Cardiff & Vale APB

Cardiff and Vale Substance Misuse Area Planning Board

Substance Misuse And Wellbeing Commissioning Strategy

2016 – 2020

FOR INFORMATION ON ACCESS TO LOCAL SERVICES:

e-das
entry to drug & alcohol services

http://www.e-das.wales.nhs.uk/home

0300 300 7000

FOR FURTHER INFORMATION ON THE APB:

Cardiff & Vale APB

http://cardiffandvaleapb.org

FOR LOCAL SERVICE USER AND CARER INVOLVEMENT:

ASFAcarduf

http://www.asfacarduf.org/

Forward

From the Chair of the Area Planning Board

The launch of the APBs first substance misuse commissioning strategy in 2013 set out an ambitious programme of system and service redesign. Whilst only three years have elapsed, much of the ambition set out in that document has been achieved, with improvements in performance, as well as positive feedback from our staff and better outcomes for those who use our services.

The extent of the APBs achievement has been at a time of change in public sector thinking with an increasing emphasis on early intervention and prevention, alongside new public agendas such as prudent services, and the whole society approach found in the Wellbeing of Future Generations Act. Therefore, the time is right to revise our commissioning strategy in a way that reflects these changes whilst maintaining positive sustainable outcomes for our service users and carers as our top priority.

Uniquely, this will be the first substance misuse strategy that focuses less on the impacts of drugs and alcohol rather than the more generic issues of deprivation, social inequalities, and cultural pressures as causal factors. I am pleased to see many firsts for the sector in Wales, such as the impact of staff wellbeing on service quality and on outcomes for services users, and the need to develop resilience among school-aged children and young people rather than simply equip them with the facts about substances. As a partnership of public services, the APB is able to ensure that the broader consequences of public policy drivers such as austerity, new and emerging legislation, and the integration of local services accounts for the needs of substance users as a group who often have multiple and complex needs.

Of course, we have not lost sight of key issues such as service capacity and throughput in order to ensure that those who need advice, information, treatment and support find a quick response that is tailored to their needs. We also address the need for long-term self-sustaining recovery in the strategy. Our treatment and support system will never have the capacity to provide continuous ongoing recovery support to everyone who successfully comes through our services; therefore, we include a renewed focus on equipping those in recovery with the skills, knowledge and confidence to return to their lives and sustain their own ongoing recovery, safe in the knowledge that the services are there if ever needed in the future.

The APB is proud of the achievements made under the first commissioning strategy, and I commend this next version to you as a logical next step in tackling substance use and misuse across Cardiff and the Vale.

Dr Sharon Hopkins
Executive Director of Public Health (APB Chair)

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Executive Summary

The first Cardiff and Vale Substance Misuse Commissioning Strategy, *Changing Lives; Improving Outcomes*, had a single primary purpose: To repair a system of services that was not working. In doing so a new direction of travel was set out for all stakeholders in Cardiff and the Vale of Glamorgan involved in tackling substance misuse that defined how we needed to be designing, commissioning and performance managing services, in order to achieve the best possible outcomes for our residents, service users, their families and carers.

It was a very practical, operational and, in many aspects, a mechanical exercise that laid out the detail of resource allocations, and areas of service development for prioritised expenditure. In the review chapter, you will read the extent of the achievement that has been made under this approach – although some areas of work have not been fully completed, and are retained in this revised strategy. The APB has also completed a more thorough assessment of need to support the revision process.

This revised commissioning strategy is a very different style of document. It weaves together a broad range of public policy agendas such as prudent public services, the Wellbeing of Future Generations, and how cultural influences, socio-economic factors and our environment all have an impact on substance use, and all of which can act as tools to address the causes of substance misuse.

There will of course be the need for the mechanics so that the commitment of the APB to transparency can be maintained. But resource allocation programmes, performance monitoring systems, gap analysis, market analysis and performance improvement – all of which are expected to be core components of a commissioning strategy – will be found in the comprehensive needs assessment found in Annex 1, and in the annual business plans for the APB. This main body of this document concerns itself more with our aspirations; with describing how the landscape needs to look by 2020, and how we are going to get there.

