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Date: 11 July 2012

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HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL

Date: Thursday 19 July 2012
Time: 2 pm
Venue: Warspite Room, Council House

Members:
Councillor Mrs Aspinall, Chair
Councillor Monahan, Vice Chair
Councillors Mrs Bowyer, Fox, Gordon, James, Dr. Mahony, Mrs Nicholson, Parker, Jon Taylor and Tuffin.

Members are invited to attend the above meeting to consider the items of business overleaf.

Members and officers are requested to sign the attendance list at the meeting.

Bob Coomber
Interim Chief Executive

HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL

AGENDA

PART I – PUBLIC MEETING

1. APOLOGIES

To receive apologies for non-attendance by panel members.

2. DECLARATIONS OF INTEREST

Members will be asked to make any declarations of interest in respect of items on this agenda.

3. MINUTES (Pages 1 - 8)

The panel will be asked to confirm the minutes of the meeting on 21 June 2012.

4. CHAIR'S URGENT BUSINESS

To receive reports on business which, in the opinion of the Chair, should be brought forward for urgent consideration.

5. TRACKING RESOLUTIONS AND FEEDBACK FROM THE OVERVIEW AND SCRUTINY MANAGEMENT BOARD (Pages 9 - 20)

The panel will monitor progress on previous resolutions.

6. RECOVERY PATHWAYS (MENTAL HEALTH SERVICES) (Pages 21 - 36)

The panel will consider a consultation document on changes to mental health recovery pathways.

7. ALCOHOL PLAN (Pages 37 - 72)

The panel will consider a draft of the Strategic Alcohol Plan.

8. DEMENTIA STRATEGY (Pages 73 - 82)

The panel will receive a Dementia Strategy Action Plan.

9. WORK PROGRAMME (Pages 83 - 84)

The panel will consider the work programme.

10. EXEMPT BUSINESS

To consider passing a resolution under Section 100A (4) of the Local Government Act 1972 to exclude the press and public from the meeting for the following item(s) of business on the grounds that it (they) involve(s) the likely disclosure of exempt information as defined in paragraph(s) of Part 1 of Schedule 12A of the Act, as amended by the Freedom of Information Act 2000

PART II (PRIVATE MEETING)

AGENDA

MEMBERS OF THE PUBLIC TO NOTE

that under the law, the Panel is entitled to consider certain items in private. Members of the public will be asked to leave the meeting when such items are discussed.

11. HEALTHWATCH SPECIFICATION (E3) (Pages 85 - 94)

The panel will consider the developing Healthwatch specification for feedback to commissioners.

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Health and Adult Social Care Overview and Scrutiny Panel

Thursday 21 June 2012

PRESENT:

Councillor Mrs Aspinall, in the Chair.
Councillor Dr. Mahony, Vice Chair.
Councillors Mrs Bowyer, Fox, Mrs Pengelly (substituting Councillor Monahan), Gordon, Mrs Foster (substituting Councillor Mrs Nicholson) James, Parker Jon Taylor and Tuffin.

Co-opted Representatives: Sue Kelley, Local Involvement Network (LINk)

Apologies for absence: Councillors Monahan and Mrs Nicholson

Also in attendance: Dr Alex Mayor – Clinical Director (Plymouth Hospitals NHS Trust), Steve Waite - Chief Executive (Plymouth Community Healthcare (PCH)), Liz Cooney - Deputy Chief Executive (PCH), Angela Saxby – Governance Manager (PCH), Mr David Morris and Mr Andrew Bogle (Express Diagnostics), Debbie Butcher – Commissioning Manager (Plymouth City Council (PCC)), Craig McArdle – Commissioning Manager (PCC), Giles Perritt – Lead Officer (PCC), Ross Jago – Democratic Support (PCC)

The meeting started at 3.00 pm and finished at 6.05 pm.

Note: At a future meeting, the committee will consider the accuracy of these draft minutes, so they may be subject to change. Please check the minutes of that meeting to confirm whether these minutes have been amended.

1. TO NOTE THE APPOINTMENT OF CHAIR AND VICE CHAIR

The panel noted the appointment of Councillor Mrs Aspinall as Chair and Councillor Monahan as Vice Chair for the municipal year 2012 – 2013.

Due to apologies submitted by Councillor Monahan, Councillor Dr Mahony was nominated as Vice-chair by Councillor Mrs Bowyer and seconded by Councillor James.

2. APOLOGIES

Apologies were submitted from Carole Burgoyne (Director for People) and Pam Marsden (Assistant Director for Joint Commissioning and Adult Social Care). It was reported by the chair that the officers were joining the portfolio holder and Councillor Grant Monahan at the Municipal Journal awards ceremony, where they had been shortlisted for the 'Redefining Quality in Adult Services' award.

Some members of the panel expressed disappointment that another Assistant Director was unable to attend.

3. **DECLARATIONS OF INTEREST**

The following declarations of interest were made in accordance with the code of conduct –

Name	Minute number and issue	Reason	Interest
Councillor Dr Mahony	10. Quality Accounts	Locum General Practitioner	Personal
Councillor James	10b. PHNT Quality Accounts	Family member experienced a never event.	Personal and Prejudicial
Councillor Mrs Aspinall	10a. Express Diagnostics	Service User	Personal
Sue Kelley	General	CQC Representative	Personal
Councillor Mrs Bowyer	9. Adult Social Care – Local Account	Son is a member of the Learning Disability Partnership Board	Personal

4. **APPOINTMENT OF CO-OPTED REPRESENTATIVES**

Following a brief debate on the appointment of co-opted representatives the panel agreed –

1. to reappoint Sue Kelley of Plymouth Local Involvement Network as a co-opted representative to the panel for the municipal year 2012 – 13;

2. that further co-opted representatives would be appointed on an ad-hoc basis.

5. **MINUTES**

Agreed the minutes of the meetings held on 7 March and 4 April 2012.

6. **CHAIR'S URGENT BUSINESS**

There were no items of Chair's urgent business.

7. TERMS OF REFERENCE

The lead officer reported that the panel's terms of reference had been amended to reflect recent legislative changes.

Agreed to commend the amended terms of reference to the Overview and Scrutiny Management Board for approval.

8. TRACKING RESOLUTIONS

The lead officer provided the panel with an update following the meeting of the 4 April 2012 resolution 74 (1,2,3,4), regarding the demerger of the Peninsula College of Medicine and Dentistry. The Leader and Chief Executive in consultation with the leader of the opposition were considering the representation to the Secretary of State and further information would be provided to the panel.

9. ADULT SOCIAL CARE - LOCAL ACCOUNT

Craig McArdle and Debbie Butcher, Commissioning Managers from Adult Social Care, updated the panel on the development of a local account. It was reported that –

(a) the coalition government has moved away from inspection regimes and scored judgments, including the abolition of the Annual Performance Assessment for Adult Social Care;

(b) in the place of inspection regimes, a Local Account would be self-assessed and published by the council and there would be no central Government role the assurance of the document;

(c) local authorities have been encouraged to develop a Local Account for 2011 recent, Association of Directors of Adult Social Services (ADASS) guidance has suggested that all councils with social care responsibilities consider producing a short, accessible local account during 2011/12;

(d) the Government had signaled that it did not intend to specify the content of a Local Account and that the account should be locally designed;

(e) the process of producing a Local Account should be linked to the wider corporate business planning cycle. It is proposed that the Local Account would be published during July/August of each year, which allows sufficient time for information to be gathered and validated;

(f) there was no prescribed method of approval or formal reporting for a Local Account, but initial guidance from ADASS suggests that Local HealthWatch would have a role in signing off the report.

In response to questions from members of the panel it was reported that –

(g) the account was aimed at service users, carers, professionals and the general public;

(h) there was an action plan with regard to surveying the views of those with physical, mental and learning disabilities. The department continually looked at new ways to engage. There was a learning disability partnership board in place and more users were being invited to sit on that board and challenge commissioners on their decisions;

(i) about 900 adults with disabilities were in the care or the local authority, many in residential care. Around 80 people were supported in paid employment and the department planned to increase this in the future. The department was also working with assistive technologies and solutions for transport to increase access to employment opportunities;

(j) the Plymouth Online Directory was an easy service to update and cost effective;

(k) the department spent less then average on individual care. However this reflected a combination of a number of different factors including unit costs for services. The figure did not include services provide by the department through other areas such as the Life Centre and libraries. The reported figure relied on a narrow focus on care packages;

(l) all feedback received through the system was reflected in the number of complaints and compliments;

(m) the target to achieve 60% of users on personal budgets was 60% for 2011-12. This target was not reached. The department plans to have the remainder of service users, if appropriate, on the personal budgets by April 2013.

The panel agreed to recommend that –

(1) the document is provided as "easy read", accessible to those with disabilities and those who do not use English as a first language;

(2) the Department will provide action plans regarding indicators 146 and 150 for distribution amongst panel members;

(3) the Health and Adult Social Care Overview and Scrutiny panel is added to the list of consultees within the document;

(4) the website address for the Plymouth Online Directory is added to the document;

(5) the final Local Account would be presented at a future meeting of the panel.

10. **QUALITY ACCOUNTS**

10a EXPRESS DIAGNOSTICS

Mr Andrew Bogle and Mr David Morris of Express Diagnostics introduced their Quality Accounts and an overview of services by the company.

In answer to questions from members of the panel it was reported that –

(a) the company hoped to expand into out-patient cardiac services in the future. The company would also be looking to expand services into the community and outside of the Plymouth boundary;

(b) the company believed that analytic services could be more efficiently provided by the private sector, allowing primary care services to receive analysis in a timely manner and make more appropriate referrals;

(c) most patients referred to the service would wait ten working days for an appointment;

(d) there was a 50% return on patient satisfaction questionnaires. The company would further develop the questionnaires to ensure that information could be gained from those with disabilities and those who do not have English as a first language;

(e) the company hoped that investment made into an 'image exchange portal' would increase the efficiency of the exchange of analytical information between organisations.

The panel were impressed by the level of service and results produced by Express Diagnostics. Although there was more work to be done in ensuring satisfaction information could be collected from all patients, the panel welcomed the private investment into the city and the contribution being made to the city's growth aspirations particularly in the medical sector.

The panel agreed -

(1) to recommend that Express Diagnostics add reference to Plymouth, the city's visions and priorities within the document;

(2) to delegate the preparation of a statement for inclusion in the quality account to the lead officer in consultation with the Chair.

10b PLYMOUTH HOSPITALS NHS TRUST

Dr Alex Mayor, Clinical Director of Plymouth Hospitals NHS Trust (PHNT), introduced the Quality Account and an overview of the services provided by the trust.

In response to questions from members of the panel it was reported that –

(a) never events were events caused by healthcare that should never happen. There are safeguards to ensure they never happen but when they did, it was important that they are acted upon. A number of previous events experienced in the trust were due to negligence around the World Health Organisation surgery checklist. Work has taken place to address this and the trust had been shortlisted for a prize for the safety of patients. Significant improvements have been made and trust is now a beacon of best practice;

(b) the trust had experienced problems with ophthalmic services. Additional resource had been provided to address this and reduce risk to patents. There had been a host of issues around administration and communication, but being a large organisation was not an excuse for not getting these things right. A review of the entire clinical administration service, including public facing clinicians had been commissioned. The priority continued to be a high quality service for patients and clinicians but efficiencies could be gained through the review;

(c) there could be a number of factors which could cause delayed such as onward care, administration difficulties, a wait for drugs to be prepared and infections. The other major issues is moving patients on to other units or packages of care from community or social providers;

(d) the document underplayed the partnership working that the trust was engaged in. The Community Transformation Board was successful in bringing together acute, social care and community health services. There had been major strides forward in the city;

(e) the city vision and priorities were not reflected in the document, but the trust was aware of the challenges shared with partners and the trust was dedicated to engaging in a community wide focus on prevention;

(f) there were normal variations in the performance against National Targets and Regulatory Requirements. There were many complex variables but the trust was committed to consistently and constantly improve in these areas;

(g) the new Chair of the Board would be in place in the near future and there was an ongoing recruitment programme for the vacant non-executive seats at the Board. A recruitment process was also underway for a Chief Executive. The Finance Director had been seconded to work on the Foundation Trust Application; there was an interim Operating Officer in place and an interim Chief Nurse. Whilst the senior management team could appear to be weak, all posts had been covered by very able and fully competent staff from within the trust.

The panel agreed to delegate the preparation of a statement for inclusion in the Quality Account to the lead officer in consultation with the Chair.

10c PLYMOUTH COMMUNITY HEALTHCARE

Steve Waite Chief Executive, Liz Cooney Deputy Chief Executive and Angela Saxby

Governance Manager attended the panel to introduce the Quality Accounts of Plymouth Community Healthcare (PCH) and provide information on the services provided by the organisation.

In response to questions from panel members it was reported that –

(a) although the Quality Account did not go into detail Child and Adolescent Mental Health service, the service was referenced within the document;

(b) in the production of the Quality Account PCH had taken on board comments made by the panel, a particular attempt was made to create a document which aimed to be clear and easily understood by members of the public;

(c) PCH was working closely with Plymouth City Council in the area of reablement;

(d) locality working did not bring an inherent risk of silo working. PCH continued to have an strategic overview of the needs of the city, which would allow reallocation of resources where required;

(e) there would be 48 new health visitors in the community following a national recruitment drive and additional resources being allocated for this purpose.

The panel agreed to delegate the preparation of a statement for inclusion in the Quality Account to the lead officer in consultation with the Chair.

10d SOUTH WEST AMBULANCE SERVICE NHS TRUST

Paul Cleeland-Smith, Operational Manager, introduced the Quality Account and overview of services provided by South West Ambulance NHS Foundation Trust (SWAST).

In response to questions from members of the panel it was reported that –

(a) strategic goals had been in place for a number of years;

(b) priorities for the coming year included engagement with frequent callers in order to reduce re-contact rates;

(c) Derriford Hospital had been designated as a Major Trauma Centre, due to this designation SWAST practioners required enhanced skills as travel and time spent with patients had been increased;

(d) initial problems were experienced by emergency helicopters when the airport closed. Problems had been overcome and a site for the landing of sea king helicopters had been established.

In addition to the above the panel heard the details of a project to provide a mobile treatment unit within the city centre. The panel supported this project and requested

that further details were provided to the panel as the project progressed.

The panel agreed to delegate the preparation of a statement for inclusion in the Quality Account to the lead officer in consultation with the Chair.

11. WORK PROGRAMME

The panel agreed to remove the Older Persons Charter from the work programme and add -

(1) the Hospital discharge process;

(2) an update on Child and Adolescent Mental Health Services.

12. FUTURE DATES AND TIMES OF MEETINGS

The panel noted the future meeting dates and agreed to change meeting start times to 2pm.

13. EXEMPT BUSINESS

There were no items of exempt business.

TRACKING RESOLUTIONS
Health and Adult Social Care Overview and Scrutiny Panel

Date / Minute number	Resolution	Explanation / Minute	Action	Progress	Target date
04/04/12 Minute 74 (1)	there is an immediate pause in the process of demerging the Peninsula College of Medicine and Dentistry;	These resolutions refer to the special meeting of the panel held on the 4 April 2012 when the panel considered the demerging of the Peninsula College of Medicine and Dentistry.	The panel's recommendations were forwarded to a meeting of the Full Council where they received unanimous support.	A further update will be provided to the panel at the first meeting of the municipal year 2012 – 13.	19 July 2012
04/04/12 Minute 74 (2)	a 12 week consultation exercise is undertaken, in line with the Government's published code of practice for consultation;				
04/04/12 Minute 74 (3)	an options appraisal detailing alternatives to the demerging of PCMD is made available during the consultation period;				
04/04/12 Minute 74 (4)	no further action is taken until the outcomes of the consultation process are known.				
21/06/12 Minute 9 (1)	the document is provided in an "easy read" format, accessible to those with disabilities and those who do not use English as a first language;	This resolution is in relation to the Adult Social Care Local Account.	Authors have been requested to make the change, a revised version will be presented at a future meeting of the Panel	Complete	July 2012

Date / Minute number	Resolution	Explanation / Minute	Action	Progress	Target date
21/06/12 Minute 9 (2)	the Department will provide action plans regarding indicators 146 and 150 for distribution amongst panel members;	This resolution is in relation to the Adult Social Care Local Account.			July 2012
21/06/12 Minute 9 (3)	the Health and Adult Social Care Overview and Scrutiny panel is added to the list of consultees within the document;	This resolution is in relation to the Adult Social Care Local Account.	Authors have been requested to make the change, a revised version will be presented at a future meeting of the Panel	Complete	July 2012
21/06/12 Minute 9 (4)	the website address for the Plymouth Online Directory is added to the document;	This resolution is in relation to the Adult Social Care Local Account.	Authors have been requested to make the change, a revised version will be presented at a future meeting of the Panel	Complete	July 2012
21/06/12 Minute 9 (5)	the final Local Account would be presented at a future meeting of the panel.	This resolution is in relation to the Adult Social Care Local Account.	The revision has been added to the work programme.	Complete	July 2012
21/06/12 Minute 10a (1)	to recommend that Express Diagnostics add reference to Plymouth, the city's visions and priorities within the document;	This was the first quality account of Express Diagnostics	Democratic Support Officer will liaise with the company to explain the City Vision and Priorities.	When confirmed the Corporate Plan will be discussed with Express Diagnostics in relation to the Quality Accounts	August 2012

Date / Minute number	Resolution	Explanation / Minute	Action	Progress	Target date
21/06/12 Minute 10a (2)	to delegate the preparation of a statement for inclusion in the quality account to the lead officer in consultation with the Chair.	The panel agreed to delegate preparation of a statement to append to the Plymouth Express Diagnostics Quality Accounts	The statement has been prepared in consultation with the Chair (due to timescales) and submitted for inclusion.	A copy of the statement is appended to these tracking resolutions.	Complete
21/06/12 Minute 10b	The panel agreed to delegate the preparation of a statement for inclusion in the Quality Account to the lead officer in consultation with the Chair.	The panel agreed to delegate preparation of a statement to append to the Plymouth Hospitals NHS Trust Quality Accounts	The statement has been prepared in consultation with the Chair (due to timescales) and submitted for inclusion.	A copy of the statement is appended to these tracking resolutions.	Complete
21/06/12 Minute 10c	The panel agreed to delegate the preparation of a statement for inclusion in the Quality Account to the lead officer in consultation with the Chair.	The panel agreed to delegate preparation of a statement to append to the Plymouth Community Healthcare Quality Accounts	The statement has been prepared in consultation with the Chair (due to timescales) and submitted for inclusion.	A copy of the statement is appended to these tracking resolutions.	Complete
21/06/12 Minute 10d	The panel agreed to delegate the preparation of a statement for inclusion in the Quality Account to the lead officer in consultation with the Chair.	The panel agreed to delegate preparation of a statement to append to the South West Ambulance Service Quality Accounts	The statement has been prepared in consultation with the Chair (due to timescales) and submitted for inclusion.	A copy of the statement is appended to these tracking resolutions.	Complete

Grey = Completed (once completed resolutions have been noted by the panel they will be removed from this document)
Red = Urgent – item not considered at last meeting or requires an urgent response

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Statement Express Diagnostics

Plymouth City Council's Health and Adult Social Care Overview and Scrutiny Panel (the Panel) has prepared this statement following consideration of the Quality Accounts of Express Diagnostics on the 21 June 2012.

