the figure was 37%. This may be due to low identification and / or recording.

Employment

In 2020-21, 58% of adults entering drug treatment services were unemployed in Northamptonshire, higher than the England average of 50%. However, a higher proportion locally were in regular employment (26%) than in England (21%). Far fewer people in Northamptonshire were on long term sick or disabled (10% locally vs 21% in England).

The pattern for those receiving alcohol treatment was similar, with 48% unemployed / economically inactive in Northamptonshire compared to 41% in England. Slightly more were in regular employment - 39% locally vs 36% in England, and fewer people were on long term sick or disabled – 8% locally vs 18% in England.

Crime

Heroin and crack use in England is responsible for nearly half of robberies, burglaries and other acquisitive crime. Alcohol is a factor in around 39% of violent crimes. In the year ending June 2022, there were 2,057 drug related offences recorded in the Northamptonshire. Most of these occurred in the three towns of Northampton (43%), Wellingborough (16%) and Kettering (15%).

Carers

Northamptonshire Carers report that 53 carers were registered where the primary disability was substance misuses. This is likely to be an underestimate, some are likely to be registered with the primary disability recorded as mental health.

Hospital admissions

Alcohol

Substance misuse has a major impact on demand for all NHS services. Routine data that identifies substance misuse is available for urgent care and hospital admissions. A high-level summary of the rates of hospital admission for both council areas is provided below.

In brief, in 2020-21 North Northamptonshire Council rates are significantly better than the England average on most measures of admissions related to alcohol (figure 24). Most indicators relating to alcohol admissions have been unchanged in recent years.

West North Northamptonshire Council are mostly in line with the England rates for most measures related to alcohol admissions and perform significantly better in a couple of areas. Admission rates have largely been unchanged or got worse in recent years.

Figure 24: Rates of hospital admission for North Northamptonshire.

Indicator	Period	N Northamptonshire			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Admission episodes for alcohol-related conditions (Narrow): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Persons)	2020/21	↓	1,477	431	502	456	805		251
Admission episodes for alcohol-related conditions (Narrow): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Male)	2020/21	↓	923	558	629	603	1,063		316
Admission episodes for alcohol-related conditions (Narrow): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Female)	2020/21	↓	554	316	387	322	597		141
Admission episodes for alcohol-related conditions (Broad): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Persons)	2020/21	→	4,912	1,440	1,502	1,500	3,459		962
Admission episodes for alcohol-related conditions (Broad): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Male)	2020/21	→	3,583	2,221	2,242	2,290	5,192		1,464
Admission episodes for alcohol-related conditions (Broad): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Female)	2020/21	→	1,329	752	849	805	1,923		445
Admission episodes for alcohol-specific conditions (Persons)	2020/21	→	1,410	413	510	587	2,276		298
Admission episodes for alcohol-specific conditions (Male)	2020/21	→	960	577	673	806	3,350		344
Admission episodes for alcohol-specific conditions (Female)	2020/21	→	450	259	356	380	1,286		138

West Northamptonshire.

Indicator	Period	W Northamptonshire			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Admission episodes for alcohol-related conditions (Narrow): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Persons)	2020/21	→	1,832	467	502	456	805		251
Admission episodes for alcohol-related conditions (Narrow): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Male)	2020/21	→	1,188	621	629	603	1,063		316
Admission episodes for alcohol-related conditions (Narrow): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Female)	2020/21	→	644	324	387	322	597		141
Admission episodes for alcohol-related conditions (Broad): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Persons)	2020/21	→	5,760	1,488	1,502	1,500	3,459		962
Admission episodes for alcohol-related conditions (Broad): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Male)	2020/21	→	4,178	2,266	2,242	2,290	5,192		1,464
Admission episodes for alcohol-related conditions (Broad): New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Female)	2020/21	→	1,582	791	849	805	1,923		445
Admission episodes for alcohol-specific conditions (Persons)	2020/21	↑	2,025	516	510	587	2,276		298
Admission episodes for alcohol-specific conditions (Male)	2020/21	→	1,275	662	673	806	3,350		344
Admission episodes for alcohol-specific conditions (Female)	2020/21	↑	750	377	356	380	1,286		138

Source: OHID Public Health Outcomes Framework

Drugs

Drug poisoning can be a future indicator of future deaths.[29] People who experience non-fatal overdoses are more likely to have a fatal overdose. Locally rates for admissions that have a code related to drugs has either increased or remain unchanged over recent years.

The indicator most often used to assess trends related to admissions for poisoning. This indicator shows admissions for Northamptonshire have been much higher than the regional and England average for several years. In 2020-21, the rate in Northamptonshire was 59 per 100,000, significantly higher than the England rate of 50 per 100,000.

It should be noted that some of this difference may be due to differences in data recording practices between different hospitals.

Figure 25: Rates of hospital admission for by drug and mental behavioural disorders

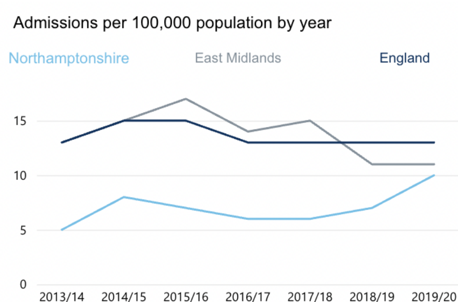


Figure 26: Rates of hospital admission for poisoning drug misuse

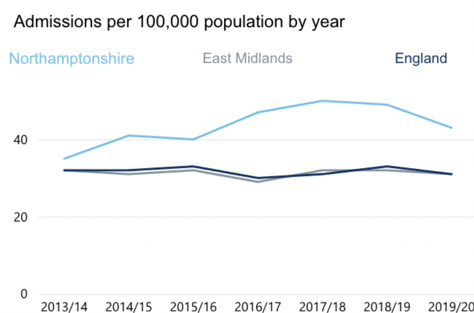
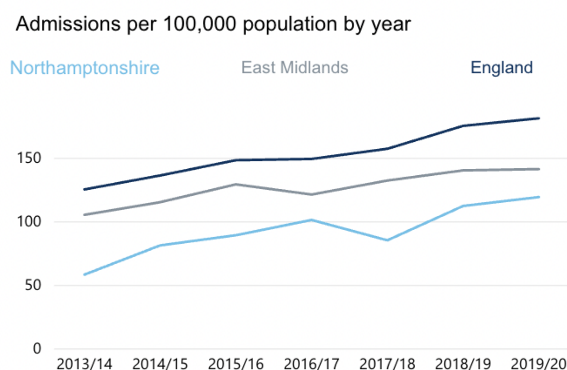


Figure 27: Rates of hospital admission for poisoning where drug related mental and behavioural disorders were a factor



Source: NHS Digital

[29] Source: OHID Commissioning Support Pack. 2022-23.

Profile of Northamptonshire's Hospital Admissions

Admissions data from the NHS's Secondary Use Statistics (SUS) is used in this next section. To match the Urgent care data, activity for the year from August 2021- July 2022 has been used. Here we have looked at the admissions to any provider for patients registered with a Northamptonshire GP.

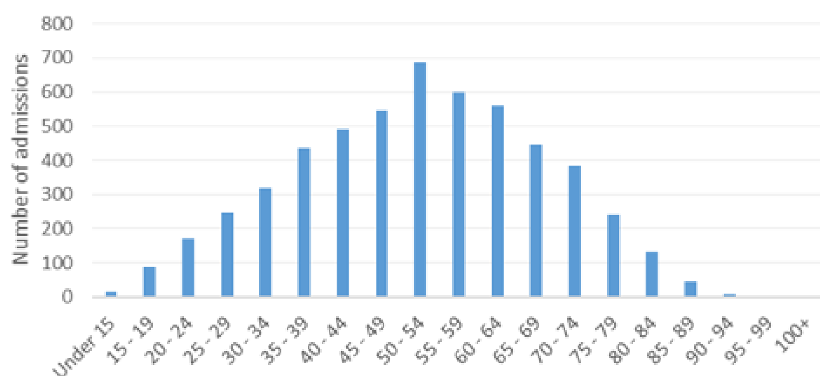
The main source by which alcohol or drug involvement in an admission is through the diagnosis coding. This can cover existing drug or alcohol issues or an individuals' history of issues. Drug and alcohol use may not be involved directly in an admission but can be a complication in any treatment provided during admission, or the cause of long-term health issues that require hospital treatment.

Some of the longer-term diseases caused by alcohol are more specific than those caused by other substance misuse. A proportion of admissions for the following may have some origins in drug or alcohol misuse but the routine data available may not always show this.

- Cardiovascular disease
- Stroke
- Cancer
- HIV/AIDS
- Hepatitis B and C
- Lung disease
- Mental disorder

Over the year, there were 311,889 admissions (of all kinds except maternity) of patients registered with Northamptonshire GPs. The diagnosis codes cover a range of mental and behavioural issues that can arise from drug or alcohol use. In total, 3455 individuals had an admission where a mental or behavioural problem related to drugs or alcohol was recorded. The number of admissions this affected was 5,412. The figure below shows the age profile for these admissions.

Figure 28: Age profile of admissions with a history of drug and/or alcohol use



Source: NHS Northamptonshire ICB

Although these diagnoses formed part of each admission, the main reason for the admission will generally have been for a physical health issue. Of the total 5412 admissions, 812 had a primary diagnosis of Mental or behavioural disorder due to psychoactive substance use'.

The figure below shows the number of admissions where each substance was involved (note that some individuals and admissions appear in more than one grouping). The majority, 78% of admissions for mental or behavioural disorders were related to alcohol and 74% of the individuals admitted for mental or behavioural disorders used alcohol.

Figure 29: Admissions for mental or behavioural disorder by substance type

Mental or behavioural disorder due to :-	Admissions	Individuals
Alcohol	4,576	2,844
Opiods	388	267
Sedatives and Hypnotics	347	282
Cocaine	154	130
Other stimulants	25	23
Hallucinogens	4	3
Volatile solvents	3	3
Multiple drug use	341	273

Source: NHS Northamptonshire ICB

The most common long-term effect of alcohol misuse for admissions in Northamptonshire is alcoholic liver disease (85%).

Figure 30: Long term effects of alcohol misuse in Northamptonshire admissions 2021/22

Diagnosis	Number of admissions
Alcoholic cardiomyopathy	16
Alcohol-induced chronic pancreatitis	75
Alcohol-induced acute pancreatitis	78
Nervous system degeneration	20
Alcoholic polyneuropathy	11
Alcoholic gastritis	63
Alcoholic liver disease (and subcodes)	1,488
Total	1,751

Source: NHS Northamptonshire ICB

Urgent care

Data for A&E and Urgent Care Unit attendances at providers within our county (for all patients regardless of where they are registered with a GP) and for all Northamptonshire GP registered patients (regardless of which Urgent Care provider they have attended). Data discussed here covers the period from April 2021 to July 2022. There are several ways of identifying Drug or alcohol involvement in attendances:

- **Chief Complaint:** When a patient arrives at A&E they present with an initial injury or illness which is the Chief Complaint; this tends to be general e.g. abdominal pain, chest pain etc. The most relevant term in the context of Drug and Alcohol attendances is 'Substance Abuse', although the Chief Complaint will not pick up all cases where a more obvious health issue such as an injury is apparent.

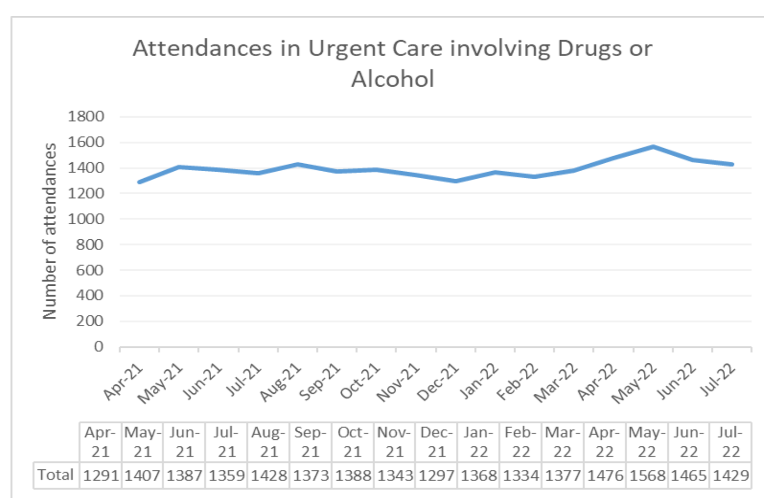
- **Drug or Alcohol involvement in an injury.** If an injury has involved any drug or alcohol, it is recorded here. The full list of 32 possible substances involved is shown in Appendix 1.

- **Diagnosis coding:** A diagnosis is established after further investigation of an individual's condition. It is possible to have a number of diagnosis codes and drug or alcohol use may be recorded here, if it is relevant to the attendance.

Figure 31 shows attendances where drugs or alcohol are mentioned in any of the three above fields. The total attendances from August 21 to July 22 was 16,846. These were attendances by 6,156 individuals. The total cost of these attendances was £2,975,833.

Figure 31

Urgent care attendances involving drugs or alcohol in Northamptonshire April 2021 to July 2022



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Total	1291	1407	1387	1359	1428	1373	1388	1343	1297	1368	1334	1377	1476	1568	1465	1429

Source: NHS Northamptonshire ICB

Number of attendances and number of individuals

Drug and/or alcohol use tends to be a factor in 'High Frequency Attendances'. On average, each of the 6156 individuals had 2.7 drug or alcohol related attendances in the year August 2021-July 2022.

The attendances of very high intensity attendances tend to be sporadic, rather than evenly spaced across the months of the year, possibly reflecting the input individuals are receiving from other services.

Figure 32: Number of attendances by individuals in Northamptonshire August 2021 to July 2022

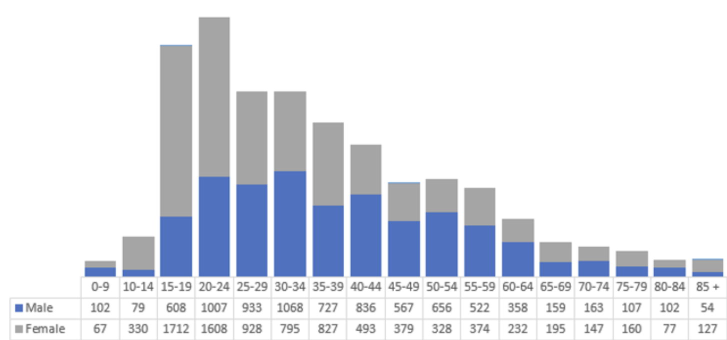
N of attendances	N of Individuals
12 per year or less	6013
13-24 per year	103
25 or more attendances per year	40
Total individuals	**6156**

Source: NHS Northamptonshire ICB

Although the number of attendances by females (8778) over the year is greater than the number of attendances by males (8057), the age profile of the individuals involved is the reverse, with the number of male individuals exceeding females by 13.2%.

The total number of individuals in the profile above is 6,156, 3,295 males and 2,861 females. This means that 53% of individual were men. The totals in the table above do not add up to this due to individuals being counted twice if they crossed age bands in the year 2020/21.

Figure 33: Age/Gender profile of individuals attending involving drugs or alcohol



Source: NHS Northamptonshire ICB

The nature of the injuries and disorders caused by Drugs and/or Alcohol mean that mental health, police and custodial services have a higher representation here than would be expected for general Urgent Care attendances.

Figure 34: Source of referral to urgent care in Northamptonshire 2021/22[30]

Source of referral	Number of attendances
Self-referral to accident and emergency department	12,304
Referred by NHS 111 service	1,181
Referred by Police	862
Referred by ambulance service	788
Referred by member of Primary Health Care Team	593
Advised to attend A&E	235
Referred by hospital emergency department	228
Referred by carer	147
Referred by urgent care service	58
Referred by hospital ward	56
Referral by out of hours service	51
Referred by Prison Service	45
Referred by Mental Health Assessment Team	39
Referred by advanced care practitioner	36
Referred by private sector physician	35
Referred by hospital outpatient department	34
Referred by detention centre	29
Referred by school nurse	18
Referred by social services	15
Referred by community mental health nurse	14
Referred by community nurse	9
Referred by Fire and Resscue Service	6

Source: NHS Northamptonshire ICB

[30] Incidences of < 5 have been excluded from this table.

Injuries involving drugs and alcohol

The major substance involved in injuries was alcohol (79%). There are more injuries by unknown drugs than there are for injuries where the drug has been identified.

Figure 35: **Number of attendances by substance type in Northamptonshire 2021/22**[31]

Substance involved in injury	Number of attendances
Injury following alcohol use	1,717
Injury following unknown drug use	270
Injury following central nervous system depressant use	38
Injury following cannabis use	32
Injury following codeine use	27
Injury following benzodiazepine use	19
Injury following herion use	16
Injury following opiate use	13
Injury following morphine use	11
Injury following cocaine	11
Injury following industrial alcohol use	11

Source: NHS Northamptonshire ICB

Cause of injury

Over half 56%) of drug or alcohol related injuries are accidental. Almost one in four (24%) of the drug and/or alcohol related injuries involves self-harm and a further 15% involved alleged assaults. The largest single group of injury types was head injuries – occurring in 21% of drug and or alcohol attendances. Multiple injuries and or illnesses were common.

Figure 36: **Causes of injury resulting in an attendance involving alcohol or drugs**[32]

Cause of injury	Number of attendances
Accidental injury	1,213
Self-inflicted injury	525
Alleged victim of physical assault by lone assailant	246
Undetermined whether injury is accidental or purposely inflicted	94
Alleged victim of physical assault by multiple assailants	80
injury due to legal intervention	7
Injury caused by animal	6

Source: NHS Northamptonshire ICB

There is some inconsistency in the coding of Urgent Care data; some providers will code an overdose, and other clear self-harm, as an injury and others do not. There are also some injuries that appear in the 'Diagnosis' fields but the relationship to drug or alcohol use is not coded. The diagnosis field however, allows us to pick this detail up.

- 929 attendances ended with the patient 'walking out' of Urgent Care before a full diagnosis could be established. The Chief Complaint indicates that Substance Abuse was the main reason for attendance, followed by Chest Pain and Self Injurious behaviour.

[31] Incidences of < 5 have been excluded from this table.
[32] Incidences of < 5 have been excluded from this table.

- 1484 attendances mentioned 'Depressive Disorder' and 692 included 'anxiety disorder' – sometimes in combination with depressive disorder.
- 1285 attendances included a mention of an overdose, often in combination with other diagnoses.
- 293 included 'poisoning' (where the level of alcohol or drug intake was excessively high)
- 165 included reference to a 'Problem with the social environment' or homelessness
- 83 included delirium

Some diagnoses include longer term effects, particularly of excessive alcohol intake:

- 156 Alcohol withdrawal induced convulsions
- 213 Gastritis or Gastro-oesophageal Reflux disease
- 56 Upper Gastro-intestinal Haemorrhage
- 222 included Alcohol or other drug dependence

Discharge from urgent care

Of the total 16,846 drug and/or alcohol related attendances, 66% ended in discharge home. A further 24% were admitted to hospital, a small number to a short stay ward. 2.2% were discharged to police or legal custody. There were 9 deaths.

Deaths

Alcohol

In 2000, there were 54 deaths specifically related to alcohol and 148 attributable to alcohol in West Northamptonshire. In West Northamptonshire, 38 deaths were specifically related to alcohol and 133 attributable. Approximately 65% of these deaths in both areas occurred in men. Death rates from alcohol in North Northamptonshire are statistically similar to the England average and have remained unchanged on all measure of mortality related to alcohol in recent years (figure 37). In West Northamptonshire morality rates are either statistically similar to or better than the England average, however no indicator has changed significantly in recent years. It should be noted that these figures do not reflect the impact of the pandemic.

Figure 37: Mortality rates related to alcohol for North Northamptonshire.

Indicator	Period	N Northamptonshire			Region	England			
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Alcohol-related mortality: New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Persons)	2020	→	133	39.1	38.1	37.8	68.9		21.5
Alcohol-related mortality: New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Male)	2020	→	95	59.5	57.0	57.3	103.7		31.2
Alcohol-related mortality: New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Female)	2020	→	38	21.5	21.7	20.9	40.5		11.1
Alcohol-specific mortality (Persons, 1 year range)	2020	→	38	10.9	12.9	13.0	29.3		5.5
Alcohol-specific mortality (Persons, 3 year range)	2017 - 19	–	124	12.2	11.4	10.9	27.3		3.9
Alcohol-specific mortality (Male, 3 year range)	2017 - 19	–	78	15.6	15.1	14.9	39.2		7.0
Alcohol-specific mortality (Female, 3 year range)	2017 - 19	–	46	9.0	7.8	7.1	17.3		1.8
Under 75 mortality rate from alcoholic liver disease (Persons, 1 year range)	2020	→	31	9.7	11.0	10.8	27.5		4.5
Under 75 mortality rate from alcoholic liver disease (Persons, 3 year range)	2017 - 19	–	95	10.1	9.4	9.1	23.9		3.7
Under 75 mortality rate from alcoholic liver disease (Male, 3 year range)	2017 - 19	–	57	12.2	11.8	11.9	33.2		5.0
Under 75 mortality rate from alcoholic liver disease (Female, 3 year range)	2017 - 19	–	38	8.0	6.9	6.5	16.6		2.2
Mortality from chronic liver disease (Persons, 1 year range)	2020	→	47	13.5	13.5	13.7	29.5		6.0
Mortality from chronic liver disease (Persons, 3 year range)	2017 - 19	–	123	12.2	12.5	12.2	31.9		5.4
Mortality from chronic liver disease (Male, 3 year range)	2017 - 19	–	73	14.8	15.9	15.8	44.2		7.8
Mortality from chronic liver disease (Female, 3 year range)	2017 - 19	–	50	9.9	9.4	8.9	19.5		3.2
Potential years of life lost (PYLL) due to alcohol-related conditions (Male)	2020	→	1,759	1,055	1,117	1,116	2,436		559
Potential years of life lost (PYLL) due to alcohol-related conditions (Female)	2020	→	1,018	576	529	500	1,125		246

Figure 38: Mortality rates related to alcohol for West Northamptonshire

Indicator	Period	W Northamptonshire			Region	England			
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Alcohol-related mortality: New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Persons)	2020	→	148	38.1	38.1	37.8	68.9		21.5
Alcohol-related mortality: New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Male)	2020	→	94	51.8	57.0	57.3	103.7		31.2
Alcohol-related mortality: New method. This indicator uses a new set of attributable fractions, and so differ from that originally published. (Female)	2020	→	54	26.4	21.7	20.9	40.5		11.1
Alcohol-specific mortality (Persons, 1 year range)	2020	→	54	13.4	12.9	13.0	29.3		5.5
Alcohol-specific mortality (Persons, 3 year range)	2017 - 19	–	88	7.5	11.4	10.9	27.3		3.9
Alcohol-specific mortality (Male, 3 year range)	2017 - 19	–	58	10.0	15.1	14.9	39.2		7.0
Alcohol-specific mortality (Female, 3 year range)	2017 - 19	–	30	5.0	7.8	7.1	17.3		1.8
Under 75 mortality rate from alcoholic liver disease (Persons, 1 year range)	2020	→	43	11.6	11.0	10.8	27.5		4.5
Under 75 mortality rate from alcoholic liver disease (Persons, 3 year range)	2017 - 19	–	68	6.3	9.4	9.1	23.9		3.7
Under 75 mortality rate from alcoholic liver disease (Male, 3 year range)	2017 - 19	–	45	8.4	11.8	11.9	33.2		5.0
Under 75 mortality rate from alcoholic liver disease (Female, 3 year range)	2017 - 19	–	23	4.2	6.9	6.5	16.6		2.2
Mortality from chronic liver disease (Persons, 1 year range)	2020	→	54	13.4	13.5	13.7	29.5		6.0
Mortality from chronic liver disease (Persons, 3 year range)	2017 - 19	–	112	9.7	12.5	12.2	31.9		5.4
Mortality from chronic liver disease (Male, 3 year range)	2017 - 19	–	75	13.3	15.9	15.8	44.2		7.8
Mortality from chronic liver disease (Female, 3 year range)	2017 - 19	–	37	6.2	9.4	8.9	19.5		3.2
Potential years of life lost (PYLL) due to alcohol-related conditions (Male)	2020	→	1,850	962	1,117	1,116	2,436		559
Potential years of life lost (PYLL) due to alcohol-related conditions (Female)	2020	→	1,332	653	529	500	1,125		246

Source: OHID Fingertips.