It is a common misconception that a strategy is a document. It is not. A strategy is the approach taken to a whole-systems work programme that is needed to reach a desired outcome, or endpoint. This includes:

- The strategic document such as this, which brings everything together
- How resources are allocated
- How our workforce is developed
- How service user and carer feedback is directed towards securing service change
- Agreeing priorities
- Being honest and clear about what is not achievable, or what lies outside of our sphere of influence

The strategic principles that this revised approach is founded on include the following:

- Setting out the aspiration of reducing the harm that alcohol and drug use causes to our population
- The wellbeing of our workforce is paramount, as it directly impacts on the wellbeing of our service users
- Many of the factors that result in substance misuse as a consequence, can often bear little relation to substance misuse in themselves
- Substance misuse sits equitably alongside all other health and social care services, and should be delivered with the same degree of professionalism
- Service solutions should be jointly designed, and co-produced with the people who are going to use them
- Everyone is capable of achieving recovery, although not everyone is ready or able to do so at any given point in time.
- We should be constantly researching and developing better and more effective ways of securing sustainable outcomes for our service users and carers

The delivery of these principles is undertaken through a series of commissioning priorities, and underpinning actions. These are as follows:

- *Reduce and mitigate the impacts of substance use on families*

- *Develop aspiration, self-esteem and motivation in young people, as tools to increase resilience to substance use*
- *Increase the numbers of service users in treatment able to move into aftercare and long term recovery*
- *To re-engage those who disengage from treatment and support*
- *Increase the extent to which primary care services can identify and respond to substance use and misuse*
- *Increase the capacity of those in recovery to source, and self-sustain their own personal recovery support needs, making full use of the resources that the communities across the region can offer to support those in recovery*
- *Improve the wellbeing and level of job satisfaction across the substance misuse workforce*
- *Ensure that services provide an individualised and tailored response to peoples' needs*
- *Lead on research and development to enhance the evidence base on which services operate, and encourage innovation in how services are designed and delivered, with service users at the centre of that design process.*
- *Enhance services such as education, employment and housing that protect the outcomes achieved through substance misuse interventions.*
- *Respond to the increasing demands resulting from a growing population across Cardiff and the Vale*
- *Build sustainability into improvements made against the national waiting times target*
- *Decrease alcohol related hospital admissions*
- *Secure a decreasing trend in annual rates of drug related deaths, and non-fatal overdose.*
- *Ensure the capacity of services to meet the needs of those with protected characteristics*

As chair of the APBs commissioning group, it is my hope that the success achieved under the previous strategy will increase in terms of impact and momentum as a result of this revised version, and under these guiding principles.

Melanie Wilkey

Chair of the APB Commissioning and Finance Group

Summary review of the 2013 Commissioning Strategy

The first APB commissioning strategy set out a programme of full-scale service redesign that included the re-allocation of resources, commissioning new services, and implementing a structured approach to performance management. The main objectives could be summarised as follows:

- To consolidate the inherited numerous lines of expenditure against the grant funding, into more generic and logical packages, and programmes of work
- To address gaps in services and support in both open access and in aftercare
- To improve and increase service user momentum through the treatment and support system
- To implement robust accountability and performance management arrangements

These objectives have largely been achieved. From 2013/14 onwards, the number of lines of expenditure that accounted for the Substance Misuse Action Fund reduced from nearly 50 to just 15. The packages and programmes of work approach has proven effective in enabling resources within a specific programme to be managed more flexibly, and in response to emerging needs in real-time.

Addressing gaps in service has also been achieved, with procurement exercises carried out for new Open Access services, Tier 2 services for young people, and for new Through-care and Aftercare services in response to the significant gaps that were identified in the first needs assessment. The new open access service, Taith, has been providing advice, information treatment and support to in excess of 1000 individuals each year, and has managed to increase the conversion rate for people accessing needle exchange into treatment from less than 1% to nearly 10%.

The new Through-care, Aftercare and Recovery Support service, Footsteps to Recovery, is delivering structured day programmes, peer-led recovery support, volunteering, education

and employment opportunities as well as the therapeutic interventions need to help people coming through treatment to sustain their recovery, and avoid relapse.

Other areas of commissioned services have also markedly improved, with faster access to assessment through the EDAS single point of entry assessment service, better quality of prison-based substance misuse support with dedicated nurse capacity added to the service, and a more consolidated and seamless provision of clinical treatment in partnership with criminal justice treatment services. The EDAS service has also become more responsive and proactive in encouraging attendance through the introduction of an SMS text messaging reminder service for individuals waiting for an assessment appointment.

There has been unplanned achievement in response to the environment of austerity that impacts on all public services. For example, the innovative Connections Counselling Service emerged as a volunteer based solution to mitigate the consequences of the unforeseen loss of the Local Authority counselling service, and is close to achieving an identical level of capacity for significantly less resource.

All the APB commitments to establishing an effective governance framework, financial risk sharing agreements, operational risk management, performance management and clinical governance have all been achieved. The full governance framework for the board can be found in the annexes.