The Panel welcomed the information contained within the document as an introduction to the services which this private sector health care company provides.

The panel were impressed by the range of services provided and the results of patient satisfaction surveys. The panel believed that more work was required by Express Diagnostics to ensure that such patient surveys were accessible by everybody, included those with a first language other than English and the disabled.

The panel requests that future Quality Accounts make reference to the city priorities and vision, paying particular regard to the aspirations to reduce inequalities and the future economic growth of the city,

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Statement PHNT

Plymouth City Council's Health and Adult Social Care Overview and Scrutiny Panel (the Panel) has prepared this statement following consideration of the Quality Accounts of the Plymouth Hospitals NHS Trust on the 21 June 2012.

The Panel found that the account provides a comprehensive coverage of the services provided by the Trust.

The panel remains concerned that the Trust has lacked permanent leadership both at the Board and Executive level. During this time of transformation in the health and social care sector, a lack of permanent leadership could provide a risk to the effective delivery of services and damage the Trust's bid for foundation status.

The panel noted a downward trend in some national targets and regulatory requirements with respect to access to care and the slight negative drop in patient experience measures. However, the panel noted the Trust's response to 'never events' and the increased compliance with the surgical safety checklist with the trust becoming an example of good practice in this area.

The city priorities and vision were again lacking from the document and the panel felt that the document had been written in isolation, without reference to other health care providers in the city, this latter concern was allayed during debate at the panel.

The document is for public consumption and whilst the panel understands there is difficulty in presenting complex medical information in a document of this nature, the panel requests in the future the document is written in plain English.

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Statement PCH

Plymouth City Council's Health and Adult Social Care Overview and Scrutiny Panel (the Panel) has prepared this statement following consideration of the Quality Accounts of Plymouth Community Healthcare on the 21 June 2012.

The panel was concerned that improvements in the Child and Adolescent Mental Health Service, which had been subject of a scrutiny task and finish group, had not been flagged as a priority for the forthcoming year and that the service received little exposure in the quality account document. The panel was also concerned that National Staff Survey results had seen a drop in the percentage of staff that had received infection control and diversity and equality training.

As a community interest company based within Plymouth and providing services to Plymouth residents the panel were concerned that city priorities and vision were lacking from the document. The panel felt that the document had been written in isolation, without reference to other health care providers in the city although this latter concern was allayed during debate and the panel were assured that dialogue had been ongoing with patient representatives.

The panel wish to congratulate Plymouth Community Healthcare for providing a document which aimed to be clear and easily understood by members of the public.

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Statement SWAST

Plymouth City Council's Health and Adult Social Care Overview and Scrutiny Panel (the Panel) has prepared this statement following consideration of the Quality Accounts of the South West Ambulance Trust on the 21 June 2012.

The Panel found that the account provides a comprehensive coverage of the services provided by the Trust.

The Panel believes that if achieved, the Trust's priorities will provide improved outcomes for patients. The Panel felt that the Trust should address the fact that it only provided provisional information on performance against category A8, regarding emergency response within 8 minutes, and also that the account lacked performance information regarding Patient Transport Services.

The Trust is commended on local work it is undertaking with regard to the night-time economy in Plymouth and the Panel would like to offer support for the project over the coming months.

The Trust is requested to reflect city priorities and vision in future quality accounts statements. The Panel also believe that the Trust needs to further consider its use of language in the quality accounts to ensure that the general public find the document clear and accessible.

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Plymouth Community Healthcare CIC

Recovery Pathway Proposals

Public Consultation Document

1. Executive Summary

This paper sets out a proposal that Plymouth Community Healthcare (PCH) re-designs its Recovery Service so that improved outcomes and efficiencies are delivered through a programme of investment in Community alternatives to in-patient treatment.

Evidence demonstrates that Plymouth has significantly more Recovery inpatient beds when benchmarked against comparable Mental Health Providers (The Sainsbury Centre 2007, "Delivering the Governments Mental Health Policies"). Through a programme of re-distribution of resources and service re-design therefore, quality of service can be improved, and resources released for further investment.

This proposal is in keeping with the trajectory of travel nationally and with good practice and key strategic drivers (The Bradley Report (2009), New Horizons – Towards a Shared Vision in Mental Health (2009)), Personalisation in Mental Health (2010), Work, Recovery & Inclusion (2009), Realising Ambitions (2009).

An analysis of delays and gaps in the service demonstrates that in the order of 3,000 bed days could avoided through developing Community alternatives to in-patient care and strengthening working arrangements with Supporting People colleagues.

The total number of current delayed discharges "in the system" equates to the capacity of either The Gables or Syrena. A marginal improvement in the period of time patients spend within these units would yield a significant reduction in the need for inpatient beds. A more rigorous focus on delayed discharge management as well as investment in treatment options (Psychological therapies) for Service Users will achieve this.

It is proposed that a newly defined service would clearly deliver improvements through pathways for people who use our services, focus on needs, demonstrate clear outcomes, provide value for money and deliver improved quality in terms of privacy and dignity for service users.

This document argues that re-design will:-

- Enhance the ability to meet the complex needs of people within the community
- Reduce the need for Out of Area placements through a more effective model of service delivery and without compromising the ability to meet existing local demands and thus ensure that fewer people are sent out of area for treatment.
- Deliver services closer to people's homes and communities.
- Develop services in response to identified individuals needs.
- Develop a model in collaboration with people who use our services and carers as well as with clinical involvement and input.
- Provide better clinical outcomes for people.
- Deliver a significant efficiency and opportunity to re-invest in areas that are known deficiencies

It is a model of care which embraces best practice and enhances the personal experience within a framework of improved service integration and efficiency.

It is important to emphasise that this consultation is based upon a whole service re-design proposal and although it is easy and tempting to focus on bed closures or the loss of a building, these are secondary and not the key consideration(s).

The views of staff, people who use our services and stakeholders are genuinely encouraged to help inform the shape of services for the future.

2. Overview

2.1 Background

Recovery Services perform a crucial function in the delivery of long term reablement for people with severe and enduring mental health problems. They are fundamental to the delivery of an effective and efficient Mental Health Service through their focus on:-

- Developing skills and resilience to live in the community
- Delivering improved health outcomes and reducing inequalities
- Reducing inpatient length of stay
- Ensuring that Primary Care Services are supported to manage more complex individuals
- Supporting the development of an integrated pathway for Recovery Services with Plymouth City Council Adult Social Care Services.

There has been a consistent move towards more Community based services in Mental Health for some time which has led to less reliance on Inpatient service provision and more robust and integrated Community Services.

This links with a focus on the concept of reablement where people are supported to regain their place in their family and the local community as quickly as possible.

Analysis of the mental health needs for Plymouth has shown that:

- 1% of the population will suffer from schizophrenia
- 4% will have a personality disorder
- 6% will suffer from significant depression

Most of this will be managed within the existing mental health services, but it is proposed that approximately 60 people will be managed by a newly designed Mental Health recovery pathway including an enhanced community element.

2.2 Current Resources

The Recovery services model presently consists of:

- Three inpatient facilities – Greenfields, Syrena and the Gables. These Units are on three different sites, two of them are located away from any other provision or campus. The inpatient service provides 28 beds and delivers support to discharge processes and resettlement from Lee Mill, other secure services as well as support to our own local acute inpatient service.

- Community based support.-The Community element of the service, both in the Assertive Outreach Team and the Home Treatment Team has capacity issues that mean that it is difficult for them to always respond to the demands of individuals and of referrers and others that have a role in the recovery service pathway.

In addition to the Recovery Beds there are 12 Low Secure Beds based at Lee Mill. These are considered to generally operate effectively.

The Teams link into other Agencies in areas of support such as Housing and Employment. The Spring Project. is viewed as an example of where these links are working well however this is not the case throughout the entirety of the Service.

There are also links to Primary Care however these need to be developed to embrace the wider opportunities for Primary Care to be more involved in Psychiatric patient management within a framework of liaison and support.

3. Impacts of Current arrangements

A SWOT analysis of the current arrangements is set out below.

3.1 Strengths

- ✓ Stable teams that understand and can deliver the service to the current specification
- ✓ Those who use our services and Carers understand what is currently available.
- ✓ Satisfaction questionnaires are largely positive about their experiences
- ✓ Syrena provide Community follow up for some individuals which has resulted in positive feedback in regard to consistency and continuity.
- ✓ Can continue to repatriate some individuals in Out of Area Placements (OATS) within the context of the current model.
- ✓ All teams have made significant improvements in recent years.

3.2 Weaknesses

- ✓ No opportunity to fundamentally re-design pathways
- ✓ Quality remains compromised e.g. Syrena and Gables are unable to always provide physical interventions should a person become distressed. This potentially puts both staff and those we care for at risk.
- ✓ No opportunity to build a service, embedding quality at its heart from the bottom up.
- ✓ Current services are not seamlessly linked with partners in employment, housing.
- ✓ It is arguable whether some current services have the critical mass to be sustainable i.e. able to cover sickness, training and annual leave. Recent bank and agency use would support this.
- ✓ Service model does not fit with local and national policy directives i.e. too many beds.
- ✓ Some buildings i.e. Syrena and Gables are not entirely fit for purpose and may cost significant amounts to make them fit for purpose.

3.3 Opportunities

- ✓ There is an opportunity to continue to focus on developing the quality of service currently provided within the parameters that are currently set
- ✓ There is an opportunity to repatriate people back into local provision from Out of Area or to prevent their referral.

3.4 Threats

- ✓ More innovative providers may approach Commissioners and re-provide services. This might pose a risk to the long term sustainability of Plymouth Community Healthcare as a provider of specialist mental health services.
- ✓ The current number of beds or model for charging does not incentivise more efficient ways of working e.g. Speedier discharge.

The analysis underlines the potential for quality improvement within this area of Care and the scope for this to be delivered within existing resources

4. Strategic Direction

4.1 Commissioning Intentions

This Commissioning Intentions of NHS Plymouth set a strategic direction of travel for the Recovery Service that is:

- Integrated with Social Care provision
- Engages Primary Care in shared care arrangements
- Focuses on Community interventions
- Ensures Housing and Employment are priorities
- Reduces the use of inpatient beds leading to a reduced capacity.

As set out above, PCH currently provide 12 Low Secure beds and 28 mainstream Recovery beds. The Sainsbury Centre, in their document "Delivering the Governments Mental Health Policies" (2007), have suggested that it would be usual for a population of 250,000 to have approximately 10 Recovery inpatient beds and 10 Low Secure beds.

Devon Partnership Trust plan to provide no recovery beds and Cornwall Foundation Trust provide 15 for a population of 560,000. The number of Recovery beds currently provided within Plymouth varies considerably from this, even taking into consideration the 6 or so beds historically provided for other Commissioners (such as Devon).

Table 1 describes services as they are currently configured.

	Lee Mill	**Syrena**	**Greenfields**	**The Gables**
No of beds	12	9	10	9
Average length of stay (days 2009/10)	361	612	234	467

Table 2 sets out a comparison with the Sainsbury Centre recommendations.

Local Provision Versus Sainsbury Centre Profile		
	Mainstream Recovery Beds	**Low Secure Beds**
Sainsbury Centre Analysis	10	10
Local Provision	30	12

The comparison highlights the potential scope for a reduction in the number of Recovery Beds.

4.2 Integrated Care Pathways

There are a number of challenges described by Commissioners within the Recovery Service Specification for 2012/13. These include the requirement to deliver Integrated Care Pathways and Services which enable the User to achieve individualised outcomes from Community living. Achieving this will entail:-

- An integrated arrangement for both Commissioning and Providers that has a shared set of outcomes;
- Agreed principles for pathway management
- Identified responsibilities for delivering interventions and monitoring outcomes;
- A commitment to reducing dependency on statutory or paid for services
- An integrated approach to co-ordinating care.

It is intended that the pathway for the Recovery Service will be based around the pathways described in the Payments by Results (PbR) clusters for the management of Psychosis, Depression, and Personality Disorder. The main focus will be clusters 12 – 17 but this will be reviewed as the understanding of cluster pathways improves.

In order to deliver these intentions there are clear commitments from the Health and Social Care Commissioners in Plymouth to co-ordinate their approach to Commissioning for Recovery Care Pathway Services.

The priority objectives for the service are described as:

- Facilitating discharge planning which results in a reduction in the average length of stay in an inpatient unit and reduction in delays in discharge to community settings
- Focusing Supporting People resources on those with the greatest need;
- Committing resources to ensuring housing solutions are available and supported;
- Co-ordinating support and treatment in supported housing services;
- Engaging GPs in the on-going medical management of people in the community, including in prescribing;
- Developing the mental health awareness and skills in generic/single homeless provision;
- Developing and co-ordinating the commissioning of employment and social inclusion programmes;
- Improving the physical health and well-being of service users as part of the locality delivery model

It is proposed, by Commissioners, that the primary task will be to facilitate discharge from inpatient facilities in order to speed the flow of patients through the pathway.

In partnership with Plymouth City Council (PCC) an enhanced service will be developed aimed at achieving two key outcomes:

- An improved flow of people from inpatient facilities into supported housing through focused work and increased support funded by PCC;

- A reduction in the bed base that will deliver QIPP savings which will enable re-investment in Mental Health Community Services and other Commissioning priorities.

5. Service Re-design Proposals

5.1 Model of Care

These suggestions are an initial proposal for comments, feedback and scrutiny. It is recognised that there are other many potential ways of re-configuring services. The over riding principle however is that we have a blank canvas in terms of what our buildings and staff can deliver. The following is a potential model upon which to consult.

It is proposed that PCH, NHS Plymouth and Plymouth City Council focuses on developing the Services it provides so that it puts the experience of using services as well as outcomes and quality at the heart of delivery. In essence the opportunity exists to re-design pathways through the service with a particular focus on flow

through Lee Mill and onto Recovery units and then onto enhanced accommodation with improved and targeted Community based support. This will enable the unblocking of current bottlenecks and the continued return of Out of Area Treatments (OATS). This proposal will illustrate that it is possible to improve efficiencies & flow, enhance quality and demonstrate improved outcomes through a process of re-design.

This proposal has several key elements at its core:

1. The development of enhanced accommodation and support to address known bottlenecks.

2. A review by PCC of existing Supporting People contracts in support of 1 above.

3. Enhanced Community Services, working in partnership with Housing Providers, to improve discharge from Units and support to Housing Providers in being able to manage a greater complexity of need.

4. The possible closure of Syrena (or another unit) and a reduction of 9 beds.

5. The potential for further reductions in bed numbers and increase in community support.

6. The development of better treatments, bed management processes and a clearer role for whichever service remains.

6. An improvement in the interface with Primary Care enabling an enhanced role In management in accordance with the Pilot currently being trialled with Knowle House Surgery.

6.2 Bed Utilisation

It is proposed that the number of recovery beds will be reduced from 28 to 19 as an initial stage.

The model will involve building an alternative to inpatient provision which addresses a range of community requirements and which encompass housing, educational, employment and recreational needs.

Through the QIPP process, gaps in the delivery of effective Psychological therapies are being addressed. This aims to improve flow by providing needs led treatments.

The following analysis is based on the proposal that Syrena closes and enhancements are made to The Gables to accommodate disabled service users..

Table 3

Unit	Current Number of Beds	Number of delayed discharges	Proposed number of beds
Lee Mill	12	2	12
Greenfield	10	2	10
Gables	9	0	9
Syrena	9	5	0
Total	**40**	**9**	**31**

Bed management and flow will be rigorously monitored and managed through a fortnightly, whole service Care Pathway meeting.