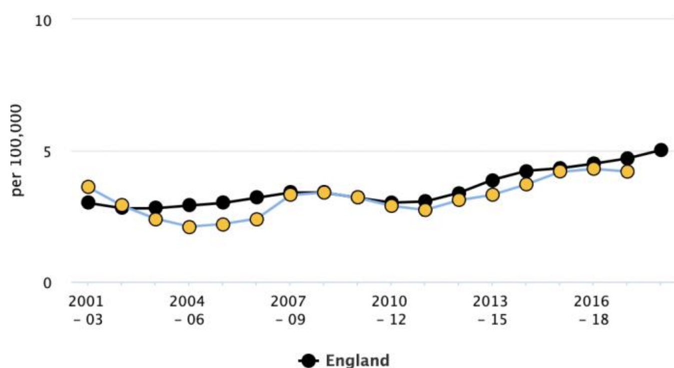
Drugs

In England and Wales, deaths from drugs have continued to rise over the last decade and in 2021 they were the highest number since records began in 1993.[33] Death rates are elevated in those born in the 1970's – 'Generation X' with the highest rates in those aged 45 to 49. More than half involved opiates and an increasing number involved cocaine. A study by Public Health England and the Local Government Association identified two important factors in the rise of deaths: the increase in the availability and purity of heroin, and ageing heroin users.[34] Other contributing factors include:

- Increased suicides by drug poisoning
- Increasing deaths among women
- Potential increase in the concurrent use of alcohol and drugs (and potentially polydrugs)
- An increase in prescription medicines
- Variations in coroner reporting

Northamptonshire trends have largely followed the national trends (figure 39). In the three year period 2018-20, there were 42 drug deaths in North Northamptonshire and 33 in West Northamptonshire. Of these, 70% were in men in West Northamptonshire and 83% in North Northamptonshire. Since 2001-02, death rates have been statically similar to the England average. In 2018-20, North Northamptonshire's morality rate from drug misuse was similar to England and West Northamptonshire significantly lower. At the time of writing (November 2022), no trend data was available at local authority level.

Figure 39: Trends in deaths from drug misuse



Source: OHID Fingertips.

In the period Jan 2019 – June 2022, 134 deaths from drugs were registered in Northamptonshire. Key findings from analysis of these deaths:

- Most deaths were in men (71%).
- 40-49 was the single most common age group.
- The mean age of death in men was 44.3 years, in women 41.3 years.

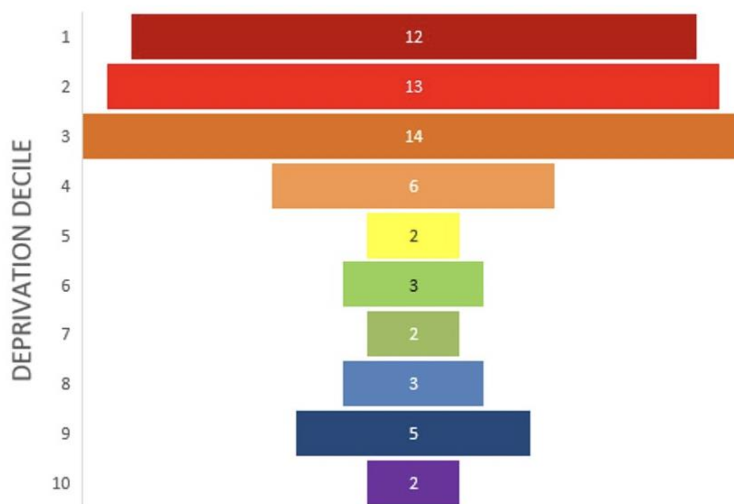
[33] ONS. Deaths related to drug poisoning in England Wales: 2021 registrations. Accessed 22nd November 2022.
[34] Public Health England. Health matters: preventing drug related deaths. 15th September 2017

- Deaths were concentrated in the most deprived areas: 63% of illicit drug deaths occurred in the 30% most deprived areas in Northamptonshire.
- Most deaths from illicit drug use occurred in Northampton (35%), Kettering (19%) and Corby (15%).
- However, death rates (taking into account the size of the population) from illicit drug use were highest in Kettering, followed by Northampton and Corby.

Deaths were closely correlated with deprivation with most deaths occurring in the 30% most deprived geographical areas in Northamptonshire (Figure 40).

Figure 40

Deaths from illicit drugs in Northamptonshire by deprivation decile (Jan 2019 – June 2022)



Source: Public Health Department – ONS mortality data

Sexual health

Sexual health and substance misuse outcomes are closely correlated, with increased consumption of alcohol or drugs associated with a higher risk of unplanned pregnancy, sexually transmitted infections and sexual violence.

A recent European report identified young people, men who have sex with men, and people working within the sex industry appear to have the greatest risk of co-occurring harms from co-occurring drug use and sexual activity. [35] This report and other recommendations from academics highlight the lack of join up between the sexual health and substance misuse services, and recommend an approach for detection, provision of advice for both behaviours and sign posting between services.[36]

[35] European monitoring centre for drugs and drug addiction. Joining up sexual health and drug services to better meet client needs. October 2017

[3636] Murali V & Jayaraman J. Substance use disorders and sexually transmitted infections: a public health perspective. BJPsych Advances (2018), vol. 24, 161–166.

A recent study UK of substance misuse in young people aged 16-24 explored this issue further.[37] This study found that substance use was strongly correlated with sexual risk and adverse sexual outcomes. Young adults frequently binge drinking or with recent drug use were more likely to report unprotected sex, sex on the first meeting of a new partner, emergency contraception use and sexually transmitted infection. Risky sexual behaviour was more common in those reporting multiple substance misuse, particularly among men. White ethnicity was also a factor, and there was no association with deprivation. This report advises on provision on advice within services and outreach (e.g., freshers week) and for interventions beyond the individual e.g. condoms in bars and clubs.

No local data was available in relation to sexual health and substance misuse.

Physical health

The rise in death rates from substance misuse in only in part related to the drugs; studies have found that increasingly deaths are related to non-communicable diseases particularly in the ageing group of opioid users.[38] Death rates from opioids are 10-15 times higher than those of the general population in the UK, however the most common causes of death have changed over time. In a recent large UK study of opioid users aged 18-64, the most common causes of death were

- Drug poisoning (33%)
- Liver disease (9.6%)
- Chronic Obstructive Pulmonary Disease (COPD) (5.2%)
- Suicide (4.9%)

Those in the study had the higher rates of death from all causes with the highest death rates for HIV, hepatitis and COPD compared to those who are not using opioids. There is no local data on the physical health of those affected by substance misuse but it is assumed national patterns apply.

Mental health

Recent data for an audit of suicide deaths in Northamptonshire has identified if drugs or alcohol were involved. Alcohol was recorded in around 60% of deaths from suicide between 2017 and to January 2021. Dependent and harmful drinking was identified in 23% of suicide deaths in both North and West Northamptonshire. Drugs were recorded in around 40% of suicide deaths in this time period, with 1 in 5 recording dependent or harmful use.

Smoking

Smoking rates in the adult general population in the UK are now below 14%, but rates are much higher in those with other additions including alcohol and drugs. At the start of treatment in 2020-21, smoking levels were much lower in Northamptonshire than the national average (tables 5 and 6).

[37] Khadr SN, Jones KG, Mann S*, et al*. Investigating the relationship between substance use and sexual behaviour in young people in Britain: findings from a national probability survey *BMJ Open* 2016;**6:**e01196

[38] Public Health England. Health matters: preventing drug misuse deaths. 15 September 2017

Table 5: Number of smokers identified at the start of drug treatment in 2020-21.

	Local				England			
Drug group	Total adults	Proportion of all in treatment	Male (%)	Female (%)	Total adults	Proportion of all in treatment	Male (%)	Female (%)
Alcohol and non-opiate	50/156	32%	34%	29%	7,017	60%	59%	62%
Non-opiate	46/136	34%	33%	36%	8,585	64%	64%	64%
Opiate	151/375	40%	42%	36%	19,664	69%	69%	69%
Total	**247/667**	**37%**	**38%**	**34%**	**35,266**	**65%**	**65%**	**66%**

Source: OHID Commissioning Packs 2022-23

Table 6: Number of smokers identified at the start of alcohol treatment in 2020-21.

Local				England			
Total adults	Proportion of all in treatment	Male (%)	Female (%)	Total adults	Proportion of all in treatment	Male (%)	Female (%)
113/455	25%	25%	24%	15,758	43%	44%	42%

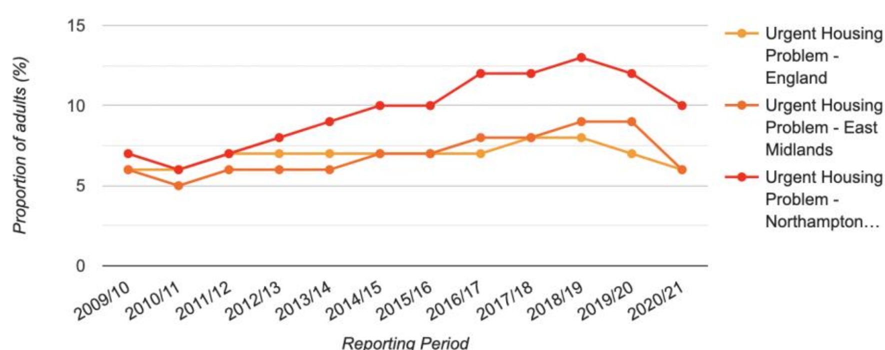
Source: OHID Commissioning Packs 2022-23

Housing and homelessness

The NDTMS dataset provides details of housing status at the time of entering substance misuse services. In 2020-21, 78% of adults entering substance misuse treatment had no problem with housing, slightly lower than the England average of 83%. The proportion with urgent housing needs was 10% 2020-21.[39] This proportion has risen since 2009-10 and has been consistently higher than the England average (Figure 41).

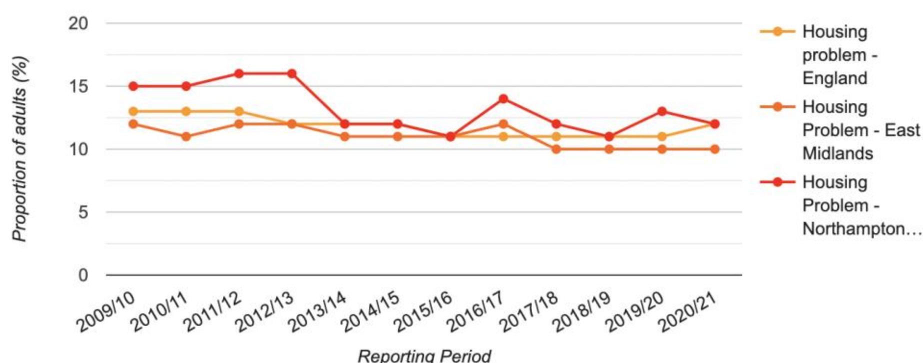
In 2020-21, the urgent housing need was higher in men than women – 12% and 6%, respectively. It was also much higher in those using opiates – 21% compared to 4% for alcohol, 6% non-opiates and 8% non-opiates and alcohol. The urgent housing issue was particularly high for the younger cohort aged 18-29 compared with the older age groups. It was particularly high for opiate users, with 33% of opiate users aged 18-29 having an urgent housing problem.

Figure 41: Number of new presentations to adult substance misuse services with an urgent housing problem



Source: NDTMS

Figure 42: Number of new presentations to adult substance misuse services with a housing problem[40]



Source: NDTMS

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[39] Urgent housing need is defined by an individual who live on streets/rough sleeper, Uses night shelter (night-by-night basis)/emergency hostels, Sofa surfing/sleeps on different friend's floor each night.

[40] Staying with friends/family as a short-term guest, Night winter shelter, Direct Access short stay hostel, Short term B and B or other hotel, Placed in temporary accommodation by Local Authority, Squatting.

Carers

Substance misuse has a significant impact on families and carers of those who are affected. Adult family members can have an impact in terms of preventing the influencing the course of the problem; supporting better engagement with treatment services; and reducing the negative impacts of substance misuse on other family members.[41] It is estimated in the UK that

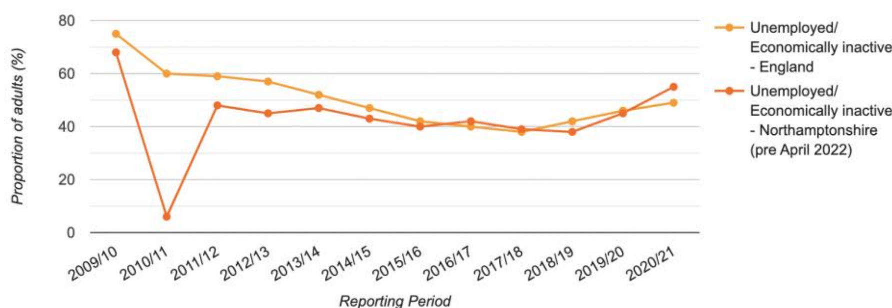
- At least 1.5 million adults are affected by a relative's drug use[42]
- The cost of harms they were experiencing was £1.8 billion per year (in 2008) [43]
- The value of support they provide was £747 million if support was delivered by health and social care (in 2008)

Northamptonshire Carers report that 53 carers were registered where the primary disability was substance misuses.[44] This is likely to be an underestimate, as many are likely have a different primary cause of registration, particularly mental health.

Employment

At the time of entering substance misuse services, most adults were either unemployed or economically inactive in Northamptonshire. The local trend has largely followed that of England, however rates have risen in the most recent year to 55%, higher than the England average of 49%.

Figure 43: Employment status at the start of specialist substance misuse treatment



Source: Source: OHID NDTMS

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[41] UKDPC. The forgotten carers: support for adult family members affected by a relative's drug problem March 2012.
[42] Pharmaceutical Services Negotiating Committee. Essential facts and stats relating to carers. Updated March 2022.
[43] UKDPC. The forgotten carers: support for adult family members affected by a relative's drug problem March 2012.
[44] Source: personal communication Northamptonshire Carers.

Crime

The social and economic impact of crime related to substance misuse is considerable, impacting on individuals, families and communities. Heroin and crack users in England are responsible for nearly half of all robberies, burglaries and other acquisitive crime.[45] Alcohol is a factor in around 39% of violent crimes in England and Wales and contributes to public disorders and antisocial behaviour.[46]

In the year ending June 2022, there were 2,057 drug related offences recorded in the Northamptonshire Community Safety Partnership (CSP) area.[47] Most of these occurred in the three towns of Northampton (43%), Wellingborough (16%) and Kettering (15%). Northamptonshire was only 1 of 3 CSP areas in England to have an increase in drug offences in the previous year – with 7% more offences occurring between June 21 and June 22. The two other areas experiencing increases were Bedford (5%) and the West Midlands (16%). Within Northamptonshire, large increases were seen in Wellingbourgh and East Northamptonshire (table x)

Table 7: % change in drug offences between June 2021 and June 2022

Corby	-20%
Daventry and South Northamptonshire	-5%
East Northamptonshire	45%
Kettering	-9%
Northampton	6%
Wellingborough	53%

Source: ONS

Economic impact

Nationally, illicit drug harms cost £19.3 billion in 2017-18. The main driver of this was drug related crime, costing £9.3 billion. Drug deaths cost £6.3 billion with treatment services at that time costing only £533 million.[48] The majority of the costs – 86% - are from illicit opiates and crack cocaine.

Of these costs, 46% are direct costs i.e., resources used directly to deal with the substance misuse issue such as policing and health service provision. Other social and economic costs associated with people with drug use include the cost of unemployment, prescribing and homelessness.

Most of the costs related to social care relate to support for children and young people impacted by substance misuse. Research indicates that drug treatment can reduce social care costs and hospital attendances by 31%. Similar economic benefits can be realised from alcohol treatment (figure 44).

Figure 44

[45] UK Government. From Harm to Hope: a 10 year drug strategy to cut crime and drugs. 6th Dec 2021
[46] Alcohol Change UK. Fact sheet. Alcohol, crime and disorder. Accessed 22nd Nov 2022.
[47] ONS. Recorded crime data by community safety partnership. Accessed 22nd Nov 2022.
[48] Dame Carol Black. Review of Drugs – evidence relating to drug use, supply and effects including current trends and future risks.

Public Health England
Investing in drug & alcohol treatment saves money
£2.4 billion
Combined benefits of drug and alcohol treatment
£4
Social return on every £1 invested in drug treatment
a total of £21 over 10 years
£3
Social return on every £1 invested in alcohol treatment
a total of £26 over 10 years
Crime
Social care
Health
QALY improvements

Section 6: Impact of the pandemic

Section summary – impact of the pandemic

Studies undertaken during the pandemic identified significant changes in the patterns of consumption of alcohol and drugs with overall increases in levels of consumption.

Drug use increased during the pandemic, and current users increased their levels of consumption during this period. Drug users also reported an increase in withdrawal symptoms, non-fatal overdoses, and sharing of injecting equipment during the pandemic compared with before. Risk factors for increased consumption were similar to alcohol, with the predominant correlating factor and trigger related to mental health. Other factors of increased risk during the pandemic include being male and older, higher levels of education, loss of income and poor physical health.

The picture for alcohol was mixed, with lighter drinkers decreasing their consumption but heavy drinkers increasing alcohol intake. Overall, levels of alcohol consumption increased. Studies also found an increase in those relapsing from addiction recovery. There were large increases in alcohol related deaths in the first year of the pandemic in England.

These studies indicate that there is likely to be a long-term impact of the pandemic on alcohol and drug consumption. Recommendations include a focus on early identification and expansion of treatment to address the resulting health needs. The impact on risk factors, particularly mental health, are likely to have an impact on substance misuse. Over the pandemic, levels of mental ill health increased considerably, particularly in children and young people.

This section provides a brief summary of some of the changes experience in substance misuse in the UK as a result of the pandemic. The main trends and resulting recommendations are highlighted. It should be noted that this section presents highlights of main reports to identify key trends, and it is not a comprehensive review of the literature in relation to this topic.

Drugs

The charity Release published a report into drug acquisition habits during the pandemic.[49] This report found that more respondents reported that their drug use had increased, rather than decreased or stayed the same, since the start of the pandemic. 43% said their drug use had increased, 21% said their drug used had decreased and the remaining 36% responded that their drug use had remained the same throughout the period of the survey, March to September 2020.

This reported also highlighted a shift to the darknet for purchasing of drugs with more than 1 in 10 obtaining supplies through this route. 13% had not used this route previously, and over a quarter had planned to use this route if necessary to buy drugs.

More of those who responded to the survey experienced increased withdraw symptoms, increased non-fatal overdoses, and increased injection equipment sharing during the pandemic than before.

[49] Aldridge, J., Garius, L., Spicer, J., Harris, M., Moore, K. & Eastwood, N. (2021) Drugs in the Time of COVID: The UK Drug Market Response to Lockdown Restrictions, London: Release.

The United Nations Office on Drugs and Crime (UNODC) published their World Drugs Report in 2021, looking at the potential impacts of the Covid pandemic on drug use and supply.[50] The report's authors warned about the potential impact on drug use of the Covid-19 pandemic, which was raising prices and reducing the purity of drugs. The report also highlights the potential impact of a post COVID-19 economic crisis, in particular expansion of drug cultivation and trafficking and the protracted economic downturn resulting in more drug use.

A systematic review of alcohol and other substances during the pandemic found a mixed picture for alcohol consumption, but overall an upward trend.[51] Risk factors for increased consumption during the pandemic include solitude, being male and older, higher levels of education, loss of income, poor physical health and mental health conditions. This review found an increased use of drugs during the pandemic. Risk factors were similar to those for alcohol. Mental health, particularly depression, was the most common risk factor correlating or triggering substance misuse. The review concludes that there is an increased need for targeting and evidence-based interventions following the pandemic.