There have however been some areas where the outcomes did not match the ambition set out. The new Tier 2 service for young people proved to have low access and take-up for structured treatment and support. It became apparent that for under 18s, substance misuse is often synonymous with a range of other wellbeing issues such as low self-esteem, self-harm, family and parental difficulties etc. To this end, the Tier 2 young persons' service was decommissioned in March 2016, and the resources were invested in partnership with CAMHS funding into a new emotional wellbeing service that will enable a broader range of issues presented by young people to be addressed concurrently, rather than substance use related needs.

The APB produced its first annual report in summer 2013, and is due to publish its fourth annual report this year. The annual report has provided an effective platform on which the board can make public statements with regards to the work completed, the levels of performance achieved, and account for how resources have been allocated. In addition to this, the board now has a comprehensive website that provides up-to-date information on business activity as well as information on performance and local services. The APBs user forum also now has its own website, and the EDAS website continues to sustain high volumes of traffic from individuals seeking advice, information and support.

Overall the first Cardiff and Vale APB Commissioning strategy has achieved measurable successes, both in terms of the scale of change, but also the pace of change, with a five-year work programme being largely achieved in three. The board and its support team are now looking for opportunities across a broader range of public services, and new service development environments within which we can exercise some influence, and seek to address substance misuse in a more cross-cutting manner. This is the new direction of travel that this revised strategy sets out to achieve.

PRINCIPLES OF THE STRATEGY

1. Outline the aspirations that we want to achieve for the population of Cardiff and the Vale in relation to substance use and misuse

There can be no denying that the effects and consequences of the use and misuse of substances have broad impacts – many of which are costly to the individual, to society and to public services. By use we refer to the consumption of substances in a manner that is likely to cause minimal harm to the individual or others such as alcohol consumption within guidelines, or the use of prescribed opiates for pain management. By misuse we are referring to a level of use that is likely to cause harm such as harmful levels of alcohol consumption, or the use of illicit opiates. It is the role of the APB to set out the ambitions and aspirations for our population that this strategy will contribute to achieving. These aspirations are summarised as follows:

- To reduce the level of alcohol consumption across the population with fewer people reporting drinking over recommended guidelines and binge drinking; thereby reducing the harm caused to individuals and communities as a result of alcohol use and misuse
- To prevent substance misuse wherever possible, and to promote safer use of alcohol
- To improve the levels of safety and wellbeing of our population in environments such as the night time economy through decreasing levels of substance use
- To ensure that anyone wanting to address their use of alcohol or drugs is able to do so quickly and effectively
- To improve levels of knowledge regarding drug and alcohol use, and thereby the capacity to respond appropriately across all professions, and in all environments

2. Focus on the underlying causes of substance misuse

In 1958, the second British cohort study commenced, following 17,415 individuals born during a specific week in March that year. 27 years later, a researcher – Doria Pilling – followed up a particular group of these cohort study individuals. Scientists had created a category described at the time as “born to fail”. This description, whilst crude, was

indicative of children who had been born into circumstances such as poverty, deprivation and areas of high unemployment, and who essentially had the odds stacked against them. Children who were "born to fail" had a predicted trajectory in life that included poor educational attainment, ill health, and low levels of achievement.

Pilling however was interested in a different angle. She sought out all those individuals who, despite having been categorised as "born to fail" from the 1958 cohort had in fact achieved the complete opposite, and had secured good educational attainment, and a least a moderately successful career. Using criteria that included either a single parent family, or 5+ children, and who qualified for free school meals, Pilling was able to identify 386 individuals who fell within the criteria of the study. Whilst most of the study group (303) had indeed adhered close to the life trajectory that was predicted for them (classified as *under-achievers*), 83 individuals were found who were identified as *achievers* i.e. who had either achieved a high level of academic qualification, or who had secured a particularly high income, or who were in a position to buy their own home.

Pilling's detailed interviews with members of the *achiever* group enabled her to pinpoint the primary factors that enabled people from the under-achiever category to break free of their predicted life course and become *achievers*. Of course for any public service faced with tackling poverty and social deprivation, understanding the factors that enable people to break free of these circumstances is of the utmost importance.

Pilling identified the following four factors that were the most influential in enabling those who were "born to fail" to achieve beyond expectation. These factors are as follows:

1. Parenting. Having nurturing parents who took an active interest in the education and wellbeing of the study group, and who had aspirations for their children was the most influential factor that separated the achievers from the rest of the study cohort.
2. Education. Having a high quality of education, and an ambitious school; often one specific teacher or other staff member who developed a positive, proactive and

encouraging relationship with the individuals that raised their own expectations and gave confidence in their capacity to achieve.

