# Barnet Adults Substance Misuse Service Review & Needs Assessment Refresh 2019

Public Health Team, Barnet Council by Linda Somerville, Oliver Taylor and Hope Grant

# Acknowledgements

This review of current service provision and the needs of adults with substance misuse issues would not have been possible without the assistance of the people below:

Oliver Taylor – Public Health Intelligence Analyst, Barnet Council

Lisa Colledge – Senior Public Health Intelligence Analyst, Barnet Council

Luke Kwamya – Head of Public Health Commissioning, Barnet Council

Hope Grant – Contract Data Analyst, Barnet Council

Bevan Kay- Service Manager, Barnet Adults Substance Misuse Service

The staff and Service users of Barnet Adults Substance Misuse Service

## Executive Summary

The provision of drug and alcohol treatment services can lead to reductions in crime and health improvements, along with providing support for individuals and families on the road to recovery. The provision of Substance Misuse Services is also cost effective. For every £1 spent on alcohol treatment, a return on investment of £3 is achieved and for drug treatment the return on investment for each £1 spent is greater, at £4[1].

This review provides action points and areas of improvement that may need attention from key commissioners, stakeholders and providers to address some of the current issues. The current treatment model has been examined and recommendations for future provision is made. The following bullet points provide a summary of the analysis of the key data and incorporate the views expressed during the consultation.

### Performance

- The number of people in treatment for alcohol dependence has fallen by 40% since 2013 and successful completion of alcohol treatment in Barnet was 48% compared to 61% nationally. An alcohol improvement plan is currently in place and in the future careful monitoring of this will be required to ensure improvements in the numbers entering treatment for alcohol issues.
- Using national data, it is estimated that 21% of Barnet residents are consuming alcohol at levels that places them at increasing and/or higher risk to their health. Consideration should be given to the treatment needs of this group, who may not require treatment at a specialist substance misuse service. A system of Identification and Brief Advice and extended Brief Advice may be more suitable to their needs.
- It is still estimated that there are 1,583 combined Opiate and Crack Users (OCUs) in Barnet, with 1,256 Opiate Users and 1,028 Crack users. The numbers in treatment are much lower than these figures, indicating that consideration is required of how to increase the numbers entering treatment and how to access these people who form a hidden harm group.
- 11% of the treatment population for alcohol in 2017/18 were aged over 60 years. The number of Barnet residents aged 65 and over is predicted to increase by 33% between 2018 and 2030[2]. In the UK, risky drinking has been noted to be declining, except among people aged 50 years and older, plus there is a strong upward trend for episodic heavy drinking in this age group[3]. We therefore need to closely monitor the number of older people entering treatment for alcohol issues, especially in the context of the predicted one third increase in over 65s in Barnet by 2030.

[1] https://www.gov.uk/government/publications/alcohol-and-drug-prevention-treatment-and-recovery-why-invest/alcohol-and-drug-prevention-treatment-and-recovery-why-invest
[2] https://jsna.barnet.gov.uk/1-demography
[3] https://www.bmj.com/content/358/bmj.j3885

- Drug Related Death's (DRD's) in Barnet have increased since 2013 and between 2015-17, there were 33 DRDs in the borough. DRDs have increased nationally, with a PHE inquiry noting that the registrations of heroin-related deaths in England and Wales more than doubled between 2012 and 2015 (579 in 2012 to 1,201 in 2015)[4]. We need to attempt to reduce this statistic by improvements in service provision and to encourage people to enter treatment.
- The Public Health Outcomes Framework(PHOF) indicator on proportion of successful completion of treatment for Opiates and not representing is better than the England average (9.7% in Barnet, compared to 6.5% nationally).
- Non-opiate client's successful completion rate as a percentage of all in treatment was 44% in 2017/18, which is an upward trend having risen from a figure of 32% in 2015/16 and 29% in 2016/17.

## Blood borne Viruses

- PHE estimates for London are that in 2017, the estimated prevalence of HIV in People Who Inject Drugs (PW was 3.9%). The estimated prevalence for Hepatitis B in PWID was 34% whilst the prevalence estimate for hepatitis C for PWID was 68%. This means that there are a number of Barnet residents who inject drugs that are at risk of these conditions.
- Barnet adult's substance misuse service has consistently provided Hepatitis C testing to a greater percentage of clients than the England average, with between 87-90% of clients in Barnet being offered a test for Hepatitis C since 2013.
- Performance is less favourable however in relation to the number of individuals who start and complete Hepatitis C treatment. This is a missed opportunity and requires improvement.
- The number of eligible people who complete a course of vaccinations for Hepatitis B is 21.9%, compared to 8.1% nationally.
- The number of needle exchanges in Barnet has reduced from 12 in 2014 to 7. It is recommended that a review of the provision of needle exchange facilities is undertaken to gain an understanding of the potential reasons for the reduction in the number of exchanges and to ensure that all opportunities to engage with hidden harm clients are explored.

## Service users and carers experience

- Service users were very complimentary about the members of staff within the current treatment service provision.
- Consultation with service users however showed concern over high levels of staff changes and feedback given included requests for greater integration of services, especially around mental health.

[4] http://www.emcdda.europa.eu/system/files/attachments/3234/7.%20Plenary%202%20%20Martin%20White%20EMCDDA.pdf

- Service users also requested an expansion of the groupwork programme, both in relation to the topics covered and the length of time the groups ran for and for greater involvement of family and friends in their treatment.
- Expansion of treatment into evenings and weekends was requested, along with a greater level of follow up after discharge.
- Service users also provided feedback that they would like to see improved communication within the service. Suggestions included providing a newsletter and/or placing a groupwork timetable weekly on a notice board.

## Health based services

- The responses received to the consultation with GP practices was very low, but the responses received asked for improved communication with treatment services, along with further clarity around treatment pathways and options for patients.
- Although it is acknowledged that some primary care practitioners may be delivering IBA as part of everyday work and/or the Making Every Contact Count (MECC) initiative, there was no data available to evidence this. Identification and Brief Advice (IBA) in health based settings and wider, represents early intervention and prevention of alcohol related harm on an individual level. As part of the proposed re-alignment of service provision towards prevention and early identification, a review of IBA provision across Barnet is recommended.
- There is an Alcohol Liaison Service (ALS) in Barnet with one nurse post attached to this and an alcohol CQUIN in operation in the borough. A review of the ALS is recommended as is a recommendation that the provider of treatment services in Barnet, formalises good links with the NHS providers of the CQUIN and ensures that the ALS works in partnership with the CQUIN.
- The number of GPs participating in the shared care scheme has reduced, we need to gain an understanding of why this has occurred and review the scheme to encourage further participation.
- A further recommendation for the longer-term future, is that attention is paid to the expansion of alcohol care teams nationally as outlined in the NHS long term plan. Barnet may develop an alcohol care team.

## Commissioning

- It is recommended that a review is completed of the strategic approach to substance misuse across Barnet. The current Drug and Alcohol strategy will finish in 2020 and therefore this is an opportune time to review the strategic systems currently in place. This will ensure that substance misuse provision across Barnet becomes continuous and any issues identified early and rectified.
- It is recommended that a new model for adult treatment services is specified before going out to tender. This model should continue to provide a recovery service and different Tiers

of treatment but greater emphasis should be placed on the prevention of substance misuse issues and in working with individuals who are consuming alcohol at levels that presents an increasing risk to their long-term health.

- Satellite provision of substance misuse treatment services in the local community should be considered, especially in relation to clients who may not wish to attend a specialist substance misuse service.
- It is recommended that a data strategy should be developed to provide oversight of all substance misuse data that is collected. A data strategy that delivers key information about the nature and scale of issues, activity, performance and impact is required to enhance the ability of commissioners to monitor and plan service provision.
- The age range for the Young People's Service is up to the age of 24 years. The adult service starts at age 18 years. This situation appears to work well with one provider, providing services to both young people and adults. If during re-commissioning, two different providers are awarded the contract however, this could potentially lead to issues over data sharing and competition for clients.

## Clinical Governance

- It is recommended that a review is undertaken of the monitoring of serious incidents and drug/alcohol related deaths in order that Barnet Council can be assured that any identified learning and preventable measures have been put in place.
- A clinical governance framework that can be monitored alongside activity and performance data is recommended, especially as there has been recent changes to clinical service provision.

## Workforce

- Given that there are concerns relating to high turnover of the workforce, it is recommended that the training needs of the commissioned providers workforce are analysed and training plans developed on a continual basis.
- As the focus of treatment services expands to include work around prevention, the training needs of the workforce will require analysis to understand what additional training is necessary to accommodate this change and ensure that the workforce is skilled.

This report starts with a brief policy background and the provision of national perspectives before moving to consideration of the available data and consultation feedback which provided the evidential background for the recommendations proposed.

# Introduction

This review of Barnet's adult drug and alcohol treatment service and needs assessment refresh was completed between December 2018 and April 2019. During this time available data was identified, collected and analysed. A range of stakeholders were engaged including service commissioners, staff employed within the service and service users and carers were consulted. Similar to the previous needs assessment which was completed in 2014, this review aimed to examine what current interventions and services were available to adults experiencing issues with drugs and alcohol, identify areas of good practice and any weaknesses within current provision. Using this evidence recommendations aimed at improving performance, outcomes and the experience of service users and carers are provided.

This report commences by providing a national policy overview and an outline of the impact of the misuse of substances on the UK. It then provides local data relating to the scale of harm and impact of substance misuse on the population of Barnet and provides data from the adult substance misuse treatment service. This data is provided into alcohol and drugs (OCU's, Opiates and non-opiates). A survey was developed for service users and carers and we received a good response of 59 people, to this survey. A survey was also developed for GP's, however the response rate to this was very low. Due to limitations of time, it was not possible to continue to pursue responses from GPs. All survey responses have been summarised and are presented at the end of this report. In the final section, a series of recommendations based on national and local policy, the data within this report and survey responses is presented.

Whilst this report draws together a range of relevant information, it should be viewed as a snapshot of data and the collection of data and feedback should be an ongoing process. Gaps in data provision and areas where key stakeholders did not respond to requests for consultation, limited the scope of the report to some extent. For example, the response rate to the GP survey was very low. For this reason and as was mentioned within the 2014 review, the strategic arrangements relating to substance misuse services should be reviewed and consideration given to the establishment of a strategic board that has a vested interest in substance misuse services in Barnet. It would be important that the membership of this group included representatives in strategic positions within Barnet council to drive this agenda forward and to ensure that some of the blockages within the current system are removed. In the previous review in 2014, it was suggested that membership of this group should include strategic posts from Public Health commissioning (to lead), the Community Safety Team, Police, CRC, Barnet CCG, Hospital Trusts, Family Services and Adult Social Care. Other strategic partners could be requested to attend these meetings as required.

## National policy

The policy background for substance misuse treatment is currently underpinned by two documents, the Drug Strategy of 2017[5] and The Governments Alcohol Strategy (2012). As the last alcohol strategy was published seven years ago, there had been calls for the government to produce a new strategy. The indications are that an alcohol strategy will be published in 2019, but an exact date has not been announced. For this reason, no further reference will be made to the 2012 strategy as an indicator of policy direction around alcohol and instead other documentation was used.

In the Public Health England (PHE) Business Plan for 2019/20[6], alcohol is mentioned, especially in relation to prevention and there are actions around supporting NHS England with the delivery of preventative interventions in the NHS Long Term plan[7], which included commitments on alcohol. Specifically, this plan discussed action to be taken within hospitals to deal with alcohol related hospital admissions. It was planned that alcohol care teams would work in up to fifty hospitals across England and Wales to deliver alcohol checks and access to substance misuse services within a day. Other actions included the provision of counselling, medically assisted help to give up drinking and support to remain abstinent. It is not clear at the time of writing if Barnet will be receiving an alcohol care team.

NICE (National Institute for Health and Care Excellence) produced two sets of guidelines specifically relating to alcohol prevention, named PH 24 and treatment (named CG115). A consultation on both guidelines has recently been announced however and therefore no further detail of these documents are included in this report. As these documents were produced in 2010 and 2011, a review of these guidelines is overdue.

Concerning substance misuse not relating to alcohol, the most recent Drug Strategy was produced in 2017. The 2017 Drug Strategy, placed a large amount of emphasis on partners working together to reduce substance misuse. The strategy reported that in 2015-16, around 2.7 million (8.4%) of 16-59 years olds in England and Wales reported using a drug in the last year, a proportion which had reduced over the last decade, but the figure had remained stable over the last seven years[8]. In 2015-16, 203,808 people received treatment for drug misuse. The Drug Strategy noted that fewer drug users were entering substance misuse treatment and the number of people aged under 25 entering treatment for the first time who used opiates, mainly heroin, had fallen substantially over the course of the last 10 years[9].

While more adults were noted to be successfully leaving treatment in the drugs strategy compared to 2009-10[10], concerning opiate users, those in treatment tended to be older and with physical and

[5] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/628148/Drug_strategy_2017.PDF
[6] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/796459/PHE_Business_plan_2019.pdf
[7] https://www.england.nhs.uk/2019/01/nhs-long-term-plan-will-help-problem-drinkers-and-smokers/
[8] Lader, D. (2016). *Drug Misuse: Findings from the 2015 to 2016 Crime Survey for England and Wales.* London: Home Office. Available at: https://www.gov.uk/government/collections/drug-misuse-declared Accessed 6 July 2017.
[9] ibid
[10] ibid

mental health conditions relating to their drug use[11]. The strategy documented that linked to this ageing cohort, the number of drug misuse deaths had risen sharply since 2012. In England and Wales, the Drug strategy reported the number of deaths from drug misuse registered in 2015 increased by 10.3% to 2,479. In an attempt to reduce the number of drug related deaths, the drugs strategy placed a greater emphasis on early intervention and on the prevention of individuals beginning substance misuse, through building resilience and confidence in young people. The current Drugs Strategy (2017, p5) suggested using a balanced approach to substance misuse based on "acting at the earliest opportunity to prevent people from starting to use drugs in the first place and prevent escalation to more harmful use, as well as providing evidence-based treatment options that can be tailored to individual need, to provide people with the best chance of recovery".

The social and economic cost of drug supply in England and Wales was estimated to be £10.7 billion a year in 2017– just over half of which (£6 billion) was attributed to drug-related acquisitive crime (e.g. burglary, robbery, shoplifting)[12]. The Modern Crime Prevention Strategy, detailed how drug-related and drug-enabled activities were key drivers of crime and there was a strong association between illegal drugs, particularly heroin and crack cocaine, and acquisitive crime. Although the numbers of heroin and crack users have fallen nationally, there remained an existing cohort of very prolific offenders, responsible for around 45% of acquisitive offences which equated to more than two million Crime Survey offences. There is strong evidence to link drug treatment to reductions in offending and supporting people to address their dependence is therefore critical to tackling the risk of reoffending. The Drug Strategy (2017) requested that in conjunction with punitive sanctions, the criminal justice system should "consider use of health-based, rehabilitative interventions to address the drivers behind the crime and help prevent further substance misuse and offending" (p23).

There were four key themes within the Drug Strategy (2017) and these are:

1) Reducing Demand

Take action to prevent the onset of drug use, and its escalation at all ages, by placing a greater emphasis on **building resilience and confidence** among our young people to prevent the range of risks they face (e.g. drug and alcohol misuse, crime, exploitation, unhealthy relationships).

2) Restricting Supply

Take a **smarter approach to restricting the supply of drugs:** adapting our approach to reflect changes in criminal activity; using innovative data and technology; taking coordinated partnership action to tackle drugs alongside other criminal activity.

3) Building Recovery

**Raise our ambition for full recovery** by improving both treatment quality and outcomes for different user groups; ensuring the right interventions are given to people according to their needs;

[11] ibid

[12] [12] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/628148/Drug_strategy_2017.PDF

and facilitating the delivery of an enhanced joined-up approach to commissioning and the wide range of services that are essential to supporting every individual to live a life free from drugs.

4) Global Action

Take a **leading role in driving international action**, spearheading new initiatives e.g. on new psychoactive substances, sharing best practice and promoting an evidence-based approach to preventing drug harms.

As the fourth action relates to global action and doesn't necessarily link with local services in Barnet, the three priorities around reducing supply, reducing demand and building recovery are referred to within this document.

The documents and strategies mentioned within this section relate to national guidance on substance misuse. Please note it is not an exhaustive list of all documentation available and only a few key documents have been referenced. In the next section, data relating to alcohol use within the London Borough of Barnet are outlined.

Public Health England produce a range of guidance documents relating to the prevention and treatment of substance misuse at a national level (see: https://www.gov.uk/government/collections/alcohol-and-drug-misuse-prevention-and-treatment-guidance). It is beyond the scope of this needs assessment to include information from these documents within this report however, it is important to provide information relating to the system of tiered provision of treatment services that was produced within the document named as 'Models of Care for the treatment of adult substance misusers' in 2002 by the National Treatment Agency. Although this documentation is seventeen years old, commissioners and treatment providers still refer to the different treatment tiers and within this report, the tier system is mentioned. The diagram below provides information on the four tiers of treatment for substance misuse.

**Tier 1: Non-substance misuse specific services requiring interface with drugand alcohol treatment**

Tier 1 services work with a wide range of clients including drug and alcohol misusers, but their sole purpose is not drug or alcohol treatment.

The role of tier 1 services includes the provision of their own services plus, as a minimum, screening and referral to local drug and alcohol treatment services in tiers 2 and 3. Services may also include assessment, other services to reduce drug-related harm, and liaison or joint working with tiers 2 and 3 specialist drug and alcohol treatment services.

**Tier 2: Open access drug and alcohol treatment services**

Tier 2 services provide accessible drug and alcohol specialist services and are defined by having a low threshold to access services, and limited requirements for participation. Tier 2 services include needle exchange, drug (and alcohol) advice and information services, and ad hoc support not delivered in the context of a care plan. Tier 2 can also include low-threshold prescribing programmes aimed at engaging opioid misusers with limited motivation, while offering an opportunity to undertake motivational work and reduce drug-related harm.

**Tier 3: Structured community-based drug treatment services**

Tier 3 services are provided solely in structured programmes of care that include psychotherapeutic interventions such as structured counselling, community detoxification, or day care. Community-based aftercare programmes for drug and alcohol misusers leaving residential rehabilitation or prison are also included in tier 3 services.The drug and alcohol misuser attending tier 3 services will normally have agreed to a structured programme of care which places certain requirements on attendance and behaviour.

**Tier 4 services: Residential services for drug and alcohol misusers**

*Tier 4a: Residential drug and alcohol misuse specific services*

Tier 4 services are aimed at individuals with a high level of presenting need and include: inpatient drug and alcohol detoxification or stabilisation services; drug and alcohol residential rehabilitation units; and residential drug crisis intervention centres.

*Tier 4b: Highly specialist non-substance misuse specific services*

Tier 4b services are highly specialised and will have close links with services in other tiers, but they are, like tier 1, non-substance misuse specific. Examples include specialist liver units that treat the complications of alcohol-related and infectious liver diseases and forensic services for mentally ill offenders. Some highly specialist tier 4b services also provide specialist liaison services to tiers 1–4a services. (e.g. HIV liaison clinics)

## Alcohol data relating to Barnet

On reviewing the available data, it was found that there are no local estimates of the risk levels of alcohol consumed by Barnet residents. To obtain a crude estimate of the number of Barnet resident in each alcohol category, national data on estimated weekly consumption proportions was extrapolated to estimates of Barnet's population. Please note however that this method, does not consider any variations in consumption patterns across different areas. For example, it is documented that individuals in London consume less alcohol than other areas of England and Wales[13] but national estimates of consumption that doesn't consider local variations are the best data source currently available.

Table 1 below outlines that 57,938 (19%) of the population aged 16 and over in Barnet, do not consume any alcohol and a further 182, 962 (60%) individuals are lower risk drinkers. A definition of lower risk is a person who is drinking less than the recommended level of 14 units of alcohol per week for both males and females. In Barnet therefore, 79% of the population aged 16 and over do not appear to be drinking at levels that are harmful to their health. The remaining 64,036 (21%) however are estimated to be consuming alcohol at amounts that represents a level of increasing and/or higher risk to their health. It is this group of people who could be encouraged to review their current alcohol intake and consider reducing alcohol consumption to lower risk drinking.

**Table 1: Barnet alcohol risk level estimate (Aged 16 years old and above)[14]**

| Barnet estimated population | 304,937 | |
|---|---|---|
| Risk Level | Estimated weekly consumption proportion (%) | Barnet estimate |
| Abstainers | 19% | 57,938 |
| Lower risk | 60% | 182,962 |
| Increasing risk | 17% | 51,839 |
| Higher risk | 4% | 12,197 |

Individuals who are consuming alcohol at a level of increasing risk may not wish to attend a specialist substance misuse service for long term treatment and at this level Identification and Brief Advice (IBA) or extended IBA may be a more suitable treatment option. To cater for the needs of this cohort, the Public Health team have commissioned an online resource named DrinkCoach.

## DrinkCoach

Barnet Public Health team have commissioned DrinkCoach (formerly named Don't Bottle It Up). This online resource allows residents to input details of their alcohol use and receive feedback. Individuals identified as drinking above lower risk levels are provided with information and/or offered the details of their nearest source of assistance. This service has been offered to residents

[13] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/drugusealcoholandsmoking/adhocs/005588alcoholconsumptioningreatbritainandlondon2005to2014

[14] Greater London Authority (ONS Mid-Year Population Estimates - Custom Age Tables), NHS Digital (Health Survey for England 2017: Adult heath related behaviours)

since January 2019 and the table below provides information relating to users of the website. Table 2 below provides information on the users of DrinkCoach.

**Table 2: DrinkCoach Statistics**

| Category | January 2019 | February 2019 | March 2019 | April 2019 |
|---|---|---|---|---|
| Visits to DrinkCoach | 900 | 80 | 110 | 42 |
| AUDITs completed* | 604 | 54 | 72 | 35 |
| Lower Risk (0-7 score) | 119 (18.9%) | 13 (24.1%) | 16 (21.1%) | 5 (13.5%) |
| Increasing Risk (8-15 score) | 275 (43.7%) | 17 (31.5%) | 33 (43.4%) | 12 (32.4%) |
| Higher Risk (16-19 score) | 100 (15.9%) | 11 (20.4%) | 9 (11.8%) | 7 (18.9%) |
| High risk/Possible dependence | 135 (21.5%) | 13 (24.1%) | 18 (23.7%) | 13 (35.1%) |

*Please note that not every AUDIT started was completed.

During January the website was promoted on social media and the national campaign of Dry January was running. This has influenced the number of visitors to the website. Since February the website has not been promoted to Barnet residents and this is reflected in the decreasing number of visitors to the website. It is interesting to note that the website is being used by many people who are found to be drinking at levels of higher risk/high risk/possible dependence and not only by people consuming alcohol at lower risk levels. All individuals consuming alcohol at higher risk/high risk/possible dependence should be referred to specialist treatment services.

In addition to the provision of online IBA through DrinkCoach the current service provider offers IBA in different settings. Table 3 below provides details of the IBA provided.