5.3 Lee Mill

It is envisaged that Lee Mill will continue to operate along existing lines.

5.4 Greenfields

It is proposed that the number of beds remains at 10. These beds could however be used more effectively overall with six of the beds being used intensively and with an average length of stay of 261 days. The remaining beds would be used by men who present with more complex needs, with an average length of stay of circa 1825 days.

The Role of this Unit within the care pathway will be to provide:-

- Step down for service users from the Low Secure Unit
- Some access for OATS service users
-
- A maximum of 4 “longer term Recovery” beds for individual Service Users with particularly long standing and enduring mental health problems for whom it is neither cost or clinically effective to discharge into an independently provided service. This may include physical needs or disability and a range of complex needs.

The profile of Service Users will be those who normally have a diagnosis of psychosis Individual assessment will however be undertaken to ensure a balanced and manageable “mix” of service users.

The patient group will include individuals with complex psychological needs requiring intensive support and treatments.

It is acknowledged that Service Users may be vulnerable and present with significant risk histories.. This may include some individuals with a learning disability Including those on the autistic spectrum.

5.5 Gables

It is proposed that the number of beds remain at 9 Beds. The average length of stay will however reduce from 467 to 261 days. The location of the current service, given some of the known risks, is a specific point for discussion.

The role of this Unit within the care pathway will be to work with women to:-

- Provide "step down" from Medium (if appropriate) and Low Secure care
- Provide a pathway through local services for OATS service users
- Provide a pathway for individuals in the local Acute Unit who require an extended period of Recovery

The profile of people using the service will be those with a mixed range of diagnoses which will require individual assessment to ensure a balanced and manageable "mix". This may include individuals with a diagnosis of personality disorder and psychosis.

It will also include individuals with complex psychological needs requiring intensive support and treatments. It is acknowledged that these individuals may be vulnerable and present with significant risk histories. This may include some with a learning disability including those on the Autistic spectrum

An analysis of the efficiencies resulting from these changes is set out in Table 5 below

Table 5
Efficiencies and flow

Unit	Current average lengths of stay (days)	Proposed lengths of stay (bed days)	Current Available beds days (per year)	Proposed Available bed days (per year)	Current flow rate (per year)	Proposed flow rate (per year)	Proposed number of beds
Lee Mill	361	361	4380	4380	12.1	12.1	12
Greenfields	234	261 **Based on Mainstream Beds**	3650	3650	15.6	13.9	4 longer stay and 6 mainstream
Syrena	612	0	3285	0	5.3	0	0
Gables	467	261	3285	3285	7.0	12.6	9
Total (Recovery Units Only)	**430 (mean)**	**261 (mean)**	**10,220**	**6,935**	**23.8**	**26.6**	**19**

The table above demonstrates how a reduction in average lengths of stay in the recovery beds of 169 days will impact upon capacity and flow. In essence, a reduction in 9 beds will potentially increase the flow rate (total number of bed days divided by average length of stay) from 23.8 to 26.6 .The majority of capacity will be maintained through the development of a more efficient model that addresses blockages and issues of quality within the system. This will be achieved within an overall reduction of 9 beds which will result in 3,285 fewer available bed days per year. Please note - the overall churn rate may be affected with the use of 4 beds for longer term treatment/care.

The proposed recovery pathway associated with these proposals is set out in Appendix 1

An SWOT analysis of the proposals is set out in Appendix 2

6. Financial Analysis

As set out above there will be an overall reduction in 9 beds resulting from the implementation of these proposals.

The impact on contract values in light of PbR arrangements for Mental Health services remains to be established. Based however on existing values there would be a reduction in the contract value of circa £900K.

Clearly such a reduction would potentially de-stabilise overall services and not be reflective of the actual reduction in cost associated with the loss of 9 beds. This is especially so in light of the overall thrust of the care pathway to utilise remaining beds more intensively.

It is considered therefore that a mechanism will need to be established to manage the issue of bed reduction income loss within the context of the service contract and the emerging PbR tariff.

In order to take the financial analysis forward it is proposed to focus this on the impact of that changes in the Recovery Care Pathway will have on staffing levels.

Table 6 Core Staffing Profile

Unit	No of staff in Post currently	No of staff in Post following implementation	Enhancement to community services	Available for re-deployment
*** Gables**	22	22	0	0
*** Syrena**	16	0	0	0
*** Greenfields**	23	23	0	0

Community			6	
Total	61	45	6	10

Within the analysis set out above Syrena would close with a saving of 16 posts. Community staffing would be strengthened by 6 posts in order to support cross agency working including Primary Care, Housing, Employment, and Education.

The focus would be on supporting Users, preventing admission and facilitating discharge.

Staffing costs at Syrena are in the order of £475k per annum. It is assumed that the 6 Community Staff will, on average be appointed on a Band 5, at a total cost of circa £210k per annum

The proposals would result in a net saving of around £265k which would be available through QIPP for re-investment in other areas of Health Provision.

At the same time the proposals would enable a reduction in the level of investment currently directed to Out of Area Treatments.

The proposals do not allow for increased staffing levels in support of additional patient dependency and complexity. It is considered that through this can be accommodated through scrutiny of current nursing practice. The situation will however be kept closely under review during the first few months of operation to ensure a smooth transition to new arrangements.

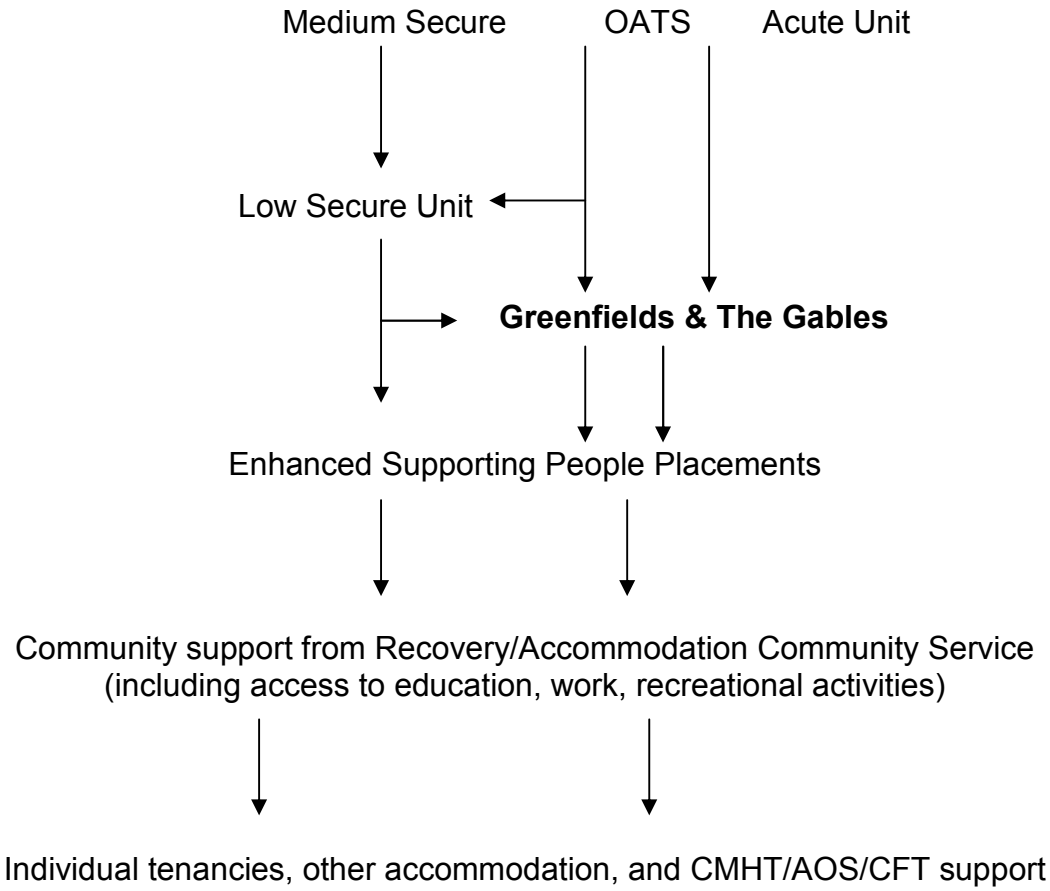
7. Conclusion and Recommendations

The analysis, set out within this document, demonstrates that by addressing blockages and flow issues within the system, the quality of care for Service Users can be considerably improved. At the same resources of approximately £265k can be made available for investment, through QIPP, in service priorities.

PCH, NHS Plymouth and Plymouth City Council are statutorily required to undertake a period of 3 months public consultation on all significant service change proposals. This document set out the basis for the discussion to inform the consultation.

Appendix 1

Proposed Recovery Pathway



Appendix 2

SWOT Analysis of Recovery Pathway Proposals

Strengths

- ✓ Joint Health & Social Care approach resulting in improved outcomes for service users
- ✓ More efficient, whole systems model achieved through the above.
- ✓ Enhanced local service that is able to provide better quality care and treatment with a broader range of skills, enabling more complex service users to be cared for locally.
- ✓ Clear pathways through services.
- ✓ Would meet the required environmental standards in terms of Disability Discrimination Act (DDA) and privacy and dignity requirements
- ✓ Plymouth would be moving towards a model; in terms of the number of inpatient Recovery beds, that matches current local needs and more closely reflects national norms
- ✓ The service would be in a position to accommodate more complex and risky individuals through enhancements to staffing levels and skills (see table 4).
- ✓ There is the potential to realise considerable CRES efficiencies as there would be approximately 11.6 WTE posts released through this process. The skills and experience these individuals bring would be invaluable when re-deployed in supporting other parts of the service.
- ✓ More complex individuals can, as a consequence of the above be managed locally, potentially enabling the treatment of service users closer to their homes and families and avoiding unnecessary out of area placements.
- ✓ Services would be safer in that there would be a greater critical mass on one site and thus able to provide a full range of safe physical interventions and support should the need arise.
- ✓ There would be more support available on one site for staff reducing the feeling of isolation
- ✓ The change provides an opportunity for staff who have not worked in other units for some time to experience new and exciting challenges
- ✓ Continued ability to return OATS service users.

Weaknesses

- ✓ This would mean the loss of single sex facilities
- ✓ The change process could de-stabilise well established staff teams
- ✓ Service users might become anxious unless the process is well managed and communicated.
- ✓ Staff anxieties could be transferred onto service users
- ✓ It will take some time and require focussed project management to move from the current service model to the one described.
- ✓ Plymouth will still retain a relatively high number of beds

Opportunities

- ✓ To develop a service of outstanding quality
- ✓ To develop a new, innovative and exciting service model
- ✓ Develop innovative partnerships and new ways of delivering services
- ✓ Improve outcomes for service users
- ✓ The opportunity to address inefficiencies. In particular delayed discharge issues
- ✓ To develop a model and approach for the ongoing care and treatment of those service users who have a complex set of needs and may meet continuing healthcare criteria.
- ✓ The potential to share skills and expertise into other areas such as the PCLS & AOS.
- ✓ In order to incentivise discharge and flow, the use of a different payment model could be explored such as replacing bed day cost with treatment episode.

Threats

- ✓ Other providers may still develop more innovative models
- ✓ Potential reduction in income once blocks contract ceases.
- ✓ Some individuals would need to be re-deployed into vacancies.
- ✓ Significant service developments will result as a consequence of these proposals. This would mean the development of additional capacity into community services. A clear service specification will need to be developed to support this.

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PLYMOUTH CITY COUNCIL

Subject:	Strategic Alcohol Plan
Committee:	Health and Adult Social Care Overview and Scrutiny Panel
Date:	19 July 2012
Cabinet Member:	Councillor Sue McDonald
CMT Member:	Carole Burgoyne (Director for People)
Author:	Dave Schwartz –Young Person's Lead for Drugs and Alcohol
Contact:	Tel: 01752 307561 e.g. 4489 e-mail: dave.schwartz@plymouth.gov.uk
Ref:	Your ref.
Key Decision:	No
Part:	I

Purpose of the report:

The report provides a briefing to Scrutiny Panel on the development of an alcohol Plan for the city. The report sets out the background to the Plan and the progress that has been made including emerging content and possible implications.

The current version of the draft Strategic Plan is available to members but this is work in progress and will be subject to refinement and change. An operational plan, setting out how the aims set out in the strategic plan will be delivered, will follow.

The Strategic Plan aims to promote responsibility and reduce harm. This is a big challenge, particularly in respect to changing our drinking culture. It will require delivery over the long term. It is proposed that the Strategic Plan is delivered over 10 years in two five year phases. It aims to prevent problems from developing, particularly amongst our most high risk groups, protect children exposed to significant parental alcohol misuse, provide intervention and treatment to more people in need and utilise enforcement and control approaches to facilitate safer drinking environments.

The report enables Members to:

- understand the background to the Plan
- consider the structures proposed to deliver the Plan
- consider the implications of the Plan

Corporate Plan 2012-2015:

The alcohol agenda is a cross cutting agenda. It is particularly relevant to two of the four level one outcome measures, namely:

- Reduce inequality – the Plan will aim to directly reduce health related harm linked to alcohol misuse. By doing so life expectancy should be increased and premature mortality reduced. We will also expect positive impact with regard to child poverty. Reduce the rate of alcohol-related admissions is a level two outcome specifically relevant to the delivery of this Plan.

- Raise aspiration – we would expect the Plan to contribute to an increase in the number of visitors coming to the city by ensuring that alcohol is supplied responsibly, that this is well managed and planned so creating safe and welcoming environments.

Implications for Medium Term Financial Plan and Resource Implications: Including finance, human, IT and land

An Alcohol Joint Commissioning Group is currently undertaking work that will set out the financial and resource implications for delivery of the Strategic Plan over both the short and medium term.

Other Implications: e.g. Child Poverty, Community Safety, Health and Safety, Risk Management and Equality, Diversity and Community Cohesion:

- The Plan will contribute toward reducing Child Poverty. Through addressing both parental alcohol misuse and the impact this can have on children we can improve the outcomes for children.
- The Plan contributes towards Community Safety through aiming to reduce alcohol related crime in both public and domestic settings. The Plan will also seek to reduce alcohol related anti-social behaviour.
- The Plan will support Equality, Diversion and Community Cohesion through working with specific community groups to better understand need, building on events such as 'Have Your Say' and through achieving its aims, reduce both health and social inequality. An EIA will be completed once the Plan is finalised.

Recommendations & Reasons for recommended action:

Members are requested to consider whether the Plan being developed is appropriate for Plymouth and to consider what further challenge and support role Scrutiny Panel can provide going forward

Additionally consideration be given as to how elected members can champion this agenda going forward

Alternative options considered and reasons for recommended action:

Background papers:

Web links must be provided to any background papers.

Sign off: comment must be sought from those whose area of responsibility may be affected by the decision, as follows (insert initials of Finance and Legal reps, and of HR, Corporate Property, IT and Strat. Proc. as appropriate):

Fin		Leg		HR		Corp Prop		IT		Strat Proc	
Originating SMT Member											
Have you consulted the Cabinet Member(s) named on the report? Yes / No* please delete as necessary											

1.0 Introduction

1.1 The Alcohol Plan will set out how the city will minimise alcohol related harm and promote responsible drinking. The Plan has been informed by a number of key pieces of work, the Plymouth Alcohol Joint Strategic Needs Assessment (2012) being the most important.

1.2 Alcohol is a complex issue and its use is deeply embedded within our culture. It contributes to economic growth, is part of people's social and leisure activities and is also a significant cost in terms of alcohol related harm. These relationships are inter-connected and we require a coherent and shared response by all key partners in the City in order to make a positive difference. A focus on preventing problems rather than waiting to 'treat' problems is one of the Plan's major challenges.

1.3 There is a 'tension' between the positive contributing impact of alcohol to the economy and people's social and leisure opportunities and the negative harmful effects of alcohol misuse. This provides us with a serious challenge in aiming to get the balance right for Plymouth between aiming to minimise alcohol related harm whilst at the same time supporting economic growth, some of which is linked to the alcohol industry. This is one of the Plan's major challenges.

2.0 Background

2.1 During autumn 2010, Plymouth 2020 agreed that Alcohol should be a city priority and Chief Superintendent Andy Bickley took on the role of Alcohol Champion.

2.2 In January 2011 the Department of Health Alcohol Harm Reduction National Support Team spent a week in Plymouth meeting with a wide range of stakeholders concerned with alcohol in the City. In April 2011 their report highlighted 5 key recommendations:

- Ensure there is clear leadership from all partner organisations backed up by visible political support
- Undertake a comprehensive needs assessment, utilising data from all partners
- Develop a strategic approach with clear priorities and a focussed action plan
- Quantify the necessary resource and set out clear commissioning arrangements to ensure resources are targeted to meet strategic objectives
- Redesign the alcohol treatment system based on need and evidence based practice

2.3 Following this the Alcohol Champions Group was set up, Chaired by Chief Superintendent Andy Bickley. This Group set about turning these recommendations into action.

2.4 An Alcohol Joint Strategic Needs Assessment (link to be identified) was commissioned and was completed early in 2012. This would form the key source for understanding need and developing the priorities.

2.5 The Young Person's Lead for Drugs and Alcohol and a Crime Reduction Officer from the Community Safety Partnership was given the task of producing the Plan.

2.6 Emerging elements of the Plan was taken to the Plymouth 2020 Executive on two occasions during March and April 2012 for challenge and support. Following this a wide range of stakeholders were met with in order to discuss specific issues that could shape the Plan.