3. Self-Motivation. Having the belief in themselves to achieve, coupled with the necessary self-discipline and determination to put that belief into action was the third significant factor that enabled members of the cohort to go on to become *achievers.*
4. Location. The level of opportunity such as job availability within a specific location, or the willingness and confidence to move to a location with a higher level of opportunity was identified as the final factor.

It is clear why these findings are so important for substance misuse policy and strategy and for public services across the board. But for substance misuse, there was one additional finding that has a particularly strong resonance. Pilling proved that whilst not all four factors were required to be present to enable someone to achieve, she was able to prove that it is very rare for motivation alone to result in achievement. Members of the study cohort were identified who were found to have not become achievers **whilst having very high levels of aspiration, motivation and self-discipline**. However, despite having high levels of intrinsic motivation, the absence of nurture at home and/or in school, and a lack of opportunities, often resulted in a failure to achieve.

It is universally recognised that within substance misuse services the attainment of successful outcomes for service users has a very strong focus on increasing service user motivation. The motivation to change, to sustain change and to build on change makes up the building blocks of many treatment programmes and approaches. However, if there is no nurturing home environment, no educational opportunities to inspire aspiration, and no opportunities for work or study, the research shows that the motivation we encourage in our services users is unlikely to be sufficient. The reality is that the focus of substance misuse support has been to motivate and encourage individuals to sustain a willingness to change, and maintain engagement with services. There has been significantly less emphasis on the importance of positive personal relationships, educational opportunities, work opportunities, and the whole breadth of other factors that are necessary ingredients of a fulfilling and satisfying life.

Service users can go through a structured support session, that equips them with a full understanding of their triggers, how to manage their behaviour, and a new-found resilience to lapse. It would not be unusual to then see them walk out, and back into a situation with no job, very little money, the stress of navigating the welfare system, and a good chance that their accommodation is anything but permanent and secure. Is it any wonder that we constantly struggle with lapse, relapse and the revolving door syndrome?

More recent research undertaken by Public Health Wales takes an in-depth look at the impact of a range of adverse childhood experiences (ACEs) on future negative behaviours and poor outcomes. The research proves that an accumulation of ACEs including different forms of abuse, parental breakdown, and negative behaviours such as alcohol and drug use all contribute to an increased likelihood of young people exhibiting behavioural traits such as smoking, drinking and criminal activity later in life.

The research by Doria Pilling, in conjunction with the ACEs report and an increasing body of evidence on the impact of a broad range of socio-economic factors on behaviours, lead us to a number of conclusions that have shaped this strategy and the APBs work programme as follows:

- The APB work programme will require a greater synergy with public service programmes aimed at improving education, employment and housing.

- Prevention and early intervention work with children and young people needs to focus less on the facts and figures of drugs and alcohol, and more on awareness and skills relating to aspiration, motivation, resilience, positive self-image, and positive decision making.

- The APBs family support services need to account for the emerging findings from the ACE research, and to create an effective join-up with other services such as those commissioned under the Families First work streams, and parenting support programmes.

- Everyone in receipt of substance misuse treatment and support should have the full breadth of their social, economic, personal, emotional needs identified and addressed, not just those specific to their use of substances. Service responses to user needs need to focus on broader issues such as personal relationships, welfare, accommodation, and provide support and guidance to enable service users to address the factors in their lives that have the capacity to negatively impact on their treatment and support. Actions in this strategy include the introduction of a policy that will place an expectation on commissioned services that wellbeing plans are drawn up for all service users, and that specific actions and steps are identified and agreed to support service users to address the socio-economic and personal challenges that they face.

The Mental Health Measure (Wales) addresses this need for a wider and more encompassing approach to treatment and care planning for service users, and the actions in this strategy include a commitment to adopt an identical approach across substance misuse services.

3. Increase the capacity for self-sustaining long-term recovery

The recovery agenda has progressed at a rapid pace during the lifespan of the previous strategy. New recovery services have been commissioned, and the recovery community is exponentially expanding across Cardiff and the Vale. It is one of the most significant successes in the local service improvement in recent years. However, this level of success brings with it a unique and new set of difficulties in relation to service capacity. The number of service users in recovery needing access to aftercare support, relapse prevention, social activities and networks cannot grow ad infinitum. Our services and facilities have limited capacity and space, and staff numbers are equally limited.