Alcohol

Two studies from the University of Sheffield and Institute of Alcohol Studies found that lighter drinkers decreased their consumption on average during the pandemic, but heavy drinkers increased their alcohol intake.[52] Both studies estimate substantial increases in alcohol-related harms and pressure on the NHS, even if drinking patterns were to return to pre-pandemic patterns from 2022 onwards. The studies also found that the increases in alcohol harm disproportionately falls on the least well-off in society, further widening inequalities.

The Forward Trust analysed YouGov data and revealed that there was not only an increase in the levels of problem drinking during the pandemic but also an increase in those relapsing from addiction recovery.

Public Health England analysed available data and the results suggest that respondents were more likely to report increasing their alcohol consumption during the pandemic compared to previous years.[53] For example, between March 2020 and March 2021, there was a 58.6% increase in the proportion of respondents drinking at increasing risk and higher risk levels. There was a rise of almost 11% in deaths from mental and behavioural disorders caused by alcohol, an increase of more than 15% in deaths from alcohol poisoning, and an almost 21% rise in deaths from alcoholic liver disease, the latter condition accounting for more than 80% of the alcohol-specific deaths.

A BMJ article exploring the impact of the covid restrictions on alcohol consumption and the associated risks noted the increased risk of alcohol related harms for a generation and highlighted those who were previously struggling with alcohol addiction and those on the brink of an addiction as requiring particular focus.[54]

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[50] United National Office on Drug Crime and Supply. World Drug Report. Accessed 22nd November 2022

[51] Roberts A, Rogers J, Mason R, Siriwardena AN, Hogue T, Whitley GA, Law GR. Alcohol and other substance use during the COVID-19 pandemic: A systematic review. Drug Alcohol Depend. 2021 Dec 1;229(Pt A):109150

[52] University of Sheffield. Shifts in alcohol consumption during the pandemic. Accessed 22nd November 20202

[53] Public Health England. Monitoring alcohol consumption and harm during the pandemic: summary. Published 15th July 2021.

[54] Editorial. Covid and alcohol – a dangerous cocktail. *BMJ* 2020;369:m1987

Section 7: What do we currently do to prevent and reduce harm from drugs and alcohol

Systems map

Systems mapping workshops held in the summer of 2022 identified a large number of organisations and groups involved in addressing substance misuse in Northamptonshire (see figure 1). The purpose of a system map is to both show those involved and the potential impact a change in one system can have on another (positive or negative). The systems map groups these organisations into categories and links between the groups. The main categories were:

- **Healthcare** including primary care, urgent care, community services and drug services.
- **Social care** involving family-focused services and the safety / protection of vulnerable people.
- **Criminal Justice System,** providing support for people in the CJS and community safety.
- **Education and development,** including educational institutions and community services.
- **Community groups** including faith groups, older people's services and social enterprises.
- **Welfare services** such as housing, employment, food banks and advice services.
- **People who use drugs** recognising their families, contacts in the family and peers.

The importance of national and local decision makers was recognised within the system map.

See section 10 for the output of this work.

Drug treatment services

Public health departments in local authorities have a responsibility to commission drug and alcohol prevention, treatment and recovery services. These services are funded from the main public health grant and in the last few years, funding from additional OHID grants. An overview of these services as at January 2023 is provide below.

Drug & Alcohol Services

In 2018, Northamptonshire County Council commissioned services for the Treatment of Drug and Alcohol Addictions in Northamptonshire. These included Structured Treatment Service, Recovery Service, Specialised Training Service and Young People's Early Intervention Service. These contracts variously expire in 2024 and 2026. The Family Support Service was commissioned separately, and was re-commissioned in 2023 until 31st March 2024.

Northamptonshire County Council dissolved in In February 2020, the Northamptonshire (Structural Changes) Order 2020 was enacted, which on 1 April 2021 abolished Northamptonshire County Council and the district councils and created two unitary district councils, known as North Northamptonshire Council and West Northamptonshire Council. Both local councils will consider how drug and alcohol services will be commissioned moving forward.

Children and Young people Service

Northamptonshire's Children and Young People's Drug and Alcohol Service is delivered by Aquarius (Ngage) as a free, confidential substance misuse service for children and young people who need support around their own drug or alcohol use. The service works with children and young people from 10 to 18 years of age in Northamptonshire. They offer age-appropriate information, one-to-one support, group work, health promotion, early intervention, drug education and awareness, positive activities, safety planning, all within a multi-agency approach. The office is based in Northampton (West Northants) but the services is Countywide.

Adult Service

The Adult Drug and Alcohol Treatment Service is delivered by Change Grow Live (CGL) who provide structured treatment in Northamptonshire. Services include prescribing, Opiate Substitute Therapy, psychosocial interventions, harm reduction, naloxone, counselling, hospital liaison, motivation interventions, group work, one-to-one support, and supported access to mutual aid. CGL have a responsibility for the management of the residential rehab, inpatient and ambulatory detox, shared care with GP surgeries, needle exchange, supervised.

CGL have four main hubs across Northamptonshire, three in the North and one in the West. These are CGL Northampton, CGL Kettering, CGL Wellingborough, CGL Corby.

Recovery Service

The recovery service is delivered by the Bridge in Northampton. The Bridge currently have three sites, one in Wellingborough (North Northants), one in Kettering one in Northampton (west Northants).

The recovery service for all treatment and recovery clients in Northamptonshire is peer-based and provides an interface with structured treatment. Services included support with housing and employment, mutual aid, recreational activities, volunteering, peer support, debt management.

The Bridge also manage the PHaSE housing project (housing support scheme for recovering substance misusers in Northamptonshire). This enables people to move on from tier 4 treatment services into supported accommodation in the community, including those who are returning from residential rehabilitation outside their area.

Family Service

The Family Support service is delivered by Family Support Link (FSL) were commissioned. FSL work with both children and adults affected by a family substance misuse. This includes specialist emotional and social support to help affected family members understand the addiction, exploring ways of improving relationships and learning skills and strategies for coping effectively, to feel more in control of their lives. The aim of the intervention is to help people to develop resilience and improve their wellbeing without directly trying to control or influence their relative behaviour. The

service are family focused and community-based provision providing evidence base structured programmes, telephone support, home visits, peer support groups for both adults and children.

FSL also deliver the lottery-funded M-PACT programme, which is a whole family, multi-family, structured brief intervention that takes a psychosocial, educational, and systemic approach. Its development was informed by a number of theoretical approaches and evaluated interventions, which included systemic family work, attachment theory, the trans-theoretical cycle of change, and the strengthening families approach. M-PACT aims to educate and raise awareness of the impact of substance misuse on children and families, interrupt repeating patterns of harmful behaviour and reduce risks associated with them through a focus on coping strategies. It also works to strengthen the protective and resilience factors around the children, including self-esteem, reducing the potential for the children to experience Adverse Childhood Experiences (ACE's) and reducing the impact of them if they do occur. At the core though, lies the importance of recognising the often-overlooked voices and experiences of children.

Specialised Training

Specialised workforce training is delivered by Aquarius. The training is provided to front line workers, managers, practitioners, and internal and external stakeholders. This includes online bespoke training, online training and face to face training for key agencies. There is a key focus on substance misuse, but this will vary to suit the learning and development needs of residents and stakeholders in relation to key public health priorities across Northamptonshire. Training has previously included Drug and Alcohol Awareness, Resilience, Brief Interventions, Dependency and Foetal Alcohol Spectrum Disorders.

Section 8: Treatment services – Children and Young People

Section summary : Treatment services – Children and young people

This section uses data from the National Drug Treatment Monitoring System (NDTMS) for service use up till 2020-21. The full impact of the pandemic is therefore not reflected in these figures.

Numbers and demographics

In 2020-21, 89 young people were in substance misuse treatment services for young people.

Around two thirds of these were males mirroring the national pattern. The number of people in treatment has more than halved since 2016-17 with the largest fall in older teenagers, particularly males. In 2020-21, the single age group with most people in treatment was 14-15 (46%); in England it was slightly older at 16-17 (42%). In contrast to other areas in England, <5% of young people accessing young persons' services were aged 18-25; across England 23% were this age.

Of aged under 18 in treatment in 2020-21, 84% were white British while the comparable figure for England was 73%. Secondary school data from the Education census indicates that in 2020-21, 70% of pupils in Northamptonshire and 65% in England were White British.[xii] Although rates of substance misuse are lower in most ethnic groups, and local patterns of consumption are unknown, and numbers impacted are small, this differential in uptake warrants further investigation.

Access to services

Young people were most likely to be referred to services by educational settings in Northamptonshire, with 41% of referrals to services from this education in 2020-21. Locally, referrals are much more reliant on education; across England, 25% were from education. Referrals from youth justice are the second most important source. In 2020-21, 17% were from youth justice, similar to the 22% in England. The proportion of referrals from youth justice has declined over time potentially reflecting the decline in new entrants to the youth justice system.

Children's early help (social care)

Most young people in treatment services did not receive early help or children's social care – 59% locally, although this figure is higher than the England average of 64%. Early help prior to entering treatment was received by 14% of young people locally – in England the figure was 10%.

Substances used

In line with the proportions seen in England, most young people in treatment services in Northamptonshire were being treated for cannabis (94%), alcohol (41%) or cocaine (17%) in 2020-21. These proportions were in line with England average. Over time the proportion treated for cannabis has increased while alcohol has decreased, mirroring the national trend. Those new to services had higher levels of alcohol consumption prior to treatment than in England.

Around 44% of new presentations locally had early onset – i.e., starting use before aged 15. This is similar to the England average of 46%. A slightly higher proportion locally used two or more substances (including alcohol) – 44% compared to 34% in England.

Smoking

Only 8% of young people in treatment were identified as being a smoker in 2020-21 compared to 27% in England. None were reported as having received smoking cessation.

Treatment and outcomes

In 2020-21, all those in treatment were receiving psychological treatment and none were receiving pharmacological therapy. This was also the case in England. In contrast to the national picture, only 16% received harm reduction compared to 66% nationally.

Treatment outcomes are similar to the England rate with 81% of exits recorded as successful completion and have been similar over the last decade. In 2020, no young person re-presented within 6 months. Length of time in treatment is slightly longer than the England average. In 2020-21, smoking cessation was recorded in 0% of smokers locally compared to 3.9% in England.

Mental health

Addressing the mental health needs of young people in substance misuse treatment is an important part of the support required for recovery. At the start of treatment, fewer young people in Northamptonshire were identified as receiving treatment for an identified mental health need compared with England – 62% vs 67%. A greater proportion of treatment occurred in GP practices than in specialist mental health settings. All of those entering treatment received psychological treatment, however only 16% received harm reduction compared to 66% nationally. Very few young people were identified as being smokers at the start of treatment.

Recent trends

The numbers accessing young people's services are relatively small, so caution is needed when interpreting trends and numbers at a point in time. The provider in Northamptonshire has been reporting an increased trend in the complexity of cases (till Nov 2022) that are not picked up in these figures, involving use of multiple drugs and involvement of mental ill health.

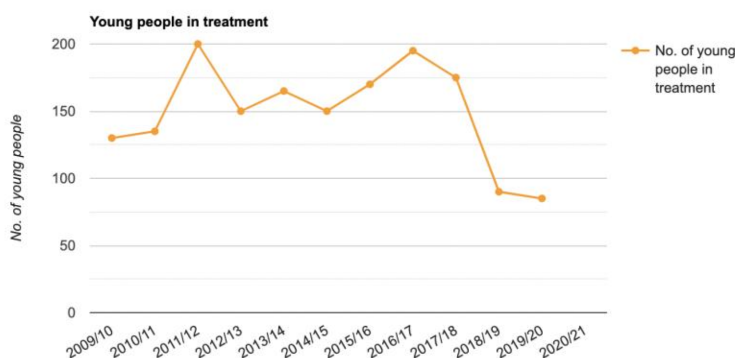
This section highlights the drug and alcohol treatment for young people aged under 18. The source of this information is the national NDTMS data, providing details of uptake of specialist substance misuse for young people, characteristics of those using services and outcomes. Details of treatment for parents are contained in the adult section alongside further details of young adults age over 18.

Specialist treatment services for children and young people are effective and provide value for money.[55] The Department for Education estimates that every £1 invested saved £1.93 within two years and up to £8.38 in the long term.

Numbers accessing treatment

In 2020-21, there were 89 young people in treatment for young people with 51 new to treatment. Of those in treatment 64% were males, the same proportion as the England average. The number of young people in treatment has declined considerably since 2016-17 (Figure 46). This is reflective of the overall trend in England, over the last decade where service use declined by around 40%.

Figure 45: Young people aged under 18 in substance misuse treatment in Northamptonshire



Source: OHID NDTMS

Source of referrals

The source of referrals for children and young people differs from the regional and England average. 41% of young people (under 18) in Northamptonshire in 2020-21 were referred into treatment from education services (25% in England), 19% were referred by children and family services (22% nationally), whilst a further 17% were referred through youth justice (22%) in England.

Locally, these three referral routes accounted for over three quarters of all local referrals (77%). This compares with 69% nationally.

33 referrals (94%) from education services were from mainstream education locally (86% in England).

12 referrals (75%) from children and family services were from other social services (96% in England).

[55] OHID Commissioning pack 2022-23

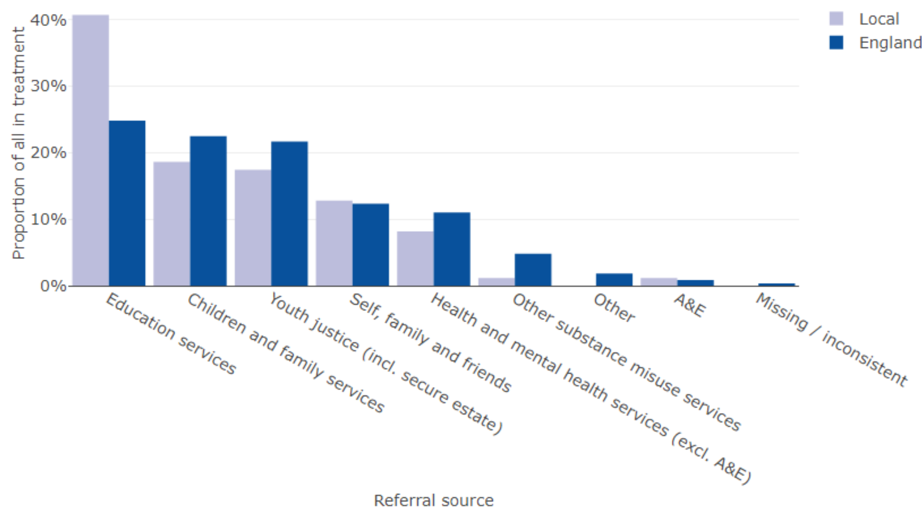
13 of the 15 referrals from young justice (87%) were from the Youth Offending Team locally, compared with 84% nationally.

Over the last decade, most referrals to substance misuse treatment services have been from education settings, and this proportion has increased over time (figure x). Referrals from youth justice are the second most important referral source and this proportion has declined over time.

Over the last decade, referrals from friends, family and self-referrals in Northamptonshire were higher than in England and accounted for about 20% in 2014-15. Over the last 5 years, the proportion has gradually declined to 7% in 2019-20.

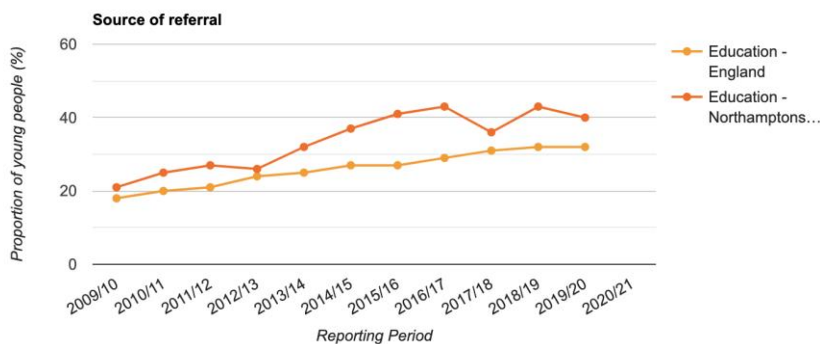
Although numbers are low and fluctuate year on year, it is notable that the proportion of referrals from health and social care have been lower than the England.

Figure 46: Source of referral for young people in specialist treatment services in 2020-21



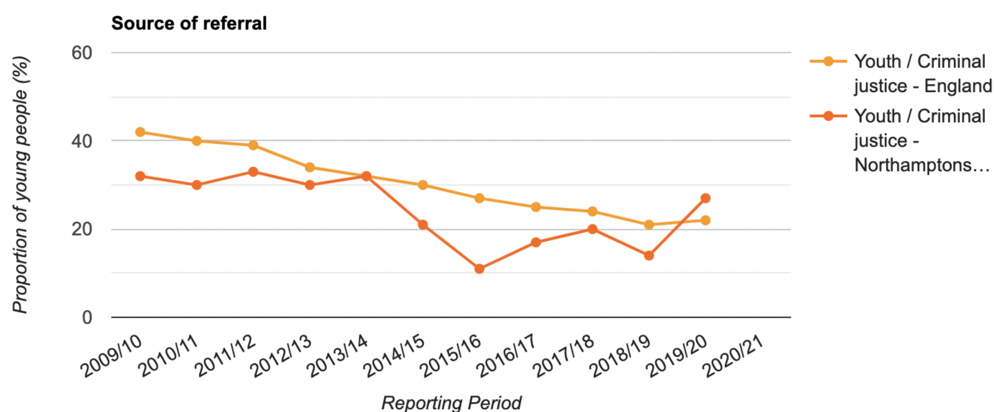
Source: OHID commissioning packs

Figure 47: Education referral to substance misuse treatment services in young people age <18.



Source: OHID NDTMS

Figure 48: Youth justice / criminal justice referral to substance misuse treatment services in young people age <18.



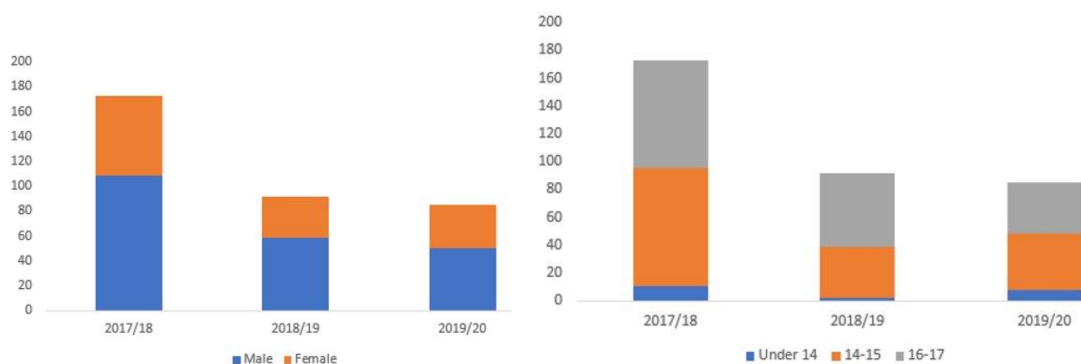
Source: OHID NDTMS

Demographics

In 2020-21, the majority (94.2%) of young people in treatment services locally were aged 14-17, which is similar to the England average of 93.2%. Most young people (under 18) were White British (84%), compared with 73% in England.

The number of young people aged under 18 in treatment has declined over the last decade in line with the England trend, although year on year the numbers have fluctuated. There are more boys than girls in treatment (64% vs 36%), mirroring the national average. Around 40% of young people aged 16-17. In terms of age groups, over recent years the largest fall has been seen in older teenagers and particularly in males (figure 50).

Figure 49: Age and sex profile of young people in specialist young person's treatment services.



Source: NDTMS Viewit – under 18's dataset (accessed Nov 2022)

In contrast to the national picture, <5% of those in young people's treatment services in Northamptonshire were aged 18–24. Across England, 23% of all those being treated in young people's services are in this age group reflecting the criteria for accessing treatment services locally.

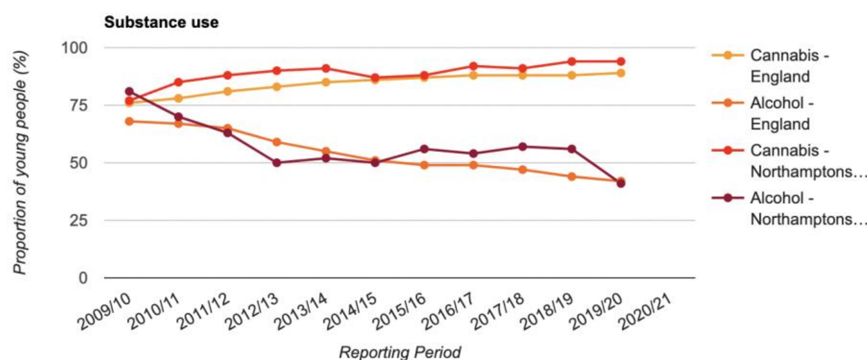
Of aged under 18 in treatment in 2020-21, 84% were white British while the comparable figure for England was 73%. Secondary school data from the Education census indicates that in 2020-21, 70% of pupils in Northamptonshire and 65% in England were White British.[xiii] Although rates of substance misuse are lower in most ethnic groups, and local patterns of consumption are unknown, and numbers impacted are small, this differential in uptake warrants further investigation.

Substance use

In line with the national pattern, most young people in 2019-20 were being treated for cannabis (94%) or alcohol (41%). Very few young people are treated for other substances – the next most common substances requiring treatment are cocaine and ecstasy (both 12%). Over the last decade, treatment for cannabis has increased while alcohol has reduced, mirroring national trends (figure 51)

Alcohol consumption in the last 28 days prior to treatment is recorded in NDTMS. In Northamptonshire, 84% of young people were recorded as drinking between 1-199 units with 14% consuming 0 units. This contrasts with the England figure of 44% consuming 1-199 units and 50% consuming 0 units. The very different patterns observed require further investigation, this could reflect small numbers and natural fluctuation, or an indication of comparatively higher levels of consumption the group accessing treatment services in Northamptonshire.

Figure 50



Source: OHID NDTMS

Mental health

Addressing the mental health needs of young people with substance misuse is an important part of the support required for recovery. NDTMS provides data on the source of mental health treatment provided at the time a young person enters the substance misuse service.