2.7 In May 2012 the inaugural meeting of the Alcohol Joint Commissioning Group took place. This group reports to the Joint Commissioning Partnership. They are tasked at overseeing commissioning that will support delivery of the Plan covering system and service design and investment requirements / options. A business case setting out the commissioning options will be submitted to the Joint Commissioning Partnership on September 27th for approval.

2.8 An initial draft was circulated in June 2012 and feedback is now being utilised to refine the Plan.

2.9 The Plan will be due to go the Health and Well-Being Board for approval in October with Cabinet to following in November or December (to be finalised).

2.10 In March of 2012 the government's Alcohol Strategy was published. It set out a 'radical change' in the way that alcohol issues are addressed and promises to 'turn the tide against irresponsible drinking'. It has a clear focus to reduce binge drinking, drive down alcohol related crime and tackle health issues through sustained local and national action. There is a clear emphasis on personal responsibility and local action. Additionally the 'industry' is highlighted as a critical leader in changing the drinking culture from one of excess to one of responsibility. The Plymouth Plan is being developed in line with the government's strategy.

3.0 Joint Strategic Needs Assessment (JSNA) – some key findings

3.1 The JSNA was commissioned to provide a comprehensive assessment of need and support the development of a Strategic Plan

4.0 69% of men and 55% of women (aged 16 and over) reported drinking an alcoholic drink on at least one day in the week prior to interview. 10% of men and 6% of women reported drinking on every day in the previous week.

4.1 Overall the evidence set out in the JSNA suggests that Plymouth performs statistically worse against the England average when comparing a range of indicators. These include hospital admissions (adults and under 18s) and alcohol related violent crime.

4.2 Estimations on levels of drinking differ depending on what tools are used. One tool used to estimate levels of use for the 'Alcohol Needs Assessment Research Project' suggested that Plymouth has 46,000 hazardous[1] or harmful drinkers[2]. Of this 6,800 are estimated as dependent drinkers[3].

4.3 There is a strong association between deprivation and an increased burden of harm linked to alcohol misuse. Compared to those living in the most affluent areas, people in the most deprived fifth of England are three to five times more likely to die of an alcohol-specific cause and two to five times more likely to be admitted to hospital because of an alcohol – use disorder.

4.4 An estimation of the number of children affected through the impact of significant parental alcohol misuse provided a range between 3,900 and 6,500. Where risk is high this has significant implications on a child's future outcomes. Addressing this issue will impact on reducing child poverty.

[1] Hazardous drinkers are defined as drinking more than the recommended weekly amount; 14 units per week for females and 21 units per week for males.
[2] Harmful drinkers are defined as drinking over the recommended weekly amount and experiencing health problems directly linked to alcohol misuse.
[3] Being dependent on alcohol means that a person feels that they are unable to function without alcohol, and the consumption of alcohol becomes an important, or sometimes the most important, factor in their life.

4.5 The JSNA supports the identification of the following as being at particularly high risk to alcohol related harm:

- Adults 40 – 64 (peak 40-44 women and 45-49 men)
- Offenders
- Single homeless
- Young Adults (18 -25) including students
- People with mental health problems
- Children affected by Parental Alcohol Misuse / Alcohol misusing parents (including pregnant women)

4.6 Data from the Department of Work and Pensions suggested that alcohol related harm costs Plymouth around £80million per year

4.7 Currently we do not have an estimate for the contribution made by the alcohol industry to the local economy

5.0 Emerging implications

5.1 Alcohol is used by the majority of the population on a weekly basis.

5.2 We need to prevent more problems and so treat or arrest fewer people. Treating people, whilst an important strand of any response to alcohol harm will not address the key reasons to <u>why</u> problems develop. Without addressing the why we will only be dealing with crisis which is often too late and very expensive.

5.3 We will never have enough funding and resources to provide interventions and treatment to all people who may require it – the numbers are too high. This is a challenge nationally not just for Plymouth. This reinforces the need to prevent problems.

5.4 We do not have enough specialist treatment and support services available for those who really need them. The National Institute for Health and Clinical Excellence (NICE) suggest we should be able to treat at least 15% of dependent drinkers. For Plymouth, NICE estimate this equates to around 900 people each year. [4] In 2011/12 we provided treatment to 582 people.

5.5 Along with promoting responsibility for individual use and the way this may impact on others we need to create safer drinking environments. In particular our night time economy needs to feel safe and vibrant for all.

5.6 We need to target at risk groups with approaches that support behaviour change. This includes education but not in isolation. It requires the provision of brief interventions. These are evidence based interventions that can be delivered within a short time.

5.7 A wide range of key stakeholders working with at risk groups all have a part to play. These include: Specialist substance misuse services; Primary health care (shared care); Hospital Emergency and Liver Units; Psychiatric services; Homelessness Services; Domestic abuse services; Antenatal clinics; Sexual Health clinics; Probation services; Occupational health services; University / HE establishments, schools and youth services.

[4] http://www.nice.org.uk/usingguidance/commissioningguides/alcoholservices/AlcoholServices.jsp?domedia=1&mid=04735425-19B9-E0B5-D4649E308E1EBF73

6.0 Proposed structure to deliver

6.1 The recommendations from the National Alcohol Harm Reduction Support Team included the need to have high level engagement and to ensure capacity within the system to provide the strategic focus the agenda requires. In response we have identified five key aims and linked these to five themes (Impact Areas) to provide clarity for governance and accountability. Each theme has a lead accountable Executive Officer. Discussions are under-way to bolster the delivery structure through Senior Officer roles and officers having a part to play.

6.2

Aim	Theme / Impact Area	Accountable Executive Officer
A strong, shared City response that will reduce alcohol related harm	Governance, Communication and Strategic Partnerships	TBC
Changing knowledge, skills and attitudes towards alcohol (particularly with at risk groups to change behaviour and with the workforce to ensure they are competent to deliver relevant services)	Prevent	TBC
Providing support for children, young people and parents in need	Protect	TBC
Supporting individual need	Treat	TBC
Creating safer drinking environments	Enforce and Control	TBC

7.0 What next

7.1 Feedback from the recent consultation has particularly reflected the need to be more ambitious with respect to prevention and to ensure there is a clear relationship with economic growth and planning to ensure we all contribute to minimising harm whilst working to build the economy. Many stakeholders see this opportunity as a real chance to 'make a difference'. Additional comments on a range of issues from content through to structure are influencing the next version of the Plan.

7.2 The Alcohol Joint Commissioning Group is intensively working to deliver a business case to the Joint Commissioning Partnership in September 2012. Whilst the final Plan is not completed yet the challenges are clearly emerging and the Commissioning Group have commenced work on some of the detail on how we achieve the aims proposed. This will include finance implications after we have determined how much increase in capacity we can achieve through system and service redesign.

7.3 There overall Plan will include strategic and operational elements of the Plan (this will be two separate documents). The Strategic Plan sets out the argument for change and our ambition over the next five years and a separate Operational Plan will set out detail on the delivery. The latter will be available in the autumn as the detail is agreed.

7.4 The Plan aims to provide a coherent structure for addressing alcohol across a range of themes – all of which have an inter-relationship with each other. This will be a big challenge and as the National Harm Reduction Support Team noted will require senior ownership by all key partners including, visible political support.

Promote Responsibility; Minimise Harm.

Plymouth's Strategic Alcohol Plan 2012 – 2017

A separate Operational Plan will follow and will set out how we will deliver the aims set out in this document

Phase 1 of a 10 year drive to reduce alcohol related harm in Plymouth

	Date	Sign off
Alcohol Champions Group	**June 20th 2012**	**X**
Joint Commissioning Partnership TBC	**September 27th 2012**	
Health and Well-Being Board	**TBC**	

THIS DOCUMENT IS WORK STILL IN PROGRESS

- **THE DOCUMENT NEEDS FORMATTING**
- **REFERENCES ARE INCOMPLETE**
- **SOME SECTIONS ARE INCOMPLETE FOLLOWING REVISION AFTER CONSULTATION**

Date	Version
July 9th 2012	**V3 refresh following consultation**

1. Overview

In January 2011 the Department of Health Alcohol Harm Reduction National Support Team recommended that, "(Plymouth) build on the commitment of the Local Strategic Partnership Executive to develop a clear strategic approach and focused action plan for taking the alcohol agenda forward".

This Plan is the response to that challenge.

The Plymouth 2020 Partnership have agreed that as a City we must act together to step up our efforts to minimise the harmful impact alcohol has on individuals, families and communities whilst building a responsible environment for alcohol to be sold and used.

There is a difficult tension between the negative and positive contribution alcohol can make to the lives of people and the communities within which we live and work. However the facts are clear.

- We have increasing numbers of people admitted to hospital for alcohol related reasons – between 2002/3 and 2009/10 there was a rise from 3327 to 6194 equating to a 71% increase[1]
- We do not have enough specialist treatment and support services available for those who really need them. The National Institute for Health and Clinical Excellence (NICE) suggest we should be able to treat at least 15% of dependent drinkers. For Plymouth, NICE estimate this equates to around 900 people each year. [2] In 2011/12 we provided treatment to 582.[3]
- There has been a historical under-investment in adult treatment and intervention services
- There are clear relationships linking some types of crime to alcohol use. In Plymouth, violence accounts for 70% of all alcohol related crime. It has also consistently been a recorded feature in more than 40% of domestic offences and incidents.[4]
- The cost of alcohol related harm within Plymouth is estimated at approximately £80million a year.[5]
- Nationally the alcohol industry contributes £28.6 billion in GDP to the UK economy. This is 2.0% of the UK's total output. [6] We do not have a figure for the contribution the alcohol industry makes to the local economy.

Alcohol is a complex issue; it is also deeply embedded within our culture. It is part of people's social and leisure activities, contributes to economic growth, and is also a significant cost in

[1] Alcohol Hospital Admissions in Plymouth (2012). South West Public Health Observatory.

[2] http://www.nice.org.uk/usingguidance/commissioningguides/alcoholservices/AlcoholServices.jsp?domedia=1&mid=04735425-19B9-E0B5-D4649E308E1EBF73

[3] National Drug Treatment Monitoring Service: https://www.ndtms.net/default.aspx

[4] Devon and Cornwall Police Alcohol Harm Profile 2011

[5] Plymouth Alcohol Joint Strategic Needs Assessment (2012): based on data from the Department of Work and Pensions

[6] 'The economic outlook for the UK drinks sector and the impact of the changes to excise duty and VAT announced in the 2008 Budget and Pre-Budget Report' – Oxford Economics, 2009

terms of alcohol related harm. These issues all have a relationship to each other and we require a coherent and shared response by all key partners in the City in order to 'promote responsibility and minimise harm'.

We need to prevent more problems and so treat or arrest fewer people. Treating people, whilst an important strand of any response to alcohol harm will not address the key reasons to why problems develop. Without addressing the why we will only be dealing with crisis which is often too late and very expensive.

We will never have enough funding to treat all people who require it – the numbers are too high - this is a national issue not one just for Plymouth. We must therefore establish a response that will help people to take more responsibility over their own use of alcohol and how it affects others, facilitate the responsible selling of alcohol by outlets across the City and provide timely and sensitive services to those in need of help.

The Plan's key aims will be:

- A strong, shared City response that will reduce alcohol related harm
- Changing knowledge, skills and attitudes towards alcohol (particularly with at risk groups and with the workforce who will deliver relevant services)
- Providing support for children, young people and parents in need
- Supporting individual need
- Creating safer drinking environments

This is a long term challenge and so the aims in the Plan will need to be delivered over ten years. This should be undertaken in two five years blocks. The second five years (phase 2) should be developed following a major review and refresh conducted in year 5 and be built on the progress and learning achieved.

The Strategic Plan sets out the key aims, objectives and outcomes to support our ambition along with the governance and delivery model.

An Operational Plan will be produced setting out how we will deliver against the strategic aims set out in this document.

The key source for evidence for the Plan is from:

- Plymouth's Joint Strategic Needs Assessment 2012.

Additional evidence and guidance include:

- Alcohol Attributable Hospital Admissions in Plymouth –South West Public Health Observatory 2012
- Findings from the National Alcohol Harm Reduction Support Team Visit 2011
- NICE (National Institute for Health and Clinical Excellence) guidance
- Signs for Improvement – commissioning interventions to reduce alcohol related harm; Department of Health 2009
- Local Routes – guidance for developing alcohol treatment pathways; Department of Health 2009

2. Our ambition

The City's overarching vision is, 'to be one of Europe's finest most vibrant waterfront cities where an outstanding quality of life is enjoyed by everyone'. This Plan will aim to support this through our ambition to:

'Reduce alcohol related harm in Plymouth'

Through achieving this we will have contributed toward Plymouth being a modern 21st century City. Success in delivery of the Plan will mean:

- increasing numbers of people drink responsibly
- alcohol related health harms are reduced
- public and private crime fuelled by alcohol is reduced
- the number of children exposed to significant parental alcohol misuse is reduced
- people socialise and relax in environments that feel safe and are family friendly
- people in need of help can access information, advice or support in a timely and sensitive manner
- the supply of alcohol is undertaken responsibly and is well managed and planned
- people visiting Plymouth, enjoy and feel safe in the evening and night time economy environment and feel motivated to return

3. Key Policy Drivers

There are a number of national policy drivers that provide a framework for local action to address alcohol related harm.

Government Alcohol Strategy: HM Government 2012
The government's Alcohol Strategy published in March 2012 signals a 'radical change' in the way that alcohol issues are addressed and promises to 'turn the tide against irresponsible drinking'. It has a clear focus to reduce binge drinking, drive down alcohol related crime and tackle health issues through sustained local and national action. There is a clear emphasis on personal responsibility and local action. Additionally the 'industry' is highlighted as a critical leader in changing the drinking culture from one of excess to one of responsibility.

Government Drug Strategy: HM Government 2010
This strategy sets out an ambition to support full recovery from addiction including alcohol dependence. This recognises that effective treatment for dependent drinkers will offer the most immediate opportunity to reduce alcohol-related hospital admissions and NHS costs.

Healthy Lives Healthy People – Our strategy for public health in England: Department of Health 2010
This strategy aims to create a new system that is responsive to the specific needs of local areas and communities. This will be characterised by public health being led from local authorities

with enhanced local freedoms and accountabilities and a ring fenced budget. Within new arrangements local Health and Well Being Boards will be responsible for oversight and leadership of the alcohol agenda. Working alongside Public Health in local authorities new NHS Clinical Commissioning Groups will also contribute to local alcohol misuse programmes through commissioning interventions that are evidenced to provide improved outcomes for individuals and savings for the health economy.

Improving Outcomes and Supporting Transparency; a public health outcomes framework for England 2013 – 2016: Department of Health 2012

This includes a number of indicators relevant to addressing alcohol:

- Improving the wider determinants of health – including sickness absence rate, violent crime and domestic abuse
- Health improvement – including alcohol related admissions to hospital and take up of the NHS Health Check programme
- Healthcare public health and preventing premature mortality – mortality from causes considered preventable, mortality from liver disease, hip fractures in over 65s.

Breaking the Cycle – Effective Punishment, Rehabilitation and Sentencing of Offenders: Ministry of Justice 2010

This sets out the government's new approach to reducing prison numbers, breaking the cycle of crime and tackling the causes of crime. It prioritises alcohol misuse and dependence among offenders and includes a focus on improving community and custody based alcohol interventions including liaison and diversion services in courts and police stations.

Police Reform and Social Responsibility Act: HM Government 2011

This Act has overhauled the Licensing Act 2003 (Rebalancing the Licensing Act) and will give local areas the powers to tackle local problems, including the ability to restrict opening and closing hours, control the density of licensed premises and charge a late-night levy to support policing. The Alcohol Strategy sets out the Government intention to bring into force all the Police and Social Responsibility Act alcohol reforms on April 25th 2012, except for Early Morning Alcohol Restriction Orders, the late night levy, and locally set licensing fees which require complex secondary legislation. These are expected to be enacted by October 2012.

Home Office: Selling Alcohol Responsibly: The New Mandatory Licensing Conditions
The Mandatory Code for Alcohol Retailers England and Wales April 2010

This document explains what the five new mandatory licensing conditions cover and the types of promotions and practices that are either prevented (such as irresponsible promotions) or expected to be implemented in all premises (such as age verification policies). These new mandatory conditions apply to all licensed premises and those with a club premises certificate in England and Wales, so this document will be of interest to those responsible for enforcing the law around licensing, as well as those selling or supply alcohol.

No Health without mental health: a cross-government mental health outcomes strategy for people of all ages 2011 Department of Health 2011

This sets out a framework for achieving better mental health for all and improved chances in life for people with mental health conditions. It highlights the issue of dual diagnosis (co-existing

mental health and drug and alcohol problems) and stresses the importance of local co-ordination between alcohol and mental health services to achieve fully integrated care.

Building Active, Safer Communities – Strong foundations by local people
This report champions community activism and priorities 'problem drinking' and associated anti-social behaviour as an area for local action. It suggests that agencies, businesses and local people work together to support a new drinking culture.

Early Intervention: The Next Steps – A review of Early Intervention Services: Graham Allen MP 2011
&
The Foundation Years: preventing poor children becoming poor adults – a review of child poverty. Frank Field MP 2010

These reports highlight a correlation between a number of factors with negative outcomes for children and young people including later alcohol and drug misuse. Amongst these factors are parental addiction (including alcohol), violence and mental ill health. Early intervention offers opportunity to intervene before problems escalate and become too expensive to cope with, difficult or impossible to remedy. In 'The Foundation Years' the impact of parental alcohol misuse alongside poverty is noted with a strong recommendation to Government to, 'develop policies and invest in services which support these children'.