It is clear to the APB that robust, safe and proven methods must be identified and/or developed that enable service users in recovery to fully embrace the mutual aid ethos of recovery being self-managed and self-sustaining. Whilst appreciating the need for empathy and shared experiences, it has always seemed slightly illogical that substance misuse

recovery activities that focus on leisure, hobbies and interests, recreation and sport are formed, when there is abroad range of community opportunities delivering those same functions across Cardiff and the Vale. In fact, it could be challenged that we are propagating and reinforcing the silos and separateness of substance misuse from our communities by making such activities specific to our group of service users only.

It will be a gradual process, but through this strategy the APB is keen to develop approaches that safely enable those in recovery to become increasingly independent of service support, to increase the capacity of user-led mutual aid approaches to recovery, and to encourage those in recovery to become dependent on themselves, rather than on services. Whilst we will always support the development and benefit of mutual aid within the recovery movement, we also want to find ways of making better use of the community resources available across the region, and to use the opportunity to integrate people in recovery with their communities through grassroots activities.

As a starting point, rather than stage a Conference in spring 2017, the APB will join up substance misuse with other areas of need such as mental health, and carers networks in order to run a community assets event, where sport, leisure and special interest groups from across the region will be invited to display information on what they do, and to give individuals the opportunity to sign-up.

ASSESSMENT OF NEED

1 Demographic profile

As the 2011 census continues to provide the most up-to-date and comprehensive overview of key population demographics in Cardiff and the Vale this data remains largely unchanged from the previous strategy. Key population figures from the census are as follows:

- The permanent resident population of Cardiff is 346,090, and the Vale resident population is 126,336. Both localities have an almost even split between their male and female populations, with the Vale female population percentage (51.3%) slightly higher than Cardiff female population percentage (50.9%).

- Although the percentage population divide for the APB area calculates as 27% in the Vale, and 73% in Cardiff, the impact of high deprivation levels in parts of Cardiff has resulted in a resource allocation weighting that reduces the Vale percentage to 22% of allocated resources, versus 78% for Cardiff[1].

- In addition to the permanent resident population, Cardiff has 3917 school children over the age of 4, and students who are resident elsewhere during term time, with 1857 equivalent individuals in the Vale. It should be noted that, particularly for Cardiff, this is a fraction of the number of full time students who are resident in the local authority from out-of-area during term time. Cardiff University and Cardiff Metropolitan University had a combined student population of 44,560 in 2010/11[2].

- There is significant variation in population densities. Cardiff has a density of 24.7 per hectare, which is more than three times the next highest for a unitary authority in Wales, with Torfaen coming in second at 7.2. Conversely, the Vale has a density of 3.8 residents per hectare, which is commensurate with other localities with an urban / rural

[1] Welsh Government, revision of the substance misuse funding formula, 2012
[2] UK University student population records 2010/11

mixed geography such as Flintshire (3.5 p/Ha) and Neath Port Talbot (3.2 p/Ha). It is therefore reasonable to surmise that, even before public transport and road network infrastructures are considered, any service location will be inherently more accessible in Cardiff to a larger percentage of its population, than an equivalent service in the Vale.

- Cardiff has a non-white resident population of 52,976 or 15.3% of the population. In contrast, the Vale has 4498 non-white residents, or 3.5% of the population.

- 26.5% or 37,719 of the total 142,557 households in Cardiff have at least one household member with a long-term health problem or disability. In the Vale this increases to 28.3% or 15,186 of the total 53,505 households.

- 75,888 of the population of Cardiff have an understanding of the Welsh language, with 65,667 Welsh speakers, and 28,932 also able to read and write through the medium of Welsh. In the Vale, there are 27,285 individuals with an understanding of the Welsh language, of whom 23,202 can speak Welsh, and 10,013 are able to read and write through the medium of Welsh.

- There are 23,343 individuals classed as either economically active and unemployed, or unemployed in Cardiff out of 260,286 individuals, and 8,038 in the Vale out of 91,816 individuals. This gives unemployment rates of 9% for Cardiff and 8.75% for the Vale.

- In Cardiff, 13,447 or 5.2% of individuals were classed as economically inactive due to long term sickness or disability, and in the Vale the figure for the same group was 4,414 or 4.8%.

- Cardiff has 63 LSOAs (Lower Super Output Areas) in the bottom quartile for deprivation out of 1896 LSOAs in Wales. In addition, there are 18 LSOAs in the 100 most deprived in Wales, with the poorest score for Cardiff ranking 23rd from the bottom. However, Cardiff also has the least and second least deprived LSOAs in Wales ranked at 1896 and

1895 respectively. There are 78 LSOAs falling in the top quartile i.e. the 25% least deprived LSOAs in Wales.