Overall mental health treatment rates for young people were lower in Northamptonshire compared to the England average, with 62% of those in need receiving treatment compared to 67% for England. A lower proportion of service users in Northamptonshire were being treated in specialist mental health services compared to England, with more reliance on GP practices (see table 8).

Other areas also identified a small number of young people (5%) receiving treatment in other services including places of safety, receiving IAPT services, and receiving any NICE-recommended psychosocial or pharmacological interventions provided for the treatment of a mental health problem in a drug or alcohol service. In Northamptonshire, no cases were recorded receiving treatment in any of these settings.

The NDTMS database records the proportion receiving psychosocial treatment across the treatment journey. These are a range of talking therapies designed to encourage behaviour change. In 2020-21, 100% of young people received these interventions, and this figure includes receipt of family interventions and harm reduction. Provision of harm reduction only in Northamptonshire is much lower than the England average – 16% vs 66% in 2020-21.

Table 8: Proportion of young people aged <18 in substance misuse treatment services identified with a mental health need receiving mental health treatment.

	Northamptonshire	England
GP practice	11%	7%
Specialist MH service	51%	55%
Other services	0%	5%
Total – receiving treatment	62%	67%

Source: OHID commissioning support packs

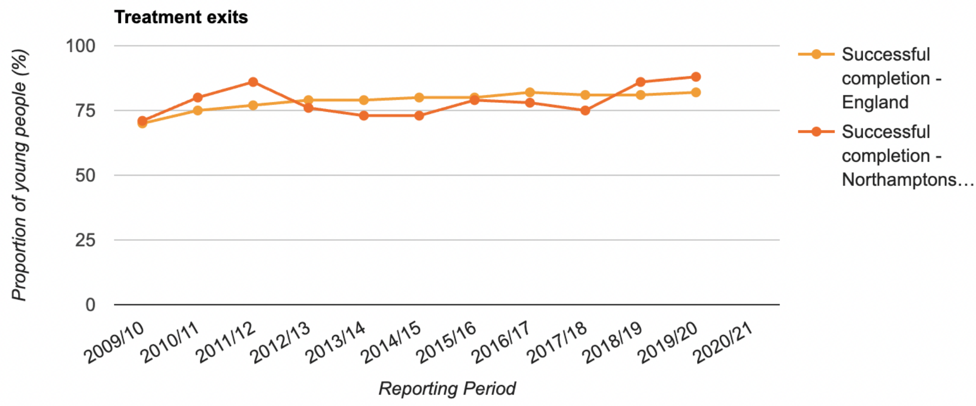
Smoking

Comparatively few young people were identified as smokers at the start of treatment in Northamptonshire – 8% compared to 26% in England in 2020-21. It is likely that there is significant under reporting or recording of smoking in this group. None of the identified smokers were receiving smoking cessation interventions treatment at the start of their treatment.

Treatment outcomes

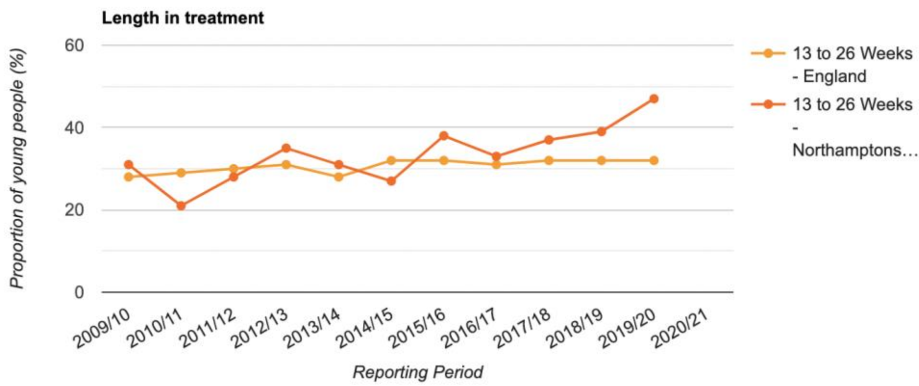
Treatment outcomes in Northamptonshire for young people have been similar to the national average for the last decade. In 2020-21 81% of exits leaving treatment were successful (figure x). Most treatments were completed within 26 weeks, with the most common timeframe 13-26 weeks. This is slightly longer than the England average (figure x). Over the last decade length of time young people spend in treatment in Northamptonshire has increased slightly.

Figure 51



Source: OHID [NDTMS]

Figure 52



Source: OHID [NDTMS]

Section 9: Treatment services – adults

Section summary: treatment services – adults

Numbers and demographics

In 2020-21, 3,165 adults were in treatment for substance misuse and 1,590 were new presentations in Northamptonshire. The rate of drug treatment has been lower than the England average but significantly higher than other similar geographical areas (CIPFA neighbours).

The age and sex profile mirrors the national pattern. In 2020-21 most adults in drug and alcohol treatment were men, 71% and 58% respectively. Access to services was highest in those aged 40-49 in alcohol treatment and 30-39 in drug treatment. Over the last decade, the group accessing opiate and alcohol services has aged with a higher proportion aged over 50.

Few of those entering drug treatment were from minority ethnic groups and there has been little change in this proportion over the last decade. Comparatively few service users reported a disability – 18% locally compared to 28% in England. Most of this difference is attributable to a lower proportion of adults with behavioural and emotional disabilities. These findings warrant further investigation with local communities to assess if there are needs that are being unmet.

Unmet need

A high proportion of those who need treatment are not currently accessing services. It is estimated that 82% of those in need of alcohol treatment are not currently accessing services in Northamptonshire. Rates of unmet need are estimated at 48% for crack, 43% for opiates, and 51% for opiate and/or crack use. These mirror the England pattern and have remained unchanged over time except for crack where unmet need has declined from 75% in 2009-10 to 48% in 2021-22.

Referral sources

Northamptonshire has a different referral pattern compared with England with a much higher reliance on self-referral. In 2020-21, 71% in drug treatment were self-referred compared to 59% in England, and for alcohol the figures were 80% self-referral compared to 63% in England. In recent years, a higher proportion locally of referrals have come from the Criminal Justice System. In 2020-21, 18% of referrals were from the youth justice system compared to 12% in England.

Referrals from prison have increased over time, and Northamptonshire has a higher proportion of adults released from prison who need treatment successfully accessing community treatment services.

Few referrals locally were from NHS and social care, and these referrals have fallen considerably in recent years. Compared to England in 2020-22, referrals were low from GPs (3% locally vs 8% England), hospitals (3% locally vs 7% England) and social care (0% locally vs 4% England).

Substances used

The profile of drugs used in Northamptonshire was very similar to the England average in 2020-21. Most of those accessing services are being treated for opiates and alcohol with little change in this profile since 2014-15. In 2020-21, 650 new presentations to services were for alcohol only and 480 for opiates. Of those in treatment for alcohol, 35% were also being treated for drug misuse. In this year, 8% of adults in Northamptonshire's treatment services were injecting drug users, a proportion that has declined from the peak in 2011-12. This mirrors regional and national trends.

Illicit use of prescription only medicine / over the counter drugs was reported by 7% of adults in treatment, similar to the England average of 10%. Club drugs were cited by 7% of adults new to drug treatment, similar to the England average of 8%.

Around 8% of adults in treatment were injecting drug users, a proportion that has been unchanged since 2013-14. Adults entering the treatment system locally had higher levels of alcohol consumption. They were less likely to have abstained from alcohol and more likely to have a higher unit consumption in the 28 days before accessing treatment compared to the region and England.

Treatment outcomes

Adults who have been in treatment for long periods of time will usually find it harder to complete successful treatment. For opiates this time period is 6 years and for non-opiate 2 years. Opiates users who complete treatment in under 2 years have a higher likelihood of sustained recovery. In 2020-21, around 1 in 5 were in treatment for more than 6 years (21% locally, 27% England). Very few non-opiate users locally or in England were in treatment for more than 2 years – 2-3%.

A range of outcomes measures are required to review the effectiveness of treatment services. Adults who stop using drugs in the first 6 months are almost five times more likely to complete successfully compared to those who do not. In all categories of drugs, treatment outcomes were similar or better than the England average in terms of both abstinence and reduction in use.

The national OHID outcomes indicator measures adults who successfully complete treatment for a substance misuse in a year and who do not re-present to treatment within 6 months. In 2020, the Northamptonshire rate for opiates and non-opiates was similar to the England average but lower than CIPFA neighbours (other similar geographical areas). There has been no change in recent years.

Outcomes for alcohol treatment were significantly worse than the England average in 2020 – 28% successfully completed treatment locally vs 35% in England. Success rates and have declined over recent years. In relation to alcohol, outcomes were significantly lower than CIPFA neighbours in 2020. Northamptonshire also had a higher rate of adults who had dropped out or left compared to England in all categories of drug and alcohol. The proportion of deaths in treatment has been statistically similar to the England average and has declined over time.

Harm reduction

Harm reduction strategies aim to reduce negative effects of continued substance misuse, accepting that for some abstinence will not be possible. The aim of harm reduction strategies is to reduce the adverse consequences, focusing on methods to improve health, social and economic outcomes. These interventions reduce premature death, ill health and improve quality of life.

Sharing injecting equipment can spread blood-borne diseases including HIV, hepatitis B and C. In 2020-21, in Northamptonshire 59% of adults in drug treatment who were eligible for a hepatitis B vaccination accepted it. This is higher than the national average of 29%. The proportion who completed the hepatitis B vaccination course was 6%, slightly lower than the England average of 9%. In 2020-21, in Northamptonshire 29% of adults in drug treatment who were eligible for a hepatitis C vaccination accepted it. This is lower than the national average of 41%. A needle exchange service is provided by the provider S2S and since Oct 2021, 308 needle exchanges have been undertaken. In 2020-21, 23% of eligible adults were issued naloxone in Northamptonshire, slightly lower than the 28% England average. This figure has increased to over 60% in 2022.

Mental health

In 2020-21, 66% of adults aged over 18 entering substance misuse treatment services were identified as having a mental health treatment need, similar to England (64%). More females (74%) than males (61%) needed mental health treatment, reflecting the national picture.
Most adults with an identified mental health treatment need reported receiving treatment – 74% for drug treatment and 79% for alcohol only treatment. Rates were similar to the England average. However, the location of mental health treatment was markedly different. In Northamptonshire there was more reliance on GPs for mental health treatment (60% locally vs 50% in England) and less use of specialist mental health service (13% locally vs 19% in England).

Housing

A safe, stable housing situation at the end of treatment is important for recovery. At the end of treatment 87% of adults successfully completing drug treatment and 89% completing alcohol treatment reported they no longer had a housing need. While this is comparable to the England average it still leaves around 1 in 5 adults completing drugs and 1 in 10 completing alcohol treatment with a housing problem.

Employment

Improving employment outcomes is important to sustaining recovery and requires a multiagency response. Although results are better than the England average, most adults leaving drug treatment services are not employed (59% planned exit; 71% unplanned exit). This is also the case for those leaving alcohol only treatment (62% planned exit; 71% unplanned exit).

Parents and children's early help (social care)

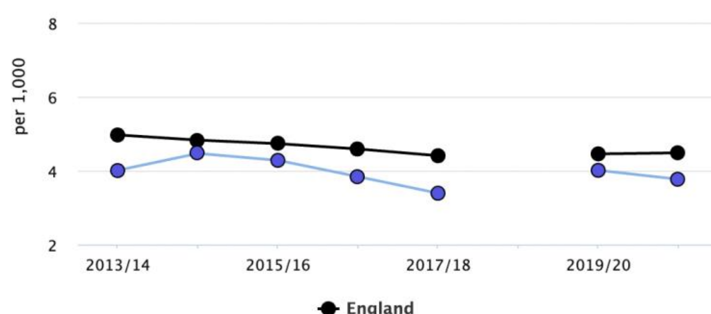
In Northamptonshire, 126 (13%) of those newly presenting to drug treatment services in 2020-21 were parents living with children. A further 246 (26%) were parents not living with children. For those presenting with alcohol only, 146 (22%) were parents living with children and a further 124 (19%) were parents not living with children. These proportions mirrored the national picture.

In relation to the children of these adults receiving alcohol only treatment, 77% in Northamptonshire received no early help compared to 70% in England. For those in drug treatment, the figures were 76% locally receiving no early help, higher than the 65% in England.

Numbers accessing treatment

In 2020-21, there were a total of 3,165 adults in treatment for substance misuse and 1,590 new presentations in Northamptonshire. The adult drug treatment rate in Northamptonshire of 3.8 per 1000 population was lower than the England average of 4.5 per 1000 population, but significantly higher than the average for similar geographical areas known as CIPFA neighbours – 3.2 per 1000 population. In recent years, there has been little change in the drug treatment rate (figure x).

Figure 53: Adults in treatment at specialist drug misuse services in Northamptonshire



Source: OHID Fingertips

Estimates of unmet need

The NDTMS database provides an indication of the level of unmet need for adults based on estimates of the prevalence of problematic drug use in local populations. While rates of unmet need are generally lower than the England average, locally rates remain high (table 9). Over the last decade, there has been little change in the proportion in the estimated to be treatment except for crack, where the rate of unmet need declined from 75% in 2009-10 to 48% in 2021-22.

Table 9: Rates of unmet need (% not in treatment) for adults aged over 18 in 2021-22

	England	Northamptonshire
Opiate and/or Crack Use (OCU)	53%	51%
Opiates	47%	43%
Crack	58%	48%
Alcohol	82%	82%

Source: OHID NDTMS

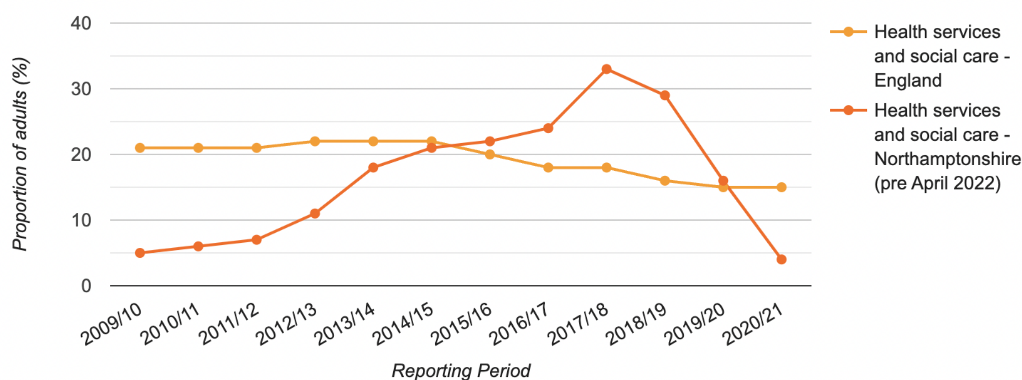
Source of referrals & waiting times

Northamptonshire has a different referral pattern compared to England, with a much higher reliance on self-referral and the Criminal Justice System. In 2020-21, of those newly presenting to services

- In drug treatment
    - 71% self-referred in Northamptonshire compared to 59% in England
    - 24% were referred from the Criminal Justice System compared to 16% in England
- In alcohol treatment
    - 80% self-referred compared to 63% in England.
    - 11% self-referred in Northamptonshire compared to 6% in England.

In recent years, adults were much less likely to be referred from health and social care setting in Northamptonshire. Referral rates locally were lower than in England across health and social care settings in 2020-21, including from GPs (3% locally vs 8% England), hospitals including A&E (3% locally vs 7% England) and social care (0% locally vs 4% England). There has been a dramatic drop in referrals from health and care settings in Northamptonshire since 2017-18 (figure x).

Figure 54: Referrals to specialist adult treatment services from health and social care



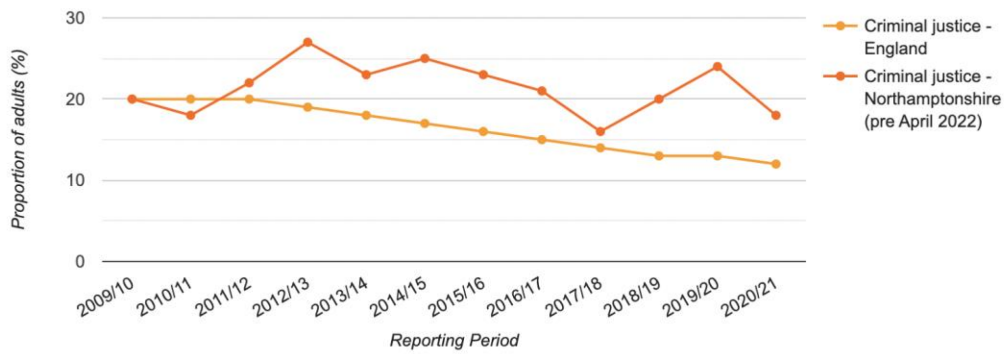
Source: OHID NDTMS

Criminal Justice System

Data contained in the OHID Commissioning Support Packs provide further details of referrals from the Criminal Justice System in 2020-21. In this year, a higher proportion of adults in treatment in Northamptonshire had a prior conviction in the prior 2 years compared with England – 35% vs 29%.

The proportion of referrals from the Criminal Justice System have been consistently higher than the England average over recent years (figure x).

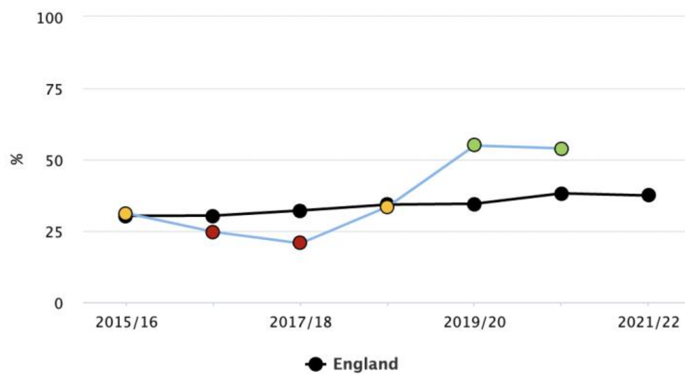
Figure 55: Proportion of adults referred into substance misuse services from the Criminal Justice System



Source: OHID NDTMS

Northamptonshire had a high proportion of adults requiring substance misuse treatment successfully existing prison into community based structured treatment. Over time a higher proportion of those in need have accessed treatment (figure x).

Figure 56: Adults with substance misuse treatment needs who successfully engage in community-based structured treatment following release from prison in Northamptonshire



Source: OHID Fingertips

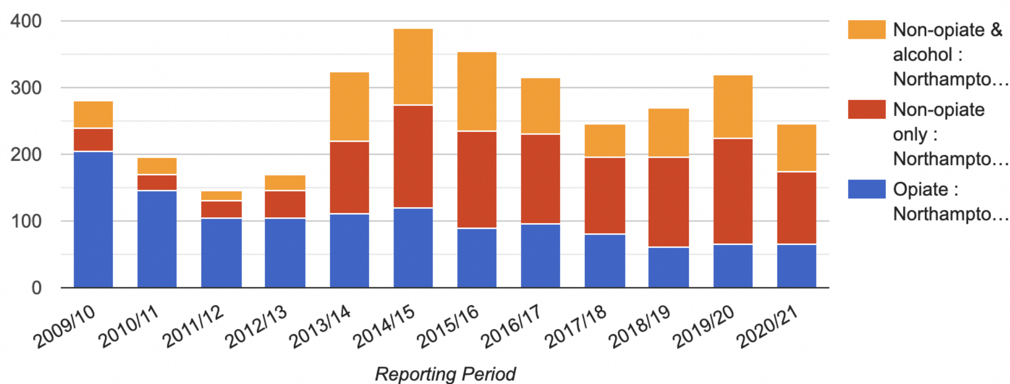
Demographics

Age and sex

The age and sex profile of those entering treatment mirrors the England average. Most of those in drug treatment are men – 71% in drug treatment and 58% in alcohol treatment. The gender profile has remained unchanged over the last decade for both drugs and alcohol. In 2020-21, access to services was highest in those aged 40-49 for alcohol treatment and 30-39 for drug treatment.

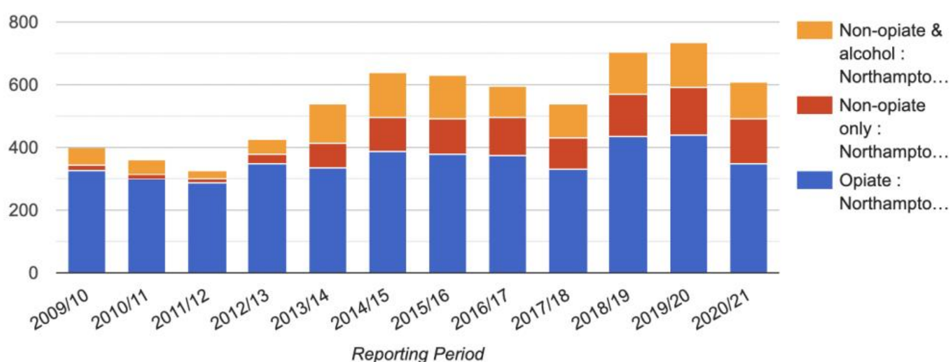
The age profile for drug use has changed over time, with fewer young people aged 18-29 entering drug treatment (figure x), a similar number of those aged 30-49, and more aged over 50 (figure x).