The Munro Review of Child Protection: Professor Eileen Munro 2011.
The report recommends that effective early help can prevent abuse or neglect and improve the life chances of children and young people. These interventions are recognised as playing a critical role in child protection. The report includes a number of examples focused on parental alcohol misuse.

'Troubled Families' (Local name: Families with a Future) Agenda
This is focused on families who have multiple-vulnerability and are engaged in crime or anti-social behaviour. The work utilises intensive models of intervention, coordinated through a key worker. The approach provides significant opportunity for early intervention with children and young people in these families. Adults including parents from these families may require access to alcohol interventions to support reduction in amount and frequency of alcohol being used.

4. Understanding local Need

The local priorities and activity for Plymouth are informed by need. The primary source is the:

- The Plymouth Alcohol Joint Strategic Needs Assessment 2012

Additional information on need came from:

- Alcohol Attributable Hospital Admissions in Plymouth 2012: South West Public Health Observatory.
- The findings from the National Alcohol Harm Reduction Support Team visit in 2011

Key Findings from the Plymouth Alcohol Joint Strategic Needs Assessment 2012

Against a number of key harm indicators, Plymouth performs statistically worse than the England average[7] – these indicators are:

- Alcohol Specific Hospital admissions – under 18s
- Alcohol specific hospital admissions – males/females
- Alcohol attributable hospital admissions – males/females
- Hospital admissions for alcohol related harm
- Binge drinking
- Alcohol related recorded crime
- Alcohol related violent crime
- Alcohol related sexual offences
- Claimants of incapacity benefit – working age

Within Plymouth there are[8]:

- an estimated 46,000 hazardous or harmful drinkers (including dependent drinkers)

This is made up of:

- an estimated 39,200 hazardous and harmful drinkers (excluding dependent drinkers)
- an estimated 6,800 dependent drinkers

(See Glossary on page 29 for definitions of hazardous, harmful and dependent drinking)

- There is a strong association between deprivation and an increased burden of harm linked to alcohol misuse. Compared to those living in the most affluent areas, people in the most deprived fifth of England are three to five times more likely to die of an alcohol-specific cause and two to five times more likely to be admitted to hospital because of an alcohol – use disorder[9]

- Young people in Plymouth are more likely to drink alcohol than national counterparts. They are also more likely to have recently been drunk, compared to national and local counterparts[10]

- Plymouth's Hidden Harm needs assessment estimates that between 3,900 and 6,500 children are affected by parental alcohol misuse.[11]

- Alcohol is persistently the most significant contributor to effect violent crime and it represents 70% of all alcohol related crime. This reflects a strong correlation with binge drinking as opposed to dependant drinking.[12]

[7] Local Alcohol Profiles for England: http://www.lape.org.uk/LAProfile.aspx?reg=k
[8] Plymouth Public Health Development Unit using the tool from; Alcohol Needs Assessment Research Project (ANARP) 2006
[9] Alcohol Use disorders – preventing the development of hazardous and harmful drinking: NICE guidance and alcohol use disorders : National Institue of Health and Cliical Excellence2010
[10] DCSF. Tellus4 Data.2010.
[11] Plymouth Safeguarding Children Board (2008). Hidden Harm Working Group Analysis of Need
[12] Plymouth Community Safety Partnership Strategic Assessment (Crime and Disorder) 2011/12

- Domestic Violence / Abuse represents 30% of all reported violent crime in Plymouth and alcohol is implicated in a high number of these cases. There is a strong correlation between sexual assault / rape and alcohol use by perpetrator and / or victim.[13]

- Key at risk groups

  - Adults 40 – 64 (peak 40-44 women and 45-49 men)
  - Offenders
  - Single homeless
  - Young Adults (18 -25) including students
  - People with mental health problems
  - Children affected by Parental Alcohol Misuse / Alcohol misusing parents (including pregnant women)

  Other at risk groups

  - Young People (under 18)
  - Older People
  - Service men and women
  - Street drinkers
  - Victims and perpetrators of domestic abuse
  - People involved in risky sexual behaviour
  - Communities at risk – neighbourhoods with high levels of deprivation also have higher levels of dependent drinkers; binge drinkers; alcohol related anti-social behaviour; domestic abuse; child protection.

- There is a gap in our current understanding of alcohol related need with respect to local Black and Minority Ethnic Communities.

- There is emerging evidence of potential significant challenges with respect to older people and their drinking. We need to build more local evidence to inform our planning at this stage

- As of 31st March 2010 Plymouth had 811 Premises licenses and 57 Club premises certificates in force

- The cost of alcohol related harm within Plymouth is estimated at approximately £80million a year[14].

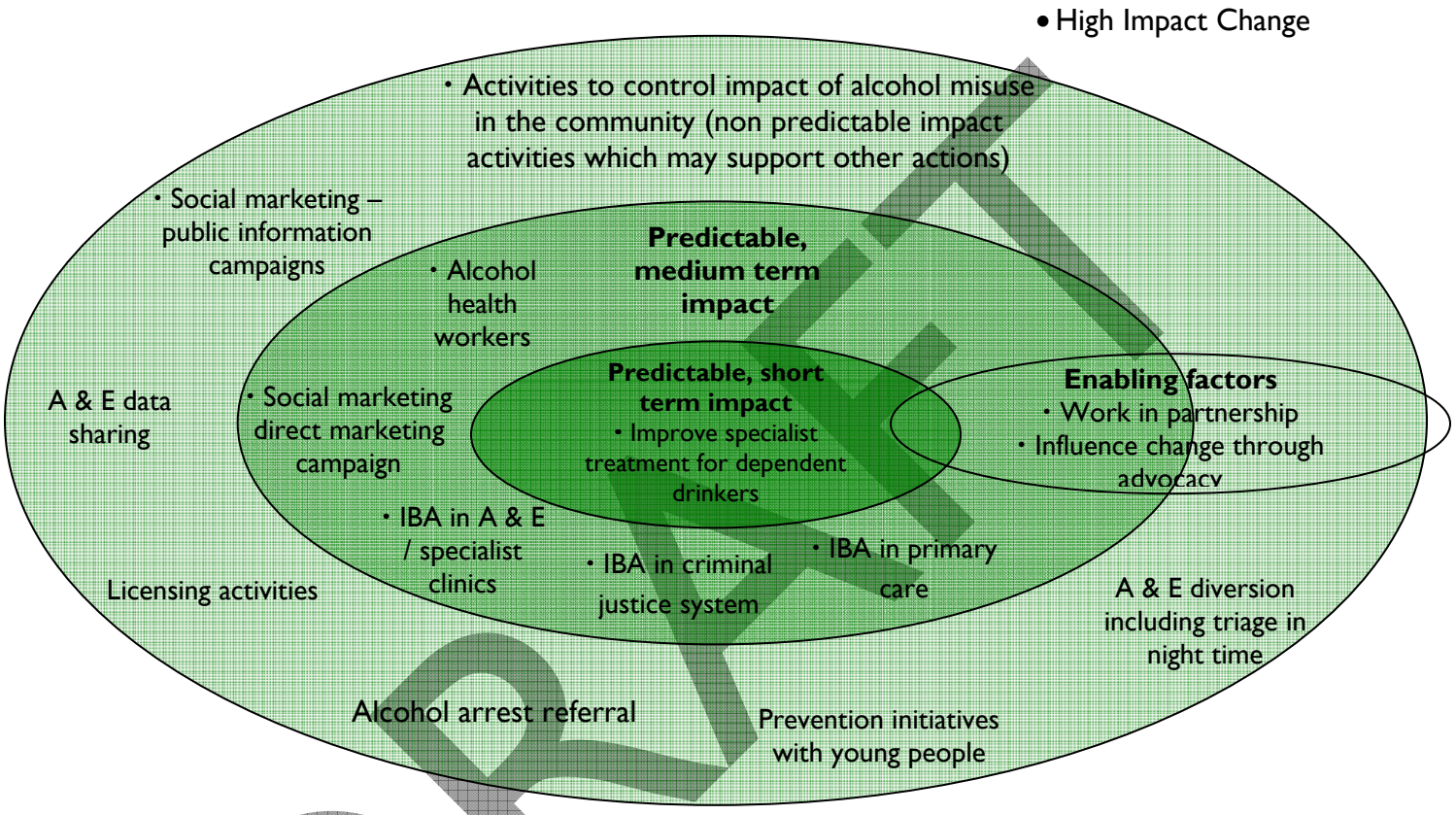
- Alcohol has an approximate cost to the health economy of Plymouth £9,630,000[15].

- Based on police data the estimated annual cost of alcohol related crime in Plymouth is in the region of £27million[16].

[13] Plymouth Community Safety Partnership Strategic Assessment (Crime and Disorder) 2011/12
[14] Plymouth Alcohol Joint Strategic Needs Assessment (2012): based on data from the Department of Work and Pensions
[15] Department of Health 2007

- Currently it is estimated that between 5% - 8% of dependent drinkers in the City access treatment each year. This range needs to be further understood to achieve a better breakdown between dependent and other harmful drinkers.[17]

5 High Impact Changes for reducing alcohol related hospital admissions



Department of Health (2009) Signs for improvement – commissioning interventions to reduce alcohol-related harm

The 'bulls eye' model above reflects a robust evidence base setting out activity that impacts on reducing hospital related alcohol admissions. This demonstrates the need to have a coherent plan driving out a range of activities many of which inter-relate. Those in the centre and middle ring reflect the most predictable evidence base for impact. Delivery will require a strong partnership approach.

The evidence suggests:

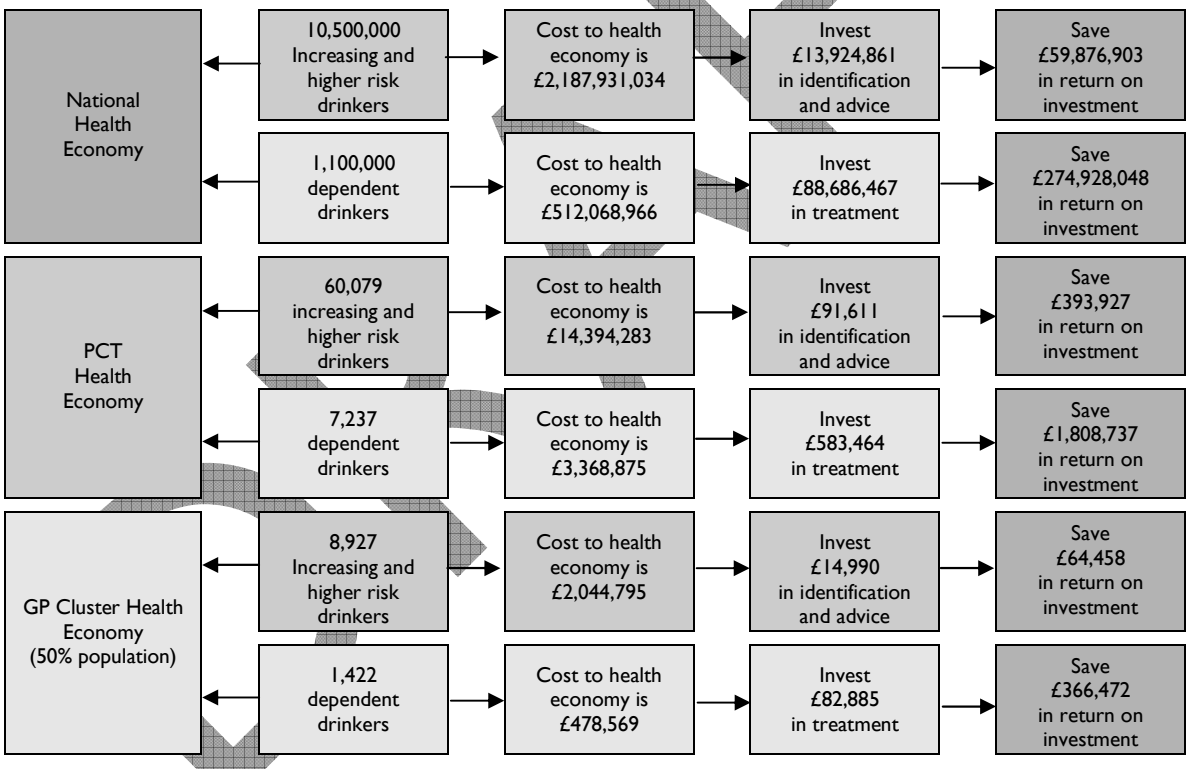
- Interventions available should address the needs of dependent drinkers, harmful and hazardous drinkers.

[16] Plymouth Alcohol Joint Strategic Needs Assessment (2012): based on data from Devon and Cornwall Constabulary
[17] An estimate based on the numbers in treatment from the National Drug Treatment Monitoring Service which includes both dependent and harmful drinkers

- Initiatives aimed at reducing alcohol related harm should be targeted at our key at risk groups and other risk groups[18], delivered in specific settings with specific relevant messages
- Strong Partnership is necessary for success
- Partnerships should have a role in advocating change e.g. supporting tackling the supply of very cheap, strong alcohol
- Outcomes from wider preventative activities are less predictable in the long term but when part of a coherent approach to tackling alcohol misuse are likely to contribute positively to the whole system

6. Return on investment

There is a strong 'invest to save' evidence base for tackling alcohol related harm. For example, the Department of Health illustrates the return on investments for the Health economy (below) made through reducing alcohol related harm for an average PCT population (350,000) or GP cluster (50,000).



The Department of Health (2009) Signs for improvement – commissioning interventions to reduce alcohol related harm.

Applying this evidence for Plymouth:

For a Plymouth population of 258,800[19] it is estimated that there are 46,000 increasing and higher risk drinkers of which 6800 are dependent drinkers

[18] See page 8
[19] ONS Population estimates 2010

- Investment of £70,540 in identification and advice is estimated to produce a return of £303,323
- Investment of £548,456 in treatment is estimated to produce a return of £1,700,213

Other studies show returns against a range of costs linked to health, welfare and crime.

- For every £1 pound spent on treating dependent (adult) drinkers £5 is saved on health, welfare and crime costs[20]
- For every £1 spent on young people's drug and alcohol treatment a benefit of between £4.66 and £8.38 is made[21].

7. Plymouth's key alcohol target within the Plymouth 2020 Performance Framework

The key overarching indicator that this Plan supports is the level 1 indicator reduce inequalities. Within this there is a specific level 2 indicator addressing hospital admissions. However, alcohol is an issue that can impact across all Plymouth 2020 aims.

Plymouth 2020 Aims

Deliver growth:	Raise aspirations:	Reduce inequalities:	Provide value for communities:
Develop Plymouth as a thriving growth regional centre by creating the conditions for investment in quality new homes, jobs and infrastructure	Promote Plymouth and encourage people to aim higher and take pride in the city	Reduce the inequality gap, particularly in health, between communities	Work together to maximise resources to benefit customers and make internal efficiencies

Specifically the alcohol target sits under reduce inequalities.

↑

Level 2 target: Reduce the rate of alcohol-related admissions by 2020 (based on 2019/20 data) to 2010 levels (based on 2009/10 data)

This indicator sits within the new Public Health Outcomes Framework - domain 2: Health Improvement[22]

[20] United Kingdom Alcohol Treatment Trial (UKATT) Research Team (2005) Effectiveness of treatment for alcohol problems: findings of the randomised UK alcohol treatment trial (UKATT)

[21] Department for Education 2011

[22] The Department of Health state (2012): "Alcohol misuse is the third-greatest overall contributor to ill health, after smoking and raised blood pressure. Alcohol consumption is a contributing factor to hospital admissions and deaths from a diverse range of conditions. Over 1 million hospital admissions related to alcohol in 2009/10. The Government has said that everyone has a role to play in reducing the harmful use of

The crude rate of alcohol-related admissions in Plymouth is projected to rise by 48.9% by 2019-20. To achieve the target (reduce the rate of alcohol-related admissions by 2020 to 2010 levels), it is anticipated that the rate will continue to rise until 2014/15. However from 2015/16 it is anticipated that the rate will drop steadily, reaching 2010 levels by 2020.

This Plan sets out activity that will support reduction in the rate.

Related targets in the 2020 framework

The Plan will also contribute toward a range of Plymouth 2020 targets. These include:

- Reduce the gap in life expectancy by at least 10% between the fifth of areas with the lowest life expectancy and the population as a whole by 2020 (based on 2017-19 data) from the 2010 baseline(based on 2007-2009 data) (Level 1 target)
- Reduce the rates of premature mortality (<75 years) in men from all causes by 40% by 2020 (based on 2019 data) from the 2010 baseline (based on 2009 data). (Level 1 target)
- NI 116 Reduce Child Poverty (Level 1 target)
- Increase in the number of visitors coming to the city (Level 1 target)
- NI 112 Reduce the Under 18 conception rate (Level 2 target)
- Reduce the rate of accidental dwelling fire casualties (per population) (Level 2 target)
- To reduce the rate per 1000 population for violence with injury (Level 2 target)
- Reduce harm from inter-personal violence (domestic violence and sexual violence) (Level 2 target)
- Reduce reported ASB incidents to police (Level 2 target)
- Reduce the gap in vulnerable families by at least 50% between the fifth most and fifth least deprived neighbourhoods by 2020 from the 2010 baseline (Level 2 target)

alcohol – this indicator is one of the key contributions by the Government (and the Department of Health) to promote measurable, evidence based prevention activities at a local level, together with a national ambition to reduce alcohol-related hospital admission."