- The LSOAs in Cardiff represented in the bottom quartile include those in Ely, Butetown, Adamsdown, Trowbridge, and Splott. The areas with LSOAs represented in the highest quartile include Llandaff, Cyncoed, Rhiwbina, Heath, Whitchurch, Tongwynlais and Old St Mellons.

- The Vale of Glamorgan has only 12 LSOAs in the bottom quartile for deprivation, and only one within the 100 most deprived, ranking at 91. In contrast, there are 41 LSOAs within the top quartile, or 25% least deprived LSOAs in Wales, which represents 53% of the LSOAs for the local authority. The highest rank for an LSOA in the Vale is 1868 out of 1896.

- The areas in the Vale falling into the most deprived quartile include Gibbonsdown, Castleland, Cadoc and Court, whilst LSOAs in Plymouth, Llantwit Major, Cowbridge and Rhoose are among the least deprived.

- High levels of overall deprivation are mirrored in the statistics for the specific health indices, with similar localities featuring at both the lower and upper end of the scale in both local authority areas.

- The situation alters when considering the rankings for access to services. The Vale has 18 LSOAs in the bottom quartile for this indicator – all of which are in the least deprived quartile for overall deprivation levels. Conversely, in Cardiff, some of the LSOAs with overall high deprivation scores in areas such as Adamsdown, Riverside and Splott, ranked amongst the best in Wales for access to services.

However, the APB is also mindful of the future impact on population that can be seen in the councils' Local Development Plans. Plans for significant increases in the number of houses

and households, particularly in Cardiff, are likely to see unprecedented levels of population growth during the lifetime of this strategic programme.

2 Findings from the 2015 comprehensive needs assessment

Appendix 1 contains the full detail of the new needs assessment that was undertaken in order to inform this strategy. The conclusions and recommendations from the needs assessment are as follows:

Whilst the top 3 prevalent substances in Cardiff and Vale of Glamorgan remain unchanged (Alcohol, Cannabis and Heroin) since the previous commissioning strategy was published, the demographic profile of the region has changed considerably. Recent prevalence data alludes to a growing older population (65+) and rising life expectancy (78-83 years); however, this too highlighted local level inequalities and disparities in deprivation (healthcare, access to services, education and employment).

Furthermore, the gap between local level inequalities and deprivation is likely to widen with reference to the introduction of universal credit and the Welfare Reform Act (see appendix A).

The Wallich Alcohol Study revealed a growing number of older people drinking alcohol in excess of national guidelines (approximately 16,902) due to perceived isolation, relaxed entrenched cultural norms and lack of awareness of information and/or service provisions. It is therefore fundamental that services are geared towards older people in the context of appropriate marketing and communication and the need to work holistically with non-specialist substance misuse services which older people are likely to frequent, e.g. GP surgeries. Where possible, outreach services would benefit this cohort of clients who are otherwise hard to engage.

Since 2004 the number of households in the UK with internet access has increased by 35% (Office for National Statistics, 2014). The latest figures published by 'Breaking Free Online'

reveal 264 people have accessed e-learning for help with drug and/or alcohol issues; which is a continuing growing trend with those seeking discretionary support or reduced accessibility to services. The internet is continuing to revolutionise services capacity to communicate targeted information to large cohorts of people in a reasonably cost effective way. A recommendation would therefore be to look to new innovative technology and social media in the delivery of therapeutic interventions and structured support within the home.

Therapeutic interventions and other new and emerging treatment therapies (e.g. positive psychology) are gaining considerable recognition by academics and practitioners alike and seem to be well received by service users in receipt of these. However due to the relative infancies in a substance misuse context, data is inconclusive to justify long term effectiveness. Despite this the APB may want to consider allocating some of its Substance Misuse Action Fund (SMAF) monies to pilot these new and emerging therapies and continue to monitor effectiveness as part of standardised performance monitoring arrangements. In doing so a blanket approach to staff competencies through formal accredited training is recommended to ensure quality and fidelity to the treatment model.

The needs assessment also highlighted the need for more robust data collection systems (which at present are not sustainable) and increased training with frontline staff around technical reporting to the Welsh National Database for Substance Misuse (WNDSM). At present some providers are triple keying data to multiple systems or manually recording activity which is complex and time consuming for the individual.

A number of third sector and non-statutory organisations are in the process of moving across to the PARIS information system for case managing clients. The perceived benefits associated with consolidating all providers on one standalone system are:

- Strengthened data quality
- Seamless management of patient care
- Identifying a number of holistic needs

- Ethical Storage solutions of comprehensive assessments, case notes, care plans, risk assessments and screening tools (AUDIT and ASSIST) etc.