**Table 3: IBA provision by provider in various settings**

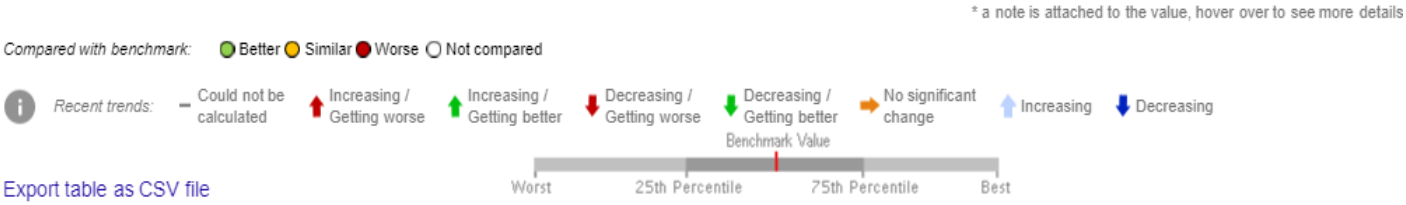
| | Q3 17-18 | Q4 17-18 | Q1 18-19 | Q2 18-19 |
|---|---|---|---|---|
| Clients in treatment at service | 149 | 132 | 133 | 136 |
| Individuals seen in pharmacy setting | 0 | 0 | 0 | 0 |
| Individuals seen in A&E/Acute setting | 131 | 109 | 123 | 111 |
| Individuals seen in a CJS setting | 81 | 30 | 37 | 24 |
| Individuals seen in all other settings | 0 | 0 | 0 | 0 |
| **Total number receiving IBA** | **361** | **271** | **293** | **271** |

Table 3 shows that whilst IBA is offered frequently to clients in the treatment service and in accident and emergency settings, much lower numbers of people are seen within Criminal Justice settings. No one has received IBA in a pharmacy setting or in any other settings. Whilst this is not a complete picture of all IBA activity across Barnet, it shows a gap in service provision around IBA.

## Local Alcohol Profile for England (LAPE): Barnet

Figure 1 below is taken from Public Health England's (PHEs), Local Alcohol Profile for England. In this Figure information is provided on a range of indicators relating to alcohol and there is a comparison between Barnet and the England average. The Figure shows that Barnet is significantly better across all indicators than the England average but this does not mean however that Barnet has no issues with alcohol. For example, years of life lost due to alcohol in 2017 was just over one, there were 1,576 admissions for alcohol related conditions (narrow measure) and 6,182 admission episodes for alcohol related conditions (broad measure).

**Figure 1: Barnet local alcohol profile indicators**




Export table as CSV file

| Indicator | Period | Barnet | | | Region England | England | England | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Recent Trend | Count | Value | Value | Value | Worst | Range | Best |
| 1.02 - Years of life lost due to alcohol-related conditions (Persons) | 2017 | – | 1,068 | 317 | 455 | 626 | 1,495 | | 317 |
| 1.02 - Years of life lost due to alcohol-related conditions (Male) | 2017 | – | 829 | 496 | 655 | 898 | 2,249 | | 459 |
| 1.02 - Years of life lost due to alcohol-related conditions (Female) | 2017 | – | 238 | 142 | 259 | 358 | 765 | | 142 |
| 2.01 - Alcohol-specific mortality (Persons) | 2015 - 17 | – | 40 | 4.0 | 7.9 | 10.6 | 30.1 | | 4.0 |
| 2.01 - Alcohol-specific mortality (Male) | 2015 - 17 | – | 31 | 6.5 | 11.7 | 14.5 | 39.8 | | 6.3 |
| 2.01 - Alcohol-specific mortality (Female) | 2015 - 17 | – | 9 | * | 4.3 | 7.0 | 20.7 | | 3.3 |
| 3.01 - Mortality from chronic liver disease (Persons) | 2015 - 17 | – | 53 | 5.5 | 9.5 | 12.2 | 33.9 | | 5.5 |
| 3.01 - Mortality from chronic liver disease (Male) | 2015 - 17 | – | 35 | 7.7 | 13.6 | 16.0 | 45.4 | | 7.4 |
| 3.01 - Mortality from chronic liver disease (Female) | 2015 - 17 | – | 18 | 3.4 | 5.8 | 8.6 | 22.6 | | 3.4 |
| 4.01 - Alcohol-related mortality (Persons) | 2017 | – | 93 | 29.3 | 38.5 | 46.2 | 84.6 | | 28.8 |
| 4.01 - Alcohol-related mortality (Male) | 2017 | – | 62 | 43.3 | 56.2 | 66.5 | 123.8 | | 41.5 |
| 4.01 - Alcohol-related mortality (Female) | 2017 | – | 31 | 17.6 | 23.6 | 28.8 | 48.6 | | 17.6 |
| 10.01 - Admission episodes for alcohol-related conditions (Narrow) (Persons) | 2017/18 | – | 1,576 | 466 | 533 | 632 | 1,097 | | 394 |
| 10.01 - Admission episodes for alcohol-related conditions (Narrow) (Male) | 2017/18 | – | 990 | 627 | 704 | 809 | 1,390 | | 472 |
| 10.01 - Admission episodes for alcohol-related conditions (Narrow) (Female) | 2017/18 | – | 586 | 327 | 381 | 473 | 824 | | 256 |
| 9.01 - Admission episodes for alcohol-related conditions (Broad) (Persons) | 2017/18 | – | 6,182 | 1,949 | 2324 | 2224 | 3,430 | | 1,412 |
| 9.01 - Admission episodes for alcohol-related conditions (Broad) (Male) | 2017/18 | – | 4,090 | 2,844 | 3288 | 3051 | 4,833 | | 1,864 |
| 9.01 - Admission episodes for alcohol-related conditions (Broad) (Female) | 2017/18 | – | 2,092 | 1,209 | 1517 | 1513 | 2,403 | | 910 |
| 6.02 - Admission episodes for alcohol-specific conditions (Persons) | 2017/18 | – | 1,348 | 403 | 544 | 570 | 1,486 | | 311 |
| 6.02 - Admission episodes for alcohol-specific conditions (Male) | 2017/18 | – | 999 | 635 | 828 | 791 | 2,143 | | 287 |
| 6.02 - Admission episodes for alcohol-specific conditions (Female) | 2017/18 | – | 349 | 191 | 283 | 361 | 892 | | 131 |

## Alcohol related Mortality

Figure 2 below, provides details of alcohol related mortality for ages of males in Barnet between the years of 2013 and 2017 as expressed as a rate per 100,000 counts of population. It shows that the rate in Barnet for males between 2013-2017 has remained less than the England average. In Barnet the rate per 100,000 appears to have followed a fluctuating pattern between 2013 and 2017, with the most recent figure in 2017 being 43.3 per 100,000.

**Figure 2: Alcohol-related mortality for Barnet males, 2013-2017**[15]

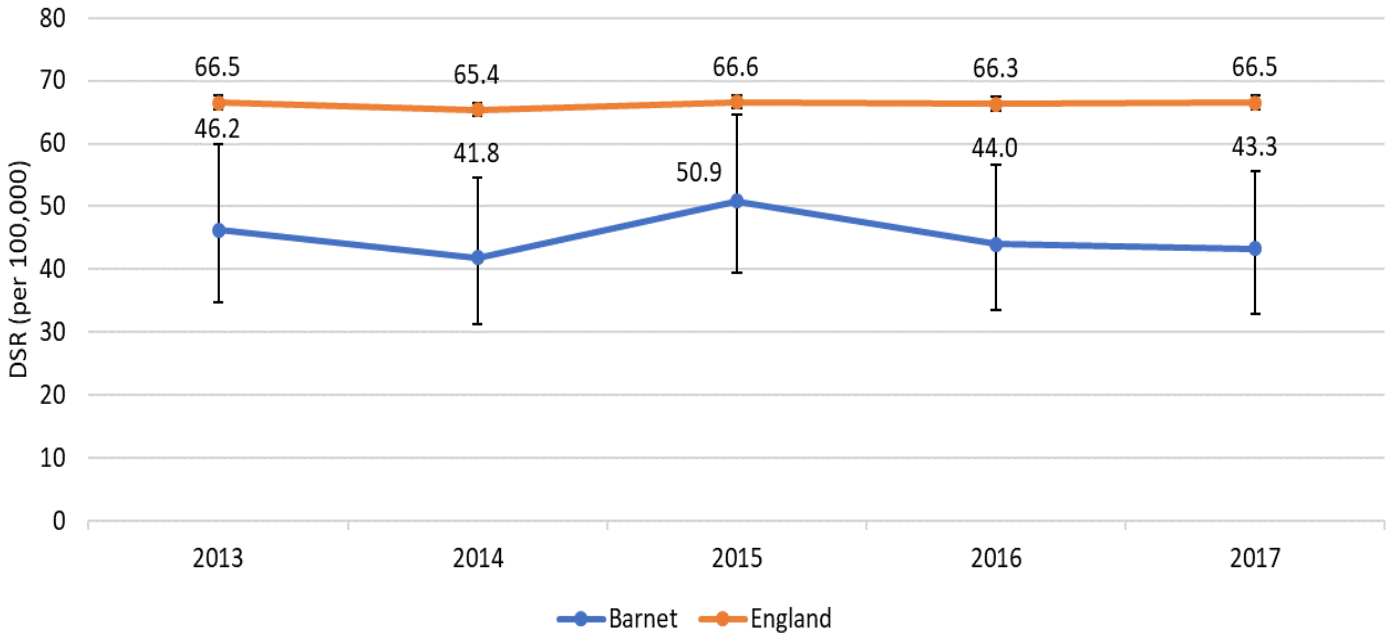



Figure 3 on the next page, outlines the rate per 100,000 for all ages of females in Barnet between the years of 2013-2017. The rate per 100,000 was lower than the England average rate in 2014, 2015 and 2017. In 2013 and 2016 however, the confidence intervals overlap between the Barnet and England rates and therefore the difference between rates in those years is not statistically significant. Figure 3 appears to show a substantial reduction in the rate per 100,000 between 2016 and 2017, however when the overlapping confidence intervals are examined, this conclusion cannot be drawn as the true value of the rate may lie within the England average range.

[15] Public Health England (Local Alcohol Profiles for England)

**Figure 3: Alcohol-related mortality for Barnet Females, 2013-2017[16]**

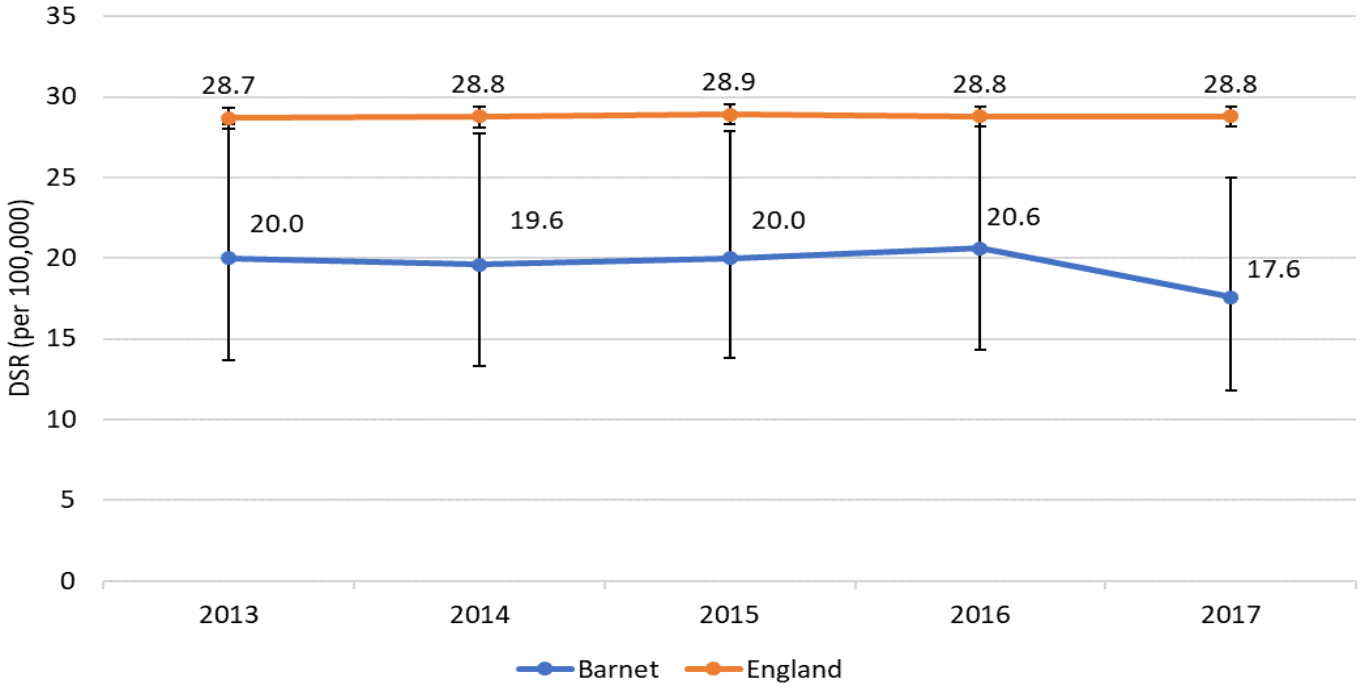
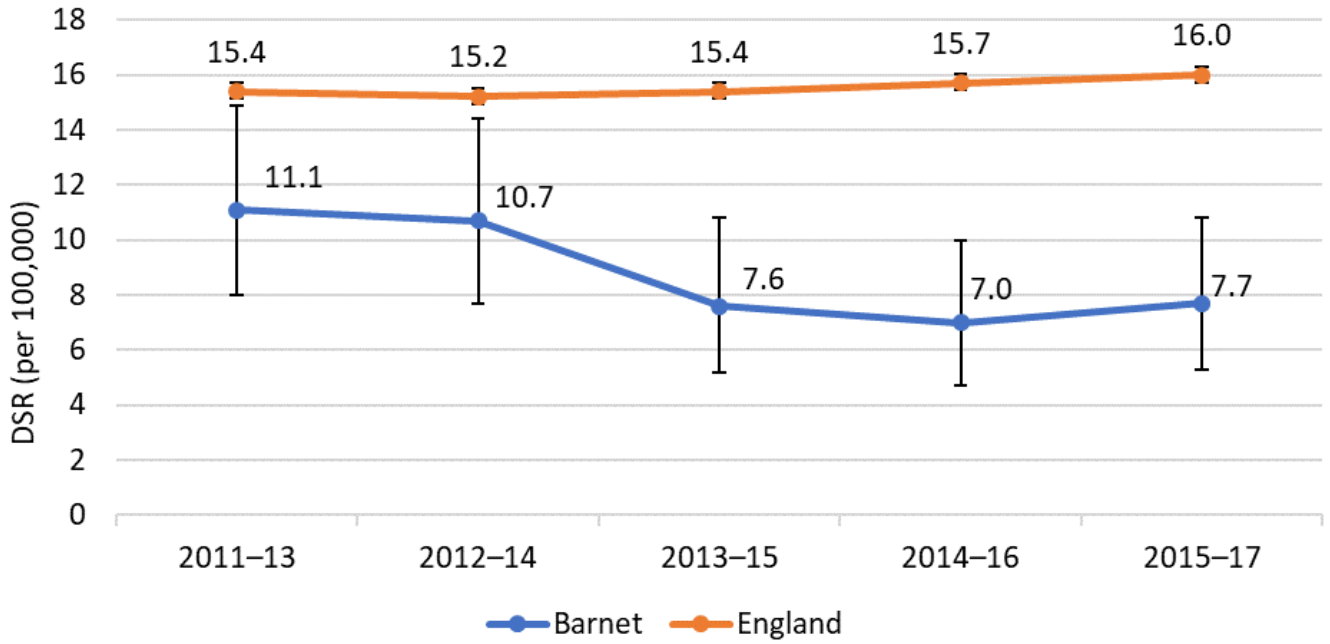



**Figure 4: Mortality from chronic liver disease for Barnet males, 2011–13 to 15–17[17]**



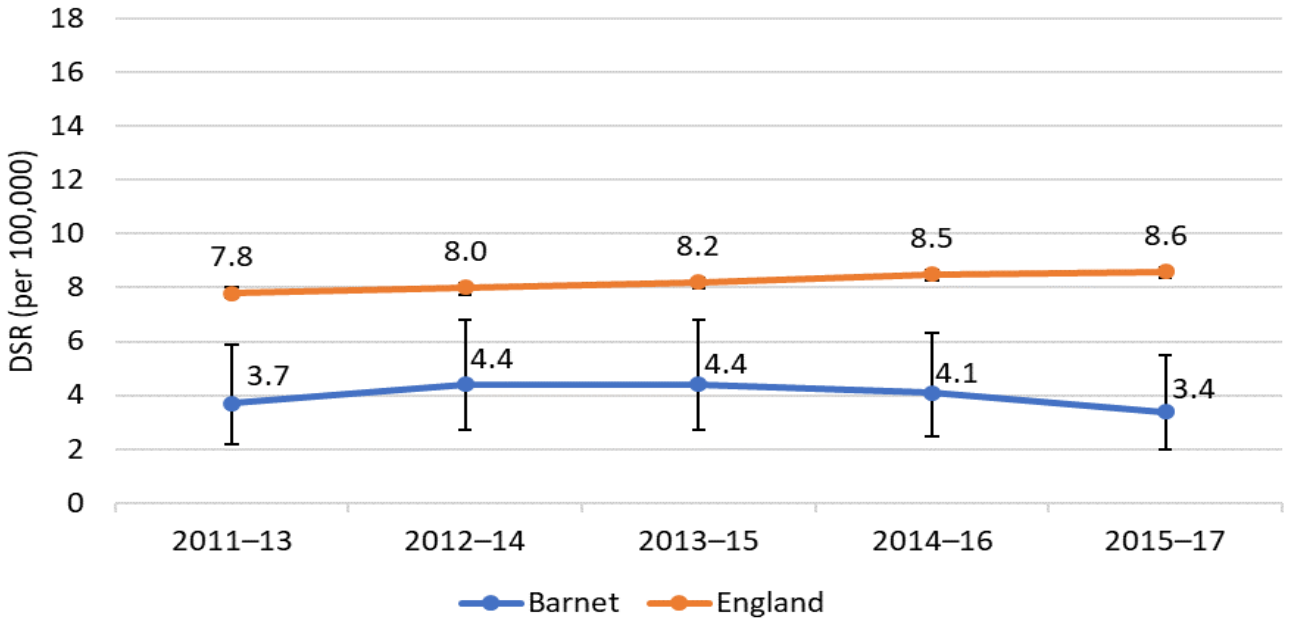

In the Figure above (Figure 4) the mortality from chronic liver disease for males of all ages, in Barnet is outlined. This shows that the DSR rate per 100,000 in Barnet for all years since 2011 are

[16] Public Health England (Local Alcohol Profiles for England)
[17] Public Health England (Local Alcohol Profiles for England)

lower than the England average. It also shows that the trend in Barnet in deaths from chronic liver disease could be stable between 2011 and 2017 for the rate per 100,000 (due to overlapping confidence intervals any assumed reduction is potentially not statistically significant).

Figure 5 below provides details of the rate per 100,000 for mortality for chronic liver disease in females of all ages in Barnet since 2011. This Figure shows that the mortality rate for females has remained constant over the time-period of 2011 to 2017 and the rate in Barnet has been consistently below the rate for the England average. It also details that the mortality rate for females from chronic liver disease in females is lower than males, however consideration would need to be given to the number of males in Barnet consuming alcohol to excess in comparison to females before this conclusion can be drawn.

**Figure 5: Mortality from chronic liver disease for Barnet females, 2011–13 to 2015–17[18]**




## Alcohol related hospital admissions (Broad and Narrow Measure)

One data source which can used as an indicator of the level of alcohol related health harm in an area is the number of alcohol related hospital admissions. Hospital admissions relating to alcohol are split into two measures, which are classed as broad and narrow. The narrow measure is where the main reason for the admission to hospital is alcohol[19]. Specifically, this means that an alcohol related disease, illness or condition was the primary reason for the hospital admission or an alcohol-related external cause was recorded in a secondary diagnosis coding field on the admission paperwork. The broad measure is when the primary reason for admission or a secondary diagnosis is linked to alcohol[20].

In Barnet in 2017/18, the actual number of alcohol related admissions by the narrow definition was 1576 and the broad definition was 6182, over the same period[21].

[18] ibid
[19] https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-alcohol/2018/part-1
[20] ibid
[21] Public Health England (Local Alcohol Profiles for England)

Figure 6 below outlines the rate of alcohol related hospital admissions in Barnet Males between 2013 and 2018. This shows that the rate per 100,000 in Barnet is lower than the England rate across all years between 2013 and 2018. The actual rate in Barnet is stable, with the confidence intervals overlapping during each time period. As this data is from the broad measure, the rate per 100,000 would be expected to be greater than the narrow measure.

**Figure 6: Alcohol-related hospital admissions (Broad) for Barnet males, 2013/14–2017/18[22]**

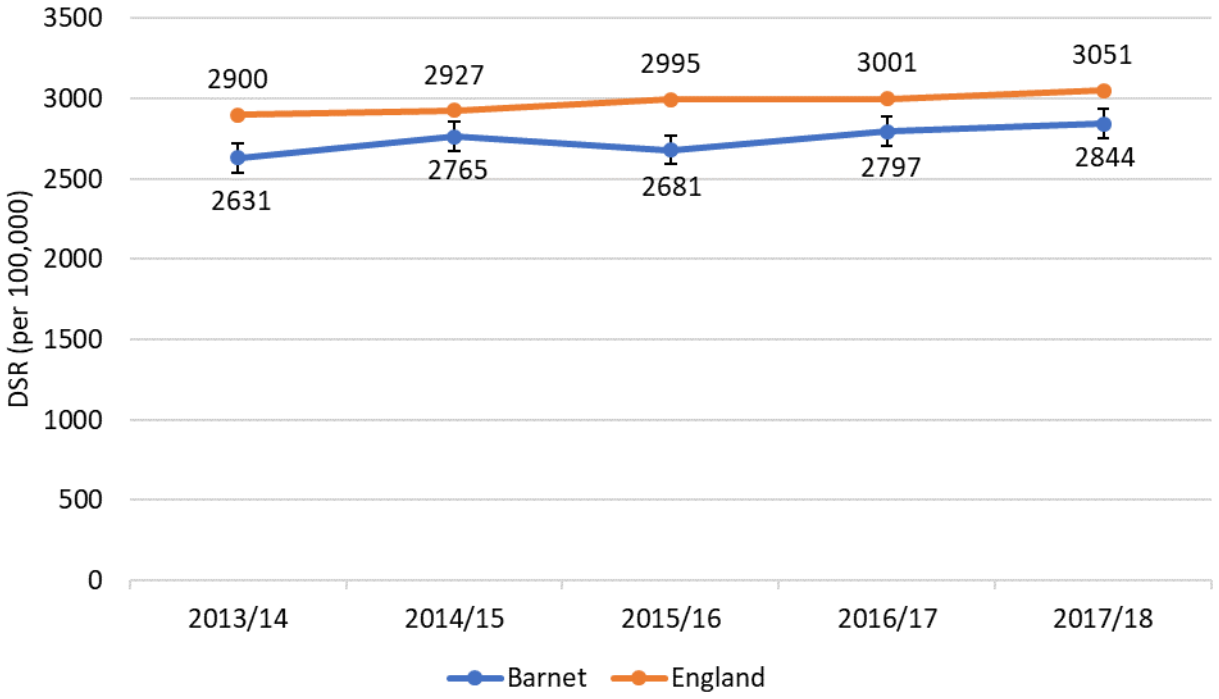
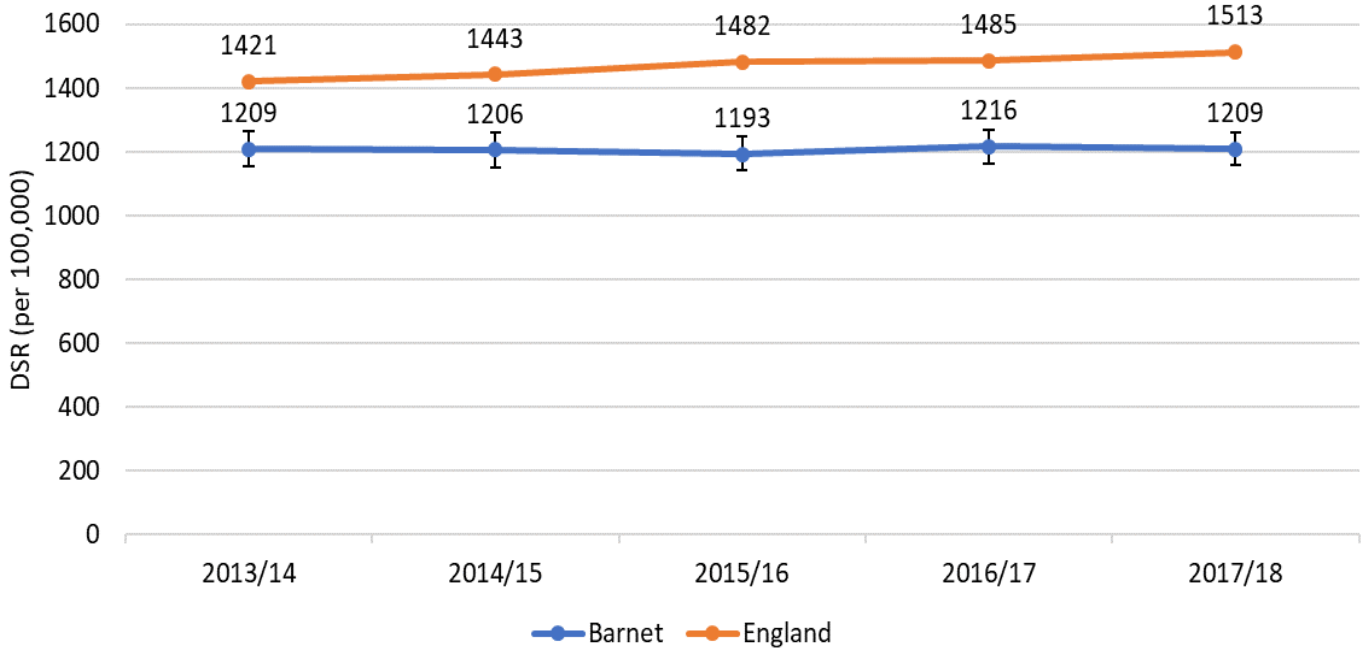



Figure 7 on the next page, outlines the broad measure rate per 100, 000 for alcohol related hospital admission for females across the same period as the males. Again, the rate per 100,000 in Barnet is lower than the England average between the years of 2013 to 2018. The trend in Barnet appears stable with no dramatic increases of decreases in the rate per 100,000, which contrasts with the England average rate which shows a slightly increasing trend. Without the confidence intervals around the England rate however, any commentary on trend should be viewed with caution.