8. Plymouth's Impact Areas / Themes supporting delivery of the Plan

Using Impact Areas

We have created 'Impact Areas' to provide structure that supports governance, accountability and delivery of the Plan. There is a risk in creating these, in that we create silos. Individual and population need does not break down into single themes constructed to deliver a Plan. For example prevention will be relevant across a number of Impact Areas. Alcohol is a complex agenda and we will need to develop a mature understanding of how the cross cutting relationships of this approach are best managed. Rather than see the Impact Areas as isolated strands of work we should use them to help provide focus on delivery within an integrated approach.

Governance; Communication and Strategic Partnerships **–** delivering **'**A strong, shared Partnership response that will reduce alcohol related harm'

OVERVIEW – GOVERNANCE; COMMUNICATION AND STRATEGIC PARTNERSHIPS

This Impact Area will ensure that we have strong and clear structures within the City that will deliver change. It will drive forward a shared ownership of delivery, financing and commissioning which is critical to the Plan's success. It will ensure annually that the Plan remains on-track and relevant. This Area will seek to establish links with the Growth Board to determine how we maximise achievement of the Aim's set out in the Plan though agreed and clear relationships to economic development**.** It will support communication with stakeholders.

WHAT DO WE NEED TO DO? - GOVERNANCE; COMMUNICATION AND STRATEGIC PARTNERSHIPS

We need to establish a strong shared response at the highest level of the City that will provide clear accountability for the delivery of the aims set out in the Plan. This will support tough decision making on investment that will need to be made, provide robust governance ensuring effectiveness and value for money and drive out a modern harm reduction system to tackle alcohol misuse. A business case setting out options on how we resource the system and service design requirements to deliver the Plan will be produced.

We need to facilitate and support communication across key stakeholders including, the people of Plymouth, elected members and partners in the private, community and public sectors. This will seek to engage stakeholders in the change process and to update on progress and challenges. This should be on-going. Influencing other corporate agendas to mainstream tackling alcohol misuse will be an important outcome to support the most efficient use of resource across all Partners.

The evidence is clear that managing the supply side of alcohol to a population is a key component to any alcohol harm reduction ambition. Much of this can be down to national government policy but local planning and decision making has an important part to play. Whilst there is activity set out in the 'Enforce and Control' Impact Area to help address this there is a

need through this Impact Area to establish a strategic relationship to the 'Growth Board' to ensure there is mutual understanding of the challenges and partnership opportunities to reduce alcohol related harm.

Elected members should have an opportunity to build their understanding of the supply side of alcohol and what measures they have at their control to manage the supply side and so reduce alcohol related harm at both a population and individual level.

An annual review to evaluate, refresh and update the Plan will be undertaken.

PREVENT – delivering 'Changing knowledge, skills and attitudes towards alcohol'

OVERVIEW – PREVENT – *this needs bolstering following consultation*

Preventing problems reduces harm and saves money. This Impact Area will primarily focus on specific alcohol related activity that will support prevention activity to reduce demand. This Area will target our at risk groups including vulnerable adults and seek to ensure education and awareness raising is available to children and young people under 18 years old

Alcohol misuse is a symptom of many factors. It is complex and not straight forward. It is important to note that addressing issues that could lead to alcohol misuse is currently delivered through a range of activity within the City, for example through work tackling child poverty, health inequality, crime and anti-social behaviour, building economic development, meeting health need, delivering education in schools, safeguarding children, youth work, etc. Influencing these areas to support delivery of the Aims in this Plan is important.

Amplifying national initiatives at a local level is important. For example, making alcohol less affordable is one of the most effective ways of preventing alcohol-related harm. This is being led by national policy on minimum pricing. There is evidence that alcohol advertising does affect children and young people and again this is being driven at a national policy level. International evidence suggests that making it less easy to buy alcohol, by reducing the number of outlets selling it in a given area and the days and hours when it can be sold, is another effective way of reducing alcohol-related harm. Locally, delivered under the 'Enforce and Control' Impact Area will help manage the supply of alcohol. It is important that wherever possible national initiatives to reduce alcohol related harm are built on locally.

Activity that sits within 'treat', namely screening and brief interventions have a significant part to play in prevention of problem use. Targeted at our at risk groups we can reduce the number of people requiring treatment by intervening early.

WHAT DO WE NEED TO DO? - PREVENT

We need, through working in partnership with schools across the City, to ensure that all school aged children and young people receive high quality alcohol education. This should be alongside out of school opportunities for under-18s to be able to access information, advice and guidance on alcohol. A partnership with higher education and further education establishments in the City should mirror the offer for school age children and young people

ensuring that young adults and young people are aware of alcohol related harm and how to reduce this. Clear links between alcohol, sexual vulnerability and also violence (public and private) should be part of this offer.

We should strive to establish through the Plymouth 2020 Partnership, awareness raising initiatives linking alcohol misuse and at risk groups, in each partner organisation. The frequency and scale of such events would need to be determined by each organisation but the potential numbers of people reached across the City could be in the tens of thousands.

Key at risk groups should be able to have access to information, advice and support that is meaningful to their specific needs and context. This should be provided by services that come into contact with key risk groups or services directly commissioned or provided to work with them. For example Primary Healthcare, Emergency Department, General Hospital Wards, Sexual Health Services; Psychiatric Services, Social Care (Adults and Children's), Targeted Youth Support Services; Parent and Family Services; Homelessness Services, Police settings (custody), Probation, Education, Employment and Vocational Services, Occupational Health Services.

We need to establish an improved understanding of need of Black and Minority Ethnic communities and also older people. Findings should identify key priorities going forward and inform refreshes of this Plan.

We need a workforce across all key partners that are competent to deliver services that provide information, advice and support particularly where they have contact with at risk groups. This includes competency to deliver interventions under the 'Treat' Impact Area. This requires high quality training being routinely available. This Impact Area should ensure that a workforce development needs assessment is undertaken and that this informs the design and delivery of training that will support the Aims in the Plan.

We must ensure that local prevention messages – where appropriate – amplify national initiatives aiming to prevent alcohol related harm.

PROTECT - delivering support for children, young people and parents in need

OVERVIEW - PROTECT

This Impact Area will build on current initiatives to ensure a strong focus on the safeguarding of children and young people affected by parental alcohol misuse. Work by the Hidden Harm Partnership identified that between 3900 and 6500 children are significantly affected by parental alcohol misuse and around 11% of all child protection plans are linked to where parental alcohol misuse is the primary risk factor. This reflects a significant challenge and hence requires a clear focus.

Graham Allen MP states, "that not intervening early enough and effectively enough with children can lead to every taxpayer paying the cost of, "low educational achievement, poor work aspirations, drink and drug misuse, teenage pregnancy, criminality and unfulfilled lifetimes

on benefits. But it is not just about money – important as this is, especially now – it is about social disruption, fractured lives, broken families and sheer human waste".[23]

This Impact Area will have a strong relationship to activity supporting diversion of children from care; the early intervention framework for children and families and initiatives focused on troubled families (Families with a future). This work can have an important part to play in reducing child poverty.

WHAT DO WE NEED TO DO? – PROTECT

We need to build on progress made in tackling parental alcohol misuse and its effects on children. Our newly commissioned services working with parents with a high level of alcohol misuse and also children affected by parental alcohol misuse will begin to have impact across 2012/13. These must be monitored closely with a view to evaluating impact.

We need to raise awareness with Parents the possible negative consequences of their alcohol use on their children. We need to jointly work alongside 'Prevent' to raise awareness with risk parents who irresponsibly buy or supply alcohol to their children.

We need to improve the detection of parental alcohol misuse across all key services working with parents with a specific drive focused on pregnant women and families with children under 5s.

We need to improve the way we identify, engage and support children and young people affected by parental alcohol misuse.

The sharing of information across services where there is concern for a child or young person must continue to be seen as core business, particularly with respect to sharing information across adult and children's services. Examples of key adult services would be substance misuse treatment services, criminal justice services, mental health services and domestic abuse services.

Commissioned and provided Parenting Programmes need to have clear eligibility criteria for parents where alcohol is a factor in the referral.

We need to ensure that organisations delivering services as part of the early intervention framework and work with troubled families (Families with a future) can support the Aims set out in this Plan.

Existing links between substance misuse services and domestic abuse services must be built upon to ensure we maximise our impact on reducing alcohol fuelled domestic violence. Along with activity (in 'Prevent') focused on awareness raising approaches with at risk groups we should build on the excellent work of Operation Encompass to offer support to children and

[23] Early Intervention: The Next Steps – A review of Early Intervention Services: Graham Allen MP 2011

young people they have identified that are affected by both parental alcohol misuse and domestic violence / abuse.

We need to continue to build a competent workforce to safeguard children where alcohol is a factor and ensure that these competencies can be developed across the lifetime of this Plan.

There need to be strong links with the 'Treat' Impact Area to ensure parents can access treatment and interventions in an accessible and swift way.

TREAT – delivering support to meet individual needs

OVERVIEW - TREAT

This Impact Area will primarily focus on the treatment and intervention system that provides a range of interventions in line with the tiered model set out in Alcohol Models of Care for Alcohol Misusers (Adults)[24]. Services for young people under 18 will be integrated into this Impact Area in line with specific guidance for them[25]. Models of Care sets out the range of evidence based interventions that work and should be commissioned.

This Impact Area will support activity that identifies persons in the early stages of problem behaviours and attempt to avert the ensuing negative consequences by supporting them to cease their problem behaviour through counselling or treatment (sometimes referred to as secondary prevention). It will also strive to end problem behaviour and / or to ameliorate their negative effects through treatment and rehabilitation. This is most often referred to as treatment but also includes rehabilitation and relapse prevention (sometimes referred to as tertiary prevention).

We need an efficient, sufficient and modern treatment system. Central to our challenge is increasing capacity to meet agreed demand and designing a system that will better meet the needs of our key at risk groups and other at risk groups. This can be addressed though doing things differently but will require additional investment.

WHAT DO WE NEED TO DO? – TREAT

We need a system in place that delivers high quality evidence based interventions within an integrated modern system that covers all 4 tiers of intervention. For those drinking harmfully, including those who are dependent, recovery must be a key outcome from the system. Recovery is described as, 'a person-cantered approach that empowers people to tackle their alcohol misuse within their community, and make permanent changes to their lifestyle that will free them from dependence and enable them to successfully contribute to society'[26].

We need a system that has been designed to meet the needs of at risk groups and interventions should be accessible to them in a variety of settings and delivered in a timely and sensitive

[24] Models of Care for Alcohol Misusers. National Treatment Agency. Department of Health. 2006
[25] Guidance on commissioning young people's specialist substance misuse treatment services. National Treatment Agency. NHS
[26] Services for the identification and treatment of hazardous drinking, harmful drinking and alcohol dependence in children, young people and adults – Commissioning Guide. National Institute for Health and Clinical Excellence. 2011

manner. Examples of where adult tier 3 treatment should be delivered from include Primary Health Care settings across the City and services operating within the Homelessness pathway. Specialist substance misuse services should continue to provide interventions from their sites as well. Young people should be able to access interventions from specialist alcohol and substance misuse sites as well as some youth settings.

We need a clear pathway of integrated support, clearly understandable by professionals and service users. Alongside setting out support available by specialist alcohol and substance misuse services (covering community; hospital and residential services) the pathway must also include key health, adult social care, criminal justice, housing, children's social care, education, employment and training services. This will support recovery.

We need the treatment and intervention system to be designed to meet clinical need; help addresses offending behaviour and support improved outcomes for children where there is parental alcohol misuse.

We need to establish clarity over how we meet the needs of people with a dual diagnosis in practice and this should be reflected within the pathway. The response should be an integrated response meaning the mental health and alcohol misuse needs are met together and not separately or through dealing with one before the other. This should also cover the Improving Access to Psychological Therapies (IAPT) service.

We need to build a clear structure to enable service users to feedback and influence the planning of services and the monitoring of services. This should be seen as core information to assess quality of provision and be on-going.

We need a system that is efficient with as much resource as possible going toward delivering the key evidence based interventions that the majority of people respond positively to and these interventions should be offered through a mix of both individual and group approaches.

We need to plan on providing provision for the uptake of evidence-based specialist treatment for at least 15% of estimated dependent drinkers in the PCT area within the first 5 years of this Plan[27]. This equates to around 1000 people. By the end of 10 years our ambition should be to achieve capacity for 20%. To achieve 15% will require the current system to have increased its current capacity by between two and three times. Work by the Alcohol Joint Commissioning Group will need to agree if this 15% covers dependent drinkers only or include harmful drinkers. Whatever the decision the target of 15%, based on dependent drinkers, will radically improve our capability to impact on reducing alcohol related harm and reduce hospital admissions. Increases in capacity need to be particularly focused on community settings including community detoxification services. Hospital services, for example the Liaison Service will need a proportionate increase in capacity to ensure a fully integrated system across community and Hospital can function. It should be noted that Liver Cirrhosis is now the 5th most common cause of death and continues to rise (the four causes above this are falling). Alcohol accounts for 58% of all liver disease. This has implications on the Hepatolgy

[27] Signs for improvement – commissioning intentions to reduce alcohol-related harm: Department of Health 2009

Department within the Hospital. Consideration should be given to review the Department in meeting the needs of the Plymouth population within a new integrated treatment system.

We need to screen for alcohol misuse amongst key at risk and other risk groups. Delivered in key settings this will provide significant opportunity to intervene earlier before need becomes more pronounced and usually more costly to treat. The National Institute for Health and Clinical Excellence benchmarking tool suggests that we should screen 13,000 people (16 years and above) each year. Of this it is suggested that 2300 will require a brief or extended brief intervention. Further detailed work needs to be undertaken to determine actual numbers we should screen and provide brief interventions to. Primary Health Care settings provide a key gateway to the alcohol harm reduction system and are well placed to spearhead this response.

Key sites where screening should be undertaken include:

- Primary Healthcare
- Emergency Department
- Sexual Health Services
- General Hospital Wards
- Psychiatric Services
- Social Care (Adults and Children's)
- Targeted Youth support services
- Homelessness Services
- Police settings (custody)
- Probation
- Education and Vocational Services
- Occupational Health Services

Key services where brief interventions and extended brief interventions should be delivered from include:

- Specialist alcohol services;
- Primary health care (shared care);
- Hospital Emergency and Liver Units;
- Psychiatric services;
- Homelessness Services
- Domestic abuse services;
- Antenatal clinics;
- Probation services
- Occupational health services
- University / HE establishments

Current estimates suggest around 90 young people a year requiring specialist alcohol treatment. This need is being met within current capacity. We need to improve the number of referrals for key at risk groups amongst young people. Pathways and support linking work with the emergency department and locality based youth support need to be improved as does

identifying earlier the needs of young women and girls. We must ensure a strong focus on linking sexual health services with alcohol interventions and alcohol services.

ENFORCE AND CONTROL – delivering to create safer drinking environments

OVERVIEW - ENFORCE AND CONTROL

This Impact Area will focus on enforcement and control and will focus on making improvements to Plymouths ENTE areas, as we know that alcohol has been sighted as the most significant contributor to violent crime and as a key contributing factor to interpersonal offences including rape, sexual assault and domestic abuse. [28]Localised data for 2011/12 (Police Data and Voluntary Sector Data) identified substance (particularly relating to alcohol or/and alcohol and drug) misuse as a key contributing factor with 30% of Domestic Abuse incidents being alcohol attributable, and 22% of Sexual Assault incidents. We will work cohesively together and plan for an Evening Night Time Economy we wish to see instead of one that has evolved over time. We will need to make stronger links with 'Growth' in order to work together to mitigate any negative impact on growth and find a balance between health harm and the cities potential for growth within our ENTE areas.

We must utilise all relevant legislation to bring stronger control and ensure early intervention is explored as a first option to reduce the need for enforcement action to be taken. This will be achieved by making improvements to practices and protocols across the partnership. E.g. to adopt a Street Drinkers Policy to ensure all agencies respond to the needs of this hard to reach group and understand access to services and support in the city whilst also understanding the criminal justice route that may have to be explored if necessary.

We know that Plymouth has a population of approx 258,000 and that we have evolved into a University town with a large student population totalling approx 33,000. The city is a known destination for a night out in the southwest with revellers travelling from Cornwall and the South Hams on a regular basis. This makes for a city with a larger than average 18 – 24 year old age range to cater for.

Clear evidence from 'The impact of pre-loading alcohol on violence in Plymouth's night time economy'[29] that was carried out in Plymouth clearly identifies that young people (a high proportion of those interviewed were aged 18 – 24) are consuming significant amounts of alcohol before entering the Evening and Night Time Economy (ENTE). It also strives to recognise that alcohol availability and low cost are still two key issues and will need to be tackled locally utilising national controls, legislation when available in order to reduce pre-loading and restrict quantity of alcohol available.

Plymouths Licensing Policy is being reviewed at the end of the year and this is likely to include new control measures to include proposals to adopt the late night levy and the introduction of Early Morning Restriction Orders (EMRO). The levy is designed to generate additional income

[28] Plymouth Alcohol Needs Assessment 2012
[29] A report that was produced by Adrian Barton and Kerryn Husk, Social and Public Policy Research Group, Plymouth University

to support aspects of Policing in the ENTE areas for businesses operating after midnight[30]. A consultation period will take place on the Levy and it is unlikely that this will be implemented until June 2013. EMRO will allow for Licensing authorities to restrict sales of alcohol in the whole or a part of their areas for any specified period between midnight and 6am. This could aid with any zoning activity the city intends to bring in to support the development of the ENTE Control Plan.