The feedback from service users and staff revealed more could potentially be done in regards to acknowledging the needs of marginalised groups, and those with protected characteristics (for example, LGBT, disabled and BME communities)

There was a clear message regarding the needs to maintain a focus on identifying opportunities for further efficiencies where possible within existing resources. There is a finite level of resources for the APB to commission with, and further improvement is still needed in areas such as waiting times between referral and treatment.

Furthermore, greater enhancement of outreach and engagement could maintain the motivation of service users seeking to reduce their substance misuse and improve their quality of life whilst waiting to commence structured clinical treatment.

Despite these areas for development, it was pleasing to see the majority of feedback in relation to current services was positive by staff and service users. Staff highlighted that capacity was limited in some areas however training opportunities were mostly readily available to enhance personal development and services capabilities.

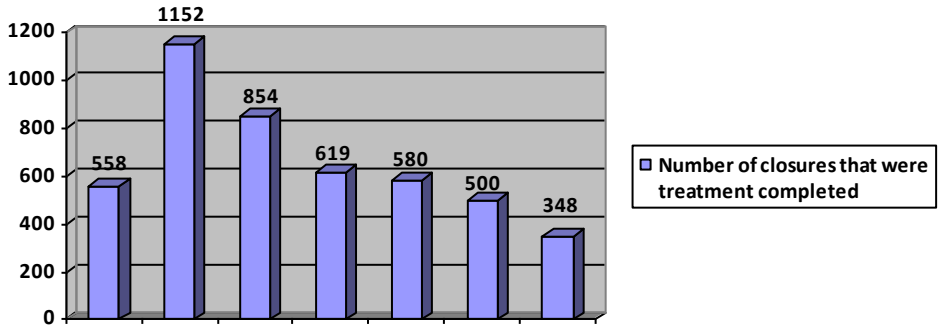
It was also positive to hear the Open Access and Engagement Service and Through-care Aftercare and Recovery Support services (commissioned by the APB in 2014) have both been well received by clients in regards to referral and assessment activity and offering clients additional treatment options.

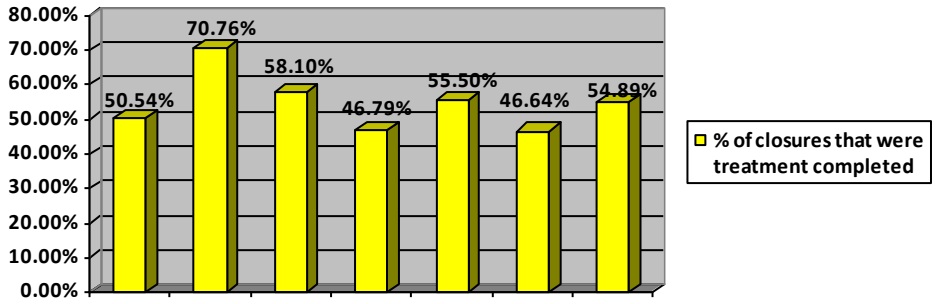
3 Statistics from the Welsh National Database for Substance Misuse

All treatment and support services are required to submit data onto the national substance misuse database. This provides the records from which performance against KPIs as well as basic demographic performance data is assessed. Some key headlines for Cardiff and the Vale are as follows:

Treatment completion rates - Cardiff

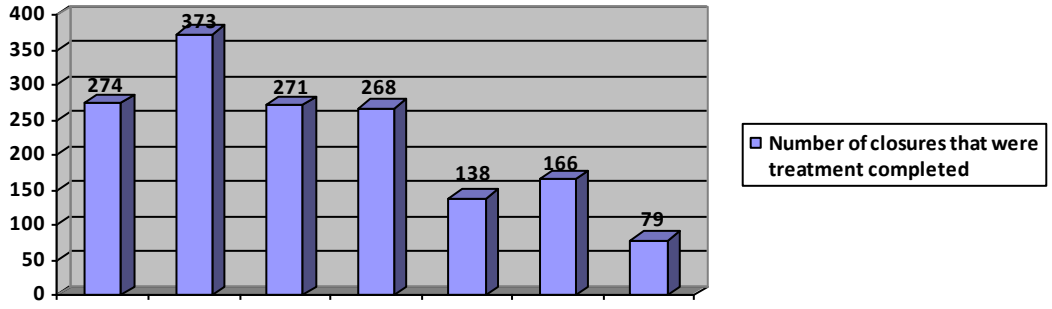
CARDIFF	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16 (up to an including Feb 16)
Number of closures that were treatment completed	558	1152	854	619	580	500	348
% of closures that were treatment completed	50.54%	70.76%	58.10%	46.79%	55.50%	46.64%	54.89%