Figure 57: New presentations to specialist substance misuse services for drug treatment in Northamptonshire, in adults aged 18-29



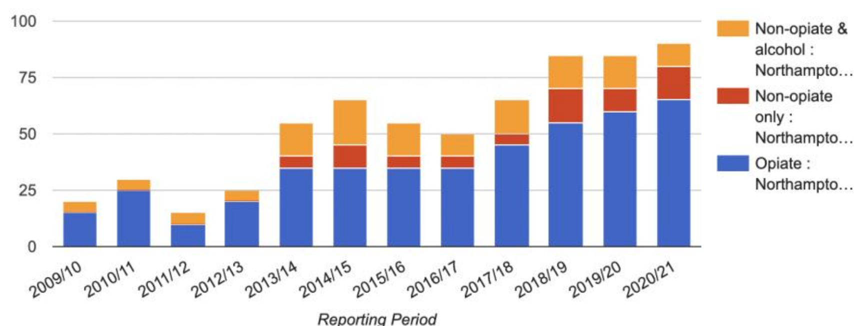
Source: OHID NDTMS

Figure 58: New presentations to specialist substance misuse services for drug treatment in Northamptonshire, in adults aged 30-49



Source: OHID NDTMS

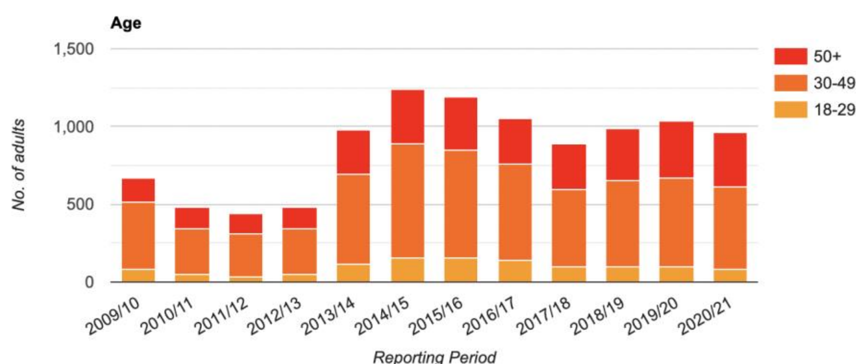
Figure 59: New presentations to specialist substance misuse services for drug treatment in Northamptonshire, in adults aged 50+



Source: OHID [NDTMS]

In relation to those accessing alcohol treatment, the proportion of young people had remained similar over the last decade at around 9% of new presentation. There has been a large in increase in those aged over 50 and a decline in the proportion of 30–49-year-olds (figure x).

Figure 60: New presentations to specialist substance misuse services for alcohol treatment in Northamptonshire.



Source: OHID [NDTMS]

The age profile was different for different substances and has changed over time. Particularly of note is the ageing cohort of opiate and alcohol users. Main changes in terms of age profile are:

- **Opiate users**: 75% were in the 30-49 age group in 2020-21. Over the last decade the proportion of over 50's was more than 4 times higher, 4% in 2009-10 to 18% in 2020-21.

- **Non-opiate only**: this group were younger, with 49% aged 18-29 and 48% aged 30-49. Over the last decade, the proportion of young adults has fallen from a peak of 60% in 2012-13.

- **Alcohol only:** 54% of these adults were aged 30-49. Over time, the proportion of older adults aged over 50 has risen from 23% in 2009-10 to 37% in 2020-21.

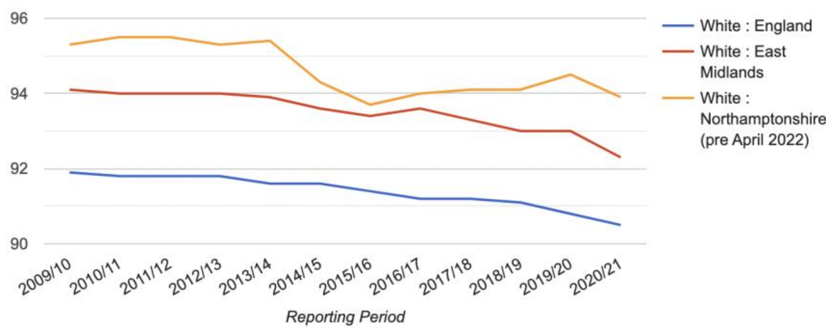
- **Non-opiates and alcohol:** most of these are aged 30-49, with little change in the age profile.

Ethnicity

Most of adults entering drug treatment are a white ethnic group. In 2020-21, 87% of new presentations to drug were White British and 4% White other. For alcohol the figures were 85% White British and 6% White Other. There has been a slight reduction over the last 10 years in the proportion of those in a White ethnicity (figure 62) and an increase in mixed ethnicity (figure 63)

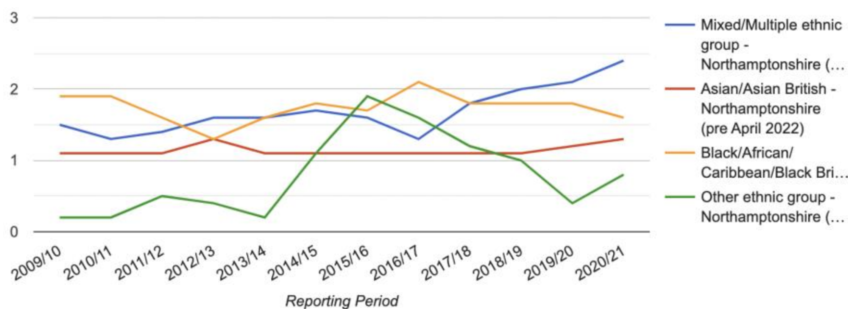
The local prevalence of drugs misuse in local ethnic groups is unknown and at the time of writing the census figures detailing the change in ethnicity over the last decade was not available. However, this finding of relatively little change in the ethnic profile of service users does warrant further investigation with local communities.

Figure 61: Ethnicity of adults in specialist substance misuse treatment services – white ethnic group.



Source: OHID NDTMS

Figure 62: Ethnicity of adults in specialist substance misuse treatment services – black and other minority ethnic groups



Source: OHID NDTMS

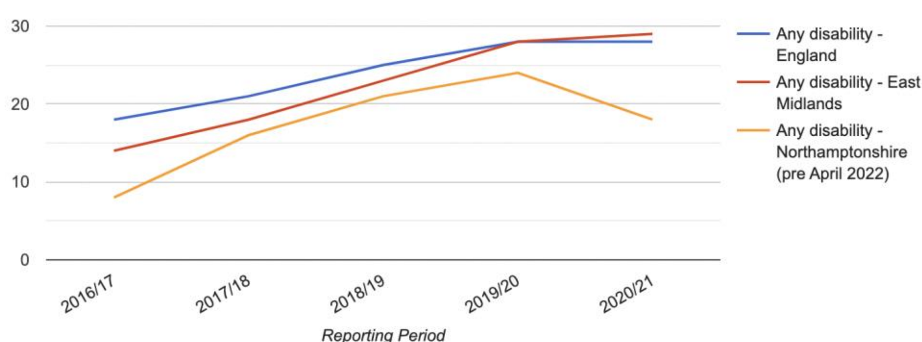
Disability and sexuality

Further work is also required to access equity of access to substance misuse services among groups who are disabled, as rates are much lower in Northamptonshire than England. In 2020-21, 18% of those entering treatment in Northamptonshire reported a disability, compared to 28% in England. Most of this difference relates can be explained by a lower proportion of adults with behavioural and emotional disabilities presenting to services, in 2020-21, this was

- For alcohol treatment, 8% reported this disability in locally compared to 14% in England
- For drug treatment, 8% reported this disability locally compared to 18% in England.

The proportion of new service users identifying as gay, lesbian or bisexual is similar to national and there are no apparent differences in the profile of religion compared to national trends.

Figure 63: Proportion of disabled adults in specialist substance misuse treatment services



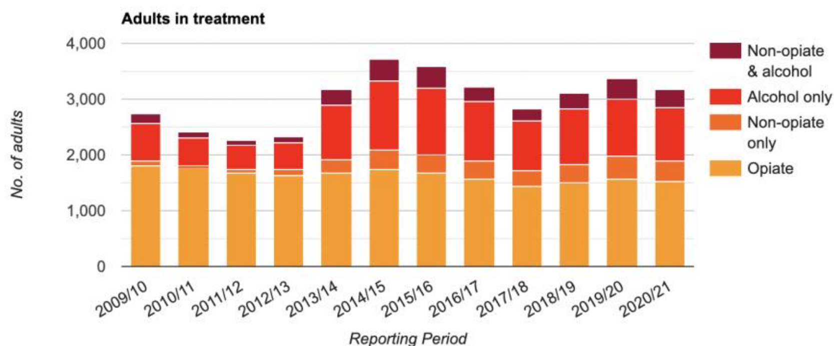
Source: OHID NDTMS

Profile of substances used

The pattern of substance misuse changed in the early part of the last decade with increases in the proportion of adults accessing services for alcohol and a decline in the proportion for opiates.

There has been little change in the profile of substance misuse treatment since 2014-15 (figure 65). The substance misuse profile in Northamptonshire in 2020-21 was very similar to the East Midlands region and England, and Northamptonshire has largely followed the same trends over time.

Figure 64: Number of adults in contact with specialist treatment services in Northamptonshire



Source: OHID NDTMS

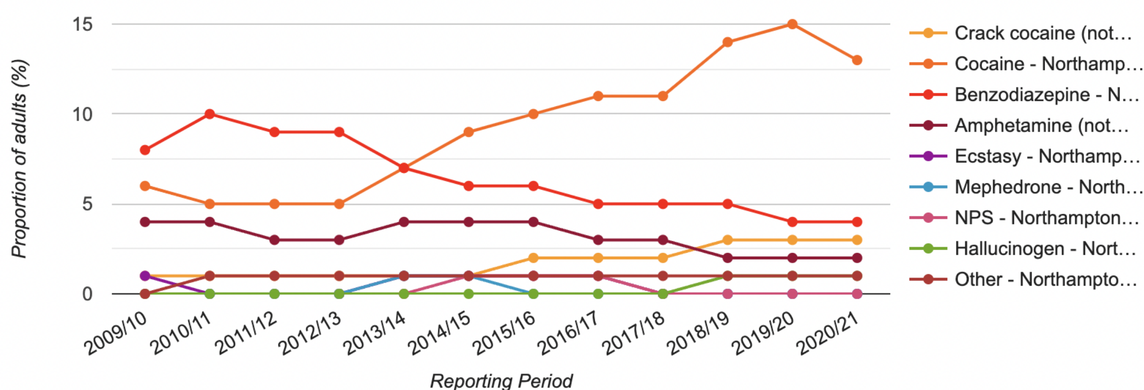
Alcohol was most common substance with 1,491 adults in Northamptonshire in 2020-21. Of those, 65% were being only being treated for alcohol, slightly higher than the national average of 58%. Others had both alcohol and problematic drug use, specifically

- **Non-opiates**: 21% of adults in alcohol treatment locally, England figure of 23% is similar
- **Opiates and non-opiates**: 9% of adults in alcohol treatment, England figure of 13%
- **Opiates**: 5% of adults in alcohol treatment, the same proportion as in England.

Of those in alcohol treatment, 9% cited use of crack, 14% use of cocaine and 10% cannabis. The proportion of adults in treatment services citing alcohol increased until 2014-15 and has slightly reduced since this period. This is in line with regional and national trends.

Of those starting drug treatment in 2020-21, crack cocaine was the most cited substance with 38% adults reporting use. Other common substances in those receiving drug treatment were cannabis (29%) and alcohol (29%). These proportions were similar to the England average. The proportion of services users using cocaine has increased substantially over the last decade while benzodiazepine has decreased (figure 66).

Figure 65: Substances used by adults in substance misuse treatment services in Northamptonshire (excluding opiates, alcohol and cannabis)



Source: Source: OHID NDTMS

Adults are in treatment for prescription only medicines and over the counter medicine as well as illicit substances. A breakdown of this group is shown below, with most of adults citing that use was illicit – 7% of the treatment population (table 10).

Club drugs were cited by 7% of adults new to drug treatment in 2020-21, similar to the England average of 8%. Among these adults the most used club drug were ecstasy (34%) and ketamine (50%).

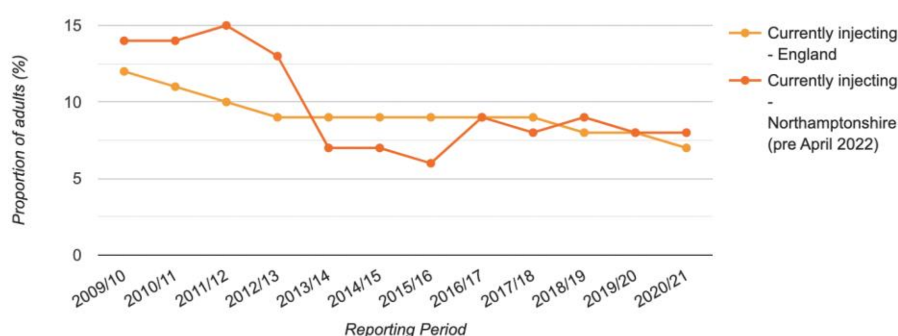
Table 10: Adults in drug treatment citing Prescription Only Medicine and Over the Counter use for Northamptonshire and England, 2020-21.

POM/OTC Use	Local (n)	Proportion of treatment population	Male (n)	Female (n)	England (n)	Proportion of treatment population
Illicit use	156	7%	117	39	19,346	10%
No illicit use	101	5%	63	38	7,608	4%

Source: OHID Commissioning 2022-23

In 2020-21, 8% of adults in Northamptonshire's treatment services were injecting drug users, a proportion that has declined from the peak in 2011-12 (figure 67). Of those adults newly presenting to drug treatment services, 14% of adults (n = 121) were current injecting drug users and 18% (n=146) had previously injected. Around 1 in 4 opiate users were currently injecting. This was comparable to England, where 12% were currently injecting and 19% had previously injected. There has been little change in this proportion over recent years, mirroring regional and national trends.

Figure 66



Source: Source: OHID NDTMS

Northamptonshire has a slightly different profile of alcohol consumption in adults entering treatment compared with the East Midlands and England. In 2020-21, adults in Northamptonshire entering treatment were less likely to have abstained from consuming alcohol in the last 28 days and

more likely to have consumed a higher number of units (table 11)

Table 11: Units consumed in the 28 days before accessing treatment, 2020-21

Number of Units	Northants	East Midlands	England
0 units	35	39	42
1 – 199 units	23	24	24
200 – 399 units	13	12	11
400 – 599 units	13	11	10
>600 units	15	15	14

Source: Source: OHID NDTMS

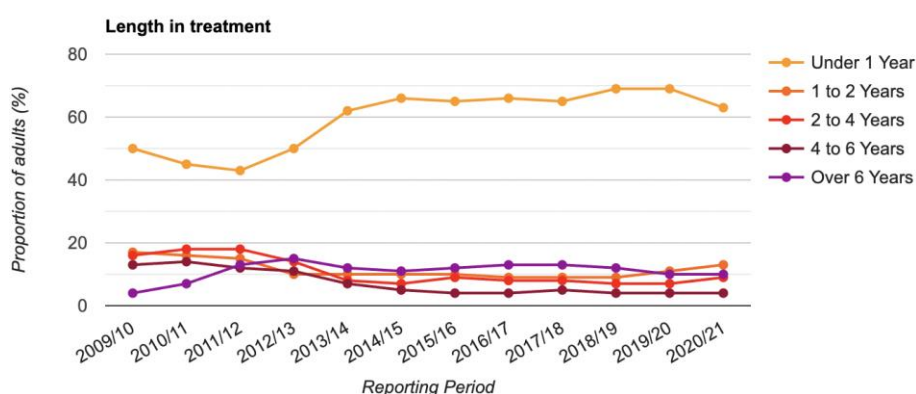
Treatment length and outcomes

Length of time in treatment

Adults who have been in treatment for long periods of time will usually find it harder to complete successful treatment. For opiates this time period is 6-years and for non-opiate 2-years. Opiates users who complete treatment in under 2 years have a higher likelihood of sustained recovery.

Most adults in Northamptonshire are in treatment for less than a year, a pattern that has mirrored the England average and remained unchanged for most of the last decade (figure 68). In 2020-21, most adults with opiate misuse were in treatment for less than 2 years (56% locally compared to 46% in England) with around 1 in 5 in treatment for more than 6 years (21% locally, 27% England). Very few non-opiate users locally or in England were in treatment for more than 2 years – 2-3%.

Figure 67



Source: Source: OHID NDTMS

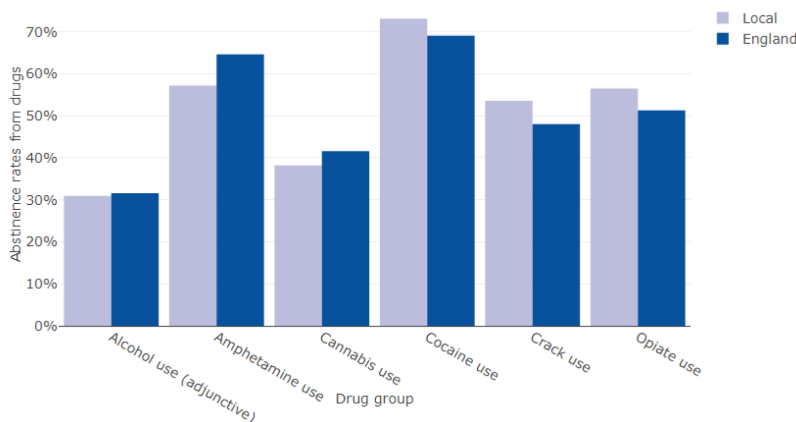
There is no single definition of successful treatment, so a range of measures are commonly used. These include in-treatment changes in substance misuse, outcomes at exit, death in treatment, and wider outcomes related to sustained recovery including measure around employment and housing.

In treatment – abstinence and reduction

Adults who stop using drugs in the first 6 months are almost five times more likely to complete successfully compared to those who do not. In all categories of drugs, in treatment outcomes were similar or better than the England average in terms of both abstinence and reduction in use (figures 69 and 70). In 2020-21, the proportion of adults no longer injecting at 6 months was 71% locally, higher than the England figure of 63%. Rates were similar for men and women.

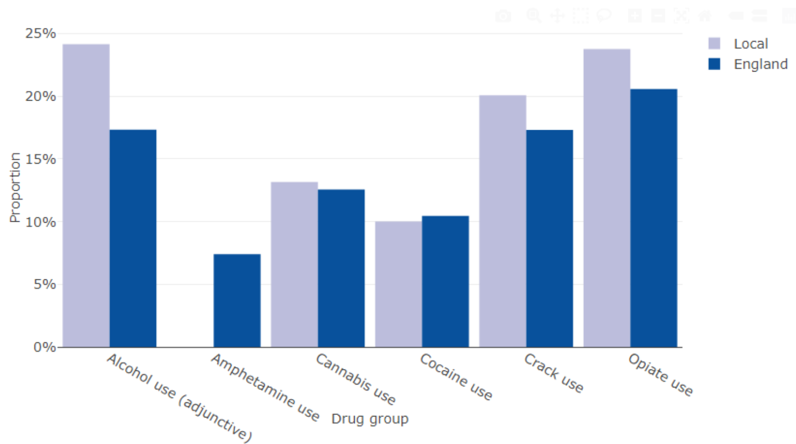
Abstinence rates for alcohol were similar locally to England at 6 months, 51% and 53% respectively. Reductions in drinking days comparable with the England average were also seen in local services.

Figure 68: Proportion of adults who became abstinent by drug group at 6 months review for Northamptonshire and England, 2020-21



Source: OHID Commissioning Packs

Figure 69: Proportion of adults with significant reduction in use at 6 months review for Northamptonshire and England, 2020-21



Source: OHID Commissioning Packs

Exit outcomes

A commonly used indicator of success is contained in the national OHID Public Health Outcomes Framework. This indicator measures adults who successfully complete treatment for a substance misuse in a year and who do not re-present to treatment within 6 months.

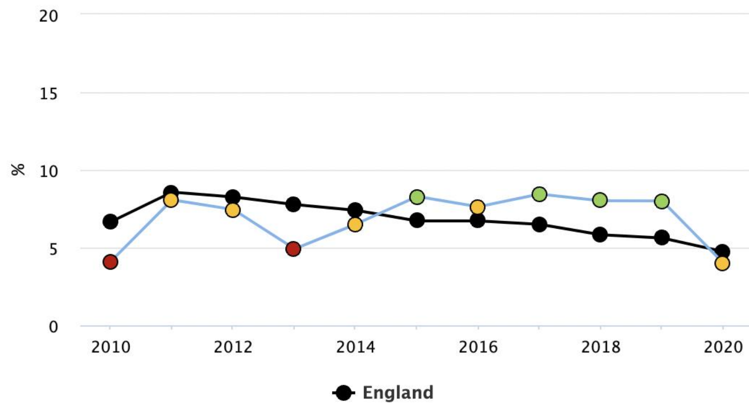
For opiate users, the Northamptonshire figure is similar to the England average with no significant change over the last few years (figure 71). In 2020, the local rate was lower than the average for other similar geographical areas - CIPFA neighbours (5.4% CIPFA vs 4.0% locally). In this year, Northamptonshire had the lowest successful competition rate in the CIPFA group.

The pattern for non-opiate users was similar, with the rates comparable to the England average and no change in recent years (figure 72). The rate was also lower than the CIPFA neighbours (35.6% CIPFA vs 30.9% locally), although several other local authorities had worse outcomes in this year.

For those on alcohol treatment, outcomes were significantly worse than the England average and have been declining over recent years (figures 73). In 2020, the success rate in Northamptonshire was significantly lower than CIPFA neighbours in 2020. Completion rates were similar for men and women being treated for non-opiates and alcohol but different for opiates where women were more successful than men. This mirrors the national pattern. In 2020-21 in Northamptonshire

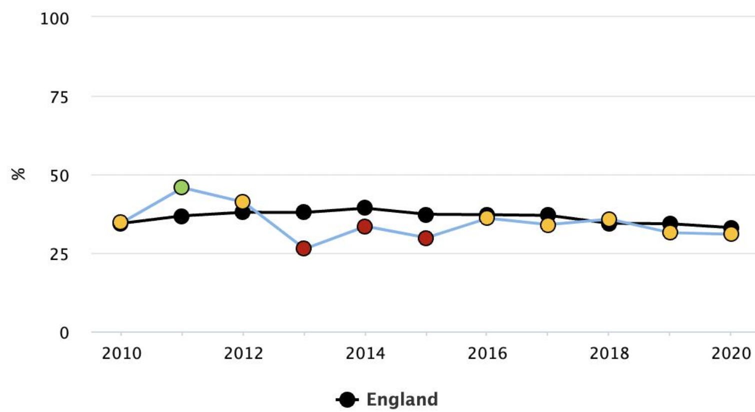
- **Non-opiates:** 30.9% success rate overall, 30.7% in men and 31.5% in women
- **Opiates:** 4.0% success rate overall, 3.6% in men and 4.8% in women
- **Alcohol:** 28% success rate overall, with 29% in men and 27% in women

Figure 70: Successful completion of drug treatment - opiate users in Northamptonshire (C19a)



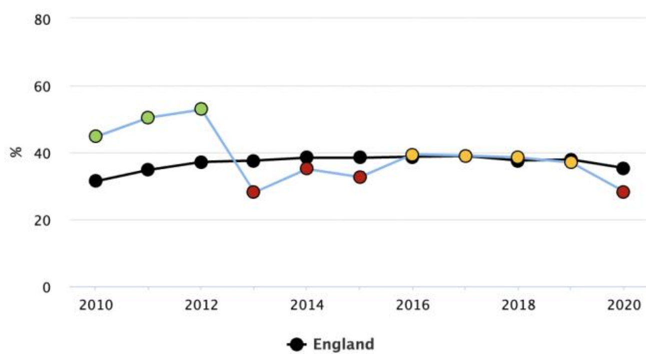
Source: OHID Fingertips

Figure 71: Successful completion of drug treatment – non-opiate users in Northamptonshire (C19b)



Source: OHID Fingertips

Figure 72: Successful completion of alcohol treatment in Northamptonshire (C19c)



Source: OHID Fingertips

Dropout rates

When engaged in services, people use less drugs, commit less crime, improve their health, and manage their lives better. Preventing early drop out keeps people in treatment long enough to benefit and improves outcomes.