[22] ibid

**Figure 7: Alcohol-related hospital admissions (Broad) for Barnet females, 2013/14–2017/18[23]**




Turning attention to the rate per 100,000 for alcohol related hospital admissions for Barnet males, using the narrow measure between 2013 to 2018 the rate is lower than the broad measure and it is also below the England average rate. The trend in Barnet, appears relatively stable as despite changes in the actual numbers between 2013 and 2018, the confidence intervals overlap. The trend for England appears to fluctuate slightly but like the previous Figure, as there are no confidence intervals plotted that relate to this figure, statistical significance cannot be assigned to this comment on the trend and it should be viewed with caution.

[23] ibid

**Figure 8: Alcohol-related hospital admissions (Narrow) for Barnet males, 2013/14–2017/18[24]**

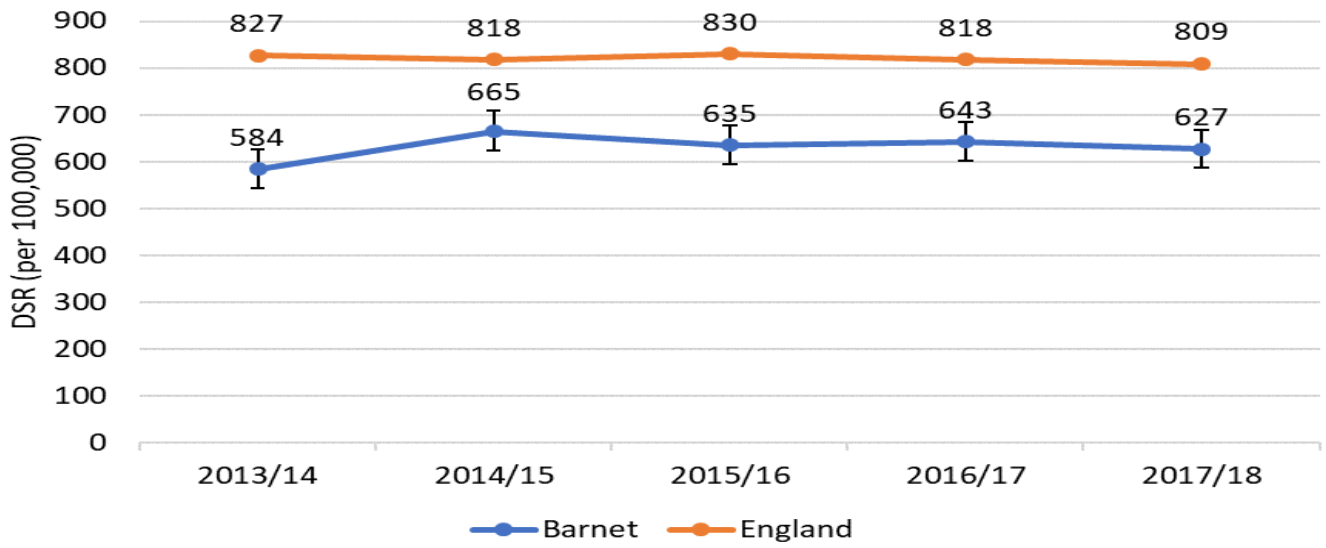
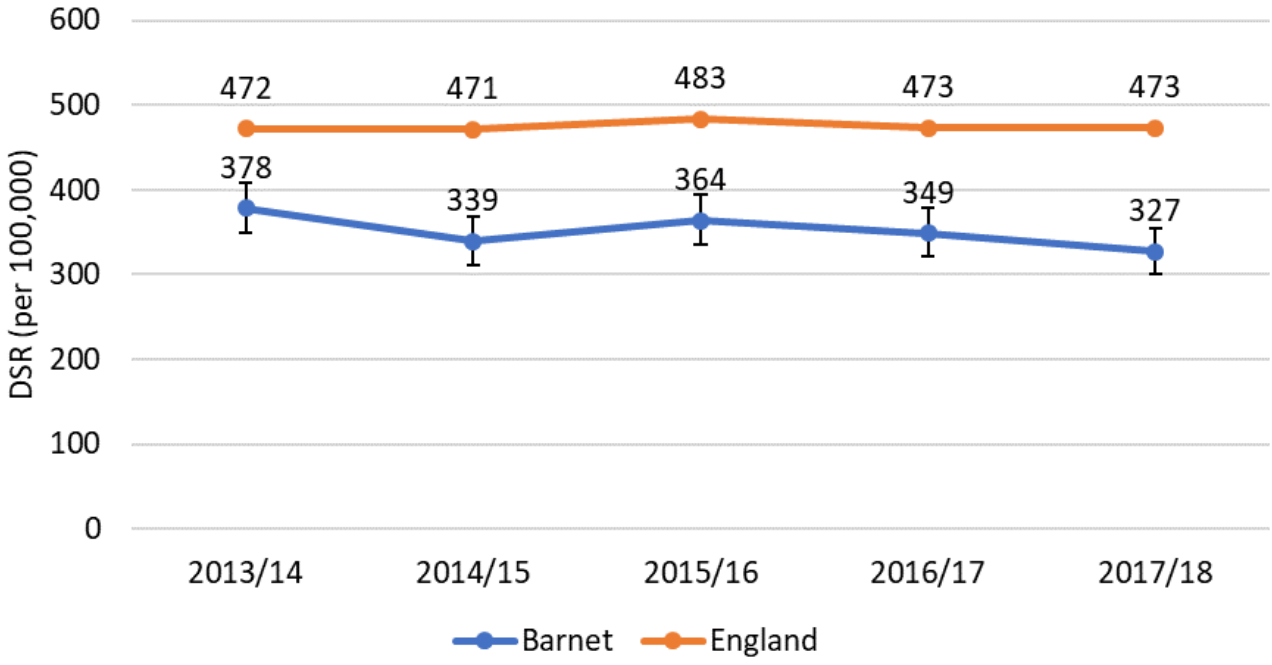



Figure 9 below outlines the corresponding figures relating to Barnet females for alcohol related hospital admissions, using the narrow measure. The rate per 100,000 appears lower in Barnet than the England rate, but without confidence intervals for the England rate, this conclusion should again be viewed with caution. The narrow measure rate is lower than the broad measure but this would be expected. The rate per 100,000 for females with alcohol related hospital admissions in Barnet appears to have decreased from 378 per 100,000 in 2013/14 to 327 per 100,000 in 2017/18 but the confidence intervals surrounding these rates overlap and therefore a conclusion of any reduction in rates should be viewed with caution.

**Figure 9: Alcohol-related hospital admissions (Narrow) for Barnet females, 2013/14–2017/18[25]**




[24] Public Health England (Local Alcohol Profiles for England

[25] Ibid

## Alcohol related Hospital admissions: Alcohol Attributable Fractions

Public Health England's (PHEs) Local Alcohol Profiles for England use a system of alcohol attributable fractions to calculate the proportion of a health condition or external cause that is attributable to the exposure of a specific risk factor (such as alcohol) in each population[26]. The following data Figures outline the LAPE data for Barnet. Conditions are deemed as alcohol specific, as in the condition could only be caused by alcohol consumption such as alcohol related liver disease or partially related to alcohol, such as breast cancer or hypertension.

Figure 10 on the next page, provides details of the alcohol specific hospital admissions for Barnet males as a rate per 100,000 between 2013/14 and 2017/18. Similar to other Figures, this shows that rate per 100,000 appears lower in Barnet than the England average. It also seems to show an upward trend in Barnet relating to admissions from 2013 to 2018, but due to overlapping confidence intervals any change is not statistically significant.

**Figure 10: Alcohol-specific hospital admissions for Barnet males, 2013/14–2017/18**

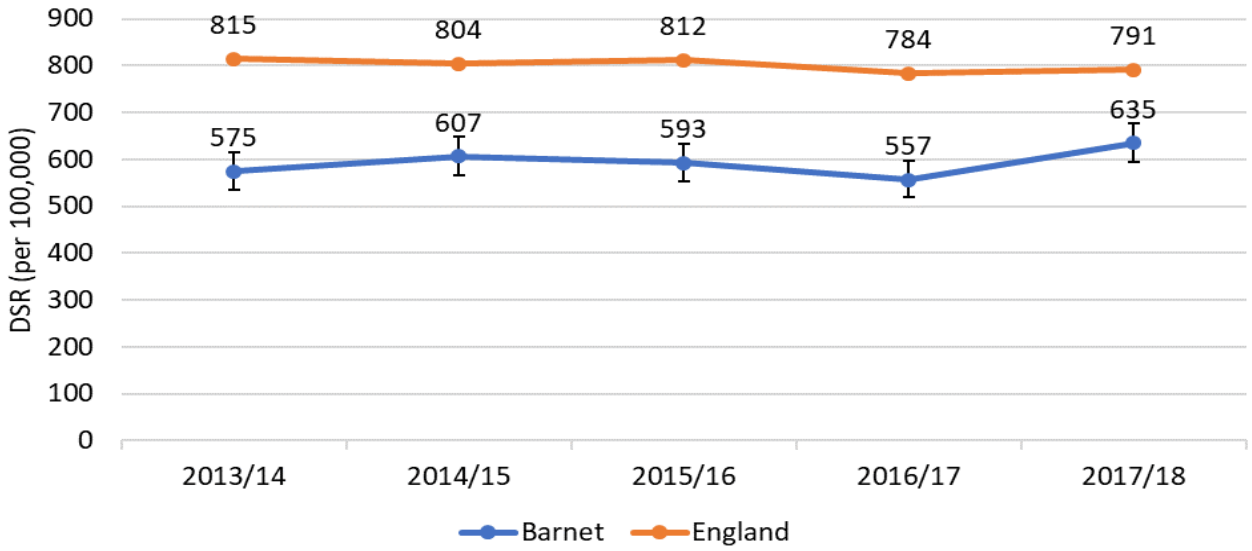
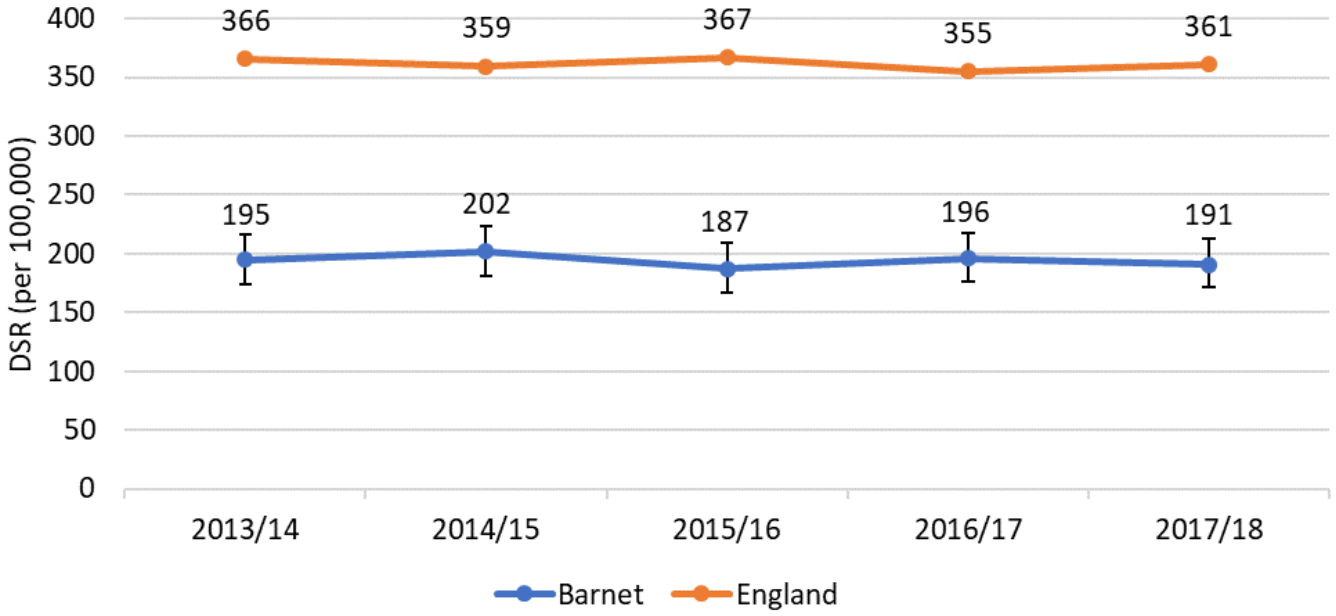



Figure 11 provides information on alcohol specific admissions for Barnet females between the years 2013 and 2018. All Barnet rates are less than the England rate (again without confidence intervals this needs to be interpreted with caution). An examination of the rate per 100,000 for Barnet females shows that the trend over time is reasonably stable with no substantial increases or decreases in rates between 2013 and 2018.

[26] Local Alcohol Profiles for England 2017 User Guide

**Figure 11: Alcohol-specific hospital admissions for Barnet females, 2013/14–2017/18**[27]




In the table below (Table 2) the number of alcohol-specific inpatient admissions[28] of Barnet residents by site of treatment (top 10 most frequent), for most recent three years (2015/16–2017/18) are presented. This table shows the most common locations for alcohol specific admissions for Barnet residents from 2015 until 2018. The majority of admissions across all years was to the Royal Free London NHS foundation trust, consisting of the Royal Free in Hampstead, Barnet Hospital and Chase Farm Hospital in Enfield. The second highest number of admissions of Barnet residents was to UCL hospitals NHS foundation trust in central London. This was closely followed by London North West Healthcare NHS Trust.

Barnet, Enfield and Haringey Mental Health Trust features on the list for alcohol specific admissions, with a substantial number of alcohol specific admissions recorded in 2015/16, this dropped in 2016/17 and in 2017/18 the number of admissions increased again. The numbers admitted to the BEH MHT, as a minimum should be monitored and reviewed. This information is important in relation to future commissioning decisions of any alcohol liaison service and substance misuse service provision in general. The current commissioning arrangements are for the provision of one nurse post, which is primarily based within the current service providers premises, with some time dedicated to Barnet Hospital. There is therefore, no service provision based within BEH MHT.

[27] Public Health England (Local Alcohol Profiles for England
[28] Excludes maternity admissions

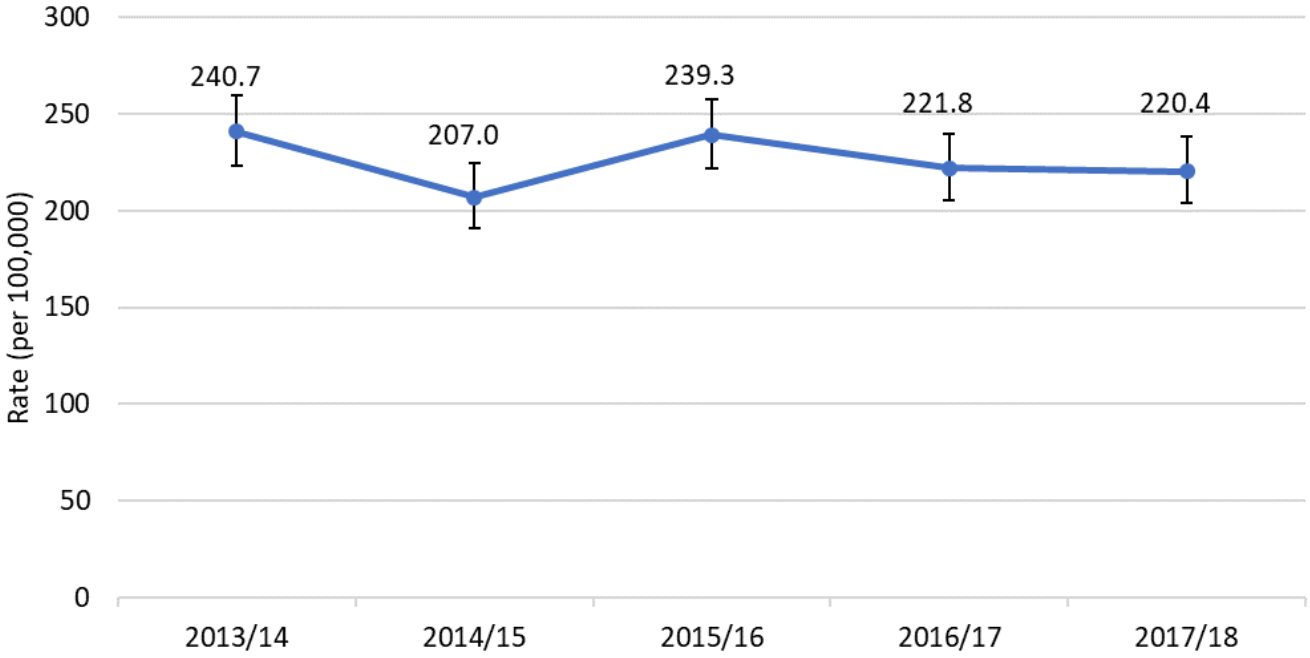
**Table 2: Number of alcohol specific admissions of Barnet residents by site of treatment (top 10 most frequent)**

| Location | Admission Numbers | | |
|---|---|---|---|
| | **2015/16** | **2016/17** | **2017/2018** |
| Royal Free London NHS Foundation Trust | 832 | 829 | 874 |
| University College London Hospitals NHS Foundation Trust | 70 | 67 | 67 |
| London North West Healthcare NHS Trust | 68 | 59 | 62 |
| Barnet, Enfield and Haringey Mental Health Trust | 61 | 40 | 53 |
| The Whittington Hospital NHS Trust | 41 | 29 | 48 |
| Imperial College Healthcare NHS Trust | 32 | 29 | 43 |
| Barts Health NHS Trust | 19 | 17 | 24 |
| Guys' and St Thomas NHS Foundation Trust | 17 | 15 | 19 |
| North Middlesex University Hospital NHS Trust | 13 | 11 | 13 |
| Kings College Hospital NHS Foundation Trust | -[29] | 5 | 7 |

## Alcohol-related ambulance callout data

Ambulance service data can provide a sense of the scale of alcohol issues in a local area. The data below was obtained from the Safe Stats website and population data was gained from the Greater London Authority (GLA) and the Office of National Statistics (ONS). Figure 12 below provides information relating to alcohol related ambulance call outs for adults in Barnet between the years of 2013 to 2018. It shows that the rate per 100,000 in Barnet fluctuates but overall it has remained similar as the confidence intervals surrounding the actual figures overlap across all years.

**Figure 12: Alcohol-related ambulance callouts for Barnet adults, 2013/14–2017/18[30]**




[29] Data suppressed due to small counts
[30] Greater London Authority (Safestats), Greater London Authority (ONS Mid-Year Population Estimates - Custom Age Tables)

Looking at the rate per 100,000 of alcohol related ambulance call outs for Barnet residents by age ranges produced the Figure below. The Figure appears to show that the highest rate of ambulance call outs between 2013/14 and 2017/18 was in the 18-25-year-old groups, but during 2014/15 and 2016/17 this conclusion is questionable, due to the confidence intervals overlapping with the 26-45-year-old age group. In addition, the confidence intervals around the rate for 26-45-year olds between 2013/14 and 2017/18 crosses the rate for 46-64-year olds across all years, apart from during the years of 2014/15. Due to the number of confidence intervals that overlap in Figure 13 below, it is difficult to draw any firm conclusions from this data.