Plymouth currently utilises a range of policing powers in order to reduce alcohol related harm utilising, 'Designated Public Places Orders' and 'Dispersal Orders', for problem areas. For problem individuals 'Drinking Banning Orders' are issued . People who are arrested as a result of being drunk and disorderly are offered the options of attending a short course to help inform them about their drinking habits (Plymouth Alcohol Diversion Scheme) or asked if they would accept a caution under the new Sobriety Scheme (sighted in the National Alcohol Strategy 2012) . Police prefer to issue 'Directions to Leave' as a preferred method of early intervention which reduces the potential for high levels of violence to occur.

WHAT DO WE NEED TO DO?

Enforce can be achieved in many ways and we intend to:

- Work with our worst offenders (who commit acts of alcohol related crime) in order to stop them re-offending and will support them through the Integrated Offender Management Programme (IOM).
- Work with offenders who are perpetrators of domestic abuse we will explore the option of a new programme designed to 'making the change' needed to address this behaviour. We will look work with partners on aspects of early prevention and work with offenders early in the process by making Alcohol Treatment Referrals (ATR's).
- We need to plan for a 'safer drinking environment' by utilising changes to the Licensing Legislative Framework. One of these changes will allow both Health and the Local Authority to act as 'responsible authorities' who will then be able to raise objections if the application impacts on the four licensing objectives[31]
- Offer sobriety schemes where relevant and Intervention and brief advice, issue low level Policing powers to prevent escalation of behaviours

Control can be achieved in many ways and we intend to:

- We propose to develop an Evening Night Time Economy Plan giving clear direction and structure to Plymouths ENTE.
- We will look to work with both 'on' and 'off' sales trade to promote responsible retailing and discourage underage sales.
- Drive up standards by formalising the Best Bar None Scheme (a nationally accredited scheme) and by maintaining strong relationships with local groups, e.g. Pub Watch and Club Watch[32]. 'Purple Flag'[33]

[30] (for exceptions to the levy - see Home Office Doc ISBN: 978-1-84987-789-6)
[31] (see Section 182 Rebalancing the Licensing Act 2003) .
[32] (Local schemes operated by the on sales trade)

- Activities such as 'Purple Flag'[34] should be considered across the partnership in order for it to be used in a positive way to promote and market our city. We need to work closely with BID Companies and Place Managers to achieve and will look to support any application to employ an ENTE Manager for the city who could act as a conduit for this work.
- Focus on reducing price and supply locally in order to reduce availability this will not be an easy task and will require Member support in order to make the necessary changes.
- Work towards changing our culture in order to reflect a less alcohol fuelled environment focusing on a more diverse mix of entertainment venues/activities in the city to allow for wider choice.
- develop a Street Drinkers Policy for the city

It is clear from the wealth of data we hold locally and the National Data that there are still significant improvements we need to make in order to achieve alcohol harm reduction in the city. We must continue to explore ways of utilise the statutory powers we have wisely ensuring that we are not only using enforcement action but are looking at ways to improve standards, diversify our night time economy and continue to focus on prevention through targeted activities to core client groups.

We need to develop an evening night time economy plan that will act as a point of reference for anyone wanting to work, visit, enjoy and reside in the area. We will need to utilise all our control and enforcement measures to achieve a vibrant well run night time economy.

We must focus on our key groups young people 15 – 25, street drinkers, persistent violent offenders and ensure strong links are made with other thematic areas in the plan particularly around prevent, protect, treat in order to achieve are aim to reduce crime and anti social behaviour and promote a safer Plymouth.

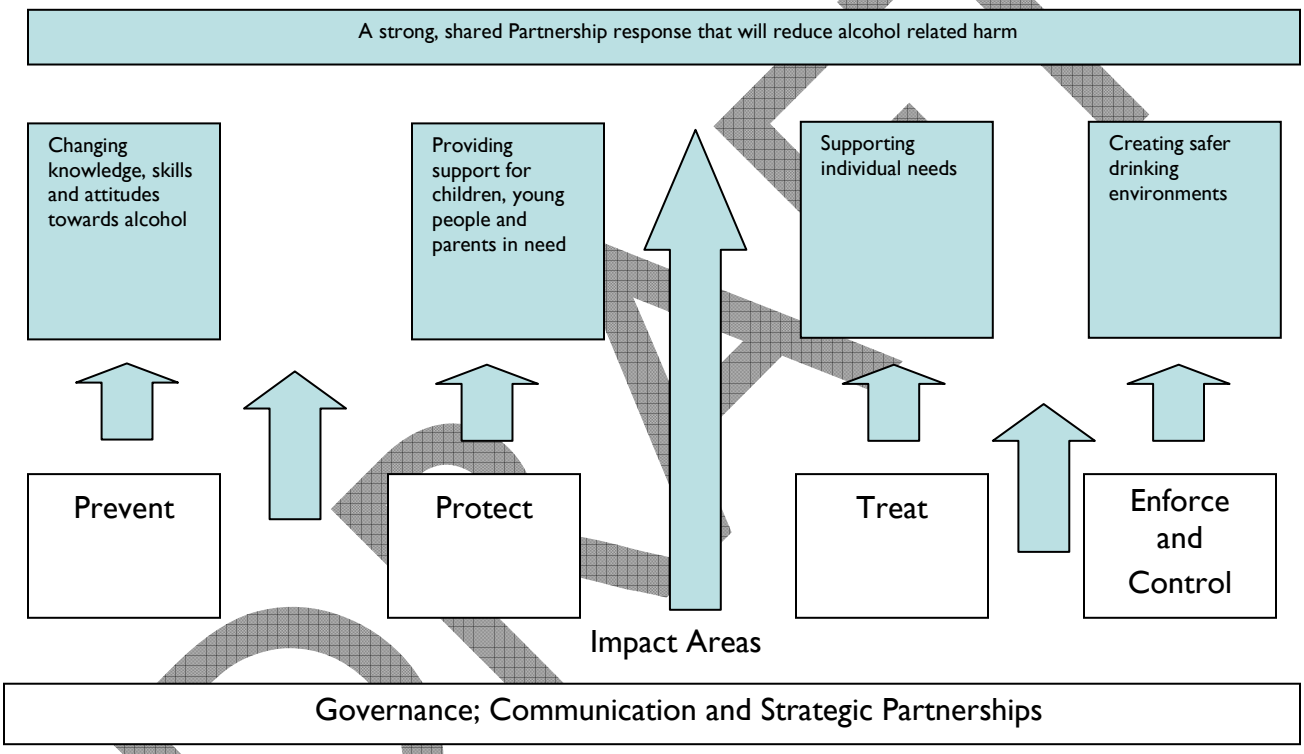
[33] An Association of Town Centre Management (ATCM) accreditation scheme awarded to areas that demonstrate they operate a vibrant evening night time economy between 5pm – 5am for everyone to enjoy safely.
[34] http://www.purpleflag.org.uk/

9. Proposed Framework for delivery of Plan

These are the proposed Aims for the plan:

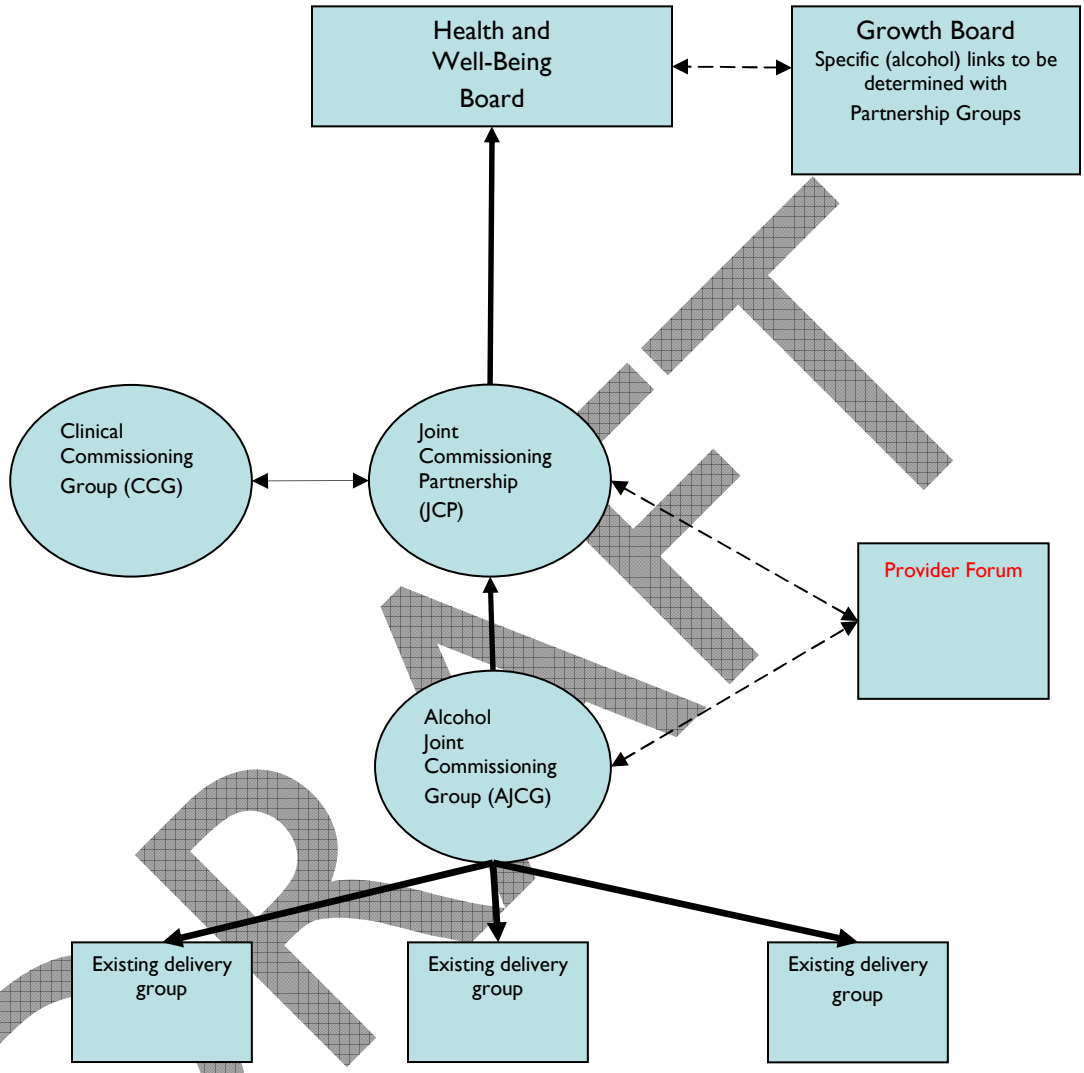
- A strong, shared Partnership response that will reduce alcohol related harm
- Changing knowledge, skills and attitudes towards alcohol
- Providing support for children, young people and parents in need
- Supporting individual needs
- Creating safer drinking environments

The Aims will be achieved through delivery across 5 impact areas. These are, Prevent; Protect; Treat; Enforce and Control, and Governance; Communication and Strategic Partnerships. These will provide a focus and structure to support accountability and governance for delivery. The Impact Areas are set out below along with their relationship to the Aims:



Executive Officers should hold responsibility for delivery against each of these impact areas. They should take reports on progress against milestones to deliver the plan as well as key performance measures reflecting impact. This should take place twice each year and could be undertaken within existing structures e.g. Joint Commissioning Partnership. The Executive Officers should collectively hold responsibility for delivery of the level 2 target, 'Reduce the rate of alcohol-related admissions by 2020 to 2010 levels. The Health and Well Being Board is responsible for oversight and leadership of the alcohol agenda.

Accountability



Thick black line: direct accountability
Thin black line: agreed routine communication / representation between differing forum
Thin dotted line: relationships to be agreed structure

10. Proposed Impact Areas / Aims / Objectives and Outcome Measures – *these need refreshing following consultation*

Governance; Communication and Strategic Partnerships

Aim 1 A strong, shared Partnership response that will reduce alcohol related harm

Objectives
1 Develop and maintain Partnership approach to ensure a strong and shared response
2 Ensure effective performance management of delivery of Plan
3 Ensure effective communication with all key stakeholders
4 Develop strategic relationship with Growth Board

Outcome measures
- Reduction in alcohol related hospital admissions
  (this to be reviewed and others to be determined by AJCG Summer 2012)

Key Leads
- Joint Commissioning Partnership
- Alcohol Joint Commissioning Group
- 2020 Executive Group
- Executive Officers
- Proposed Alcohol Lead / Lead Commissioner

Prevent

Aim 2 To change knowledge, skills and attitudes towards alcohol

Objectives
1. To raise awareness of the impact of alcohol misuse on health, crime and well-being and promote a culture of safe, sensible drinking
2. Improve capability to raise awareness and meet need

Outcome Measures
- Change in behaviour so that people think it is not acceptable to drink in ways that could cause harm to themselves and others
- Reduction in the number of adults drinking above the NHS guidelines
- Reduction in the number of people binge drinking
- Reduction in the number of alcohol-related deaths
- Reduction in the numbers of 11-15 year olds drinking alcohol and the amounts consumed

(this to be reviewed and others to be determined by AJCG Summer 2012)

Key Leads
- Public Health
- Youth Service
- Health, Wellbeing and Citizenship Service
- Services working with at risk groups

Protect

Aim 3 Support for children, young people and parents with an alcohol related need

Objectives
1. Effective safeguarding of children living in families where there is significant parental alcohol misuse, including where there is a dual diagnosis
2. Improved detection of parental alcohol misuse
3. Improved awareness by parents of the potential negative impact their alcohol use can have on their children and the risks of irresponsible supply to their children
4. Increased sharing of appropriate information between agencies

Outcome Measures
- Change in behaviour so that people think it is not acceptable to drink in ways that could cause harm to themselves and others
- Reduction in the number of adults drinking above the NHS guidelines
- Reduction in the number of people binge drinking
- Reduction in the number of alcohol-related deaths
- Reduction in the numbers of 11-15 year olds drinking alcohol and the amounts consumed

(this to be reviewed and others to be determined by AJCG Summer 2012)

Key Leads
- Hidden Harm Partnership; Public Health; Community Safety Partnership; Families with a Future; Local Authority Commissioning Team

Treat (1)

Aim 4 Supporting individual needs

Objectives
1. To have a modern local treatment system delivering evidence based treatment interventions with capacity to be able to treat 15% of dependent drinkers in place by 2014 (this is subject to more detailed work)
2. To deliver treatment in an integrated system, reflected through agreed pathways of support, with clear relationships between alcohol services and mental health services; adult social care; children's social care; key children's and family services; criminal justice services; housing and employment services
3. To deliver treatment within a system that has a strong focus on recovery such that the number of people returning to treatment within a year is minimised from 2013
4. To deliver tier 2 and 3 treatment interventions from a range of community based sites including Primary Health Care and Homelessness settings
5. To annually screen (agreed number) of individuals at risk of alcohol related harm through developing a more systematic, co-ordinated and effective approach to alcohol screening and brief interventions with Primary Care as a key gateway alongside other key sites identified (2014) (this is subject to more detailed work)
6. To provide brief interventions to around (agreed number) of hazardous and harmful drinkers each year from 2014 (this is subject to more detailed work)

Treat (2)

Aim 4 Supporting individual needs

Outcome Measures
- Reduction in alcohol related hospital admissions (over18s and under 18s)
- Reduced alcohol related injuries, physical and psychological morbidity and mortality
- Individuals in need receive timely, sensitive and appropriate support
- Proportion of people accessing specialist alcohol services who achieve their treatment goals (over18s and under 18s)
- Effective recovery reduces number of people returning to treatment within 12 months of exiting (over18s and under 18s)
- Increased detection and referral of harmful and dependent drinkers
- Increased number of quality brief interventions delivered across NHS and other settings targeting key at risk groups
- Reduction in adults on benefit due to alcohol related incapacity

(this to be reviewed and others to be determined by AJCG Summer 2012)

Key Leads
- Joint Commissioning Partnership; Alcohol Joint Commissioning Group; Young Peoples Substance Misuse Commissioning Group; Sexual Health Commissioning Group

Enforce and Control (1)

Aim 5 Create safer drinking environments

Objectives Enforce

1. Reduce incidents of alcohol related violent crime
2. Reduce incidents of rowdy drunken behaviour that result in anti-social behaviour
3. Reduce the numbers of problem premises in Plymouth by Utilising licensing Powers where necessary
4. Reduce alcohol related A & E Admissions
5. Adopt a partnership approach to 'Street Drinkers'

Objectives Control

1. Produce a Plymouth ENTE Plan to sit within the Plymouth Plan which will inform future licensing decisions regarding (types of establishments granted licences/density/planning and economic growth).
2. Support the Best Bar None Scheme to improve standards in Plymouths licensed venues
3. Ensure all 'responsible authorities' comment on all applications for a license to sell alcohol both off sales and on sales. Local information regarding related health concerns, alcohol-related violence including domestic violence and levels of alcohol-related child protection cases should be considered
4. Agree a consistent and approach across the whole Partnership to street drinking
5. Support the University to deliver the National Healthy Higher Education Programme
6. Gain local political support to engage with 'Super Markets' (off sales) to reduce cut price drink offers/volume

Enforce and Control (2)

Outcome Measures

Enforce
- To achieve a reduction in alcohol related crime and disorder through effective partnership working, policing and implementation of Licensing Legislation

Control
- To enable partners to contribute and produce a citywide ENTE Plan that is designed to provide the controls needed to create a safe, vibrant waterfront city.