Reviewing drop-out rates is another approach to reviewing the success of treatment services. In all treatment areas, Northamptonshire had higher rates of people who have either dropped out or left the service than the England average (table 12). Local drop-out rates have been higher since 2013-14. Early unplanned exit is defined as those who have dropped out before 12 weeks. In this measure, Northamptonshire has worse outcomes that the England average (table 13)

Table 12: Treatment exists - dropout or left in 2020-21

	Northamptonshire	England
Non-opiate and alcohol	49%	37%
Alcohol	44%	30%
Non-opiate only	48%	35%
Opiates	44%	34%

Source: OHID NDTMS

Table 13: Early unplanned exits by drug group for Northamptonshire, 2020-21

	Local				England			
Drug groups	Total adults	Proportion of new presentations	Male (%)	Female (%)	Total adults	Proportion of new presentations	Male (%)	Female (%)
Alcohol and non-opiate	48	24%	24%	24%	3,299	16%	17%	14%
Non-opiate	82	32%	36%	22%	3,374	17%	18%	14%
Opiate	85	18%	20%	13%	5,598	15%	16%	13%
Total	**215**	**23%**	**25%**	**18%**	**12,271**	**16%**	**17%**	**14%**

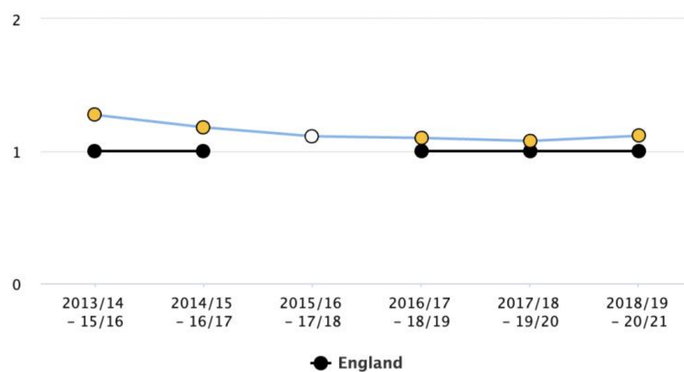
Source: OHID Commissioning Pack: 2022-23

Deaths in treatment

In 2020-21, in England the proportion of adults dying in drug treatment rose by 18%.[56] Deaths in alcohol treatment increased by 44%. This is likely to reflect the impact of the pandemic on changes in service provision, changes to lifestyle and social circumstances and COVID-19 infection.

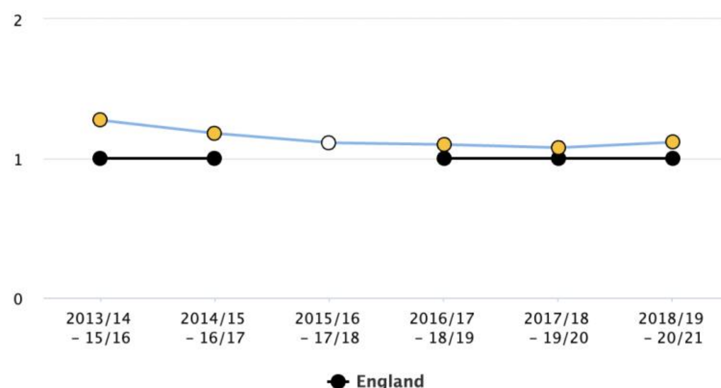
In Northamptonshire, a similar rise was seen in drug deaths in 2020-21 but not in alcohol deaths. All drug related deaths in 2020-21 related to opioids and this accounted for 2% of the adult treatment population. Over the, the mortality rate for deaths in treatment for drugs and alcohol has been similar to the England average (figures 74 and 75). In the most recent three-year period national data is available, 24 adults in alcohol treatment and 80 in drug treatment died in Northamptonshire.

Figure 73: **Deaths in drug treatment; mortality ratio in Northamptonshire**



Source: OHID Fingertips

Figure 74: **Deaths in alcohol treatment; mortality ratio in Northamptonshire**



Source: OHID Fingertips

[56] OHID Commissioning Pack. Adult Commissioning Drugs and Alcohol Support Packs. 2022-23.

Harm reduction

Harm reduction strategies aim to reduce negative effects of continued substance misuse, accepting that for some abstinence will not possible. The aim of harm reduction strategies is to reduce the adverse consequences, focusing on methods to improve health, social and economic outcomes.[57] Interventions can reduce ill health and premature death in this cohort, and are cost effective.

Blood-borne viruses

Sharing injecting equipment can spread blood-borne diseases including HIV, hepatitis B and C. Providing opioid substitution treatment, sterile injecting equipment, and antiviral treatments protect people who are injecting drug and communities and provides long term health savings. Eliminating hepatitis C requires the identification and treatment of many more infected people who use drugs. I

Hepatitis B

In 2020-21, in Northamptonshire 59% of adults in drug treatment who were eligible for a hepatitis B vaccination accepted it. This is higher than the national average of 29%. The proportion who completed the hepatitis B vaccination course was 6%, slightly lower than the England average of 9%.

Hepatitis C

In 2020-21, in Northamptonshire 29% of adults in drug treatment who were eligible for a hepatitis C vaccination accepted it. This is lower than the national average of 41%. This difference may reflect the different pathways used in different areas making comparisons difficult.

In this time period, 20% of eligible adults had a hepatitis B antibody test, the same as the national average of 21%. The provider of this service has reported considerable increase testing in 2022.

Needle exchange

The adult substance misuse treatment provider in Northamptonshire, S2S, provides a needle exchange service. A team established as a result of the Universal Funding (UF) in 2021 has worked to improve knowledge and skills of local staff around needle exchange transactions. Since October 2021, local needle exchange data shows that:

- 308 needle exchanges undertaken by all S2S staff since October 2021 – 102 (33.1%) were carried out by the UF Team, 206 (66.9%) by non-UF Team staff
- 63.9% of needle exchanges performed by the UF Team are with new clients (46 out of 72), 36.1% are with existing clients (26/72)

[57] Harm reduction: An approach to reducing risky health behaviours in adolescents. Paediatr Child Health. 2008 Jan;13(1):53-60

Naloxone

Naloxone is a drug used to counteract the effect of opioids and used to prevent overdoses. One major intervention the UF team has provided was to increase the provision of the overdose reversal medication Naloxone, working directly with users and other agencies in contact with injecting users.

In 2020-21, 23% of eligible adults were issued naloxone in Northamptonshire, slightly lower than the 28% England average. Local figures indicate that this has increased to over 60% in Northamptonshire in 2022, recent figures indicate that uptake is higher than England.

In 2020-21, 1% of eligible adults were administered naloxone, slightly lower than the England average of 3%.

Smoking

Of all smokers in the service in Northamptonshire in 2020-21, 0% were recorded as receiving a smoking intervention. These figures need further investigation indicates that there may be issues with the identification within the service, recording or service offer in relation to smoking cessation.

Housing and homelessness

A safe, stable housing situation at the end of treatment is important for recovery. At the end of treatment in substance misuse services, most adults successfully completing treatment reported no housing needs at exit for both drugs and alcohol (table 14). However, 18% of adults completing drug treatment and 11% completing alcohol treatment still had a housing need at this point.

Table 14: Proportion of adults successfully completing treatment but no longer reporting a housing need at exit in 2020-21

	Northamptonshire				England			
	Total adults	Proportion	% male	% female	Total adults	Proportion	% male	% female
Drugs	37	82%	87%	73%	2,069	83%	83%	84%
Alcohol	16	89%	87%	100%	1,178	83%	84%	85%

Source: OHID Commissioning Pack. 2022-23.

Employment

Improving employment outcomes is important to sustaining recovery and requires a multiagency response.[58] In 2020-21, employment outcomes in Northamptonshire were better than in England for adults leaving treatment services with a higher proportion of adults working (table 15).

Although results locally are better than the England average, most of adults leaving services are not in employment potentially impacting on their longer-term recovery. For both drugs and alcohol, there was little change in the employment status at the start and exit, a pattern seen nationally.

Table 15: Employment outcomes for adults in alcohol and drug treatment, 2020-21

Northants	Planned exit (drug treatment)				Unplanned exit			
	At start (n)	%	At exit	%	At start (n)	%	At exit	%
Full time (16+ days)	76	32	85	35	20	21	35	37
Not working	141	59	139	58	67	71	57	60

England	Planned exit (drug treatment)				Unplanned exit			
	At start (n)	%	At exit	%	At start (n)	%	At exit	%
Full time (16+ days)	5,408	23%	5,831	25%	594	12%	521	10%
Not working	16,061	69%	15,839	68%	4,253	84%	4,348	86%

Northants	Planned exit (alcohol treatment)				Unplanned exit			
	At start (n)	%	At exit	%	At start (n)	%	At exit	%
Full time (16+ days)	81	30%	96	36%	13	17%	16	21%
Not working	167	62%	154	57%	54	71%	71	75%

England	Planned exit (alcohol treatment)				Unplanned exit			
	At start (n)	%	At exit	%	At start (n)	%	At exit	%
Full time (16+ days)	6,381	25%	6,589	26%	452	18%	380	15%
Not working	17,258	67%	17,426	68%	1,936	76%	2,056	81%

Source: OHID Commissioning Pack. 2022-23.

[58] OHID Commissioning Pack. Adult Commissioning Drugs and Alcohol Support Packs. 2022-23.

Section 10: Qualitative – focus groups and interviews

Section summary – focus groups and interview

In November 2022 focus groups and semi-structured interviews were undertaken with adult service users, families and carers across Northamptonshire. The services involved were the main adult treatment service S2S; the recovery service The Bridge; the children and young people's service provided by Aquarius; the family support service Family Support Link; and the homeless outreach service provided in the Hope Café in Northampton town centre. The interviews were held in different geographical areas – Corby, Kettering, Northamptonshire and Wellingborough. A total of 86 people took part in focus groups and 1-2-1 interviews.

Access to advice on harm reduction from non-specialist agencies apart from the Criminal Justice System was perceived to be very limited, particularly for injecting drug users. Provision of advice on harm reduction at needle exchanges and equipment other than injecting equipment was viewed as limited. Service users thought that access to naloxone had improved. Prior to entering treatment, advice and information on substance misuse from health professionals was viewed as 'hit and miss,' with no evidence of brief intervention and screening in primary care in those interviewed.

Most of those interviewed entered treatment and recovery services as a result of a crisis or understanding of the serious consequences of continued use. Motivations for entering treatment included avoiding prison, child protection, individual and family safety, and pressure from family. It was perceived that there was low awareness of treatment services among statutory services and communities, and for some a perception that services focused on heroin and were of little benefit to address other issues such as crack. Access to services was cited as an issue for those in rural communities, compounded by lack of public transport. The lack of support in the transition from children to adult substance misuse services was noted as an issue.

There was positive feedback of the structured treatment service and friendliness of the staff, and a welcoming atmosphere at the point of entry was seen as important. Those interviewed talked about the importance of the relationship and quality of key workers, and this was inconsistent. For some, this was impacted by a high turnover of staff. People also saw the value in people in recovery being part of the workforce. There was some confusion among users over care and treatment plans, with a lack of a strong relationship with formal care planning. Some confusion among professionals was identified in relation to the role and referral routes for recovery. This was particularly related to the aftercare and recovery part of the service user journey. There was no concern over safety of issues of confidentiality. Some families felt they were unsupported.

This topic area generated the strongest opinions and debate. Concerns over mental health services came up in almost every discussion with similar concerns raised. There was a view that the substance misuse treatment services and mental health services do not work well together, with issues of thresholds and joint working frequently cited. A particular concern was the perceived exclusion of those with substance misuse from mental health services and the high threshold for accessing services impacting on the ability to address their substance misuse. Other concerns were around transition from children to adult mental health services, the lack of discussion of mental health treatment issues in substances misuse services, and the difficulty in accessing mental health services in the homeless group due to unrealistic expectation around keeping appointment times. Few service users mentioned social care but those who did related experiences around child protection. There was a perception that social workers had a poor understanding of drug use and priorities of users and did not work well with treatment services.

In 2022, the Northamptonshire Public Health teams commissioned a qualitative study to understand the views of adult services users in substance misuse treatment, those in recovery, and family and unpaid carers. The study looked at the needs of young adults and identified themes related to children but not include focus groups with interviews with children (under 18).

A total of 86 people took part in study, attending either focus groups or 1-2-1 semi-structured interviews conducted over 4 days between 1 – 4th November. Two researchers with experience of working with substance misuse groups undertook the interviews. Recruitment for the study was facilitated by the following services:

- S2S – the main adult treatment service S2S
- The Bridge - the recovery service
- Aquarius - the children and young people's service
- Family Support Link - the family support service

In addition, the homelessness outreach service provided by S2S facilitated focus groups with people using the Hope Centre in Northampton town centre. The interviews and focus groups were held in different geographical areas – Corby, Kettering, Northamptonshire and Wellingborough.

All those attending focus groups and interviews were asked to complete a consent form and provide demographic and characteristics information. The consent form and demographic information were collected separately to ensure anonymity. A topic guide was developed for the focus groups and the interviews. Thematic analysis was undertaken on the notes from the focus groups and interviews, focusing on the following areas:

- Harm reduction
- Structured treatment
- Key workers and staff
- Treatment and care planning
- Safety and wellbeing
- Joining up treatment with other services
- Gaps in services and other comments and suggestions.

A detailed report was provided to the Northamptonshire Public Health teams summarising these findings. This section provides a demographic summary of those involved in the study and details the main themes identified in the focus groups and interviews.

Study participants

Of the 86 people who were involved in the study

- 74 were people who used drugs and alcohol
- 7 were carers and family members
- 5 were both family members and used drugs or alcohol themselves.

Of those that provided information on the type of substances used, the primary drug use was identified as follows:

Primary	Number	Percentage

Alcohol	33	43
Heroin	14	18
Crack	7	9
Cannabis	12	16
Cocaine	7	9
Other (MDMA, Amphetamines, Gaba)	<5	4
Total	**76**	**100**

Poly-drug use was common with 54 of these people mentioning more than one drug.

The average age of the participants was 44 Of the people reporting their gender said they were 44 men, 43 women and 3 non-binaries, with one person identifying as having a gender different to the one that they were assigned at birth.

About two-thirds of the people reported that a health condition (physical health or mental health) affected their day-to-day life either "a little" or "a lot," with mental health the most common issue, reported by half the participants who completed this section.

The sample was predominately white British (91%), with 5% from other white backgrounds and 5% from black and other minority ethnic groups.

Emerging themes

Harm reduction

Key themes:

- **Limited harm reduction advice in non-specialist agencies (e.g. the CJS and NHS services)**
- **Little evidence of needle exchanges offering more than injecting equipment.**
- **Improvements in availability of naloxone, but potential gaps in family and carer provision.**
- **Assessments of alcohol consumption in health services, including primary care limited.**
- **Perception that specialist services are not well know or advertised.**
- **Issues reported with access to pharmacies and relationship with pharmacy staff.**

Access to harm reduction advice from non-specialist agencies was reported to be limited – particularly for injecting drug users. Some people had come into treatment through the criminal justice system but there were no good examples of harm reduction advice from probation or prison staff. Very few people had received harm reduction advice from health professionals prior to entering treatment, although some of the study participants reported being given advice by a GP, nurse in a hospital and diabetes nurse. There were examples of advice and information being provided to alcohol users by health professionals, but this appears to be hit and miss, no evidence of assessment in primary care (e.g., use of Information and brief advice including AUDIT or other screening tools).

Study participants had experience of using both pharmacy and agency needle exchanges, but the equipment available seemed to be limited. There was little evidence of needle exchanges offering more than injecting equipment or harm reduction advice being offered in needle exchanges.

Injecting drug users reported not being provided with foil or water ampoules for people who could not access clean water. Some people were aware that the needle exchanges provided equipment for injecting steroids, though no Image and Performance Enhancing Drug Users in the study had attended the sessions.

The impression from the focus groups was that access to naloxone had improved and people are now being offered it. The homeless groups discussed being issued with naloxone by the S2S workers. The carers and family members were the least aware of naloxone and none had been issued with naloxone in case of an overdose by a family member, though they had been given a presentation through Family Support.

A recurrent theme in the study related to the lack of awareness of services. There was a widely held opinion among study participants that services were not well known or advertised.

No service users in the study reported a good relationship with their pharmacy. There appeared to be limited pharmacies that were open seven days and we spoke to at least one person who found pharmacy opening hours (particularly at weekends) a barrier to employment. Participants spoke about a particular pharmacy where they needed to ring a bell to gain admittance for either OST or NSP. They reported that it was difficult to hear from outside if the bell had worked or not and more than one reported being treated punitively because they had rung it more than once, with one participant saying:

> *"they told me to come back in an hour …to come back when I had learnt to use a bell properly"*

Structured treatment

Key themes:

- **Incentive to accessing specialist treatment was often a crisis.**
- **Motivations included fear of prison, domestic violence, and child protection.**
- **Experience of specialist services was mostly positive**
- **Friendly and welcoming staff were viewed as important.**
- **Mixed views of the value of the Starline – single point of access**

Most of those interviewed entered treatment and recovery services as a result of a crisis or understanding of the serious consequences of continued use. Motivations for entering treatment included avoiding prison, child protection particularly the fear of children being taken into care by social services, individual and family safety, and pressure from family. Examples of two participants motivations for accessing treatment were

> *"it was treatment or prison for me."*
>
> *"the consequences [of continued drug use] were getting scary,"*

There was a range of reasons for not accessing services sooner. For some a perception for some that services focused on heroin and were of little benefit to address other issues such as crack. Other reasons included not realising there was a problem, feeling that the problem could be handled without specialist help and not wanting to let others know there was a problem.

Quite a few participants mentioned the value of having people who had used treatment services themselves volunteering or working in services, with one participant saying:

> *"I was happy to see them doing well, [you get a mixture of] inspiration and envy, [it shows] recovery is possible."*

Quite a few of the people who came into treatment didn't have much idea what to expect, "I just turned up …" Some reported having received texts or a phone call prior to their first appointment, but this was unusual. Most people reported a positive first experience of treatment. One person discussed attending coffee mornings before they came into treatment and found this "drop in" approach a helpful way to engage with treatment.

There were also positive comments regarding the activities and social support given at the Bridge. With one person describing the Bridge's drop in approach as helpful as they felt it reduces pressure to keep appointments. Overall, the first experience of entering treatment was good, the services were seen as welcoming. The availability of tea and coffee in reception was mentioned, most people were seen on time and felt the services were helping them. Although there was one participant that felt that they had received little or no help outside of OST provision, saying:

> *"The script was the help …"*

Several study participants mentioned "Starline", a Single Point of Contact telephone number that performs a brief triage and then refers people to the appropriate service. There were mixed feelings about this, with study participants at the Family and Carers service finding it helpful, whereas service users at S2S felt that it was pointless being assessed just to be referred and then assessed by another service. Several study participants viewed it as a separate service and did not see it as a part of an integrated treatment journey. Most people's initial referral had been to S2S, but some people said they had been referred directly to the Bridge.

Key workers and staff

Key themes:

- **A good relationship with key worker was viewed as important.**
- **Some concerns related to the quality of key workers and impact of staff turnover.**
- **It was unclear if the gender of key workers was routinely discussed with new service users.**
- **Inclusion of former service users in the workforce was generally viewed as positive.**

For many study participants having a good relationship with their key worker seemed to be important to the success of treatment and keeping a key worker was seen as helpful. The most positives for keyworkers came from the focus group in Corby – which seems to have had the most stable staff group - while Northampton and Kettering seem to have had higher rates of staff turnover. The measure of a good keyworker appeared to be that they listened and were interested, were consistent in their approach and agreed an approach to treatment with the person in treatment and stayed long enough to develop a meaningful relationship. With participants saying:

> "*I don't like having to keep telling my story to new people."*

with one person highlighting the difference that they felt a good keyworker made:

*"When I first came my keyworker was s**t. They left me for three months. I got a new one, got detoxed and got on to naltrexone."*

There were some positive comments for key workers collaborating with people in the criminal justice system. One person felt that there was a variation in quality with different keyworkers

"for some of them it's just a job."

It was not clear from those in the study that service users are asked about the gender of their keyworker when entering in treatment. Study participants included some very vulnerable groups including those who had been sexually abused and exploited. The gender of their keyworker was important to some people but other qualities including competence and consistency were also valued.

Study participants also saw the value in people who are in recovery being part of the workforce.