**Figure 13: Alcohol-related ambulance callouts for Barnet adults, by age, 2013/14–2017/18[31]**

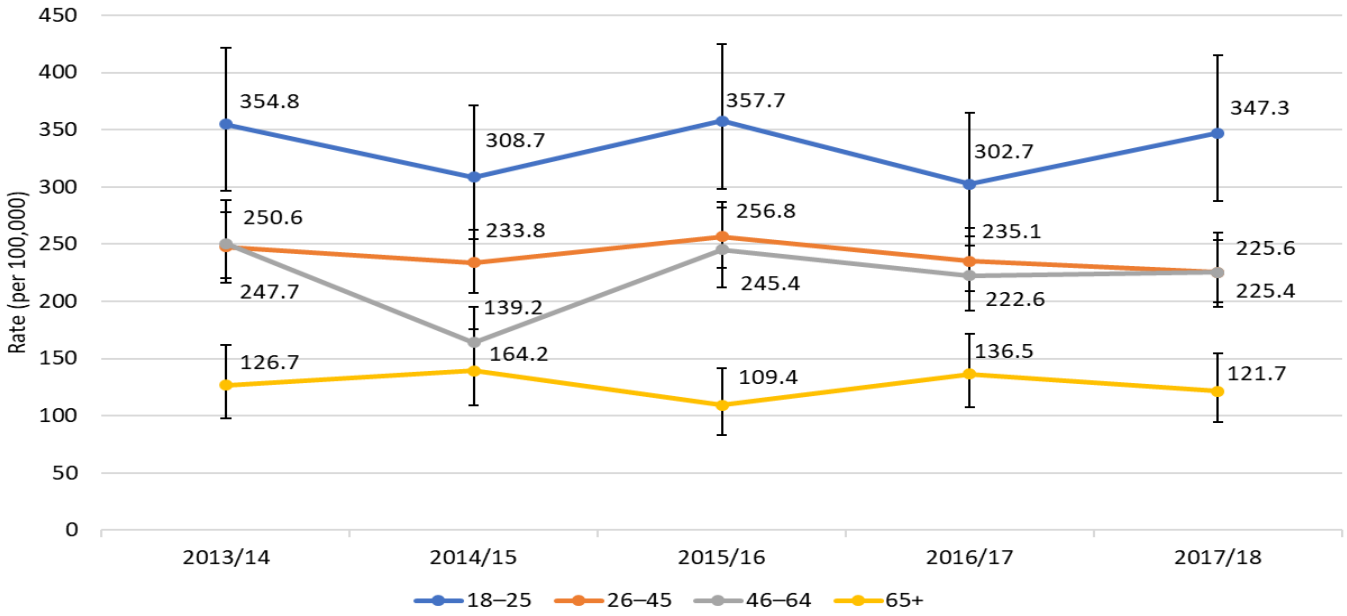
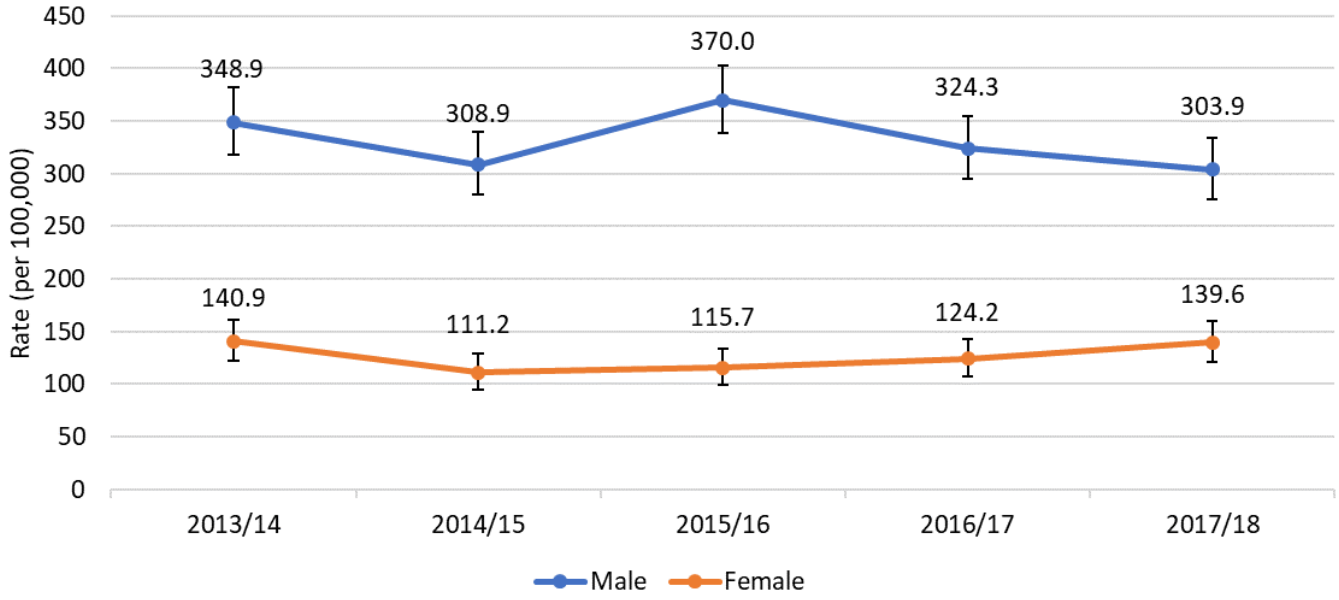



Figure 14 below provides the rate per 100,000 for ambulance calls out for Barnet adults between 2013/14 and 2017/18, divided by gender. This shows that the male rate was over double the female rate per 100,000 during all years. The rate per 100,000 for males has fluctuated between 2013/14 and 2017/18 but as the confidence intervals for the rates overlap during these years, any conclusion must be viewed as speculative.

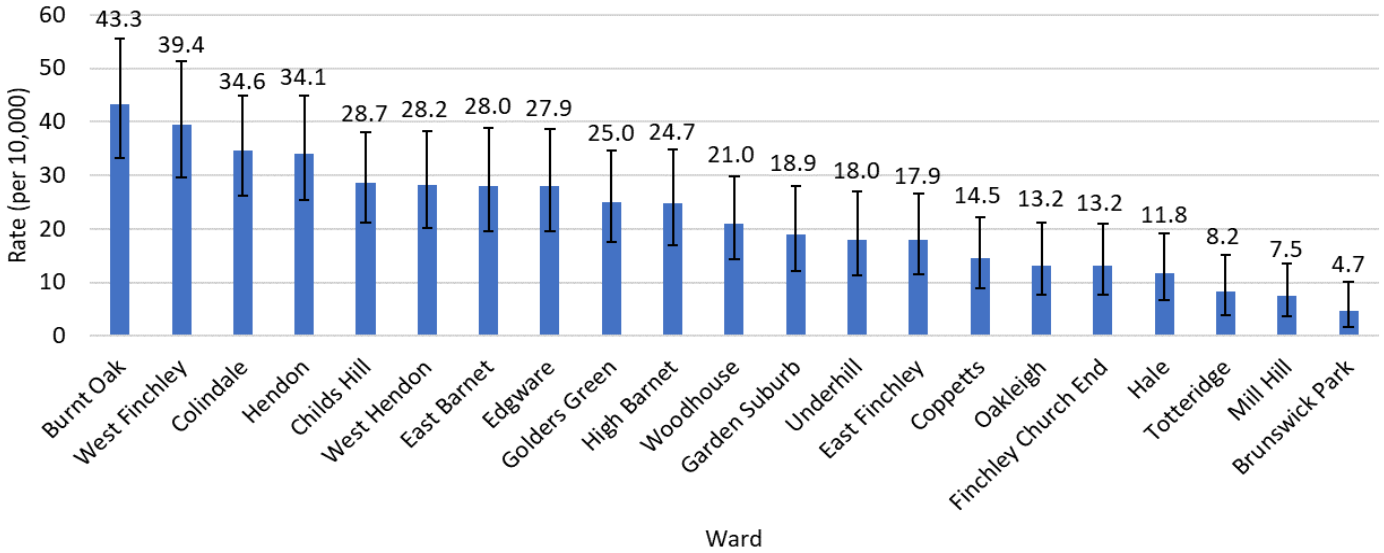
[31] Source: Greater London Authority (Safestats), Greater London Authority (ONS Mid-Year Population Estimates - Custom Age Tables)

**Figure 14: Alcohol-related ambulance callouts for Barnet adults, by gender, 2013/14–2017/18**[32]




In the final Figure in this section, the ward location of the Barnet call outs during the years of 2017/18 was plotted as a rate per 100,000. The highest rates of ambulance call outs appear to be in Burnt Oak ward, however, when consideration is given to the confidence interval surrounding this rate, this conclusion cannot be made due to overlaps with the confidence interval around the second highest ward of West Finchley. There is also overlap in the confidence intervals around the rates for Burnt Oak, West Finchley and the third highest ward rate for Colindale. The wards with the lowest rates are listed in this Figure as Totteridge, Mill Hill and Brunswick Park, again due to overlapping confidence intervals, this should be viewed with caution. Please note that data on ambulance call out rates, could be a reflection of a number of issues not related to alcohol consumption by residents who live in these wards. For example, the location of on trade licensed premises could influence the data.

**Figure 15: Alcohol-related ambulance call outs for Barnet adults, by ward, 2017/18**[33]




[32] Ibid

[33] Source: Greater London Authority (Safestats), Greater London Authority (ONS Mid-Year Population Estimates - Custom Age Tables)

## Alcohol related Crime

The Crime Survey for England and Wales produces data on alcohol related crime, with the most recent
publication of data being in December 2018. The table below outlines data for England and Wales published by the Office for national statistics.

**Table 4. Percentage of Crime Survey for England and Wales incidents[1] which were alcohol-related[2], year ending March 2017**

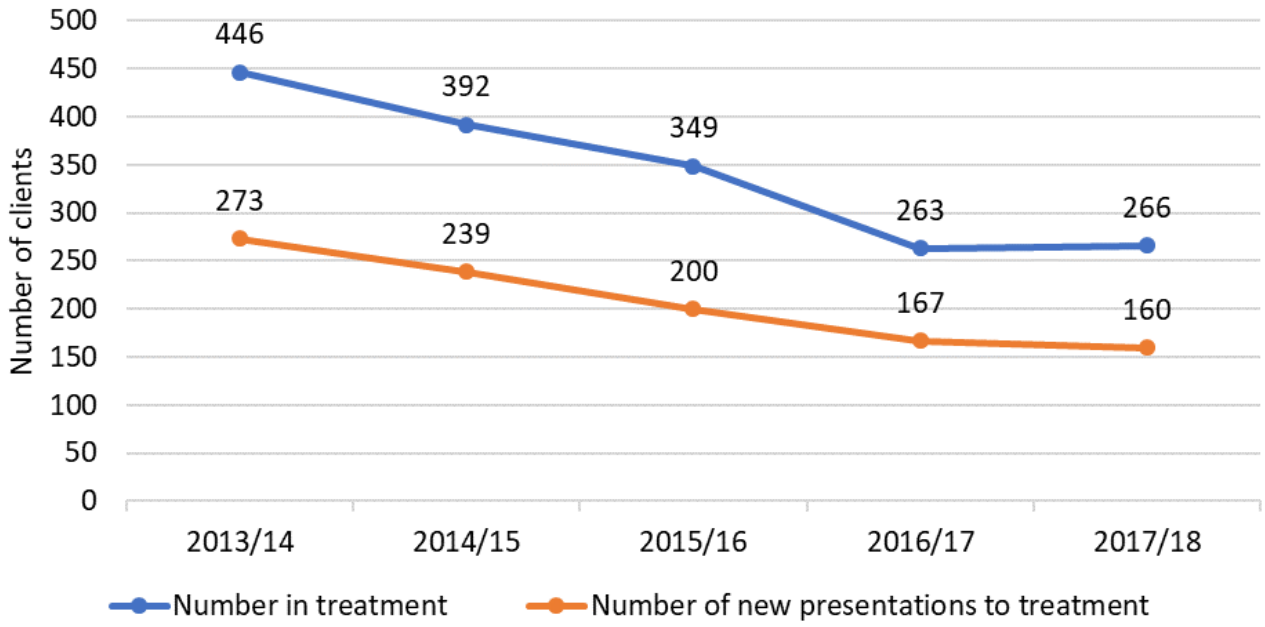
| **England and Wales** | | | | **Adults aged 16 and over** |
|---|---|---|---|---|
| Offence group[3] | Alcohol-related | Not alcohol-related | Not known if alcohol-related | Unweighted base - number of incidents |
| **THEFT OFFENCES** | 12.4 | 47.5 | 40.1 | 776 |
| **Theft from the person** | 10.8 | 50.0 | 39.2 | 124 |
| **Other theft of personal property** | 8.4 | 55.4 | 36.2 | 103 |
| **Domestic burglary** | 18.1 | 43.0 | 38.9 | 261 |
| With entry | 17.6 | 45.4 | 37.0 | 165 |
| Attempts | 18.9 | 38.4 | 42.7 | 96 |
| Domestic burglary in a dwelling | 20.2 | 44.9 | 34.8 | 219 |
| Domestic burglary in a non-connected building to a dwelling | .. | .. | .. | 42 |
| **Other household theft** | 14.8 | 50.3 | 35.0 | 143 |
| Theft from a dwelling | 23.4 | 63.3 | 13.3 | 64 |
| Theft from outside a dwelling | 7.1 | 38.6 | 54.3 | 79 |
| **Vehicle-related theft** | 6.7 | 30.4 | 63.0 | 95 |
| **Bicycle theft** | 6.5 | 53.3 | 40.2 | 50 |
| **CRIMINAL DAMAGE** | 20.6 | 51.2 | 28.2 | 340 |
| Criminal damage to a vehicle | 15.6 | 48.2 | 36.2 | 175 |
| Arson and other criminal damage | 24.9 | 53.9 | 21.3 | 165 |
| **HATE CRIME[4]** | 21.5 | 57.1 | 21.4 | 88 |

The above table outlines that alcohol is implicated in a number of criminal offences in England and Wales and this will also apply within Barnet**.**

## Alcohol treatment data and performance

Over the past five years the numbers of clients in treatment for alcohol issues has reduced from 446 clients in 2013/14 to 266 in 2017/18 as detailed in Figure 16 below. In addition to this the number of new presentations into treatment has reduced during the same period from 273 to 160 clients. Table 5 on the next page, outlines how these reductions represent a 40% reduction in clients in treatment overall and a 41% reduction in the percentage of new clients accessing treatment. These statistics are concerning and although there has been a reduction nationally relating to the number of clients accessing treatment, the reduction in Barnet is greater than the national figure, of a 19% fall in the number of people entering treatment for alcohol issues between 2013/14 and 2016/17[34].

**Figure 16: Number in treatment and number of new presentation in Barnet alcohol treatment, 2013/14–2017/18**




[34] https://www.gov.uk/government/publications/alcohol-treatment-inquiry-summary-of-findings/phe-inquiry-into-the-fall-in-numbers-of-people-in-alcohol-treatment-findings

**Table 5: Alcohol numbers in treatment and number of new presentations[35]**

| | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 | % + or - over 5-year period |
|---|---|---|---|---|---|---|
| Number in treatment | 446 | 392 | 349 | 263 | 266 | -40% |
| Number of new presentations to treatment | 273 | 239 | 200 | 167 | 160 | -41% |

A report from PHE which examined the national fall in the number of individuals accessing alcohol treatment nationally reported that the reducing numbers of people entering treatment was occurring in a context of high levels of unmet need, with an estimated 4 in 5 alcohol-dependent adults not accessing alcohol treatment[36]. The fall in treatment numbers therefore cannot be attributed purely to a reduction in the number of people requiring treatment and further investigation is required.

The PHE report concluded that in a few areas in England and Wales, numbers in treatment for alcohol had actually increased. The investigation into the potential reasons for this, led to the production of the list below, which detailed the features in areas which had not experienced a fall in clients accessing alcohol treatment[37]:

- leadership commitment to alcohol treatment and a strategic approach by the local authority to alcohol harm reduction
- a commitment to service improvement, as opposed to just cost saving
- an intention by commissioners to increase numbers in alcohol treatment to meet unmet need
- commissioners working with providers to ensure alcohol-specific needs were addressed in service models and that service cultures were appropriate for alcohol users
- very accessible services, in a wide range of non-stigmatizing settings and in-reach arrangements with partner agencies
- services actively promoted and clearly identifiable as being for alcohol users
- having alcohol-specific treatment pathways and interventions
- staff with alcohol specific competences and roles
- quick access to treatment (including medically assisted withdrawal) following initial contact
- a proactive, motivational and empathetic approach to engaging service users
- commissioners addressing referral pathway issues at a strategic level
- service providers maintaining good partnership arrangements, which lead to effective referral pathways

In Barnet, measures have been taken to improve clients accessing services. A service improvement plan is in operation and the service commissioner and the service provider meet regularly to discuss the plan. This situation will however require monitoring to ensure

[35] Public Health England (Local Area Trend Report 2017-18 Barnet)

[36] Ibid

[37] https://www.gov.uk/government/publications/alcohol-treatment-inquiry-summary-of-findings/phe-inquiry-into-the-fall-in-numbers-of-people-in-alcohol-treatment-findings

improvements are achieved and consideration should be given to the list of features outlined above.

**Table 6: Successful completions in Barnet substance misuse treatment for alcohol[38]**

| | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|---|---|
| Number in treatment | 446 | 392 | 349 | 263 | 266 |
| Successful completions | 137 | 134 | 131 | 90 | 127 |
| Successful completions as % of all in treatment | 31% | 34% | 38% | 34% | 48% |

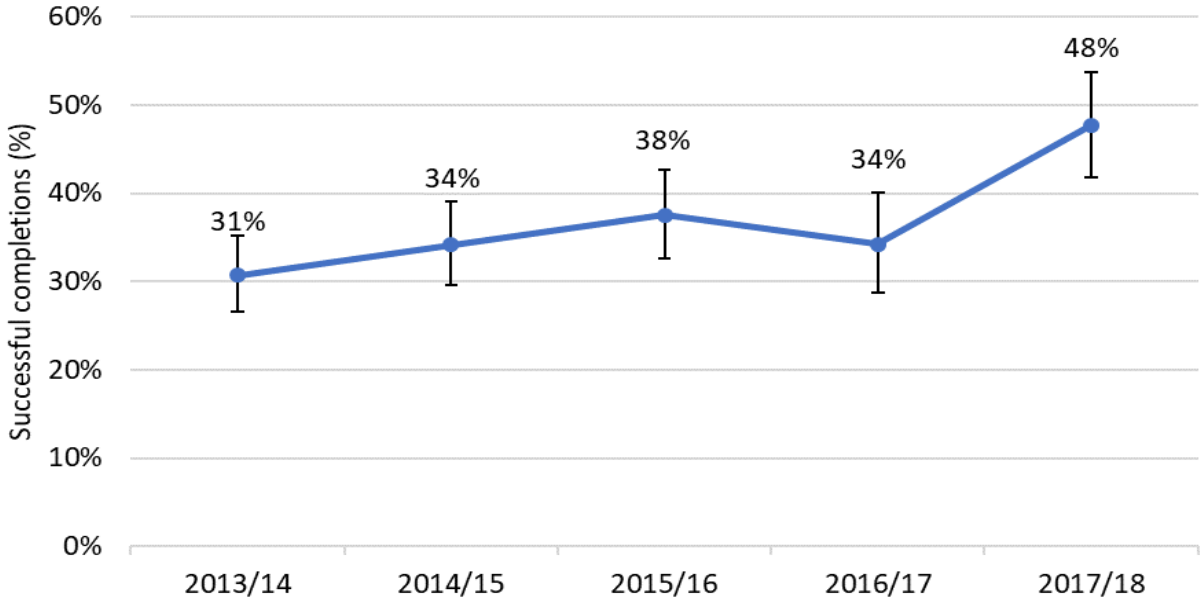
Table 4 above provides further information about the outcomes of clients who entered substance misuse treatment for alcohol between the years of 2013 and 2018. The table includes a calculation of the number of successful completions and the percentage that this number represents in relation to the numbers in treatment. This shows that in 2013/14, 137 people had successful completions. This number dropped during 2014/15, 2015/16 and 2016/17 before increasing again in 2017/18. In 2017/18, 48% of the clients in treatment had a successful completion of their treatment episode. Nationally, PHE report that 61% of individuals complete treatment for alcohol successfully[39]. Performance in Barnet is below this rate.

In Barnet, the percentage of successful completions has increased with decreasing numbers of clients entering the service. It could be asserted that the increase in the numbers achieving a successful completion is an indication that the treatment service is performing well, however caution needs to be taken before drawing this conclusion due to the reductions in the number of clients entering treatment. Therefore, the number of clients needed to achieve a greater percentage in successful completions as a percentage of all in treatment has reduced. Figure 17 below, provides this information in a graphical format whilst only including the percentage of everyone in treatment.

[38] Source: Public Health England (Local Area Trend Report 2017-18 Barnet)

[39] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/752993/AdultSubstanceMisuseStatisticsfromNDTMS2017-18.pdf

**Figure 17: Successful completions as a percentage of all in treatment for Barnet alcohol treatment, 2013/14–2017/18[40]**




The length of time that a client is in treatment can be viewed as an indicator relating to the performance of a substance misuse service. Each client has individual needs however, and these may not be met by a time limited contact within a treatment service. The importance of good quality assessment of needs and ongoing care planning and reviews, cannot be underestimated.

Table 7 below outlines the time spent in alcohol treatment in 2017/18 by each client. This shows that 23% of clients where in alcohol treatment for under 3 months, 31% for between 3-6 months, 33% in the next category of between 6-9 months and finally 13% remained in treatment for over one year. There is therefore no clear time-period for which the majority of clients remain in treatment or any indication of the optimal time for a client to remain in treatment in order to successfully complete treatment.

**Table 7: Time in structured alcohol treatment, 2017/18[41]**

| Time in treatment | Under 3 months | Between 3 and 6 months | Between 6 and 12 months | Over 1 year |
|---|---|---|---|---|
| Number | 43 | 59 | 63 | 24 |
| % of all exits | 23% | 31% | 33% | 13% |

[40] Public Health England (Local Area Trend Report 2017-18 Barnet)
[41] Public Health England (Adults - alcohol commissioning support pack 2019-20: key data)

In the Figures below, further information is provided relating to clients in treatment for alcohol issues in 2017/18. This information includes breakdowns by age, sex, ethnicity, employment status and parental responsibility.

**Figure 18: Age and gender of Barnet adults in alcohol treatment, 2017/18[42]**

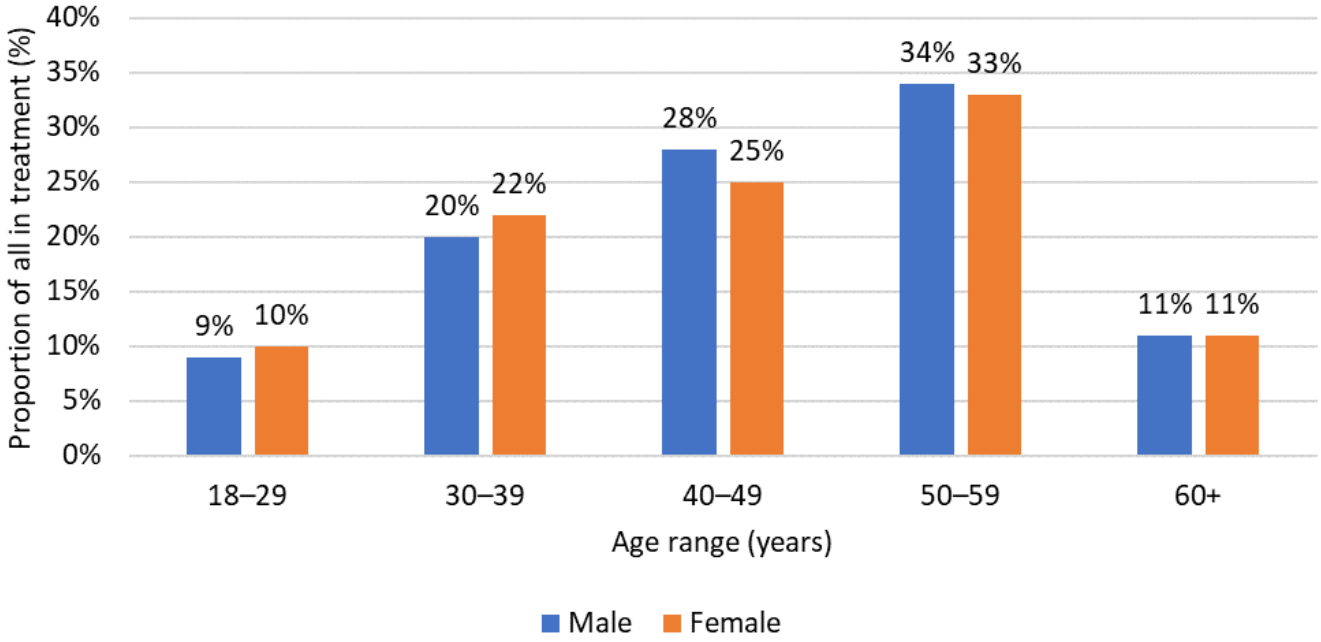



Figure 18 above uses data provided by the current service provider to detail the age and gender of clients in treatment for alcohol. In the age category of 18-29 years, there is a one percent difference between males and females in treatment (9% males, 10% female). Between the ages or 30-39 years, 20% of clients in treatment were males and 22% were females during 2017/18. The two age ranges with the greatest percentage of clients in treatment were 40-49 years and 50-59 years. In the 40-49 years age group, 28% were male and 25% female and in the 50-59-year category, 34% were male and 33% female. This means that males aged between 40-59 accounted for 62% of the males in treatment for alcohol, the corresponding figure for women was 58%. Consideration should be given to whether this demographic matches the figures on the age ranges using alcohol to excess in general and secondly, if the current treatment system is meeting the needs of this client group. It is interesting to note that individuals aged 60 and over for both sexes constitute over 10% of the proportion of individuals in treatment for alcohol. Given the changes in relation to older clients experiencing health issues connected to long term alcohol misuse, it is important to continue to monitor this group and ensure that their needs are met.