(this to be reviewed and others to be determined by AJCG Summer 2012)

Key Leads
- Police; Plymouth City Counsel Licensing; Violence and Crime Delivery Group; Community Safety Partnership; Strategic Housing; Anti-Social Behaviour Champions Group

13. Glossary

Alcohol misuse	Harmful drinking and alcohol dependence can be collectively referred to as 'alcohol misuse'.
Alcohol related harm	Physical or mental harm caused either entirely or partly by alcohol. If it is entirely as a result of alcohol, it is known as 'alcohol specific'. If it is only partly caused by alcohol it is described as 'alcohol attributable'.
Alcohol use disorders	Alcohol-use disorders cover a wide range of mental health problems as recognised within the international disease classification systems (ICD-10, DSM-IV). These include hazardous and harmful drinking and alcohol dependence. See 'Harmful' and 'Hazardous' drinking and 'Alcohol dependence'.
Brief Intervention	This can comprise either a short session of structured brief advice or a longer, more motivationally based session (that is, an extended brief intervention – see also below). Both aim to help someone reduce their alcohol consumption or abstain, and can be carried out by non-alcohol specialists.
Dependent drinking	Alcohol is both physically and psychologically addictive. Being dependent on alcohol means that a person feels that they are unable to function without alcohol, and the consumption of alcohol becomes an important, or sometimes the most important, factor in their life. Depending on their level of dependence, a person can experience withdrawal symptoms if

	they suddenly stop drinking alcohol. Withdrawal symptoms can be both physical and psychological
Extended brief intervention	This is motivationally based and can take the form of motivational-enhancement therapy or motivational interviewing. The aim is to motivate people to change their behaviour by exploring with them why they behave the way they do and identifying positive reasons for making change. All motivationally based interventions can be referred to as 'extended brief interventions'.
Harmful Drinking	Harmful drinking is defined as a pattern of alcohol consumption causing health problems directly related to alcohol. This could include psychological problems such as depression, alcohol-related accidents or physical illness such as acute pancreatitis.
Hazardous Drinking	A pattern of alcohol consumption that increases. Some would limit this definition to the physical or mental health consequences (as in harmful use). Others would include the social consequences. The term is currently used by World Health Organisation to describe this pattern of alcohol consumption. It is not a diagnostic term.
Models of Care for alcohol misuers	Best practice guidance for local health organisations and their partners in delivering a planned and integrated local treatment system for adult alcohol misuers.
Motivational Interviewing	Extended brief interventions that aim to motivate people to change their behaviour, by exploring with them why they behave the way they do and identifying positive reasons for making change.
Partnership	Plymouth 2020 Strategic Partnership
Plan	Plymouth's Alcohol Commissioning Plan
Recovery	Recovery is a person-cantered approach that empowers people to tackle their alcohol misuse within their community, and make permanent changes to their lifestyle that will free them from dependence and enable them to successfully contribute to society.
Screening	Screening is used to define the initial process of identifying people who are not seeking treatment for alcohol problems but who may be a hazardous or harmful drinker, or who have alcohol dependence.
Tiers	Models of Care for the treatment of adult drug misusers outlined a four-tiered framework of provision for commissioning drug (and alcohol) treatment, providing a conceptual framework to aid rational and evidence-based commissioning in England. Commissioners need to ensure that all tiers of interventions are commissioned to form a local alcohol treatment system to meet local population needs. The tiers are: Tier 1 interventions: alcohol-related information and advice;

	screening; simple brief interventions; and referral Tier 2 interventions: open access, non-care-planned, alcohol-specific interventions Tier 3 interventions: community-based, structured, care-planned alcohol treatment Tier 4 interventions: alcohol specialist inpatient treatment and residential rehabilitation
Adapted from NICE guidance	

The Alcohol Joint Strategic Needs (JSNA) Assessment is available from the Plymouth Public Health Development Unit.

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PLYMOUTH'S JOINT DEMENTIA STRATEGY

Living Well with Dementia

1. Prime Ministers Dementia Challenge

There are a number of work streams at national, regional and local level around the commissioning of dementia provision. Dementia care is a highly important policy area for central government and there is a requirement on health and social care commissioners to have joint plans in place and to report progress against key areas. On the 26th March David Cameron launched his ***Challenge on Dementia*** which has 4 key elements:

Improving health and care services

- This includes improved prescribing and application of NICE guidelines around antipsychotic medication;
- Improved care across all settings with a strong focus on Care Homes and in peoples own homes;
- Improved diagnostic rates with a national return to central government outlining local plans.

Creating dementia friendly communities

Developing a focus on inclusive services for people with dementia and their carers and raising the awareness of dementia within communities.

- An example of this work includes the developing specialist designed housing such as extra care;
- The use of assistive technology;
- And locally a ***Dementia Action Alliance.***

Better research into dementia treatment and care

The government will be announcing a bidding round to accelerate research programmes over the autumn.

1.2 Creating Dementia Clinical Networks

The Department of Health via the SHA will be establishing 12 *National Dementia Clinical Networks* aimed at spreading clinical expertise.

A key function of the Dementia Clinical Network will be to contribute to engagement on service redesign across wider health communities. It will be important to challenge whole systems' thinking, to assert the position of social care and champion the role of Councils in supporting people with dementia. Two lead commissioners from the region have been asked to represent the ADASS Social Care perspective.

1.3 NHS South of England Dementia Challenge Fund

This fund provides an opportunity for local areas to respond to the Prime Minister's Dementia Challenge and a £10m pot has been made available to Clinical Commissioning Groups through a formal bidding process. This will be the first opportunity CCGs will have in directly commissioning provision for their local communities and health services. Plymouth commissioners are working closely with the Western Locality Clinical Commissioning Dementia lead on the local bid.

2. Local Commissioning Arrangements

In addition to these key areas outlined by the Prime Minister we also need to report on the areas outlines in the Joint Action Plan, appended.

Plymouth has a Joint Strategic Programme Board chaired by Paul O'Sullivan which monitors delivery of local plans against the national priorities. The Programme Board reports into the Joint Commissioning Partnership chaired by Carole Burgoyne and will report into Health and Wellbeing Board.

The Terms of Reference for this group is currently under review to reflect the Western Locality Clinical Commissioning arrangements.

2.1 Dementia Care and Support in Plymouth – Commissioning Plans 2010-13

Commissioning work streams include the following:

2.2 Dignity in Care Homes

We recognise that there will always be a requirement for good quality care home provision in Plymouth. These are the commissioning principles upon which the strategy to improve quality of care in Plymouth is based.

- To commission services that improve the quality of life for those people who are living, dying and working in care homes in Plymouth;
- For people who move into a care home setting ensure that they are able to make supported decisions wherever possible and choices about everyday activities;
- Ensuring that there is access to health and health care and that best practice guidance is embedded;
- To commission a skilled workforce.

As a result of this we have established a Dignity in Care Homes Forum supported by My Home Life Plymouth.

2.3 Dementia Quality Mark

With the ending of Care Quality Commission (CQC) ratings and changes to registration conditions for care homes, the Dementia Quality Mark for Care Homes Project was set–up in partnership with Councils across the South West to provide a single standard of dementia care within Care Homes. Plymouth City Council was selected to take the lead on this project and is currently working with 5 regions Bristol, Gloucester, Wiltshire, Dorset and Bath.

Quality standards and expectations will always be subject to changes, so the award of a Dementia Quality Mark places onus on the provider to assure care and will indicate that:

- The care service has a sound approach to the provision of dementia care;
- The essential building blocks are in place to deliver good care;
- The care service has an effective quality assurance system to check that the outcomes for people with dementia are good;
- The service is committed to ongoing improvement and development.

We have 17 care homes that have been awarded the Dementia Quality Mark with a further 20 in the pipeline.

2.4 Care Home Improvement Team

This team supports care homes to improve the quality of their care to residents and prevent safeguarding. We have commissioned My Home Life to develop 12 Dignity Champions to improve leadership within care homes in Plymouth.

Our work with Care Homes has been acknowledges through a national award.

2.5 Specialist dementia and enabling Domiciliary Care Teams

In 2011 we commissioned specialist domiciliary care teams in the independent sector to support people with complex dementia and their carers

2.6 Community and Voluntary Sector

We commission the Alzheimer's Society to work alongside our memory service to support early intervention and prevention including extending the number of memory cafes and increasing access to trained volunteers to support with befriending and Singing for the Brain. We have commissioned a range of short break services for people with dementia and their carers.

2.7 Workforce Development

Plymouth has been able to identify budgets to support the independent and community and voluntary sector with Dementia Awareness programmes. These programmes will be funded by the Council in 2012 as we see the priority of improving standards of care.

Training programmes include – Jackie Pool – Bee Inspired and our "Dementia Detectives "training and awareness programme for all carers of people with Dementia.

Over 300 people have accessed this awareness training.

This programme extends to GP training and awareness.

2.8 Libraries and Community Hubs

We have invested £200k over 2 years into our Plymouth Libraries to become Community hubs and provide advice, support and drop in events for people with dementia and their carers.

2.9 Extra Care Housing

Plymouth has the only specialist extra care housing for people with dementia in the south west region.

2.10 Improving Diagnosis

Plymouth Community Memory Service has received national accreditation in recognition of the quality of service it provides. This service will be re- accredited in 2012. Adult Social Care have commissioned the Alzheimer's Society to work with individuals who are newly diagnosed or are awaiting diagnosis to ensure they are referred into support services at an early stage .

2.11 Reducing Anti Psychotic Medication

Projects in place led by Health commissioners to deliver this work stream through Plymouths Dignity in Care Homes Forum. (A full report is available)

2.12 Support to Carers

Support to carers is an absolute priority for the Council and our Health partner's .These are the headline developments in Plymouth for our Carers.

- GPs and health staff have direct access to services which support Carers
- Health commissioners have invested into the Councils offer for Carers which includes:
- Carers Emergency Response Service
- Hardship Fund
- Training for Carers through St Johns Ambulance service
- Counselling Support from Simply Counselling – a free service which operates on a self referral basis rather than through GP referral.
- Carers Champions – emotional support information and advice.

In 2012 we will be jointly commissioning health and social care support for Carers in the form of a new ***Carers Enhanced Carers Support Service*** to include access to personal budgets and short break provision through a Carers Support Fund. Services will be tailored to carers of people with dementia.

2.13 Increase in re-ablement support for people with dementia

Increased investment and gone into reablement services to support people with dementia leaving hospital or to prevent in appropriate admission.

3. Plymouth as a Dementia Friendly City 2012 and Beyond

We feel that our commissioning achievements will provide a good foundation to extend awareness of dementia and the Dementia Challenge into the community through city centre business and intergenerational work with schools. In November 2011 City Centre Businesses signed up to the ***Plymouth Dementia Action Alliance***.

The City Council will work with the Alzheimer's Society to develop this programme further in 2012 through strengthening partnerships with the private and community and voluntary sector which will include:

- Meeting with strategic partners in the City to develop the memorandum of understanding to deliver awareness training across the City. – April 2012
- Framework of dementia specific accredited training organisations. July 2012
- Second event to publicise training framework July /August 2012
- Extension of Dementia Quality Mark to encompass City Centre Business
- Intergenerational projects with schools.

Additionally Plymouth City Council will be incorporating Dementia Awareness as part of the induction for front line Council staff.

Dementia Strategy Action Plan 2012/13

Ref	Task	Lead	Start Date	Finish Date	Status update	Key Milestone	Date Achieved
1.0	**Improving hospital care**						
1.1	Delivery of PHT action plan	KG	01 July 2011	31 March 2013	Action plan in place. SHA peer review 30/09/2011. Peer review report shared, working action plan in place.	Update on RAG ratings of action plan	August 2012
1.2	Delivery of Plymouth Community Health action plan	KE	01 July 2011	31 March 2013	Verbal update received in February	Update on RAG ratings of action plan	April 2012
1.3	Review of specification for liaison psychiatry	NB	01 November 2011	30 August 2012	On Track	New Specification / Business Case	August / September 2012
2.0	**Improving earlier diagnosis**						
2.1	Review of memory service capacity	KA	01 June 2011	30 November 2011	Complete	Short term capacity in place	November 2012
2.2	Refresh of memory service specification	NB	01 September 2011	30 September 2011	Complete	Specification signed off within PCH contract	Complete

2.3	Delivery of training to GPs	KA/JOD	01 September 2011	31 March 2012	Report received on mastercalsses. Plan for 12/13 being developed.	Reviewed training needs & plan. Develop revised plan	August 2012-07-10 ongoing
2.4	Improvement in process for coding diagnosis	KA/JOD	01 September 2011	31 March 2012	Implemented	'Handy guide' produced.	Completed
2.5	MSNAP re-acreditation achieved	KA	01 March 2012	01 July 2012	Acheived	Re-accreditation assessment 19 June 2012	July For Judgement
3.0	**Improving care in care homes**						
3.1	Dementia Quality Mark for care homes	DB	01 April 2011	Ongoing	Evaluation complete. Rolling project going forward	20 Homes Kite Marked	December 2012

3.2	Care Home quality team	DB/CG	01 September 2011	31 March 2012	Completed.	Monthly update- including consideration of how to work alongside OPMH pathway redesign Care Home practitioners appointed	Complete
4.0	**Reducing the use of antipsychotics**						
4.1	Refresh of prescribing project	OR	01 October 2012	30 April 2012	Re-audit is completed. Data being analysed. Graham Parsons will present report July meeting	Update on completion of project and outcomes	July 2012
5.00	**Providing support in the community**						
5.10	Redesign of rapid response team delivered.	FP / JY	27 June 2011	31 May 2012	Offer made. Aiming to commence post in May	Post Appointment	Complete
5.20	Increase in reablement capacity	FP / JY	27 June 2011	31 March 2012 Ongoing	Capacity acheived	Integration Project on Track	July 2012

5.30	Development of dementia specialism in dom care market	DB	01 April 2011	September 2011	Training commissioned. Completed.	Additional specialist capacity in market. Review of training and commissioning intentions for 2013/14	Ongoing
5.40	Negotiate opening of new DE nursing homes	DB / CG / NB	01 January 2011	31st October 2012	One home opened with 60 beds. Second home to open in 2012-regular meetings with provider	Second home open to admissions.	01 October 2012
5.50	OPMH redesign	SM	01 September 2011	31 March 2015	NB / KS & Finance Contracts to review	Monthly update	ongoing
5.60	Implement locality-based support	SM	01 September 2011	31 March 2012	Implementation phase-monthly updates	Monthly update. Awaiting locality improvement plan.	July 2012
5.70	Insert Dementia Quality standards into contracts	NB	01 September 2011	31 March 2012	Complete		August
5.80	Invest NHS support for social care: provision of support for memory services	NB / DB	01 December 2011	31 March 2012	Complete		

5.90	Development of Plymouth Dementia Alliance	DB	Ongoing	Ongoing		Update on progress	July via scrutiny
5.10	Commissioning additional support in community and voluntary sector	NB	Ongoing		DH Dementia Fund		end August 2012
6.00	**Supporting carers**						
6.10	Delivery of increased provision through NHS support for carers	EF & DB	Start April 2011	Tender out June 2012	Investment in place. Future NHS investment to be agreed following evaluation to feed into procurement..	New service to commence October 2012	October 2012
7.00	**Training our workforce**						
7.10	Dementia workforce programme	NW	01 April 2011	Ongoing	Workforce strategy agreed and number of actions in place.Training matrix for 2012 drafted.	Final training matrix	September 2012
7.20	Development of dementia CQUIN	NB	19 December 2011	31 March 2012	Contractual discussion ongoing.	Update on contractual agreement	July 2012

7.30	Dementia Clinical governance programme for GPs	Sally Dutton	01 April 2012	31 March 2013	Currently in development	Investment in place and agreed scheme with GPs. Updates to follow in October and March.	October update required.

Health and Adult Social Care Overview and Scrutiny Panel

Work Programme 2012/13

Topics	J	J	A	S	O	N	D	J	F	M	A
Health Integration Programme											
Healthwatch				**13**							
Health and Wellbeing Board / Joint Strategic Needs Assessment (JSNA) / Joint Health and Wellbeing Strategy (JHWBS)				**13**							
Public Health Transition (TBC)											
Joint Priorities											
Alcohol Strategy		**19**									
Dementia Strategy		**19**									
Safeguarding Vulnerable People (review of recommendations)						**22**					
NHS Devon Cluster Primary Care Trust											
QIPP Programme											
NEW Devon, Clinical Commissioning Group (Western Locality)											
Authorisation				**13**							
Commissioning Intentions						**22**					
Plymouth NHS Hospitals Trust											
Hospital Discharge Process (tbc)											
Foundation Trust Business Case		**19**									
Plymouth City Council – Adult Social Care											

Topics	J	J	A	S	O	N	D	J	F	M	A
Social Care Transformation Programme						**22**					
Plymouth Community Healthcare											
Child and Adolescent Mental Health Service											
Recovery Pathways (Mental Health Service)		**19**									
Forward Plan Items											
Advocacy Provision						**22**					
Performance Monitoring											
Quality Accounts											**11**
Referred by Local Involvement Network											
Services for Gypsies and Travellers				**13**							

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