Treatment and care planning

Key themes:

- **Little understanding about the overall treatment pathway and how the parts joined up.**
- **Limited knowledge of employment opportunities beyond working in treatment services.**
- **The role and services offered by the Bridge is perceived to be unclear, for some the service was perceived to be as cliquey and unwelcoming.**
- **The relationship between the NDAS hostel and treatment system needs clarifying.**

There was some confusion among study participants over care and treatment plans. Some people had a clear understanding of treatment planning but others, particularly those now in recovery focussed organisations, who may not have individual care plans and where structured treatment may have ended, much less so. There were some participants who reported the opportunity to influence the contents and to review it regularly:

"*yes I've got one and we discuss it and change it"*

Others were aware of a treatment plan but felt that it wasn't meeting their needs and that they had limited opportunities to influence it. With one person saying:

"I'm on a controlled drinking programme and it's not going down as fast as I would like"

Other study participants were less clear about the existence of a care plan and/or the opportunity to influence the contents. With one saying:

"I must have one, I suppose"

and another saying:

"I think I've got one, but we don't talk about it much."

Views on the role of individual services were explored with study participants. There seemed to be consensus that S2S provided prescribing, one-to-one support, key working and groups. Many saw this as time limited and were not sure what might be available to them once they completed the group programme or key-working.

While some people mentioned being referred to the Bridge, no-one mentioned employment support, but some mentioned volunteering (currently, previously or in the future) at S2S with a view to working in the treatment field. Almost all study participants seemed to think that working in the addiction (or allied) field was the only employment that was available to them.

In relation to the Bridge recovery service, for many study participants it was a valuable part of their recovery although the role of the organisation for many was unclear – the researchers concluded that the service was often perceived to be a low threshold Lived Experience Recovery Organisation drop-in. While valued by many study participants, there seemed to be some variation between different sites and some study participants who described it as

> "*cliquey and unwelcoming*."

Some people had been through the CGL groupwork more than once, as the aftercare services were not felt able to meet their needs and it was felt some people could be entering the peer mentoring pathway as a form of aftercare, which may not be the most appropriate approach.

The relationship between the NDAS hostel and the treatment system seemed confusing for some of the study participants, with people being supported by different agencies.

Safety and wellbeing

Key themes:

- **No concerns raised over safety and confidentiality**

The response to these questions was reassuring. Nobody raised concerns over the safety of the organisations they worked with or had issues with confidentiality. The main concern was:

> *"seeing people you don't want to bump into when you come into the treatment service."*

Joining up drug treatment with other services

Key themes:

- **In general, the join-up between the criminal justice system was viewed as good.**
- **Mental health services was the area with the strongest consensus, with concerns around**
    - **Lack of join-up of mental health and substance misuse services.**
    - **Exclusion criteria and high thresholds for accessing mental health services.**
    - **Keeping appointment times for mental health services in the homeless population**
    - **Difficulties in transitioning from child to adult mental health services.**
- **Social workers were perceived to have a poor understanding of drugs and alcohol.**
- **Potential gap in support for sex workers, although there is now a service in Northampton.**

This section was one of the areas where study participants had the strongest opinions and engendered the most debate. Study participants had mixed views about prison and the criminal justice system, but in general it seemed that the join-up between addiction services and the prison

estate and the community was good. But, many felt that there was a lack of other support, such as housing, benefits and mental or physical health services. With one saying:

> *"I left prison and was homeless, but the drugs stuff was sorted out."*

Others felt they had not been helped with their other needs and one said:

> *"you get more help if you are a MAPPA [i.e. are considered a high risk of harming others] q case."*

Concern over mental health services was the area where there was the strongest consensus among the focus groups. This came up at every group, many of the people in the groups said they had mental health problems and similar concerns were expressed in almost every group. There was a view that that mental health services and drug and alcohol treatment services don't work well together, that mental that services exclude people from treatment if they use drugs or alcohol.

People felt that the threshold for accessing mental health services was too high, with one saying:

> *"you have to be suicidal to get any help"*

Many reported being unable to access support for their mental health, because they didn't meet the criteria. With one saying:

> *"I was told it was my drug use and mental health that led to me losing my kids and then the mental health services said I didn't meet the threshold for help from them".*

Some of the study participants had been admitted to hospital for their mental health problems. There were concerns that mental health services were reluctant to work with people with drug or alcohol problems, even when in treatment and there should be services for less acute mental health problems. As one person said:

> *"there's nothing in the middle."*

Some people had benefitted from contact with MIND.

The group where the participants were homeless felt that mental health services made it difficult for them to get into treatment and they were discharged from treatment if they did not comply with appointments that were difficult for them to keep.

The families and carers' group had a strong view that the transition from children's mental health services (which they had found much more helpful) to adult services had been a real problem for their (now adult) children. They also highlighted the difficulties that their loved ones had complying with treatment requirements and that many had been discharged from treatment for this reason.

There was concern that mental health and treatment services did not talk to each other. Many of the people had been prescribed medication for their mental health by GPs, but this was not discussed with treatment services.

If concerns regarding mental health had the clearest consensus it was child protection services that evoked the strongest emotional reaction, usually from people, mostly women, who had their children taken into care. The main criticisms were that the social workers had a poor understanding of drug or alcohol use – there were many complaints that children had been taken into care unnecessarily. There was concern that parents were not helped when struggling with children, particularly single parents with limited support. Parents who had regained custody of their children

felt they were not trusted by social services and the social workers. They did not feel that the social workers worked with drug and alcohol treatment or mental health services when they did get into treatment.

The street sex workers that we spoke to reported a historical lack of targeted services for them although it should be noted that the S2S street outreach team in Northampton has just recruited a dedicated women's worker.

Gap in treatment services

Key themes:

- **Limited transport from smaller towns and villages creates issues for access to services.**
- **Boundary issues with those with Leicestershire postcodes created access issues for some.**
- **Lack of services tailored for young adults and transition was identified as a concern.**
- **For vulnerable women, there may be a gap a provision of appropriate group service.**
- **Gap in provision for those with multiple, complex needs was identified.**

The lack of outreach services and difficulties in getting into treatment came up in all the groups. In terms of transport many smaller towns and villages have a poor, and worsening, bus service. Several people had long journeys to get treatment and reported difficulties getting in on time for groups. A particular concern was raised at one of the meetings in Corby regarding people from nearby villages in Northamptonshire but with Leicestershire postcodes being asked to go into treatment in Leicestershire. The lack of buses from Towcester was raised in one group. Some people raised a concern that although they lived in Northamptonshire on the border, they were receiving health services from a neighbouring county, and this confused access to drug treatment services which are provided on a county basis.

One of the groups raised concerns about services for young adults, and this was also raised in the group containing family members. This was both in respect of young people moving from children's to adult services and in respect of services specifically for young adults, who may have different patterns of drug use and not find the currents services approachable - though we did interview some young adults in the focus groups.

There was some debate about the balance between individual work with a key worker and group work. While many found groups helpful, some did not, including some women in mixed groups and people with less common types of drug use or personal profiles. Some people found the times the groups were held at made travelling to them difficult.

The physical access to services was a clear issue.

Some of the young people we spoke to had been drawn into gangs and drug dealing, something that was not raised by older people. They also gave evidence of different patterns of drug use, with the use of prescription opiates a particular concern and less likely to be alcohol or heroin users. They echoed the concern regarding transition from children's to adult services and felt that adult services were not always geared for their needs.

The focus groups with homeless people were very well attended and the only sessions organised through a non-specialist drug treatment service. The work of the homelessness outreach team was

well regarded, but there was evidence that some needs (e.g., street sex workers) where services were lacking.

The families in the focus groups were mostly supporting their now adult children. They described long and difficult journey with people with multiple and complex needs of which drug use was only one.

Section 11: Qualitative work - system mapping with professionals and service users

This work was carried out by researchers at the University of Bath and Manchester Metropolitan University on behalf of Change Grow Live and the Public Health teams in North and West Northamptonshire Councils. Over two days of workshops with around 70 local stakeholders, the researchers facilitated sessions based on methods to understand complex systems to help understand harm reduction in the county and to identify opportunities to improve delivery.

The stakeholders were from a wide range of organisations in Northamptonshire including the criminal justice system, NHS providers, local authority, drug treatment and recovery services, social care, the community and voluntary sector and people with lived experience.

Session 1: Understanding the system

The session began with presentations on i) the local context, ii) national context and harm reduction priorities, iii) introduction to systems thinking and overview of the day. Attendees were split into break out groups and participated in two activities:

a) Identifying stakeholders who influence local harm reduction
b) Identifying and discussing key factors that affect local delivery of harm reduction

In both activities, attendees were encouraged to take a 'whole system' approach and to think across socioecological levels (e.g., individual, social, community, societal) about who and what contributes to harm reduction.

Each group created a 'canvas' where they recorded and grouped stakeholders who they believed do, or should, be involved in reducing drug-related harm. This included those involved in drugs services or wider healthcare, and the wider system. They discussed factors that enable or restrict harm reduction delivery across the system and grouped similar factors together. The groups were asked to record what they thought were the key relationships or connections between the factors that they identified.

In the final part of the session, the groups presented an overview of what their group had discussed to all attendees and together debated key points and opportunities to improve the system.

Following the session, the research team analysed the five canvases to create two outputs:

1. A stakeholder map (available online here)
2. Factors affecting harm reduction delivery (available online here)

Stakeholder map

The **stakeholder map** detailed in Figure 76 below included generic roles (e.g., school nurses) and specific roles or organisations (e.g., CGL), and included stakeholders who both could/should and already have a role in harm reduction. Stakeholders were grouped into different categories based upon on type of service or type of support that they provide. The connecting lines link similar

stakeholders together, or connect stakeholders to more than one category. Stakeholder categories were:

- Orange: Social Care including i) safety/ protection for vulnerable people, ii) family-focused services, iii) Welfare services
- Blue: Healthcare services including i) Drugs services, ii) Primary care, iii) Urgent & emergency care, iv) Community healthcare
- Purple: Crime and safety including i) criminal justice system, ii) Community safety/crime
- Green: Community care & support groups
- Red: Sport & lifestyle
- Green: Decision-makers, including i) National bodies, ii) Local leadership
- Brown: People who use drugs
- Yellow: Education/ development

Factors affecting harm reduction

To create the second output of **factors affecting harm reduction delivery** detailed in Figure 77 below, the research team pulled out the factors that were identified by attendees. These were initially grouped into themes (e.g., factors affecting client engagement; characteristics of service staff) and, where appropriate, combined to reduce overlapping or very similar factors. These factors were regrouped into a socioecological framework with levels:

- Yellow: At the centre are individual- and social-level factors relating to people who use drugs, their experiences, and their social networks.
- Green: Factors within services including at the service provider level (light green) and at an organisational level (dark green).
- Blue: The outer layer includes factors at the sector-wide and community level (light blue) and wider national, societal, and cultural level (dark blue).
- Orange circles represent 'themes' in the data across the system. These are presented as opportunities to improve delivery of harm reduction.

Factors are presented 'neutrally'. For example, it was discussed that current high caseloads for service providers act as a limit on time spent with more complex clients: this is included as 'case load levels'.

There was a lack of data recorded on connections between different factors, so these connections are not represented in the output. Some of the links and relationships between components in the output appear logical and apparent however.

Based on analysis of the data, the research team identified eight opportunities to improve delivery of harm reduction in the county. These are recorded around the outside of the image.

Using the outputs

The outputs are intended to help look across the 'big picture' of the whole system, and to support understanding that harm is influenced by multiple factors in multiple parts of the system. While they

are interesting images and provide information that can be used to understand harms and identify opportunities for improvement, the added benefit for reducing drugs-related harms will come through how they are used.

Figure 75: Stakeholder map of harm reduction in Northamptonshire (as at August 2022)

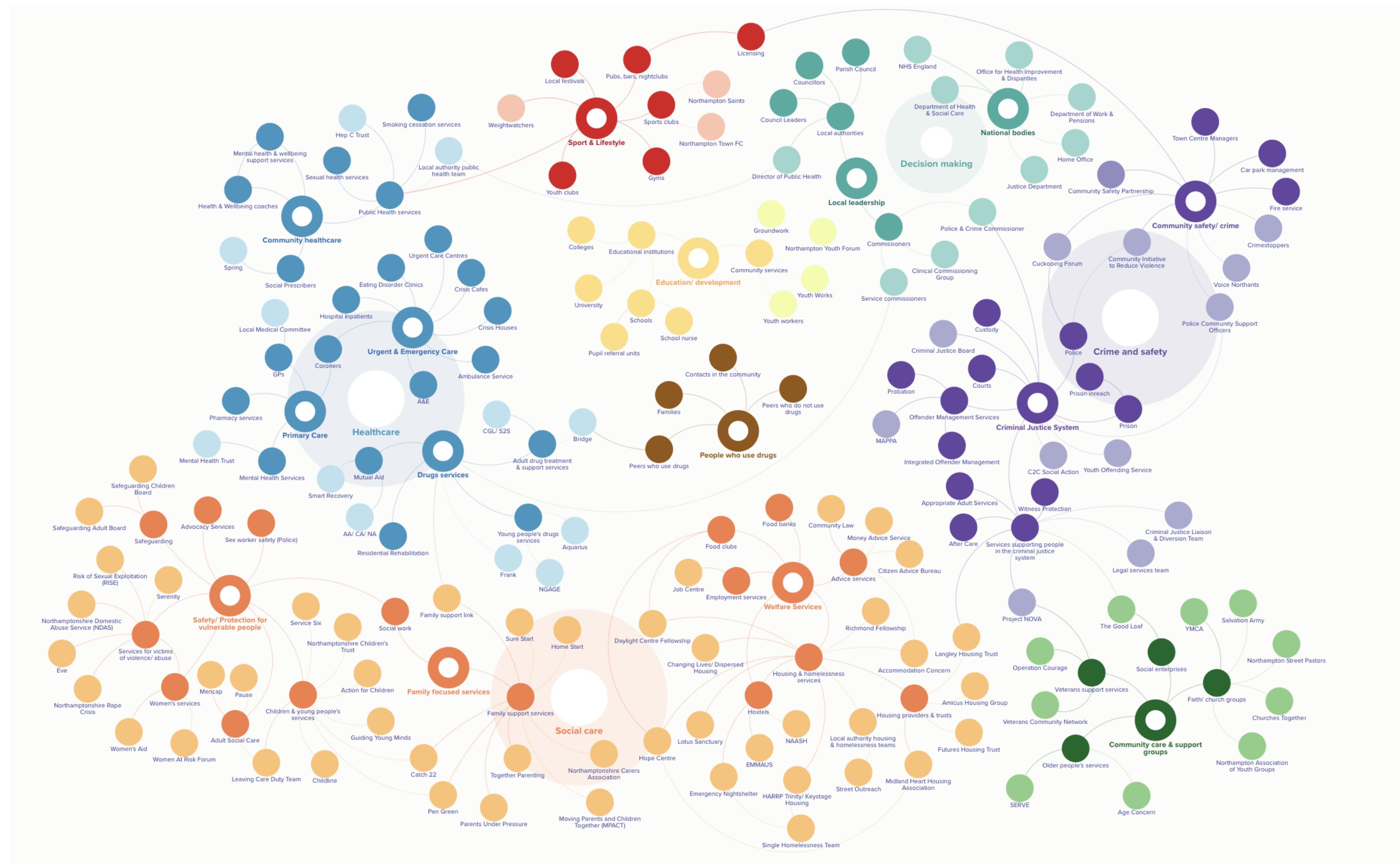
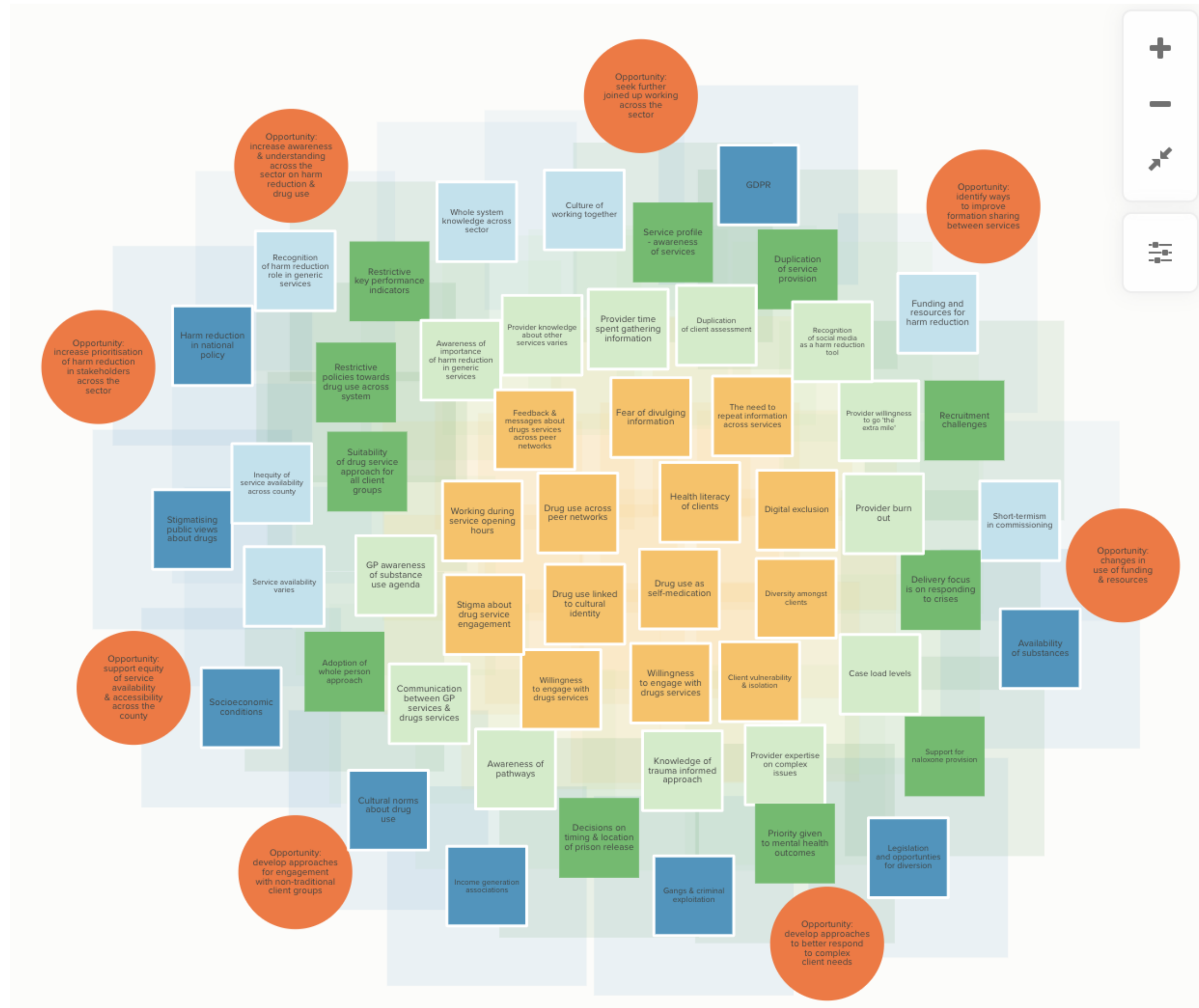


Figure 76: Factors that affect harm reduction delivery (as at August 2022)



Session 2: Opportunities for improvement

Following presentation of the two outputs, attendees discussed in break out groups eight questions based on the 'opportunities' identified during the systems mapping exercise. Approximately 50 stakeholders participated in the discussions, in 6 groups. Each group made notes recording their responses.

Key points were discussed with the whole group in a 30-minute feedback session. The headline points based upon collation of group notes and the feedback session are summarised here, by 'opportunity' theme:

Improving service delivery for clients with complex needs/ trauma

Key ideas to address current gaps in support for clients with more complex needs included the importance of supporting a client-focussed approach and Trauma Informed Care. Training and education were highlighted as needed for staff in all services to support more complex clients (e.g. training on Trauma Informed Care).

Service staff's ability to provide this support was linked with the need to reduce staff caseloads and for more partnership working to help increase time availability and resources available to work this client group.

Establishing a Complex Needs Forum and expanding what already exists with Police/ NHS/ Fire brigade to bring together expertise on these issues.

Funding & resource needs

There was support for more collaborative funding approaches and collaborative service provision, for example sharing of funding between services, bringing commissioners together to develop joint strategies, bringing together where drug services and mental health services sit to reduce duplication of work and lack of funding.

The payment by results model was not generally supported. There were calls for longer contracts, lower caseloads, and sustained recruitment approaches.

It was recommended to consider funding dedicated bid writers to reduce pressure on staff and increase likelihood of successful funding bids.

Improve equitability of harm reduction provision across the county

Recognising that provision of services was thought to vary on a county level and that services are less accessible for some members of the local population, a range of ideas were highlighted including:

- Undertaking a review of all community and voluntary services to see what each service provides, geographical coverage, what the gaps are, and how they can work together better.
- Working with senior management/ leadership to ensure commitment to harm reduction in generic services. This commitment was suggested to vary currently.
- Improving mobility access in all buildings across county as some were suggested to be unfit for purpose and risks excluding some of the population.

- Training for staff to reduce stigma and unconscious bias. This reflected that in some services and some parts of the county stigma and negative attitudes were felt to be a barrier to engagement more than in other parts, possibly due to individuals within services and historical factors.
- Increasing opportunities for clients to express their opinions and provide feedback on experiences to improve understanding of gaps in the system and where needs are being met/not met. One example was an online 'Ideas Board' that anyone can add to. It was highlighted that this needs to be easy to access and use.
- Providing more accessible services outside of the Monday-Friday 9-5 model, particularly to reach groups for whom that model does not suit e.g. full time workers.

Increasing prioritisation & awareness of harm reduction

These two themes are combined here due to commonality in responses. These responses were linked to other themes, in particular through the role of leadership and partnership working. Training & education in harm reduction was commonly suggested to be needed for generic services, including a focus on reducing stigma around drug use and harm reduction. The use of case studies in this training were highlighted as useful to demonstrate the importance of harm reduction and how different services outside of drugs service can have a critical role in reducing drug-related harms. It was recommended that ideally harm reduction should be thought of similarly to how issues such as safeguarding are considered. Additional suggestions included:

- Focus on partnership working and building relationships between substance use services and other services to improve knowledge and understanding in generic services.
- Dissemination of up to date and engaging literature/ information that promotes harm reduction. It was suggested that it would help if 'one voice' locally was promoting these issues to reduce confusion and establish credibility.
- Awareness raising to the public was also discussed, for example through local media campaigns to reduce stigma around drug use and to increase awareness of support and services available.