Figure 19 below provides details on the ethnicity identified by clients in alcohol treatment during 2017/18. This shows that nearly two thirds of the clients in alcohol treatment identified their ethnicity as white British. In Barnet, using GLA figures for 2018, it is noted that 40% of the

[42] Public Health England (Adults - alcohol commissioning support pack 2019-20: key data)

population identified as White British[43]. In Figure 19, 10% identified as White other which is lower that the borough figure of 18.2% of the population identifying their ethnicity as White Other[44]. Figure 19 also shows that in relation to alcohol treatment in 2017/18 4% identified as African (5.9% of Barnet residents identify with this as their ethnic group[45]), 4% Indian (the corresponding figure for all Barnet residents in 2018 was 7.6%[46]) and 4% of individuals in treatment for alcohol issues in 2017/18 identified as White Irish (2.2% of all Barnet residents in 2018 identified their ethnicity with this group[47]). All other ethnic groups were identified by 11% of clients in treatment for alcohol issues.

**Figure 19: Ethnicity of Barnet adults in alcohol treatment, 2017/18[48]**

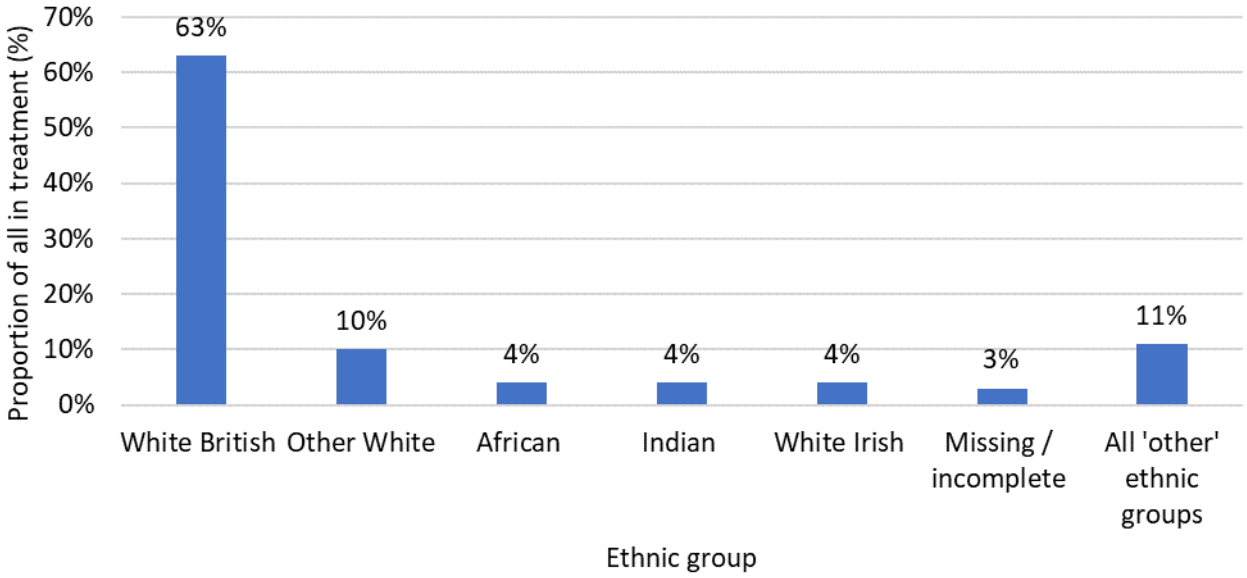



Table 8 below outlines the employment status of people in treatment for alcohol use during 2017/18 and provides a comparison of the rates within Barnet to national level data. Clients in Barnet appear to be less likely to be in regular employment than national figures (23% in Barnet, compared to 32% nationally) and are more likely to be unemployed or economically inactive than national rates (45% of clients in Barnet, compared to 32% nationally). No clients in treatment for alcohol issues in Barnet were in education. The corresponding figure nationally was however, very low at only 1% and 10% of clients in Barnet did not have any employment status listed (6% of clients nationally did not have an employment status listed). A possible reason behind this statistic could be that as this data related to new presentations, other factors were more important to address at the beginning of treatment such as prescribing or housing and identifying employment status was viewed as an issue to be discussed further into each treatment journey. Barnet clients were reported in smaller numbers to be long term sick or disabled (18%) than nationally (25%) and

[43] GLA (2017): 2016- based housing led ethnic group projections. [Population counts are rounded to the nearest 100].

[44] Ibid
[45] ibid
[46] Ibid
[47] Ibid
[48] Public Health England (Adults - alcohol commissioning support pack 2019-20: key data)
* including unpaid voluntary work

were more likely to be in the category labelled as other, which includes unpaid voluntary work (5% in Barnet, 3% nationally).

**Table 8: Employment status of those in substance misuse treatment for alcohol[49]**

| Employment status at start of treatment | Proportion of new presentations - Barnet | Proportion of new presentations - National |
|---|---|---|
| Regular employment | 23% | 32% |
| Unemployed/ Economically inactive | 45% | 32% |
| Long term sick or disabled | 18% | 25% |
| In education | 0% | 1% |
| Other* | 5% | 3% |
| Missing / incomplete | 10% | 6% |

Adults in treatment for alcohol in Barnet appear to have lower levels of parental status than national figures. Table 9 below shows that only 18% of new presentations are living with children (24% nationally) and 17% are parents who don't live with children (25% nationally). The majority, 65% are not a parent and have no contact with any children, which is greater than the national figure of 50%.

**Table 9: Parental status of those in substance misuse treatment for alcohol[50]**

| Parental Status | Proportion of new presentations – Barnet | Proportions of new presentations - National |
|---|---|---|
| Living with children (own or other) | 18% | 24% |
| Parents not living with children | 17% | 25% |
| Not a parent/ no child contact | 65% | 50% |
| Missing/ incomplete | 0% | 1% |

## Alcohol Treatment Requirements (ATRs)

An Alcohol Treatment Requirement (ATR) is aimed at people who have been assessed as Alcohol dependent and their use of alcohol can be a factor in their offending. Under Section 212 of the Criminal Justice Act 2003, an ATR is available to courts as a sentencing option for offenders aged 18 and over. The table below provides details of the numbers of ATR's in Barnet from Q3 of 2016/17 to Q4 of 2017/18. This data has been provided by the Adult Substance Misuse Service. Due to reporting Restrictions on small number, any figure less than five has been suppressed.

The table shows that there are only small numbers of individuals receiving ATRs as a sentence within Barnet. All individuals referred may not start an ATR as they may not be assessed as appropriate. In relation to the individuals who start, the majority complete their ATR and in addition, most complete it successfully. Table 10 below provides information on the number of individuals who were subject to an Alcohol Treatment Requirement.

[49] Ibid
[50] Public Health England (Adults - alcohol commissioning support pack 2019-20: key data Barnet)

**Table 10: Number of Individuals on Alcohol Treatment Requirements[51]**

| | 2017-2018 |
|---|---|
| Number of referrals | 33 |
| Percentage of referrals who started treatment | 70% (23) |
| Number of ATR completions* | 26 |
| Percentage of ATR completions that were successful completions | 58% (15) |

*Please note this figure includes people who completed their ATR in 2017-18 but didn't necessarily start treatment during this period.

## Drug treatment data and performance

Public Health England have recently released prevalence estimates for the number of people aged between 15-64 years who used opiates and/or crack in 2016/2017 in Barnet. Previous estimates were produced in 2014/15. Comparing the two sets of figures showed that the overall difference between the opiate and crack users (OCU) in Barnet between 2014/15 and 2016 was a reduction of 85 individuals. For opiate users over the same period, the reduction was 134 individuals and in relation to crack users the difference was 2 clients. Please note however that none of the reported figures on difference between 2014/15 and 2016/17 were statistically significant and therefore this data should be viewed with caution. As these figures are also all based-on estimates, the reliability of the data accuracy is reduced.

It does however provide a crude estimate of the number of Barnet residents who are Opiates and/or Crack users. The numbers in treatment for these substances is lower which could be viewed as an indication that current service provision is not reaching this cohort. However, consideration should also be given to the type of service that could attempt to engage individuals who may not feel that specialist drug treatment is required.

**Table 11: Prevalence estimates (2016-17) of drug misuse in Barnet[52]**

| Prevalence estimates (Aged 15-64) | Barnet | | National | |
|---|---|---|---|---|
| | N | Rate per 1000 | N | Rate per 1000 |
| OCU | 1,583 | 6.25 | 313,971 | 8.85 |
| Opiate | 1,256 | 4.96 | 261,294 | 7.30 |
| Crack | 1,028 | 4.06 | 180,748 | 5.10 |

[51] Source: Provider data
[52] https://www.gov.uk/government/publications/opiate-and-crack-cocaine-use-prevalence-estimates-for-local-populations

Table 12 below provides details of the number of drug related deaths in Barnet between the years of 2011 and 2017 based on NDTMS data that uses rolling years. The recorded number of deaths was 17 people in 2011-13, this declined to 14 deaths in 2012-2014 and since then the number of deaths has increased year on year to 33 deaths between 2015-17. In Table 13 below, the number of recorded deaths whilst individuals were in treatment are outlined. This data was provided by the treatment provider and the format is not rolling years however, the number of deaths in clients in treatment is lower than the number of drug related deaths in Barnet.

**Table 12: Drug misuse data relating to Barnet[53]**

| Drug related deaths in Barnet, 2011–13 to 2015–17 | | | | | |
|---|---|---|---|---|---|
| | 2011–13 | 2012–14 | 2013–15 | 2014–16 | 2015–17 |
| Number of deaths | 17 | 14 | 23 | 30 | 33 |

**Table 13: Deaths in substance misuse treatment (all tier levels) for Barnet, 2015/16–2017/18[54]**

| | | | |
|---|---|---|---|
| | 2015/16 | 2016/17 | 2017/18 |
| Number of deaths[55] | 21 | 6 | 9 |

The table above (Table 13) shows that in 2015/16 there were 21 deaths of individuals who were in treatment. The fell substantially in 2016/17 to 6 deaths and then increased to 9 deaths in 2017/18. The potential reasons behind the reduction and increases in these figures is unknown. Whilst any potential explanation is speculation at this point, perhaps an examination of the prescribing and distribution of the opioid antagonist, named Naloxone may provide an explanation for the reduction in deaths between 2015/16 and 2016/17. As previously mentioned nationally drug related deaths are increasing and one potential explanation for this relates to long term substance misusers experiencing higher levels of poor physical health as they age because of substance misuse on their body. In Barnet, the age ranges and physical health condition of individuals in treatment should be monitored closely.

## Drug-related Hospital admissions data

Moving away from deaths and instead examining hospital data, Table 14 below provides information on the inpatient admissions[56] numbers of Barnet residents during 2017/18 with a diagnosis of substance misuse related mental/behavioural disorder, where a specific substance was identified as causing the admission. It is important to note that most of the admissions for substance related mental or behavioural disorders also involve alcohol related disorders or causes, therefore the figures below underestimate the numbers of admissions.

[53] Source: Office for National Statistics (Deaths related to drug misuse in England and Wales, 2001-2017)
[54] Source: Barnet Public Health Commissioning Team
[55] number of deaths in treatment are those episodes with the outcome listed as 'incomplete – client died'
[56] Excludes maternity admissions

**Table 14: Inpatient admissions* of Barnet residents for a diagnosis of substance-misuse-related mental/behavioural disorder, in 2017/18, by causal substance[57]**

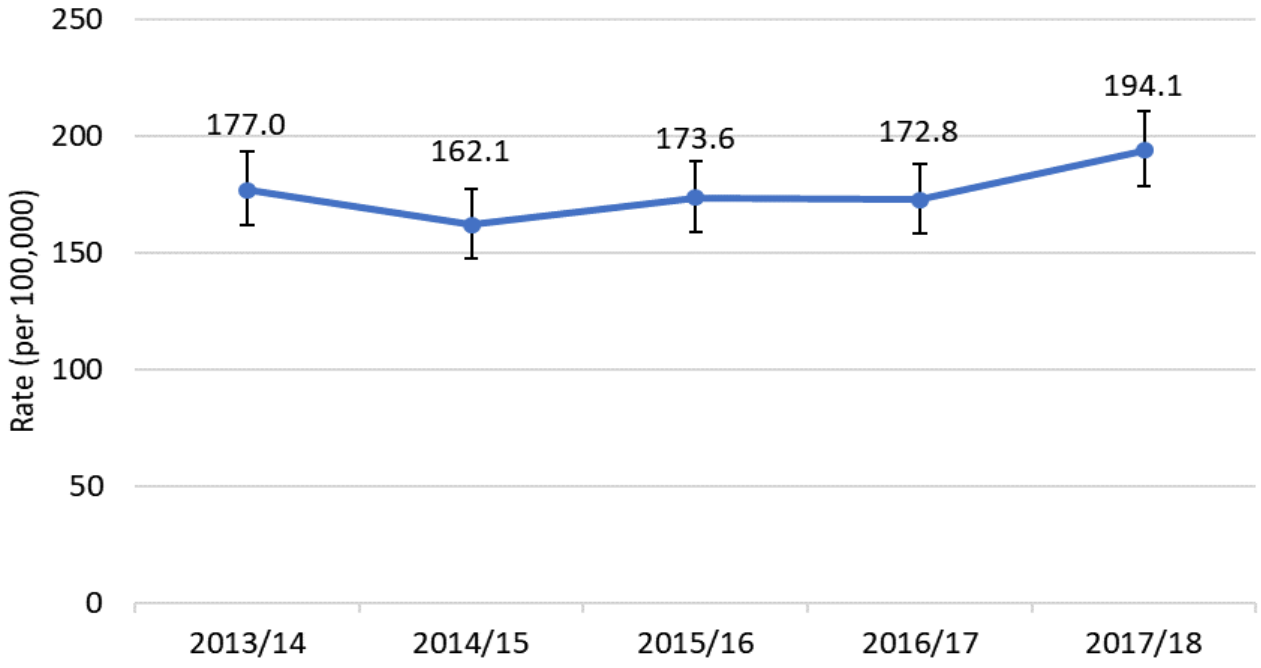
| Cause category | Admissions (n) |
|---|---|
| Opioids | 46 |
| Cocaine | 29 |
| Cannabinoids, hallucinogens, or 'other stimulants, including caffeine' | 87 |
| Sedatives and hypnotics | 9 |

Inpatient admissions data for Barnet residents with any recorded diagnosis of substance misuse related poisoning in 2017/18 was also accessed and it was found that there were less than five admissions, where the casual substance could be identified[58]. Due to the number of admissions being less than five, this information is suppressed. Similar to the information contained in Table 14, the great majority of admissions for substance related poisoning also involve alcohol-related disorders or causes, therefore the exact number of admissions will be higher.

## Drug-related ambulance data

The Figure below (Figure 20) outlines the rate per 100,000 of drug related ambulance call outs in Barnet, between the years of 2013 and 2018. Although the Figure appears to show that the numbers are increasing, from 177 per 100,000 in 2013/14 to 194.1 per 100,000 in 2017/18, when consideration is given to the confidence intervals surrounding these rates, due to overlapping that conclusion should be viewed with caution.

**Figure 20: Drug-related ambulance callouts for Barnet adults, 2013/14–2017/18[59]**

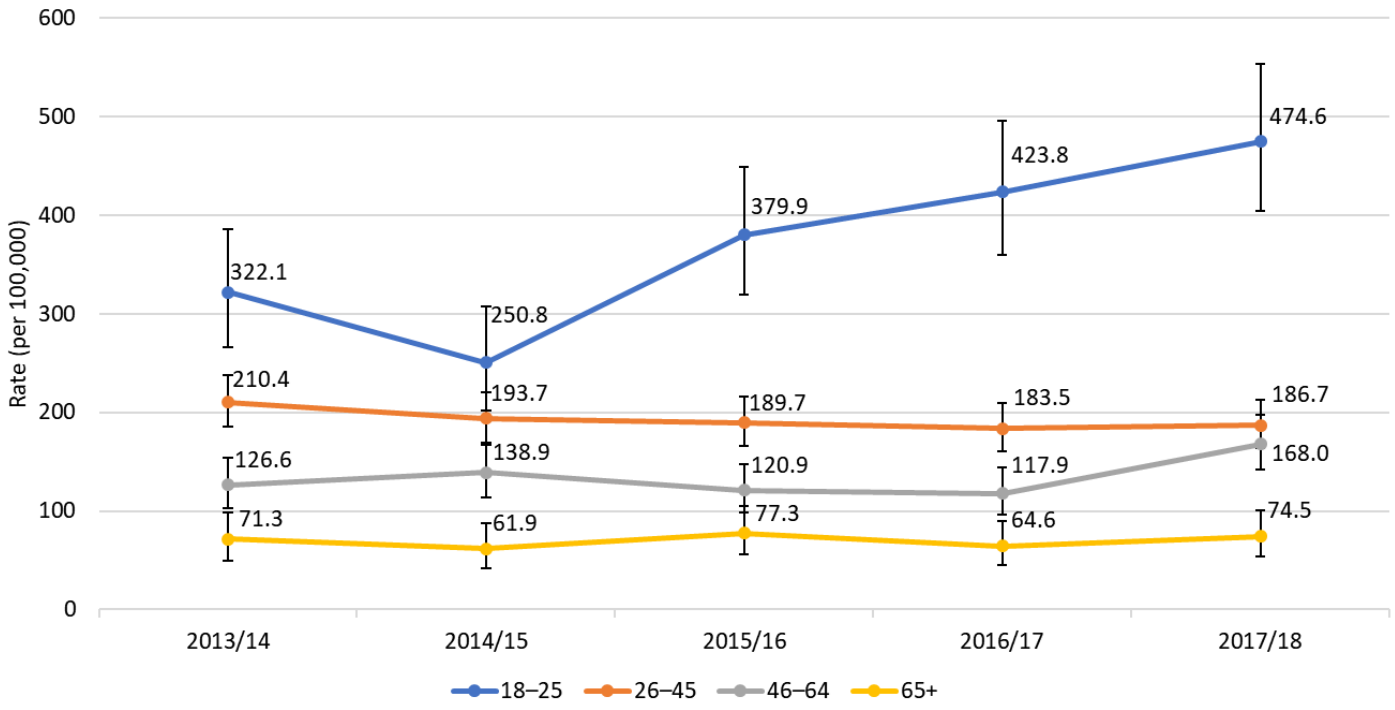



[57] Source: NHS Digital (HES Data Interrogation Service; confidential data)
[58] Ibid
[59] Greater London Authority (Safestats), Greater London Authority (ONS Mid-Year Population Estimates - Custom Age Tables)

Looking at data on drug related ambulance call outs in relation to age ranges, produced the results below as displayed in Figure 21. The highest rate per 100,000 was in the younger age range of between 18-25 years. This applied to all years from 2013/14 until 2017/18, with an exception that during the years of 2014/15, the confidence intervals overlapped with another age group. In relation to 18-25-year olds there appears to be an increase in the rate of ambulance call outs since 2015/16, but there are wide confidence intervals surrounding these figures and therefore the results need to be viewed with caution. The overall rate per 100,000 is recorded as rising from 379.9 in 2015/16 to 474.6 in 2017/18 but this is not statistically significant.

In the 26-45 age range, the rate per 100,000 fluctuated slightly over the same time period but overall there has been no significant change in rates when the confidence intervals are considered. A similar statement can be made in relation to the individuals within the age groups of 46-64 years old and 65 plus. The potential increase in call outs for those aged 18-25 years, will require further monitoring.

**Figure 21: Drug-related ambulance callouts for Barnet adults, by age, 2013/14–2017/18[60]**




An examination of data on gender by ambulance call outs between 2013/14 and 2017/18 produced some interesting results as displayed in Figure 22. For males the rate per 100,000 in 2013/14 was 163, then it appears to drop in 2014/15 to 148.7 (not statistically significant due to overlapping confidence intervals) and rise to 191 per 100,000 in 2015/16. For males the rate dropped again in 2016/17 and remained similar in 2017/18. This increase in rates for males between 2014/15 and 2015/16 was large but the rate has reduced again. For females, the rate in 2013/14 was 189.9 per 100,000. There were decreases to 174.6 per 100,000 in 2014/15 and 157.2 per 100,000 in 2015/16 (not statistically significant due to overlapping confidence intervals). Since 2015/16 however, the rate

[60]Ibid

of ambulance call outs for females appears to have increased to 190.9 per 100,000 in 2016/17 and another increase is observed in 2017/18 to a rate of 227.9 per 100,000. Due to overlaps in confidence intervals across the year ranges, this conclusion should be viewed with caution however and there needs to be further monitoring of this data in the future to observe for significant increases or decreases in rates.