Engaging with client groups who are less engaged currently

Specific groups where more engagement was highlighted as needed included: rough sleepers, sex workers, females, non-English speakers, steroids, spice & chemsex clients, LGBT populations, young people, prison leavers, mental health clients. Suggested approaches to do this included:

- Advertising on, and better use of, social media informed by people with lived experience.
- Working more people with lived experience from the groups highlighted above, and bringing them in to decision-making meetings to break down barriers and ensure their experience reaches leadership.
- Mobile units and 'going out to people' rather than waiting for them to come in e.g. outreach in gyms to engage with people who use anabolic steroids.
- Development of literature accessible to non-English speakers and targeting specific groups, again co-produced by people with lived experience. I

Improving information & data sharing

This issue was highlighted as important to prevent the same traumatic questions being repeated across services, and to reduce staff time collecting data. Shared records were discussed, but a joint system across organisations was not supported as a solution. Several recommendations were made, including:

- Establishing client "Passports" with details such as key information about clients, their needs, and the care they received. A "Recovery passport" was discussed as supporting autonomy for more complex clients.
- Developing partnership agreements on data sharing.
- Identifying key contacts in different services and dissemination of this so that staff know who to contact.
- Training for staff on GDPR and possibilities for data sharing, to reduce confusion around what is allowed and what is possible within current legislation and guidance.
- Increasing partnership working in general to increase ease of information sharing

Supporting joined up working

Further improvements to joined up working across the county were anticipated to result from the implementation of many of the above recommendations above were met.

In addition to points described previously, the role of senior leaders was discussed relating to joined up working. Bringing together leadership from different organisations regularly to discuss common issues was recommended as important to support joined up working, establishing a culture of working together, and developing shared expectations around harm reduction awareness and prioritisation.

Harm minimisation agreements across services to establish expectations and norms were anticipated to support joined up working. Similarly, training for generic services on harm reduction and their role in the system were anticipated to have knock-on effects on awareness around the importance of, and opportunities for, working with partners across the local system.

Section 12: What works to prevent or treat substance misuse

National guidelines have been published to inform practice of Local Authorities, the NHS and other providers in prevention and treatment of young people and adults with substance misuse. The recommendations in this report have drawn on many of these. It should be noted that in preparing this needs assessment, a comprehensive review of the literature was not undertaken and further evidence on specific topics will be required. The evidence base is evolving continuously and should be reviewed regularly to assess against current practice.

Overview

The Office for Health Improvement and Disparities (formerly Public Health England) and National Institute for Health and Care Excellence (NICE) have produced evidence-based guidance and examples of best practice in relation to substance misuse.

- OHID. Collection. Alcohol and drug misuse prevention and treatment guidance. Published 20 December 2017. This includes links to guidance on treatment, screening, dual diagnosis, hospital patients, parental substance misuse, prevention and service improvement.

- NICE has produced 6 guidance and 2 quality standards in relation to alcohol prevention and treatment.

- NICE has produced 8 guidance, 6 advice, 2 quality standards and 2 technology appraisals in relation to drug misuse. Links to shared learning in relation to alcohol and drug screening, co-existing mental health and substance misuse in older people are on this site.

- Local Government Association provides over 70 case studies of innovative substance misuse programmes run by local councils.

Alcohol

NICE has produced guidelines aimed at preventing and treating harmful drinking and alcohol dependence.

- NICE Clinical guideline [CG115] Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence. 23 February 2011
- Public health guideline [PH24] Alcohol-use disorders: prevention. Published: 02 June 2010
- NICE Clinical guideline [CG100] Alcohol-use disorders: diagnosis and management of physical complications. Published: 02 June 2010
- RCGP, Alcohol Concern, Drugs Scope, and RCP. Practice standards for young people with substance misuse problems. RCGP 2012.

Drugs Misuse

NICE and the UK government Health Departments have produced guidelines aimed at preventing and treating harmful drinking and alcohol dependence.

- Department of Health and Social Care. Drug misuse and dependence: UK guidelines on clinical management. Published 17th July 2017

- NICE guideline [NG64] Drug misuse prevention: targeted interventions. Published: 22 February 2017

- NICE Public health guideline [PH52] Needle and syringe programmes. Published: 26 March 2014

- NICE Clinical guideline [CG52] Drug misuse in over 16s: opioid detoxification. Published: 25 July 2007

- NICE Clinical guideline [CG51] Drug misuse in over 16s: psychosocial interventions. Published: 25 July 2007

Substance misuse and mental health

NICE guidelines and quality standards to address co-exiting mental health and substance misuse detail the need for a co-ordinated, multi-disciplinary approach to planning care and supporting recovery for young people and adults.

- NICE Guideline [NG 58] Co-existing severe mental ill health and substance misuse: community health and social care health. Published: November 2016

- Clinical guideline [CG120] Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings. Published: 23 March 2011

- NICE Quality Standard [QS188] Co-exiting severe mental ill health and substance misuse. Published: 20 August 2019

Public Health England guidance emphasises the principals of “no wrong door” and “everyone’s job” and recommends a framework for delivery of care.

- Public Health England. Better care for people with co-occurring mental health and alcohol/drug use conditions. A guide for commissioners and service providers. June 2017.

Parents with substance misuse

- Public Health England. Parents with alcohol and drug problems: adult treatment and children and family services. Published: 10 May 2021

- Institute for Social Research and Innovation. Parental substance misuse and social worker intervention. 17 November 2017

- Public Health England. Addressing the impact of nondependent parental substance misuse upon children. A rapid review of the evidence of prevalence, impact and effective interventions. April 2018.

Adverse Childhood Experiences

- Di Lemma L.C.G., Davies A.R., Ford K., Hughes K., Homolova L., Gray B. and Richardson G. (2019). Responding to Adverse Childhood Experiences: An evidence review of interventions to prevent and address adversity across the life course. Public Health Wales, Cardiff and Bangor University, Wrexham.

- Early Intervention Foundation. Adverse childhood experiences: What we know, what we don't know, and what should happen next. Published: 26 February 2020.

- NIHR Collection. Adverse Childhood Experience: what support do young people need? Published: 8 June 2022.

Substance misuse in pregnancy

- NICE Clinical guideline [CG110] Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors. Published: 22 September 2010

- BMA. Alcohol and pregnancy. Preventing and managing foetal alcohol disorders. June 2007 (updated February 2016)

- British Association for Psychopharmacology. Consensus guidance on the use of psychotropic medication preconception, in pregnancy and postpartum. 2017

- World Health Organization. Guidelines for the identification and management of substance use and substance use disorders in pregnancy. 2014

Housing and homelessness

The ACMD published evidence-based recommendations for statutory sector organisations to reduce the harms from drugs in the homeless populations.

- Advisory Council on the Misuse of Drugs. Drug related harms in the homeless population and how they can be reduced. 19 June 2019.

- Carver, H., Ring, N., Miler, J. *et al.* What constitutes effective problematic substance use treatment from the perspective of people who are homeless? A systematic review and meta-ethnography. *Harm Reduction Journal* **17**, 10 (2020)

- Miler J.A., Carver H., Masterton W., Parkes T., Maden M., Jones L., Sumnall H. What treatment and services are effective for people who are homeless and use drugs? A systematic 'review of reviews'. PLoS One. 2021 Jul 14;16(7)

Prisons and secure settings

- OHID. Collection. Public Health in Prisons and Secure Settings. Published 27 May 2014

Social work

- Manchester Metropolitan University. Alcohol and other drug use. The roles and capabilities of social workers. March 2015.

Section 13: Recommendations

Breaking drug supply chains

1. **Targeted community intervention to better understand the workings of gangs, drug lines and County Lines operating within the County and prevent further recruitment of young and/or vulnerable nominals.**

   Intervention at schools to prevent recruitment at a young age, with schools where drugs exclusions are high being prioritised. Partnership work including with UoN, OPFCC and CIRV to continue developing lesson plans to educate on gangs, violence and drugs harm. Improve community intelligence submissions to aid understanding of emerging risk groups/gangs

2. **Continued engagement with Partners, providing support and training to encourage community intelligence submissions.**

   Offer training and support to all partners to ensure understanding of the Proactive Crime and Intelligence Function and signs of drugs exploitation to improve intelligence submissions. Ensure all Designating Safeguarding Leads at Northants Schools have a Police contact and access to the Partnership Intelligence Submission Forms. Retain police presence at partnership meetings and forums, including Community 1. Consider intelligence gaps as a standing agenda at Community 1 and other relevant joint meetings, with the Chair to review and group to devise collaborative solutions regrading barrier to intel submissions.

3. **Encourage the use of appropriate ancillary orders, including SCPOs, DDTROs and Slavery & Trafficking Prevention Orders, to disrupt criminal activity of OCGs/Violent groups.**

   Positive media campaigns to be circulated once orders are approved to generate wider public knowledge. Collaborative working with partners to generate more information to support applications of orders.

4. **Reassess the intelligence sharing within the Partnership to gain a better understanding of nominals and locations involved in drug supply and production as well as early intervention and prevention.**

   Improve intelligence sharing between Police and Partners with continued efforts to increase the use of Partnership Intelligence Forms. Intelligence development to understand the nominals and organisations involved in firearms and drug criminality to prevent serious, violent crime.

5. **Targeted intervention in the Town Centres to disrupt nominals using recreational drugs in the night time economy.**

6. **The Government's 10 year Drugs Plan identifies reducing recreational drug use as a priority, with future sanctions to be introduced as consequences. Proactivity during high risk times in Town Centre locations would allow for disruption opportunities to remove**

supply of recreational drugs from circulation, while also providing the opportunity to protect vulnerable persons from harm caused by drug usage combined with alcohol. Use innovative ways of remaining engaged with the Western Balkan communities within Northamptonshire to prevent, disrupt and protect those involved in drug criminality.

Community engagement days in Western Balkan Communities to allow NPT to build positive relationships with individuals, to better understand the lifestyle and generate reliable streams of intelligence.

7. **Work collaboratively as a Partnership to tackle County and Local Drug Lines and protect vulnerable youths/adults from exploitation, cuckooing and harm. Utilise the knowledge and expertise of internal and partner contacts to determine suitable early intervention techniques to reduce drug use and supply in young people.**

   Close work with Partners including Social Services to inform a holistic overview of risk nominals. Consistent data and intelligence sharing between all police and partner systems to improve data quality and collective response to threat, risk and harm.

Delivering world class treatment and recovery services

1. **Improve treatment for those with both mental ill health and substance misuse.**

   Addressing the needs of those with dual diagnosis is a high priority for stakeholders. Concerns were raised in the lack of join up of mental health and substance misuse services, exclusion from services of those with dual diagnosis, high thresholds and provision for vulnerable groups entering mental health services.

   The data showed that in Northamptonshire, those newly entering specialist treatment services were less likely to have access to specialist mental health services compared to other areas. Increased prevalence of mental health issues resulting from the pandemic are contributing to increased needs. Locally, levels of self-harm and suicide in those with problematic substance misuse are high.

   Organisations in Northamptonshire need to ensure there is 'no wrong door', underpinned by development and implementation of referral pathways and ongoing collaboration between services. This recommendation applies to both adults and young people's services.

   Specific recommendations are:

   - Complete and implement the dual diagnosis policy and pathway.
   - Continue to build collaboration and information sharing on individuals between mental health support and treatment services.
   - Consider increased support for those with lower-level mental health issues and more flexible access for the homeless population in relation to appointment times.

2. **Increase the capacity of specialist treatment and recovery services, addressing the increasing complexity of cases.**

   There continues to be a high level of unmet need for treatment in Northamptonshire, particularly for alcohol, and this has remained unchanged over time. Cases are becoming more complex, with the pandemic contributing to increased trends of more problematic substance misuse Stakeholders report the increasing complexity of cases, with lack of capacity and skills in certain areas contributing to high caseloads and provider burnout.

   Service provision needs to be expanded to address the unmet need and complexity. Regional and national collaboration on care pathways for complex cases may be beneficial. Supporting a more client focused approach and Trauma Informed Care and establishing a Complex Needs Forum would help.

3. **Improve the promotion and branding of treatment services to make them more visible and acceptable to those in need. Develop clear referral pathways for professionals.**

   Access to adult treatment services in Northamptonshire is more reliant on self-referrals and the Criminal Justice System compared to other areas. Comparatively few referrals come from health and social care. Stakeholders identified a lack of awareness among professionals of treatment services and missed opportunities for earlier referral, particularly from primary care. Stakeholder felt knowledge of services in the community was low and there were some negative messages about services. Stigma related to service users remains an issue.

   There needs to be a consistent approach to promoting treatment services among professionals and in local communities, with credible messages in the community as well as digital platforms. Clear referral pathways, particularly across health and social care, are required. Tailored messaging to reduce the stigma of services would improve acceptability.

4. **Address the geographical access and improve access for clients who are less engaged currently.**

   Delivery of services is focused on the main towns in Northamptonshire. Stakeholders identified concerns about under representation in services of certain groups, the lack of assertive outreach and transport issues impacting on more rural areas. Issues with the timing of services in relation to release from prison was noted. Data indicates that disabled groups are under-represented in treatment services and some ethnic groups may be under-represented.

   Our stakeholder provided feedback that more engagement was needed with other groups, including rough sleepers, sex workers, females, non-English speakers, steroids, spice & chemsex clients, LGBT populations, young people, prison leavers, mental health clients.

   Services need to work proactively with local communities to improve equity of access. New approaches delivering and engaging with communities are being established within the ICP's Place work programmes and Primary Care Networks could provide opportunities for

geographical coverage. Further work with communities less engaged to determine needs will be required.
Specific recommendations are:

- Address issues impacting on access for disabled groups including physical access to buildings and those who are neurodivergent.
- Improve engagement and co-production to continuously improve and tailor services for under-represented groups.

5. **Earlier identification, support and treatment of those with problematic substance misuse.**

Compared to other areas, many of those entering treatment services in Northamptonshire present higher levels of dependency for alcohol which is more difficult to treat. Stakeholders and service users told us access to services is often triggered by a crisis with missed opportunities for brief intervention and early intervention for less complex cases. Primary care and social care were often mentioned, where it was felt that there was a lack of awareness of drugs and alcohol and understanding of individuals' situations.

A structured, evidence-based approach to identifying cases in non-specialist settings, particularly in primary care, social care and services addressing other related risky behaviours, e.g., sexual health and smoking. Implementing trauma-informed approaches across services would support this recommendation and is a priority for stakeholders.

6. **Improve provision for young adults, including the transition for young people moving to adult substance misuse services.**

Over time, fewer young people are entering drug treatment services in Northamptonshire at a time of rising levels of drug use in young adults. Hospital admissions due to substance misuse in those aged 15-24 remain significantly higher than the England average. Stakeholders have reported the transition experience from young people to adult services is often poor.

Services need to be developed to meet the age group, with young people involved in designing services and the processes around transition.

7. **Address areas in treatment and recovery where outcomes could be improved, and where the service offer is unclear.**

Effective recovery services are vital for the long-term sustainability of harm reduction or abstinence. While there was positive feedback for those in recovery, professionals and service users were often unclear on the routes to accessing service. Service users reported a lack of clarity on the care and treatment plan. A more detailed review of the service offer for recovery is needed, including acceptability of the services and clarity on routes of referral into service.

While the outcomes for drug treatment are in line with the national trend, outcomes for alcohol treatment have been lower than England for several years. Comparatively high

dropout rates in adult services may reflect the complexity of the cases being seen in treatment locally but may also require further investigation.

8. **Continue to strengthen the harm reduction offer provided by specialist treatment services, and knowledge of harm-reduction in other organisations.**

   Many of those with substance misuse will never achieve abstinence, but their outcomes can be improved by harm reduction. There have been significant improvements in harm reduction provision in recent years, particularly in relation to testing and vaccination of blood borne viruses and provision of naloxone. Stakeholder feedback indicated that this work programme remains a high priority. There remain gaps in specialist provision in relation to provision of some harm reduction equipment. The cohort of opiate users is ageing, with increased risk of ill health from other conditions.

   Priorities include improving knowledge and skills of staff in non-specialist services in relation to harm reduction. A holistic approach is needed to addressing health needs particularly in the older age group; further work to scope this is required.

Achieving the shift in generational demand for drugs

1. **Support children and young people at high risk of problematic substance misuse to break the generational cycle, particularly those with adverse childhood experiences.**

   A high number of adults with problematic substance misuse have experienced trauma in their early years. Those who have multiple adverse childhood experiences (ACEs) such as parents with severe mental ill health and domestic violence are particularly at risk.

   Young people experiencing ACEs need to be supported to build resilience, local solutions need to draw on the rapidly emerging evidence base for effective interventions.

2. **Starting before birth and focusing on the early years, supporting the most vulnerable parents.**

   Supporting parents to have healthy pregnancies and positive parenting is one of the most effective ways to break the generational cycle. Many babies in Northamptonshire are born suffering from the immediate effects of drugs and alcohol. Many more will experience neglect, injuries and emotional distress in early childhood. Provision was not examined in detail in this needs assessment, so gaps are unknown. There is good evidence to support interventions in maternity services and parenting programmes. Further work is necessary to identify any gaps in provision and the need for a co-ordinated approach across Northamptonshire.

3. **Healthy communities and settings (schools and workplaces) will protect the next generation from substance misuse.**

Preventing substance misuse cannot rely solely on providing support to individuals. Factors including community cohesion, safe environments and sense of belonging can protect against substance misuse. Communities know the local problems and potential solutions. The system mapping identified many community and voluntary organisations already engaged with their local communities on substance misuse. Working with the newly established Local Area Partnerships may provide a mechanism to take this forward.

Schools and workplaces play a vital role in raising awareness of substance misuse and having supportive polices in place to reduce risk.

There is potentially more we can do to protect people with housing solutions**.** At the point of entering services, a high proportion of services users locally have an urgent need meaning they are living on the streets, use night shelters or sofa surf. Local rates of urgent housing need continue to be higher than England. This is particularly the case for young adults and those on opiates. This is likely to contribute to the complexity of cases.

Cross cutting recommendations

Three main cross-cutting recommendations were identified throughout in the process of developing the needs assessment. These need to be considered alongside the specific recommendation above.

1. **Strengthening stakeholder relationships and collaboration between services**

   Throughout this process, we heard that services were run in isolation, with organisations often unaware of each other, creating silos and duplication. It was viewed that in Northamptonshire we lack a culture of cross sector working. The systems mapping identified many organisations involved in this work and links between them. A change in one (positive or negative) will have an impact on others across the system.

   Providing more opportunities for networking will address this and is likely to lead to a generation of interagency solutions. A local directory of services would be beneficial. Bringing services and commissioners together to develop strategies and approaches would reduce duplication and address lack of funding.

2. **Pooling intelligence, working towards real-time surveillance to improve the agility. Improve information and data sharing for clients.**

   This process has involved collection of routine data from national datasets and many local agencies in Northamptonshire. However, there are gaps in our knowledge, issues of timeliness, quality and lack of join up of intelligence (quantitative and qualitative). Local organisations told us that difficulty sharing information on individuals hampers response.

   Partners in the system should work towards developing a systematic approach to sharing of intelligence, using real time intelligence, and addressing the gaps. We need to move to a position where needs are better understood, and we can assess the impact of an emerging problem or intervention across the system. Addressing barriers to sharing information on

individuals should be part of the solution. Links to academic partners will help with this.

For clients, repetition of information is timewasting and can be traumatic. Suggestions include establishing client "Passports", developing partnership agreements on data sharing, GDPR training for staff and increasing partnership working.

3. **Strengthening workforce planning across the system.**

   All these recommendations are reliant on the knowledge, skills and capacity of our workforce. Stakeholders told us that recruitment for specialist staff is increasingly challenging in a tight labour market, staff are burnt out, and workloads are high. Non-specialist services are equally pressured with multiple competing demands.

   Our work needs to be underpinned by effective workforce planning across the sector, addressing the gaps in capacity, training and development needs. Links to the local education providers to support this work and build capacity locally would be beneficial. Plans need to address the leadership as well as operational delivery.

Section 14: Intelligence Gaps

There are gaps in the needs assessment in relation to specific areas. Views of some professional groups, including those in working in primary care and social care. More detailed work will be required to understand in more detail needs of some of the most vulnerable, particularly children and young people and ethnic minority groups who were underrepresented in the qualitative work. Detailed analysis of some areas of the service delivery would be beneficial, including an understanding of equity of access to harm reduction services and more understanding of the support for employment (excluding opportunities within substance misuse services). Local prevalence data is lacking for both drugs and alcohol, except for young people. Consideration of a lifestyle survey in Northamptonshire to understand attitudes and levels of alcohol consumption in adults could be considered.

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[i] https://onlinelibrary.wiley.com/doi/full/10.1111/cfs.12795
[ii] https://www.childrenscommissioner.gov.uk/chldrn/
[iii] Adverse childhood experiences | NIHR Evidence
[iv] Adverse childhood experiences and adolescent drug use in the UK: The moderating role of socioeconomic position and ethnicity - ScienceDirect
[v] https://committees.parliament.uk/committee/136/scottish-affairs-committee/news/102748/adverse-childhood-experiences-and-mental-health-are-drivers-of-drug-use-mps-told/
[vi] e036374.full.pdf (bmj.com)
[vii] https://bmjopen.bmj.com/content/8/12/e020591
[viii] https://www.communitycare.co.uk/2021/01/28/alarmingly-weak-evidence-base-toxic-trio/
[ix] Safeguarding children affected by parental substance misuse: developing parenting interventions to support non-using parents - NIHR School for Public Health ResearchNIHR SPHR
[x] https://pilotfeasibilitystudies.biomedcentral.com/articles/10.1186/s40814-017-0138-7#:~:text=LAC%2C%20aged%2011%20to%2019,not%20looked%20after%20%5B22%5D.
[xi] https://bmcmedresmethodol.biomedcentral.com/articles/10.1186/s12874-019-0674-3
[xii] https://explore-education-statistics.service.gov.uk/data-tables/school-pupils-and-their-characteristics#subjectTabs-createTable

[xiii] https://explore-education-statistics.service.gov.uk/data-tables/school-pupils-and-their-characteristics#subjectTabs-createTable

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