**Figure 22: Drug-related ambulance callouts for Barnet adults, by gender, 2013/14 - 2017/18[61]**

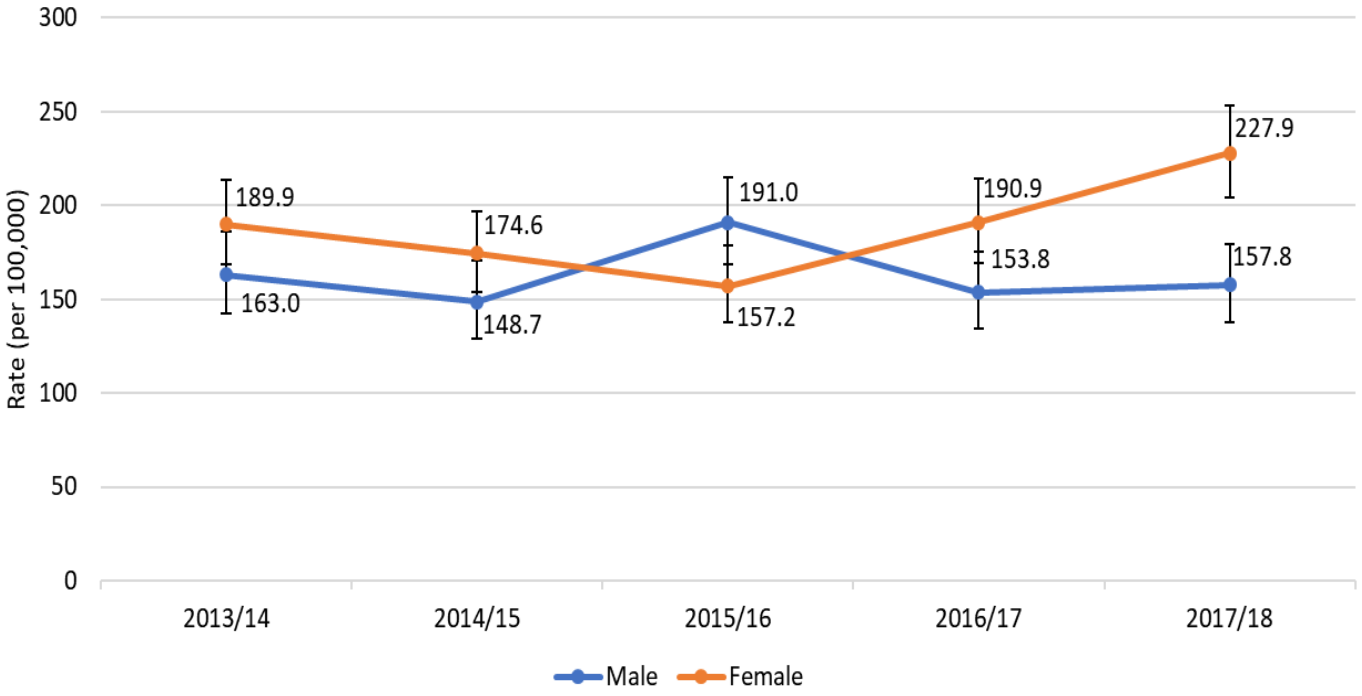
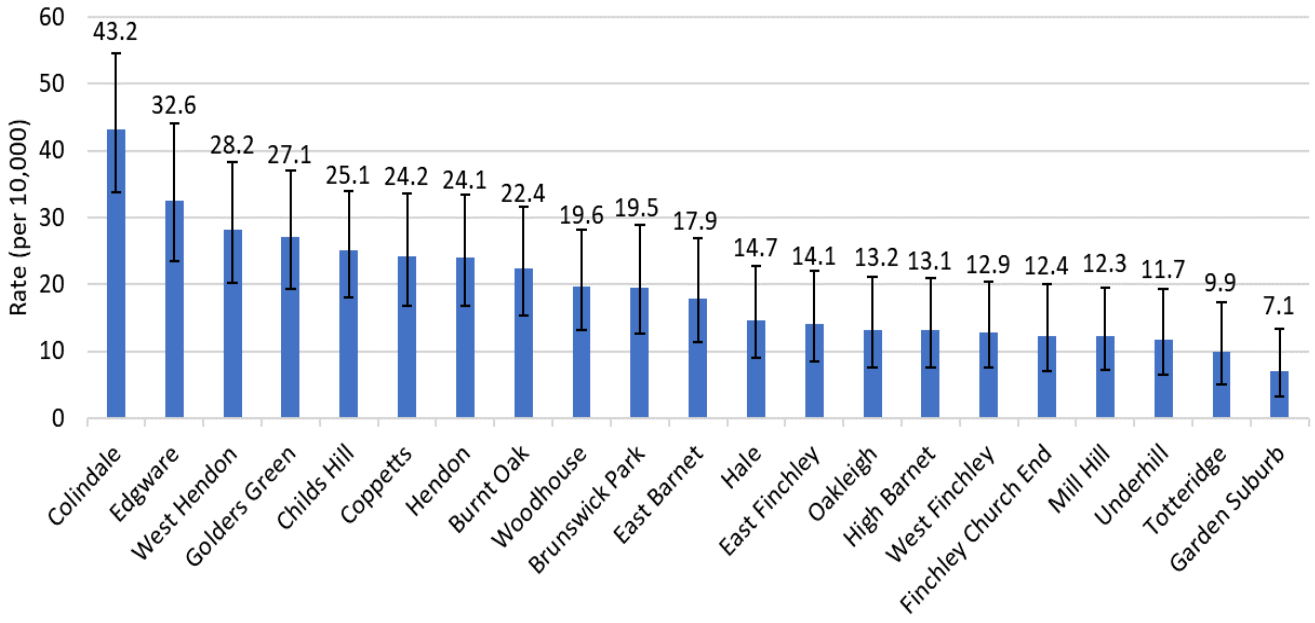



Figure 23 below provides details of Barnet wards in which drug related ambulance call outs for adults were received from during the period of 2013/14 to 2017/18.

[61] Source: Greater London Authority (Safestats), Greater London Authority (ONS Mid-Year Population Estimates - Custom Age Tables)

**Figure 23: Drug-related ambulance callouts for Barnet adults, by ward, 2013/14 - 2017/18[62]**




Please note due to overlapping confidence intervals, these results outlined should be viewed with caution. The three wards which seem to have the highest rates per 100,0000 were Colindale, Edgeware and West Hendon and the wards with the lowest rates seem to be Underhill, Totteridge and Garden Suburb. In addition to concerns with this data relating to overlapping confidence intervals, the accuracy of this data would potentially be affected by the flagging of each call out as drug related.

## Spend on substance misuse treatment services

The annual contract value for substance misuse services has changed yearly due to a requirement to make cost savings. Over a five-year period, the contract value equates to £12, 851,155.

**Table 15: Annual spend on substance misuse services in Barnet**

| | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
|---|---|---|---|---|---|
| **Revised budget** | **1,714,600.87** | **2,916,206.41** | **2,809,783.04** | **2,737,620.82** | **2,672,944.16** |

The table below (Table 16) outlines the predicted amount spent on shared care services, family/carer specific services, needle exchange and prescribing services during 2018/19. Given that the average annual budget for substance misuse services in Barnet is over 2.5 million pounds, the amount spent on each of these service areas, besides prescribing appears low. It

[62] Ibid

could be proposed that this requires review to ensure that these service areas meet the needs of service users.

**Table 16: Predicted spend on specific areas within substance misuse services in 2018/19**

| | |
|---|---|
| **Shared care** | **£ 36,354** |
| **Family/carer specific services** | **£ 75,284** |
| **Needle exchange** | **£ 18,639** |
| **Prescription costs** | **£ 282,399** |

## Description of substance misuse services

The current provision of substance misuse services for adults is at Barnet Recovery Centre. The current provider is Westminster Drugs Project (WDP) and it is a recovery-focused service which works with alcohol and drugs clients. Services are currently delivered from two main sites, one in Hendon Lane and the other at the Denis Scott unit within Edgeware Community Hospital. Although both sites provide services for clients around alcohol and drugs, provider data shows that a higher number of clients with alcohol issues decided to attend the Hendon Lane site.

The service is open to all Barnet residents aged 18 or over, as well as their families and carers with referrals accepted from any professional and clients can self-refer. Services available at Barnet Recovery Centre include:

- Assessment
- Drop-In and Open Access
- Needle exchange
- Access to prescribing
- Community detox
- Blood Bourne Viruses and health interventions
- Group work
- 1 to 1 sessions with a keyworker
- Counselling
- Housing and benefit support
- Families and carer services
- Services for women
- Reintegration activities
- Education, training and employment
- Abstinence-based services
- Access to inpatient detox and residential rehab

A separate Young People's Substance Misuse Service is also based within the Denis Scott Unit at Edgeware hospital and this service will see clients up to the age of twenty-four years. As the adult service works with individuals aged eighteen years and over there is an overlap in relation to the age ranges of clients. The decision over which service to attend is based on both client choice and

caseworker assessment of need. This situation does not appear to cause any major issues currently as one provider, namely WDP provides both services. If once the re-commissioning process is completed, the result is two separate providers offering services, this could potentially lead to issues around data sharing and complicate the decision-making process over which service is most appropriate. This situation will require monitoring.

## Barnet drug treatment performance data

The Figures and tables below were based on data from Public Health England and from the currently commissioned services in Barnet. Substance misuse treatment performance data was divided into opiates and non-opiates as this reflects the categories that are used within national data.

### Opiate user's treatment performance

Table 17 below outlines the numbers of clients in treatment from 2015-2018 for opiates, the successful completion numbers and the percentage of these completions as a proportion of numbers in treatment. Substance misuse is described as a chronic relapsing condition and therefore successful completion rates can be low. In Barnet, the percentage of successful completions as a percentage of individuals in treatment have been increasing year on year, rising from 7% in 2015/16 to 13% in 2017/18. Pease note that the increase in completions as a percentage of all in treatment will be affected by the overall reductions in the number in treatment.

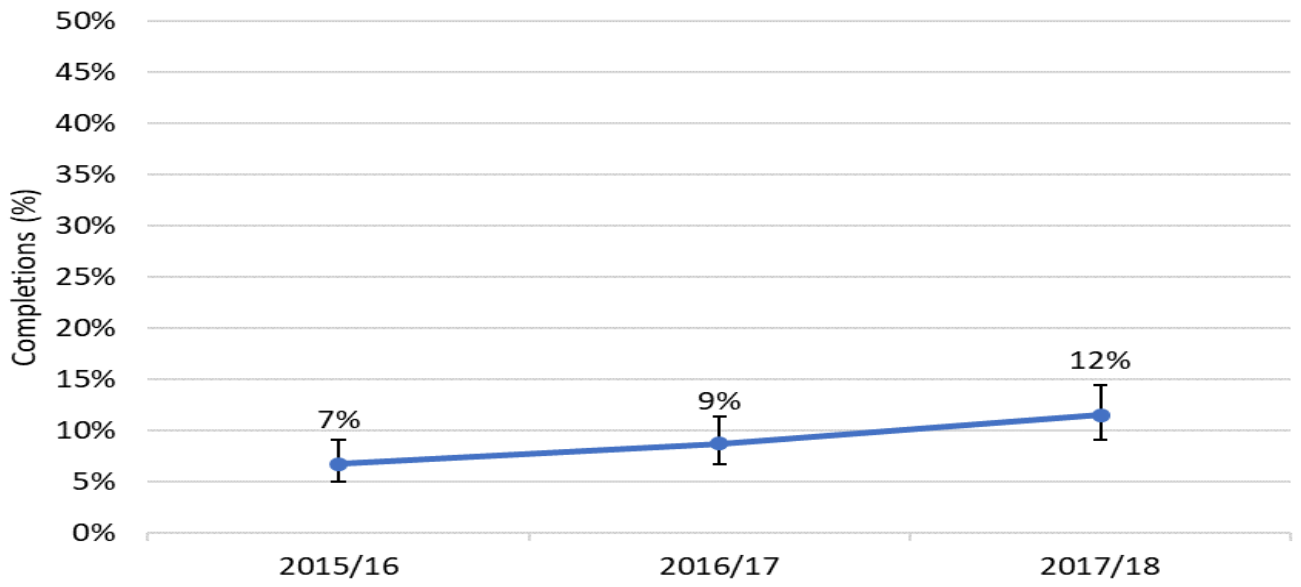
**Table 17: Number of Opiate clients in treatment and successful completions**[63]

| | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|
| Number in treatment | 595 | 562 | 539 |
| Successful completions | 40 | 49 | 62 |
| Completions as a % of all in treatment | 7% | 9% | 12% |

Figure 24 below presents the information contained above relating to proportion of completions of opiate clients in Barnet in a graphical form.

[63] Source: Public Health England (Local Area Trend Report 2017-18 Barnet

**Figure 24: Proportion of completions of Opiate clients in Barnet substance misuse treatment, 2015/16-2017/18[64]**




Due to substance misuse being a chronic relapsing condition, to gain a better understanding of successful completion of treatment, the number of clients who re-present at treatment services in the six months after successful completion of treatment is used to measure treatment outcomes. In Barnet, the actual number of individuals who re-present to treatment services for opiates from provider data is restricted data.

Table 18 below from PHOF data however provided information on successful completion of drug treatment for Opiates in Barnet. In this table the proportion of clients in treatment who successfully complete treatment and do not represent to treatment within six months was included. The data describes that in 2015/16 it was 6.1%, in 2016/17 it was 8.3% and in 2017/18 it was 9.7%. With reference to the confidence intervals surrounding these figures, there is overlap and therefore caution should be used with interpretation of these figures. Table 18 also outlines performance in England and this shows that Barnet may have under-performed in comparison to the England figure for 2015/16 (due to confidence interval overlap this should be viewed with caution) in 2017/18 however, Barnet performed better than the England figure of 6.5% and this result was statistically significant as the confidence intervals do not overlap.

[64] Ibid

**Table 18: PHOF Indicator 2.15i: Successful completion of drug treatment in Barnet – opiate users**[65]

| | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|
| Proportion of all in treatment (completing & not representing) | 6.1% | 8.3% | 9.7% |
| Lower Confidence Interval | 4.4% | 6.4% | 7.5% |
| Upper Confidence Interval | 8.3% | 10.9% | 12.5% |
| Numbers completing and not representing – Barnet | 37/608 | 48/575 | 53/547 |
| England performance | 6.7% | 6.7% | 6.5% |

## Non-opiates treatment performance data

Table 19 below provides information on the number of non-opiate clients in treatment. This shows that after a reduction in numbers, from 2015/16 and 2016/17, numbers in treatment have again risen in 2017/18 to 117 individuals. The reported successful completion as a percentage of non-opiate clients in treatment follows a similar pattern with a slight reduction in percentage between 2015/16 and 2016/17 before an increase again to 44% in 2017/18. As the numbers in treatment increased so has the successful completions as a percentage of all in treatment.

Figure 24 on the next page presents this information in a graphical form, in relation to the proportion of non-opiate clients successfully completing treatment from 2015/16 to 2017/18.

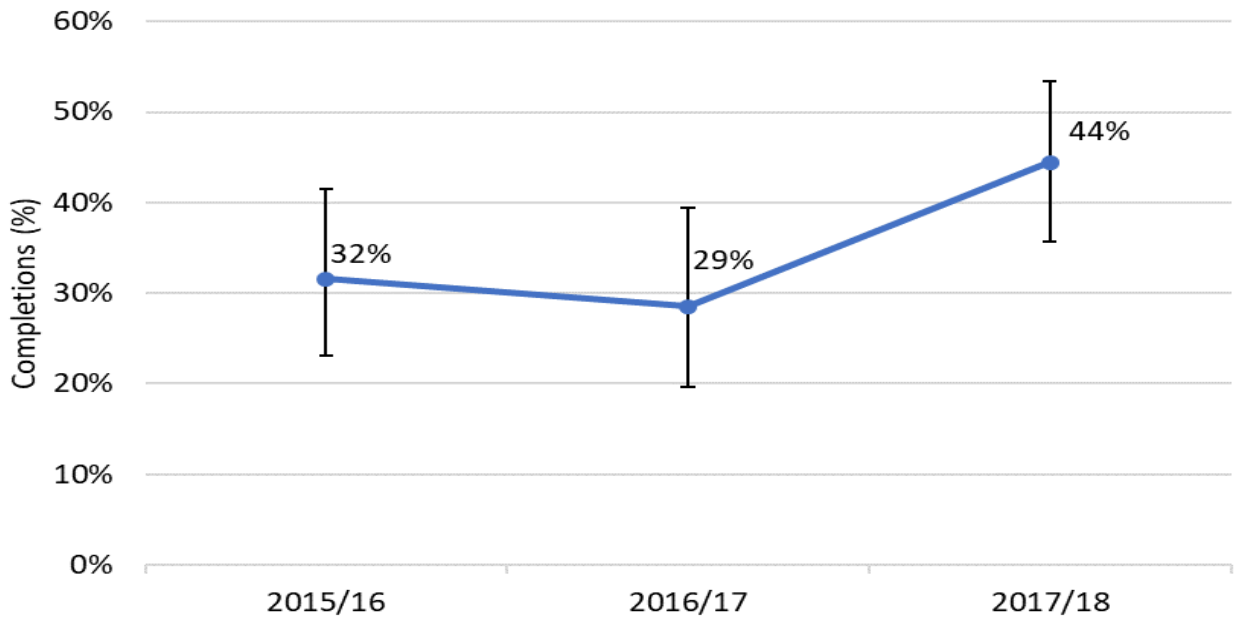
**Table 19: Number of Non-opiate clients in treatment and successful completions**[66]

| | *2015/16* | *2016/17* | *2017/18* |
|---|---|---|---|
| *Number in treatment* | *95* | *77* | *117* |
| *Successful completions* | *30* | *22* | *52* |
| *Completions as a % of all in treatment* | *32%* | *29%* | *44%* |

[65] Source: Public Health England (Public Health Outcomes Framework)

[66] Source: Public Health England (Local Area Trend Report 2017-18 Barnet)

**Figure 24: Proportion of completions of Non-opiate clients in Barnet substance misuse treatment, 2015/16–2017/18[67]**




Similar to the previous section on Opiate clients, Table 20 below outlines the Public Health Outcomes Framework (PHOF) indicator for successful completion of treatment for non-opiate clients in Barnet. The data on representations after successful completion of treatment for non-opiate substance misuse is restricted data from the provider data and therefore, there is no commentary available on this information within this needs assessment. The PHOF data shows that performance in 2015/16 was that 24.3% of clients successfully completing treatment and did not represent for non-opiates, in 2016/17 it was 30.4% and in 2017/18, the most recent figures available it was 36.1%. This appears to be an improving trend in Barnet but with consideration of both the confidence intervals surrounding these figures and the comparison with the England proportion; performance in Barnet could be below the England average performance figure in 2017/18. This requires further investigation and resolution.

**Table 20: PHOF Indicator 2.15ii: Successful completion of drug treatment in Barnet – non-opiate users[68]**

| | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|
| Proportion of all in treatment (completing & not representing) | 24.3% | 30.4% | 36.1% |
| LCI | 19.7% | 24.6% | 30.3% |
| UCI | 29.6% | 36.8% | 42.3% |
| Numbers completing and not representing | 69/284 | 65/214 | 88/244 |
| England performance | 37.3% | 37.1% | 36.9% |

[67] Source: Public Health England (Local Area Trend Report 2017-18 Barnet)

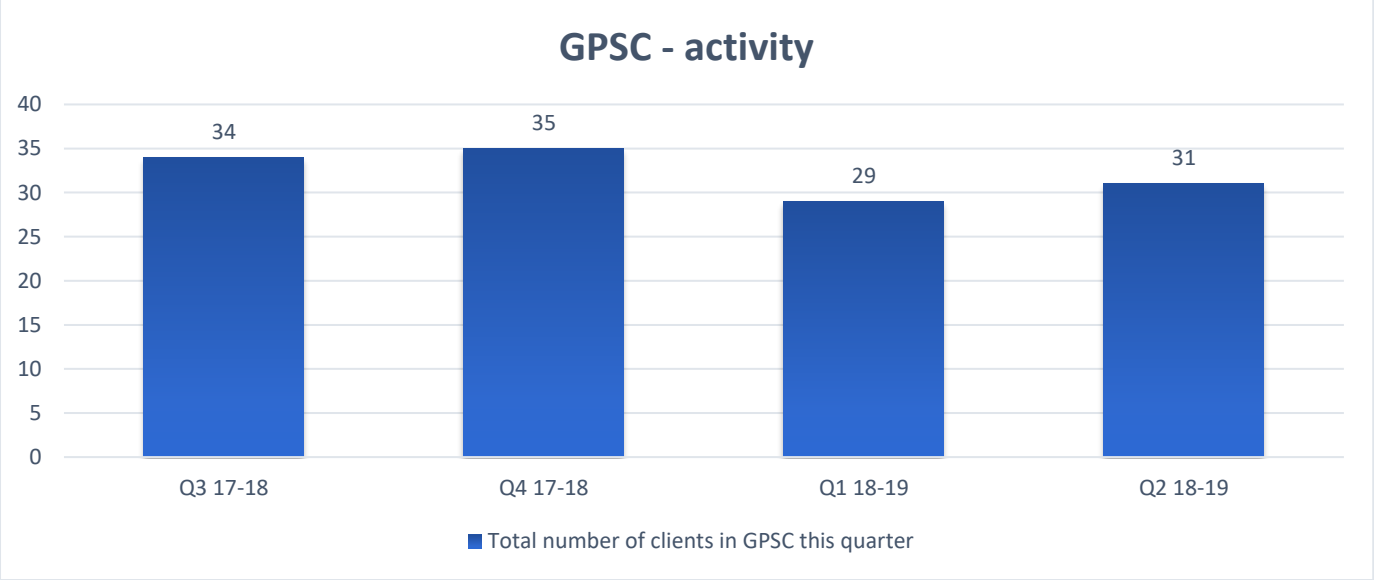
[68] Source: Public Health England (Public Health Outcomes Framework)

## GP Shared Care Scheme

Part of the provision of substance misuse services in Barnet includes the provision of a shared care scheme with Barnet General Practitioners (GPs). The shared care scheme means that substance misusing clients would begin to receive substitute medication prescribing within the treatment service as part of their treatment programme and then the prescribing element of their treatment programme would transfer to a GP.

Figure 25 below provides further details of the Barnet GPSC scheme. There are currently six GP's involved in the scheme, which is a decrease from eight in quarter 4 of 2017/18 however all members of the scheme are now active. In relation to the number of clients within the scheme, it remains reasonably stable at around thirty clients per quarter. A review of this aspect of the provision of services could be necessary to increase the number of practices involved and the number of clients within the scheme.

**Figure 25: Barnet GP Shared Care Scheme[69]**




## Characteristics of individuals in Barnet substance misuse treatment

To assist individuals to make and maintain changes to their substance misuse behaviour, within the substance misuse service a full assessment is made of the needs of each client at the beginning of each treatment journey. This includes examining issues beyond substance misuse, such as employment status and whether the person has parental responsibility.

The table below (Table 21) lists the employment status of all individuals commencing treatment for substance misuse issues during 2017/18. A comparison in percentages with Barnet and

[69] Provider data

England/Wales is outlined. Barnet has slightly less people in regular employment (19%) as a proportion compared to the national figure of 22% and a higher number of new presentations are unemployed/economically inactive in Barnet (45%) compared to 38% nationally. On a positive note, the proportion of people in Barnet entering treatment who are long term sick or disabled is much lower than the national figure (13% in Barnet compared to 30% nationally).

These figures should be viewed with some caution however as in 15% of new presentations the data on employment status is missing or incomplete. It could be proposed that as this information appears to be collected at the beginning of the treatment journey, some clients may be reluctant to provide this data as they have other issues that they wish to address at the beginning of treatment.

**Table 21: Employment status of those in substance misuse treatment for drugs[70]**

| *Employment status of those starting substance misuse treatment for drugs in Barnet 2017/18* | | |
|---|---|---|
| Employment status at start of treatment | Proportion of new presentations - Barnet | Proportion of new presentations – National |
| Regular employment | 19% | 22% |
| Unemployed/ Economically inactive | 45% | 38% |
| Unpaid voluntary work | 0% | 0% |
| Long term sick or disabled | 13% | 30% |
| In education | 1% | 1% |
| Other | 8% | 3% |
| Missing / incomplete | 15% | 7% |

As previously mentioned, individuals entering treatment are asked a range of questions as part of their initial assessment and this includes requests for information relating to parental status. Table 23 below details the number of clients who entered treatment in 2017/18, who had parental responsibility. Nearly two thirds of clients in Barnet (60%) were not parents or they had no contract with children. This is greater than the national figure of 48%. In addition, a quarter of clients were parents but did not live with their children. This is lower than the national figure of 34% in 2017/18. Only 14% of clients starting treatment in 2017/18 lived with children (their own or others). This is slightly lower than the national figure of 18%.

**Table 22: Parental status of those in substance misuse treatment for drugs[71]**

| *Clients who are parents/carers starting substance misuse treatment for drugs in Barnet 2017/18* | | |
|---|---|---|
| Parental Status | Proportion of new presentations - Barnet | Proportions of new presentations - National |
| Living with children (own or other) | 14% | 18% |
| Parents not living with children | 25% | 34% |
| Not a parent/ no child contact | 60% | 48% |
| Missing/ incomplete | 0% | 1% |

[70] Source: Public Health England (Adults - drugs commissioning support pack 2019-20: key data Barnet)
[71] Source: Public Health England (Adults - drugs commissioning support pack 2019-20: key data Barnet)

## Drug use and demographic information

Within this section the current providers data is presented. In the Table below (Table 24), a breakdown of the primary substance used by individuals in treatment is provided. As this table provides data from 2013/14 to 2017/18, it provides a picture of changing trends in the substances most commonly used by clients in treatment. The main primary substance used by clients in treatment are Heroin (reported by 37% in 2017/18) followed by alcohol (31.9% in 2017/18) and other opiates (8.2% in 2017/18). Cocaine was reported by 6.5% of clients as their primary substance in 2017/18 and Crack use was reported as the primary substance by 5.3% of treatment attendees in 2017/18.

Table 23 also provides details of the percentage change over five years in relation to the reported use of each substance as the primary drug. This shows that in Barnet, the number of clients reportedly using alcohol has reduced by 9.2% over five years. Please note that this figure concerns clients in treatment and therefore may not reflect overall substance misuse patterns in Barnet. The reported use of Cannabis, solvents, hallucinogens, benzodiazepines and amphetamines (excluding ecstasy) as the primary substance used have also experienced reductions in use over five years as reported in treatment service data. Nationally and locally the number of individuals using substance misuse treatment services have fallen. With less clients coming into treatment and changes in the primary substance reportedly used over the past five years, it could be suggested that a review of current treatment service provision may be required to meet the changing needs of clients.

The primary substances where use had increased were Heroin (6.2% increase over 5 years), Other Opiates (2.9% over five years), Cocaine (2.1% over five years), Crack (0.2% over five years) and Methadone (0.1% over five years). The use of prescription drugs as the primary substance used appears to have increased by 0.2% over five years but this is misleading as actually the numbers reporting this appear low.

**Table 23: Proportion of Primary Substance use in Barnet Substance Misuse Treatment (%)[72]**

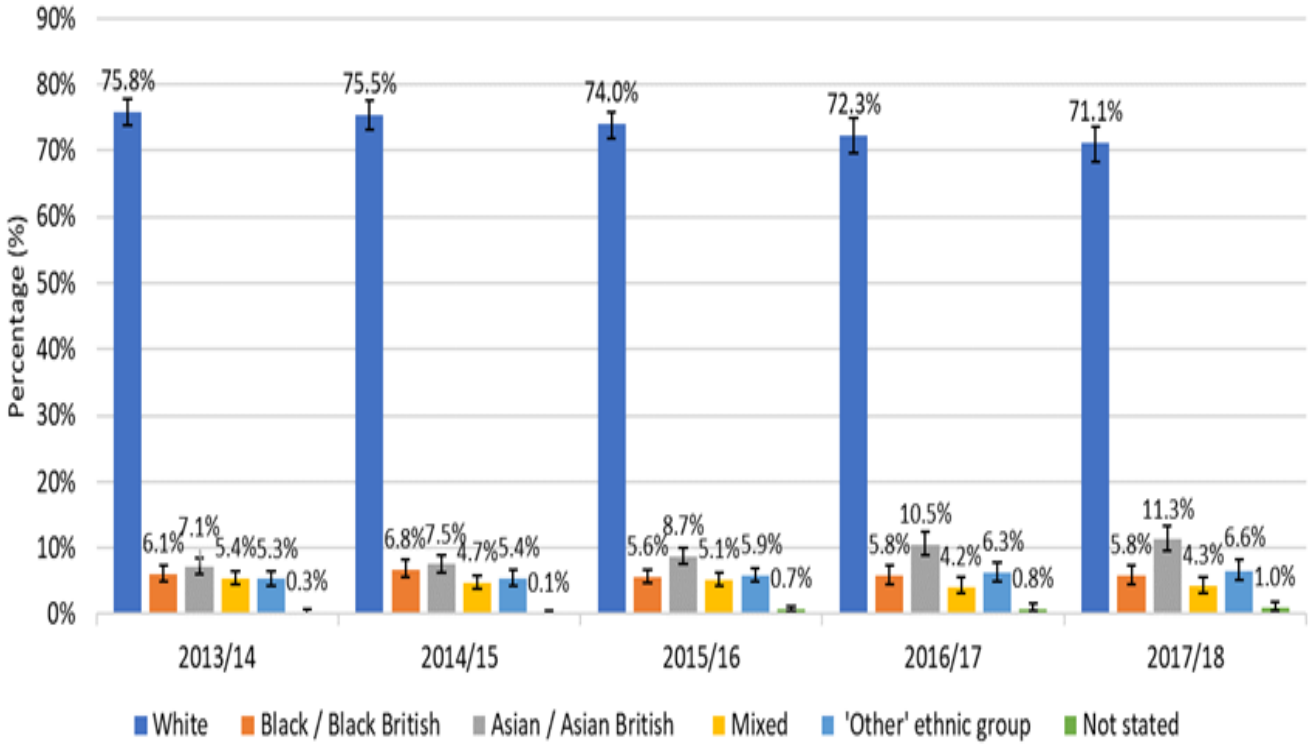
| *Proportion of primary substance use in Barnet substance misuse treatment (%)* | | | | | | |
|---|---|---|---|---|---|---|
| **Substance** | **2013/14** | **2014/15** | **2015/16** | **2016/17** | **2017/18** | **% change over 5 yrs.** |
| Alcohol | 41.1% | 40.1% | 35.1% | 33.3% | 31.9% | -9.2% |
| Amphetamines (excluding Ecstasy) | 1.0% | 0.9% | 0.5% | 0.5% | 0.9% | -0.1% |
| Benzodiazepines | 0.8% | 0.2% | 0.5% | 0.7% | 0.4% | -0.4% |
| Blanks / No drugs used | 0.6% | 1.1% | 0.5% | 0.0% | 0.0% | -0.6% |
| Cannabis | 6.6% | 6.5% | 4.5% | 5.0% | 5.5% | -1.1% |
| Cocaine (excluding Crack) | 4.5% | 4.2% | 4.4% | 5.9% | 6.5% | 2.1% |
| Crack | 5.1% | 3.6% | 2.5% | 3.5% | 5.3% | 0.2% |

[72] Source: Barnet Public Health Commissioning Team

| | | | | | | |
|---|---|---|---|---|---|---|
| Ecstasy | 0.1% | 0.0% | 0.0% | 0.1% | 0.1% | 0.0% |
| Hallucinogens | 0.4% | 0.3% | 0.4% | 0.2% | 0.1% | -0.3% |
| Heroin | 30.8% | 33.4% | 39.2% | 38.0% | 37.0% | 6.2% |
| Methadone | 3.2% | 2.9% | 3.8% | 3.2% | 3.3% | 0.1% |
| Other drugs | 0.4% | 0.5% | 0.3% | 0.3% | 0.6% | 0.2% |
| Other Opiates | 5.3% | 6.1% | 8.0% | 9.0% | 8.2% | 2.9% |
| Prescription drugs | 0.1% | 0.0% | 0.2% | 0.3% | 0.3% | 0.2% |
| Solvents | 0.2% | 0.3% | 0.1% | 0.0% | 0.0% | -0.2% |

Figure 26 below provides details of the ethnicity of clients by treatment episodes between 2013/14 and 2017/18. This shows a consistent pattern that most clients report their ethnic group as White, although there has been a slight decrease in the proportion of clients reporting this ethnic group from 75.8% in 2013/14 to 71.1% in 2017/18. Approximately 6% of clients reported their ethnicity as Black/Black British between 2013/14 and 2017/18. An increase in the proportion of clients reporting their ethnicity as Asian/Asian British can be observed in treatment episodes between 2013/14 (7.1%) and 2017/18 (11.3%). Mixed ethnicity appears to have reduced over the five-year period but due to confidence intervals overlapping, this conclusion should be viewed with caution. 'Other' ethnic group appears to have increased slightly as does the proportion who did not state their ethnicity, but again due to overlapping confidence intervals this conclusion should be viewed with caution.

**Figure 26: Proportion of Barnet substance misuse treatment episodes, by ethnicity, 2013/14–2017/18**[73]

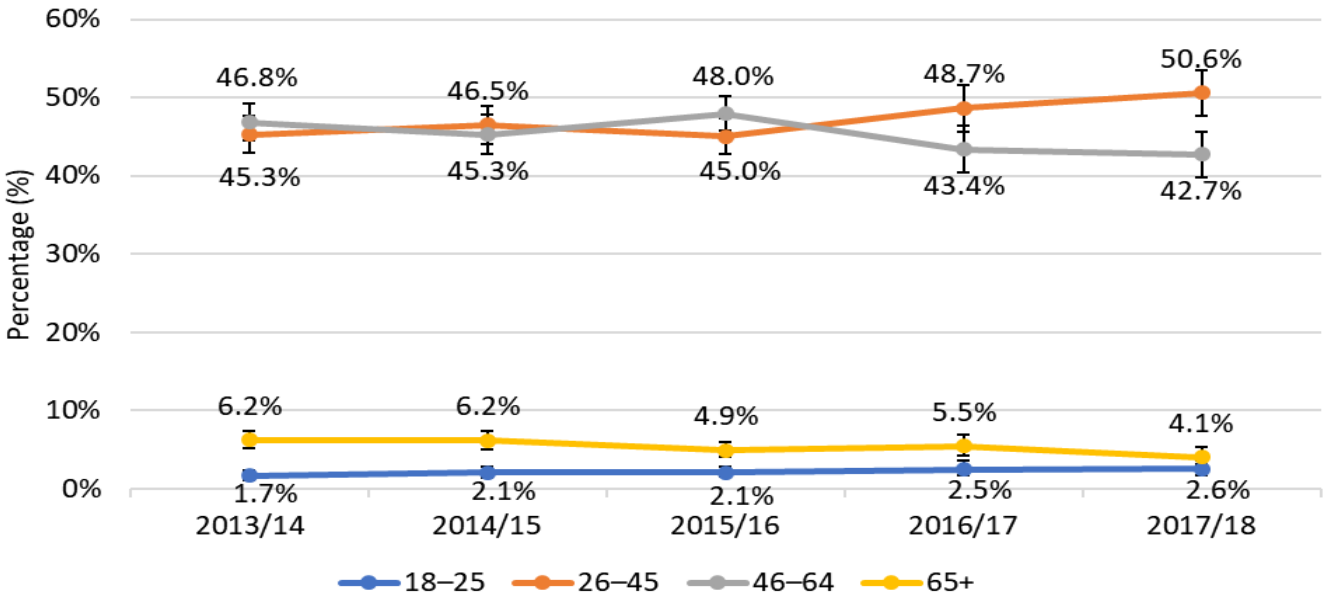



The Figure below (Figure 27) details the age ranges for the proportion of clients experiencing treatment episodes over the last five years. Within the adult's service, the proportion of people

[73] Source: Barnet Public Health Commissioning Team

aged between 18-25 years who have experienced substance misuse treatment between 2013/14 and 2017/18 appears to have remained stable between 1.7% and 2.6%. Individuals aged between 26 and 45 years, has risen from 45.3% (2013/14) to 50.6% (2017/18). The age range with the greatest proportion of treatment episodes is therefore between the ages of 26-45 years. The proportion of clients experiencing treatment episodes aged between 46-64 years over the previous five years began at 46.8% in 2013/14 and appears to have reduced to 42.7% in 2017/18. The confidence intervals surrounding these percentages do overlap at times however, so this trend should be viewed with some caution as it is not statistically significant. The proportion of treatment episodes in individuals aged over 65 years has consistently remained below 6.3% between 2013/14 and 2017/18, with a figure of 4.1% in 2017/18. Again, due to overlaps in the confidence intervals surrounding these figures, all commentary on the interpretation of these figures should be viewed with caution.

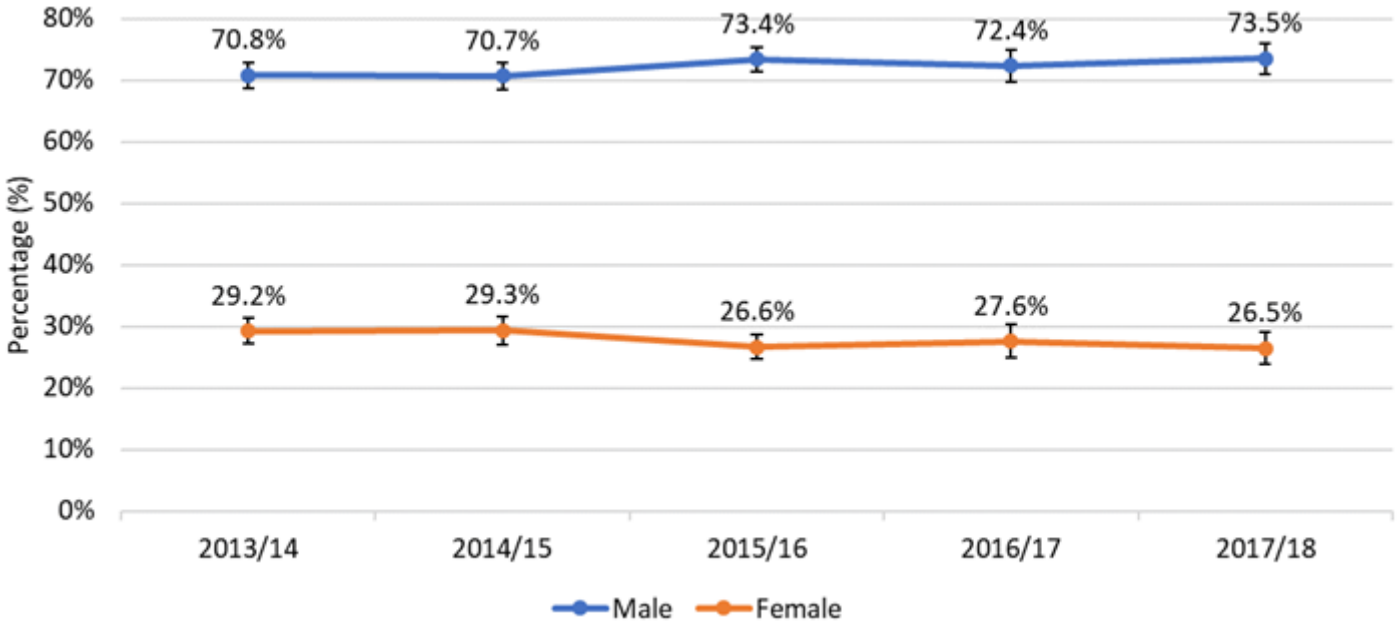
**Figure 27: Proportion of Barnet substance misuse treatment episodes, by age range 2013/14–2017/18**[74]




The final graph in this section outlines the proportion of treatment episodes by gender between 2013/14 and 2017/18. This shows that the proportion of males in treatment has consistently stayed between 70-74% between 2013/14 and 2017/18. For females the comparison percentage is between 26-30% over the same time range. Due to this small percentage, any additional details of this have been suppressed in Figure 28 below.

[74] Source: Barnet Public Health Commissioning Team

**Figure 28: Proportion of Barnet substance misuse treatment episodes, by gender, 2013/14–2017/18[75]**




In the previous needs assessment, completed in 2014, it was noted that little was known about the treatment needs and experiences of individuals from the LGBT communities who access substance misuse services. Data is now collected on sexual orientation and clients with a recorded sexuality other than heterosexual, represented 5.8% of treatment episodes in 2017/18. This is an upward trend from 2.9% in 2013/14 but overall the numbers remain small. Between 2013/14 and 2017/18, transgender individuals made up no more than 0.1% of the annual treatment episodes in Barnet. This very low percentage of treatment episodes being completed by individuals who identify as transgender, should be monitored in the future.

## Blood Borne Viruses (BBV)

Information relating to BBV prevalence is collected by Public Health England and PHE London regional level data is the lowest level of data available. National data for England and Wales report that in 2017, using data from the Unlinked Anonymous Monitoring Survey of HIV and Hepatitis in People Who Inject Drugs (PWID), the estimated prevalence for HIV was 3.9%, Hepatitis B was 17% and Hepatitis C, 52%. In London, the estimated prevalence of HIV in PWID was 3.9%, Hepatitis B was 34%, whilst the prevalence estimate for Hepatitis C for was 68%.

Hepatitis C is therefore the condition that has the greatest prevalence rate in relation to BBVs in London, followed by Hepatitis B and HIV. Figure 29 below outlines the number of eligible persons who have received a Hepatitis C test in Barnet compared with England from 2012/13 to 2016/17.

[75] Ibid

This shows that Barnet has consistently provided Hepatitis C testing to a greater percentage of clients than the England average. The only exception to this was in 2015/16 where the confidence intervals between Barnet and England overlap and therefore this result is not statistically significant.

Although data has been provided on the number of clients in treatment who receive a Hepatitis C test, there is little data relating to the numbers of clients who go on to attend for Hepatitis C treatment from Barnet. It would be useful to have this data to see the number of clients who are successfully treated for Hepatitis C.

**Figure 29: Persons in drug misuse treatment who inject drugs - Percentage of eligible persons who have received a Hepatitis C test[76]**

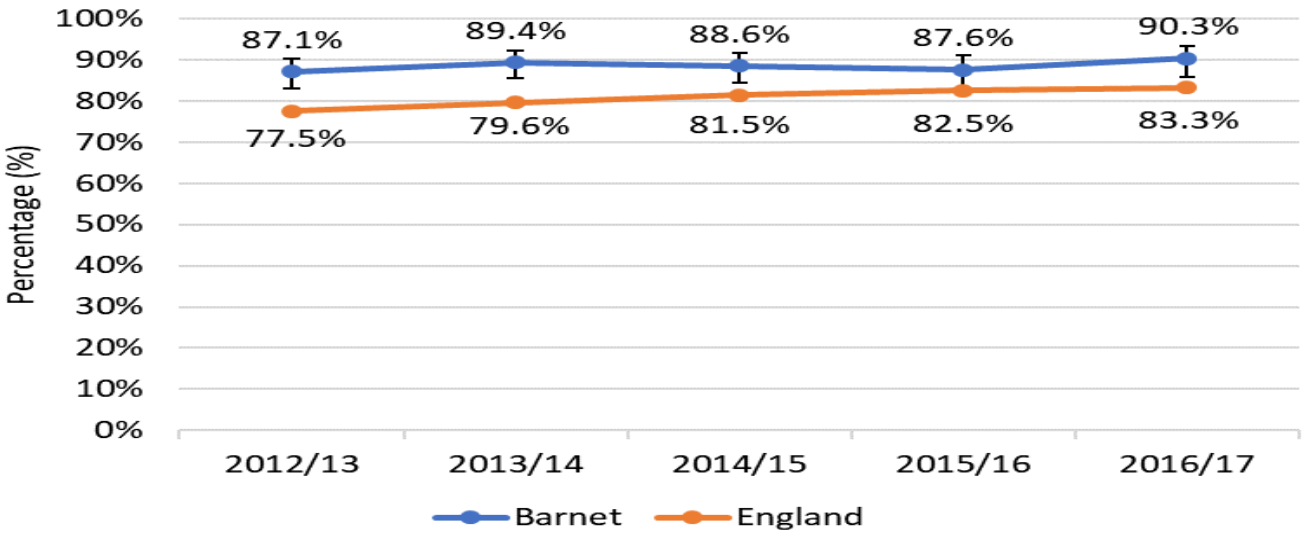
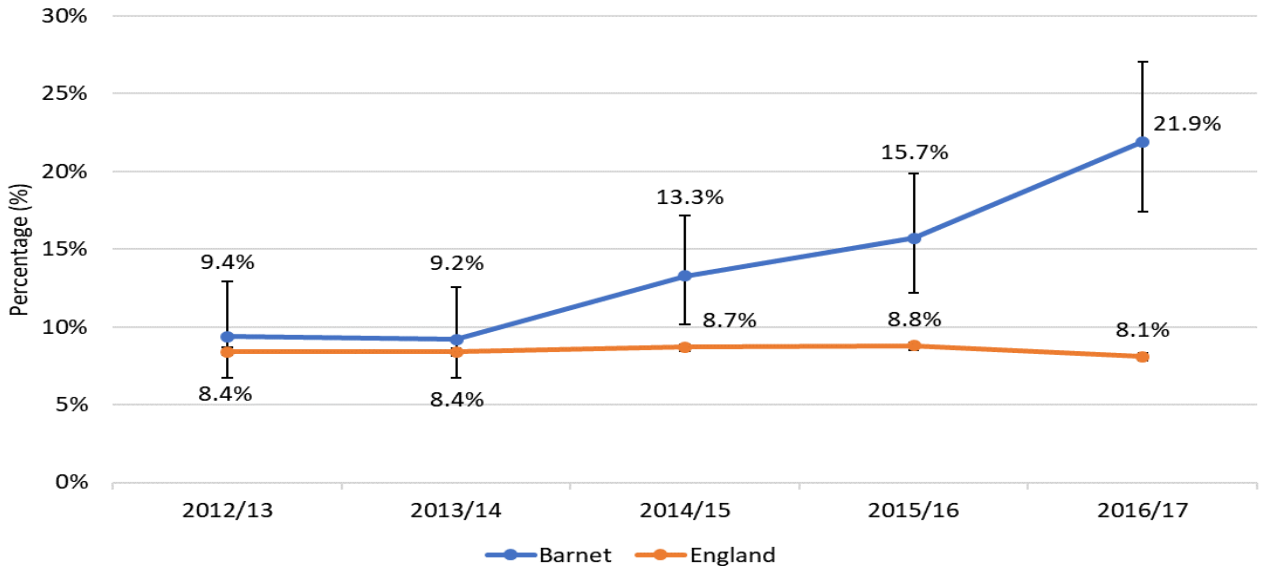



**Figure 30: Persons entering drug misuse treatment - Percentage of eligible persons completing a course of Hepatitis B vaccination[77]**




[76] Source: Public Health England (Health Protection profile)

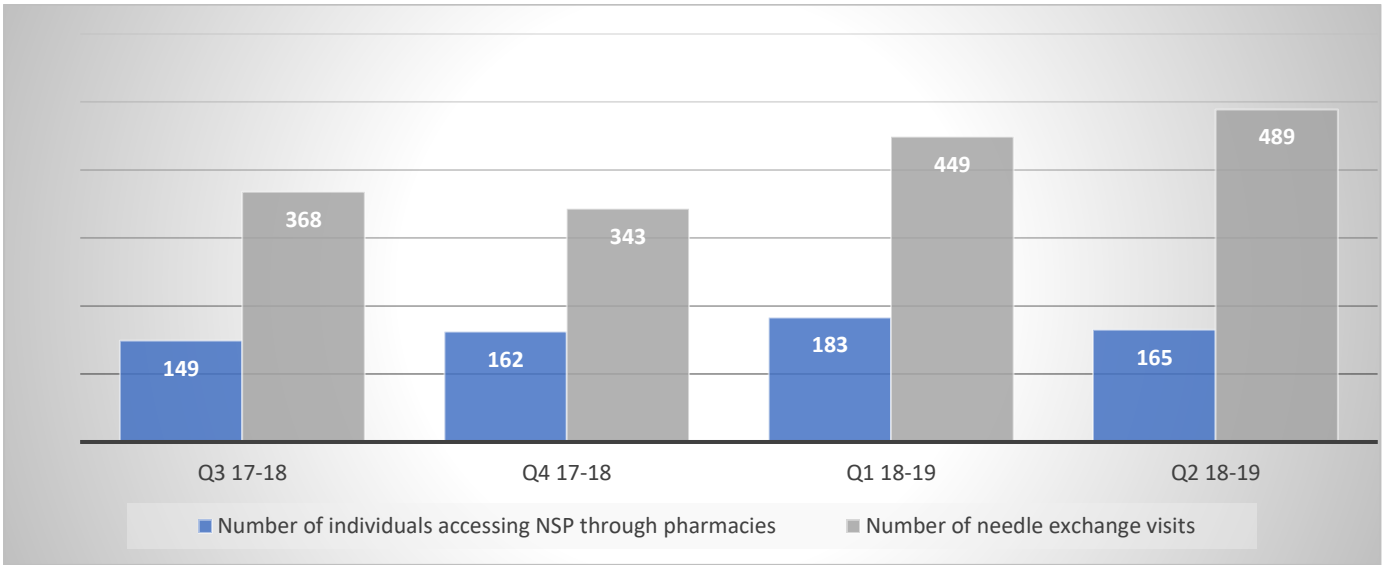
[77] Source: Public Health England (Health Protection profile)

Figure 30 above displays the number of eligible people who completed a course of vaccinations for Hepatitis B, with a comparison between Barnet and England between the years of 2012/13 and 2016/17. This shows that performance in Barnet is higher than the England average. This is an area where the current treatment provider is performing well, with 21.9% of clients completing a course of vaccinations in 2016/17, compared to 8.1% in England over the same time period.

## Needle exchange service

This provision of a needle exchange service within substance misuse services is an integral part of a harm reduction approach for drug users. The needle exchange service not only aims to reduce the spread of blood-borne viruses, such as Hepatitis; it can act as a referral point for service users into treatment services. Seven pharmacies in Barnet are commissioned by WDP to provide this service[78]. This is a reduction from twelve pharmacies involved with the scheme as reported in the Pharmacy Needs Assessment (2015). Figure 31 below provides details about the needle exchange scheme in relation to activity over the previous year. This data was supplied by the current service provider. This Figure shows that the number of individuals using the needle exchange in the pharmacies has remained relatively stable but the number of visits has increased. It would be interesting to review the service to gain an understanding behind the increase in visits to pharmacies to use the needle exchange and whether these clients are offered referral into services.

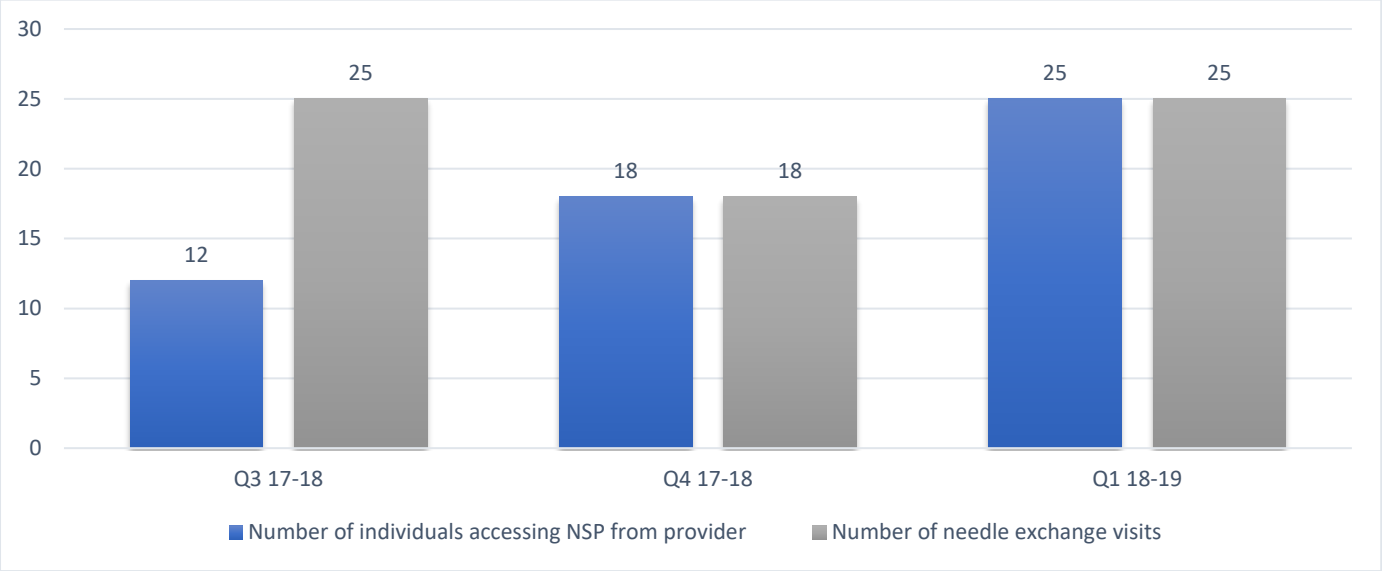
**Figure 31: Barnet needle exchange activity in pharmacies**




In addition to the provision of needle exchange facilities in pharmacies, needle exchange facilities are offered by the current provider. Figure 32 below provides details of the activity within this provision. Please note that this activity is not for a full year, the provider data submitted covers three quarters of the year only. This shows that the number of individuals accessing needle exchange services has increased over the time and for Q4 of 2017/18 and Q1 of 2018/19, each individual made only one visit to the needle exchange per quarter.

[78]https://www.barnet.gov.uk/sites/default/files/assets/LondonBoroughofBarnetPNA2018FVupdated.pdf

**Figure 32: Barnet needle exchange activity in the treatment service**




## Criminal Justice system – Drug Rehabilitation Requirements and MARAC data

The number of referrals to the Multi-Agency Risk Assessment Conference (MARAC) as reported by substance misuse service data between Q4 2016/17 to Q4 2017/18, was a small count and therefore this data has unfortunately had to be suppressed. Please note that a worker from the substance misuse service attends each MARAC and this may be a possible explanation for the small count of referrals from the substance misuse service into MARAC. Instead of a case being escalated for discussed within MARAC, it could be suggested that issues may be addressed within the service without a MARAC referral being required.

The equivalent to an Alcohol Treatment Requirements (ATRs) for drugs is a Drug Rehabilitation Requirement (DRR). The Figure below provides information on the number of clients who were required to complete a Drug Rehabilitation Requirement (DRR). The percentage of DRR completions that were successful in 2017/18 was 62% but the total number of referrals was low at 29. This is an area where further work should be completed to increase DRR referral rates into services.

**Table 24: Drug Rehabilitation Requirements (DRRs) activity**

| | 2017-2018 |
|---|---|
| Number of referrals | 29 |
| Percentage of referrals who started treatment | 48% (14) |
| Number of DRR completions | 13 |
| Percentage of DRR completions that were successful completions | 62% (8) |

## Consultation with key stakeholders

During the preparation of this report, the key stakeholders of service users, carers and GP surgeries were invited to provide feedback on current service provision around substance misuse. A survey for GP's was developed and approved by Barnet Council communications team. The CCG communications team sent the link to the survey out in the weekly GP Bulletin but we received no response to the short survey. The survey was again circulated and a member of the Public Health team telephoned GP practices that were involved in the substance misuse shared care scheme to encourage participation, which resulted in two responses to the survey. This level of response was disappointing but due to time limitations, no further resource could be dedicated to achieving a higher response level from Barnet GPs.

Given the small number of responses in comparison to the number of GPs and practices in Barnet, any recommendations based on the results of two GP survey responses should be viewed with caution. One respondent reported that they were not clear about the referral criteria for patients into the substance misuse service as they had never been told or received up to date information. In relation to Identification and Brief Advice on alcohol, this respondent reported that they felt that GP's responded well to any patients who needed this support. Respondent two requested easier access to treatment for patients and stated that the GP's learned about the pathway from patients, again indicating that there is a lack of information on the pathways into treatment available for GPs. This respondent requested training in Identification and Brief Advice and recreational drugs. Concerning recreational drugs, the request for training about the best way to access support for users of these substances. Again, indicating that the pathway into treatment is not clear.

A short service user survey was developed and the substance misuse service distributed this to service users utilising the assistance of the Barnet Service User Group (BSUG). Fifty-nine responses to the survey were received from service users. The first question asked about how the person had heard about the service. Health services, such as hospitals and GP's were reported in the high numbers. GP's were reported by 16 people and hospital by 5 people. Friends were reported by 15 people as the source of information, Criminal Justice Services by 4 people, online searches by 4 people and other sources by 12 people. Only one person reported hearing about

the service from social services and two people had heard about the service through family members.

Respondents were asked what was good about the current service provision. Please note that the survey used open questions so some respondents listed a number of things that they liked about the service. In addition, a few of the respondents left this question blank or said they had recently started treatment and therefore couldn't answer this question. They key points that service users liked were the staff (19 people mentioned this), the support offered (15 people) and the groupwork programme (9 people). Four people liked the confidentiality offered at the service, 3 service users liked that they had better health since attending, 3 people liked being able to have a prescription and two people liked the Capital Card service offered by WDP.

The survey then asked about the less positive things at the service. Of the 59 respondents, 25 people reported less positive points, meaning that nearly 60% of the service users did not identify any less positive elements within the current treatment provision. Of the twenty-five people reporting concerns, the issue most commonly mentioned related to requests for appointments in evenings and weekends and requests for more time to be allocated to groups and more groupwork (5 people). Better communication was mentioned by 5 people. Staff turnover (4 people) and staff quality (3 people) was viewed as a less positive point. Two people felt that the doctors were too busy to dispense their prescriptions on time. Finally, there was a range of individual less positive points, such as there being no milk, no spoons in the waiting area, issues with the Capital Card scheme and timekeeping.

The service users were asked about improvements to the service and the suggestions were noted as:

- Out of hours appointments during evenings and weekends and/or telephone help (4 people)
- Increased groupwork provision (4 people)
- Better communication such as a weekly notice board announcement of activities or a newsletter (3 people)
- Better food and beverages in the treatment services (2 people)
- More time dedicated to SMART recovery (2 people)

Other suggestions included support post discharge (1 person), more art and exercise provision (1 person), better linkage between substance misuse and mental health services (1 person), funding for provision of a service around gambling (1 person), increased access to rehab (1 person), Funding detox for longer (1 person) and setting up preventative services (1 person). One service user suggested that people should be taken off their prescription medication quicker and one person suggested less groupwork.

Finally, people were asked for any other comments they had concerning the provision of substance misuse services in Barnet. There was a range of very positive comments about the current service provision, especially in relation to keyworkers and the staff working on the reception desk. In addition, the service users stated that they hoped that the service would be re-funded. One person wrote that they had wanted to become more involved in their partners

treatment, potentially indicating that the involvement of family and friends and/or carers may require further investigation.

The treatment service also completes its own consultation with service users every six months (the Independent Service User Experience Questionnaire) and there is a family and friends test questionnaire that service users receive to ask about if they are happy with their treatment experience and if they would recommend this service to their family and friends. Given the number of questionnaires that service users are asked to complete, the number of responses received to our questionnaire was good. A consultation with carers was not held as the service reported that the needs of carers were consulted on with the family and friends test. The needs of carers should be reviewed however to ensure that they are being met, especially as one service user reported in their feedback, that they wanted their partner more involved in their treatment programme.

## Key Gaps and Recommendations:

| Key Area | Gap/Problem | Recommendation/Actions | Commissioning Implications |
|---|---|---|---|
| 1. Adult Treatment pathways | • Clients in alcohol treatment reduced by 40% and new presentations into treatment has reduced by 41% between 2013/14 and 2017/18. This is higher locally than national figures.<br>• Successful completions of alcohol treatment were 48% locally compared to 61% nationally.<br>• People entering treatment are older and have an increased amount of physical and mental health conditions relating to long term substance misuse. For example, Males aged between 40-59 years accounted for 62% of the treatment population and 58% of women were in this age group for alcohol. 11% of clients in treatment for alcohol issues are aged over 60 years.<br>• Alcohol treatment clients are less likely to be in regular employment than national figures but smaller numbers were long term sick or disabled. Non- opiate users in treatment, less likely to be in regular employment than national figures but less likely to be on | • Develop and implement a new alcohol improvement plan with the new provider.<br>• Consideration to be given to service re-alignment towards ensuring the needs of residents requiring non-specialist treatment for issues are catered for in addition to clients requiring specialist treatment.<br>• Consider the completion of an audit of DRD's reviews to ensure that the lessons learnt were implemented.<br>• Consider reviewing the prescription of naloxone to ensure that all clients who require access to this medication have it. In addition, consideration is to be given to the prescription of nasal naloxone.<br>• Consider options for extending service provision in evening and weekends. For example, a 24/7 telephone services for clients.<br>• Consideration to be given to increasing service provision to hidden harm clients who current provision is not reaching, | The review of service provision has concluded that the new service will be an integrated adult treatment model – delivered from 2 key locations with satellite locations in the community spaced across the borough.<br><br>Ensure model provides adequate input to meet demand.<br><br>Prescribing available from both main sites plus GP shared care expansion.<br><br>All discharges have a recovery plan and check-up telephone calls/meetings on a regular basis.<br><br>Integrated model to include measures for the treatment of all |

| | | | |
|---|---|---|---|
| | long term sick or disabled than national figures.<br>• The prevalence estimates of OCU's is lower than the England average. It is still estimated that there is 1,583 OCU in Barnet, 1,256 Opiate Users and 1,028 Crack users. Our numbers in treatment is much lower than this.<br>• Increase is Drug Related Deaths (nationally and locally). We have had 33 deaths between 2015/17 in Barnet. Deaths in treatment reduced between 2015/16 and 2016/17, from 21 to 6 and then increased to 9 in 2017/18.<br>• Successful completion of treatment rates for Opiates are low but it is an increasing trend (needs to be viewed with caution as the numbers in treatment are reducing). PHOF indicators on treatment completion and not re-presenting was 36.1% (slightly less than the England Average of 36.9%)<br>• Treatment services are located in two areas only, therefore the geographical coverage is limited.<br>• Last needs assessment noted an issue with access to interpreters, not clear if this is resolved. | | substances including legal highs and prescription drugs. |
| 2. IBA | • 21% of Barnet residents are consuming alcohol at levels that | • Service provision to increasing and high-risk alcohol drinkers she be assessed. The | These actions may require the allocation of either additional |

| | | | |
|---|---|---|---|
| | places them at increasing and/or higher risk to their health.<br>• Barnet had a count of 1,576 alcohol related hospital admissions for alcohol related conditions (Narrow measure) and a count of 6,182 episodes (Broad measure) in 2017/18.<br>• Clear Majority of alcohol related admissions were to the Royal Free Hospital. There is an alcohol CQUIN in operation across the Royal Free Hospital London Trust.<br>• Greatest rate per 100,000 of ambulance call outs in younger age groups (18-25 years and 26-45 years), with the male rate being double that of females.<br>• Area with highest ambulance call outs is Burnt Oak, West Finchley and Colindale (Not statistically significant).<br>• It is not clear if IBA training for GP's is being completed<br>• Alcohol liaison service has limited capacity as it consists of one nurse post.<br>• Adult social care report issues with older people consuming alcohol at levels that places them at risk of health harm. | increasing risk drinkers may not wish to attend specialist treatment services.<br>• Complete a review of IBA provision and increase offering around IBA in settings outside of the treatment service such as GP practices, adult social care, children's social services, across health system, housing support workers.<br>• Consideration to be given to the provision of Extended Brief Advice (EBA) across the borough and potentially commissioning DrinkCoach to offer this service via Skype sessions, once data can be added directly into NDTMS.<br>• As the majority of Alcohol related admissions are to the Royal Free Hospital consideration should be given to the location of the Alcohol Liaison Service nurse.<br>• Commissioners and the new service provider should work in partnership around the alcohol CQUIN to ensure that improvements are achieved on the number of individuals screened for alcohol issues.<br>• Establish a project with adult social care and partners such as Middlesex University to review the needs of older people in relation to substances, especially alcohol | resources or a change in current resource allocation to provide staff and to commission additional projects, such as EBA through Skype sessions on Drinkcoach. |
| 3. Prevention Strategy | • The current model focuses primarily on the provision of specialist treatment services. | • Realignment of service provision to include a focus on the prevention of substance misuse. | Additional resources may be required or a redistribution of |

| | | | |
|---|---|---|---|
| | • There is only a small team working on outreach work.<br>• There is no evidence of any prevention work being completed and there is no borough wide prevention strategy. | • Inclusion of actions relating to prevention in a substance misuse action plan with an annual delivery plan to ensure that actions are completed and progress made. | existing resources to ensure that the realignment is successful. |
| 4. BBV Pathway | • Great performance in Hep C testing rates (90.3% of all clients) but recorded access to Hep C treatment is low.<br>• Hep B course completion is 21.9% which outperforms England (8.1%)<br>• HIV testing is offered through sexual health services.<br>There are no support groups run within the service for clients in treatment for Hepatitis. | • Consider a review of the BBV existing pathway in relation to accessing confirmatory tests for Hepatitis C within the treatment service instead of within the hospital at the weekly RFH clinic.<br>• Promote Hepatitis C treatment within the services<br>• Consideration to be given to a Hep C support group within treatment services to encourage individuals into treatment or a Hep C champion. The could be a role for a peer mentor for example.<br>• The links/pathways with sexual health need clarified in relation to HIV testing. | This should have no commissioning implications besides the new service specification listing the actions in it, |
| 5. Shared Care | • The shared care service is currently based on 7 GP practices, which is a reduction in participants since 2014.<br>• No shared care forum or monitoring meetings are noted.<br>• There is no action plan for shared care and no targets to increase numbers and flow through the practices involved.<br>• No requirement for update training for GP's and there is limited involvement of the Barnet GPwSI in this service as the clinical lead | • Ensure clinical governance framework is applied across shared care; to include support/training/audit and monitoring.<br>• A strategic focus and plan is needed to address all issues – strong support, target setting and monitoring of progress from commissioners, consider the role of the current GPwSi to promote shared care from within and address need for clinical support.<br>• Information sheet for clients being transferred to shared care – reassurance about ongoing support available from across the system. | This should not have commissioning implications as the current GPwSI should be approached to deliver on this work stream. |

| | | | |
|---|---|---|---|
| | is provided by the current service provider (since 2016). | | |
| 6. Needle Exchange | • 7 pharmacies involved (reduced from 12 pharmacies)<br>• There is a lack of information in relation to the ongoing training on needle exchange staff.<br>• The static needle exchange service does not see many clients and the data suggests that each client attends only once per quarter. | • It is recommended that a review of needle exchange provision and training is completed to ensure coverage meets the needs of service users.<br>• This review should include reviewing the training provision as needle exchange is an opportunity to engage with hidden harm clients and encourage them into treatment. It is also an opportunity to provide harm reduction advice and assess the health of each individual. | There should be no impact on commissioning as this service provision should already be part of the current commissioning package. |
| 7. Service Users | • No Barnet Service User Group members are currently involved in commissioning or strategic structures<br>1. Concerns from service users:<br>2. Staff turnover.<br>3. Lack of mental health provision within treatment services<br>4. Not enough time allocated for groupwork.<br>5. Would like service provision at evenings/weekends/holidays | • It is recommended that consideration is given over how to increase the involvement of service users in strategic decision-making processes.<br>• As mentioned in the treatment pathways section previously, consideration should be given additional service provision for out of hours. | Commissioners/BSUG to discuss development/training opportunities to enable BSUG to become more strategically involved. |
| 8. Carers | • The provision of services to carers is not clear and concern was raised within the service user survey about carers lack of involvement in client treatment. | • It is recommended that a review of the services offered to carers is completed to ensure that service provision is adequate for this group. | Additional resources may be required if additional groups/services are established. |
| 9. Criminal Justice Pathways | • High rates of clients are not entering treatment on discharge | • It is recommended that a review of the current criminal justice pathways into substance | A portion of this work is already being |

| | | | |
|---|---|---|---|
| | from prison. This is a national issue which PHE has investigated but Barnet underperforms on the national figure.<br>• Custody suites - current provider is reviewing the coverage in the suites.<br>• Low numbers of referrals for ATR and DTRs<br>• There are no records of IBA training being completed in criminal justice settings.<br>• Low number of referrals of Barnet clients from Probation to groupwork. | misuse treatment is reviewed before a new provider is commissioned.<br>• The current provider is working to improve links with CRC and to increase referrals of probation clients into substance misuse services.<br>• Trigger Trio issues (Substance misuse, domestic violence and mental health issues) remain a concern in Barnet and this is an area where work is ongoing.<br>• The provider should work with criminal justice services to increase referrals for ATRs and DRRs. | completed within the current commissioned services but if new provision is required that will require further resources. |
| 10. Serious Incident Policy and Reporting of Drug Alerts | • The current provider has a serious incident policy and standard operating procedure and the reporting methods are not totally clear as there is a requirement to report all incidents to the commissioners. It is not clear how 'learning' from any incidents is implanted in practice.<br>• There is a Drug Alerts system in place but no feedback to commissioners on the use of this system is received. The current provider stated that they receive the alerts as do commissioners and that they send this information to external and internal stakeholders but no | • To monitor and ensure learning is identified a shared policy needs to be developed and implemented locally. Commissioners need to monitor its implementation along with the implementation of any learning from the policy.<br>• Review the Drug Alert System to ensure that commissioners are aware that this system is fully operational and information is circulated to stakeholders and commissioners. | No commissioning implications as this should be in place within existing resources or developed within the current resource provision. |

| | | | |
|---|---|---|---|
| | evidence of this has been provided. | | |
| 11. Clinical Governance Framework | • It is not clear when the Clinical Governance framework was last reviewed and updated.<br>• Changes to clinical services provision as contract removed from CNWL, this requires monitoring to assure commissioners that there have been no detrimental effects to service provision. | • Review the existing clinical governance framework considering the changes to the provision of clinical services.<br>• Ensure that the clinical governance framework is reviewed annually to ensure compliance is achieved if this is not already completed by the provider. | No commissioning implications as this should be completed within current resource allocation. |
| 12. Data Strategy | • There is no strategy relating to which data to collect and how this will be disseminated and which sources are restricted.<br>• Data is collected for NDTMS and from the provider and on occasions this data differs due to differing reporting schedules.<br>• With the recommissioning process we are changing database systems, this process requires careful management to ensure minimal risk of error and data loss.<br>• A minority of data recording fields have been left incomplete, for example, 15% of records on employment status of those in substance misuse treatment is incomplete.<br>• In Barnet, the primary drug reported to being used has changed since 2013. Nearly 10% | • It is recommended that a data strategy is produced to provide clarity in relation to which data is produced for whom and for what purposes.<br>• It is recommended that a decision is made over which data source should be used for the database, either NDTMS or provider data.<br>• It is suggested that the project relating to the changing of databases is carefully considered and a project plan developed to ensure that the risks of this data move are minimised.<br>• It is recommended that all data relating to substance misuse patterns and services is completely reviewed annually to ensure that service provision reflects the evidence produced from the data. For example, the data produced for this needs assessment could be produced annually to assist in the monitoring of trends. | • This strategy should be produced within current resources and therefore the commissioning implications are minimal. |

| | | | |
|---|---|---|---|
| | reduction in alcohol consumption, 6.2% increase in Heroin, 2.9% increase in other opiates, 2.1% increase in Cocaine (not Crack) and 0.2% increase in Crack use reported. These changes should be recorded in the data strategy and service re-commissioning decisions made based on these. | | |
| 13. Communications Strategy | • Feedback from GP survey concerned a lack of knowledge of referral criteria's and general information on Substance misuse.<br>• A number of groups work around substance misuse, e.g. Probation, providers, CCG, Community Safety Team but there is a lack of communication between these groups.<br>• DrinkCoach has been commissioned but there is no strategy for ensuring that residents are aware of this resource. | • It is recommended that current communication methods are examined and a communications strategy is developed to increase the numbers entering treatment and awareness of available services such as DrinkCoach.<br>• The communications strategy should include information on referral criteria and general updates relating to changes in substance misuse patterns in Barnet.<br>• All partners should be consulted on the strategy to ensure that the most appropriate methods of communicating with each group are used. | Implications for commissioning are that this work will be undertaken by the commissioning team within existing resource. |
| 14. Workforce Strategy | • There is a high staff turnover within the current commissioned service provider.<br>• Areas identified for staff training relate to Domestic Violence, mental health and Dual Diagnosis. | • The new provider should provide evidence that they have undertaken a training needs analysis of staff who will be working in Barnet and a workforce development plan should be devised in consultation with key stakeholders, to skill up and support staff especially in the areas already identified of mental health and domestic violence. | Commissioning implications of this are that the commissioning team should ensure that the new provider has a workforce strategy as this will be a requirement in the re-commissioning process. |

## Appendix 1

Before moving on to conclude this report with a section on identified gaps in treatment provision, recommendations and commissioning implications, this section provides additional notes on the methods used within this report. Readers of this report should note that:

- Rates were calculated using the Association of Public Health Observatories method for rates (updated February 2014).
- Confidence intervals were calculated using the Association of Public Health Observatories methods for proportions and rates (updated February 2014).
- Data from the Barnet Public Health Commissioning team includes both drugs and alcohol episodes in one. Data from Public Health England is separated by drugs and alcohol as noted on sources.
- Commissioning team data is for tier 3 substance misuse services.
- Some proportions from Public Health England commissioning support packs add up to more than 100%. This may be due to rounding percentages to whole numbers.