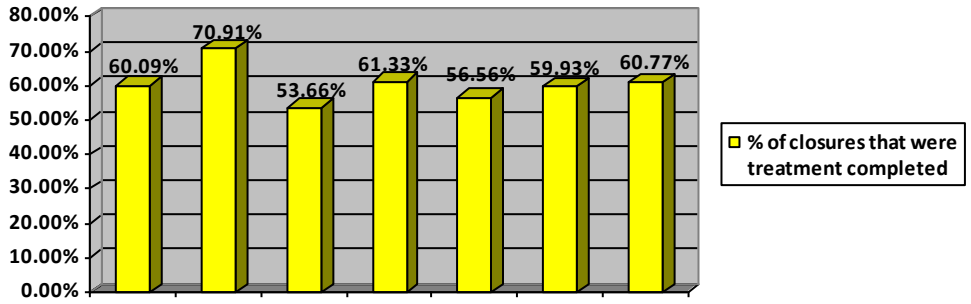




Treatment completion rates – Vale of Glamorgan

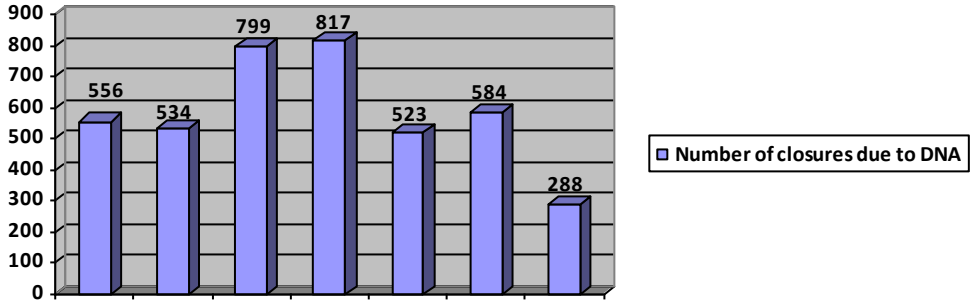
VALE	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16 (up to and including Feb 16)
Number of closures that were treatment completed	274	373	271	268	138	166	79
% of closures that were treatment completed	60.09%	70.91%	53.66%	61.33%	56.56%	59.93%	60.77%

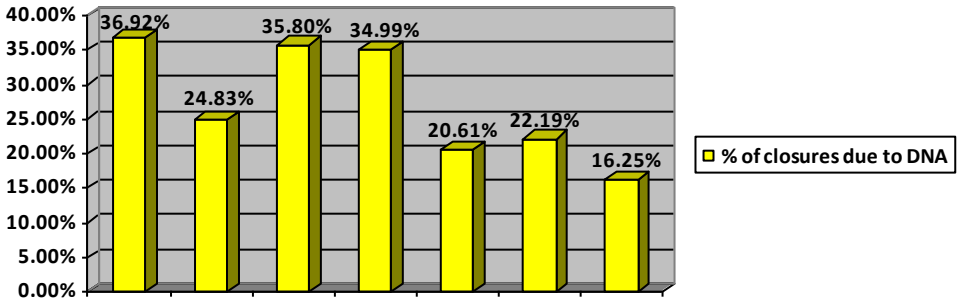




Discharges resulting from Post-Assessment DNA - Cardiff

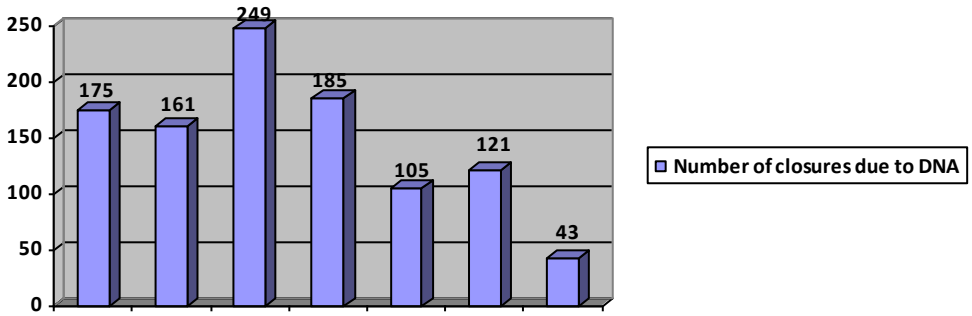
CARDIFF	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16 (up to and including Feb 16)
Number of closures due to DNA	556	534	799	817	523	584	288
% of closures due to DNA	36.92%	24.83%	35.80%	34.99%	20.61%	22.19%	16.25%

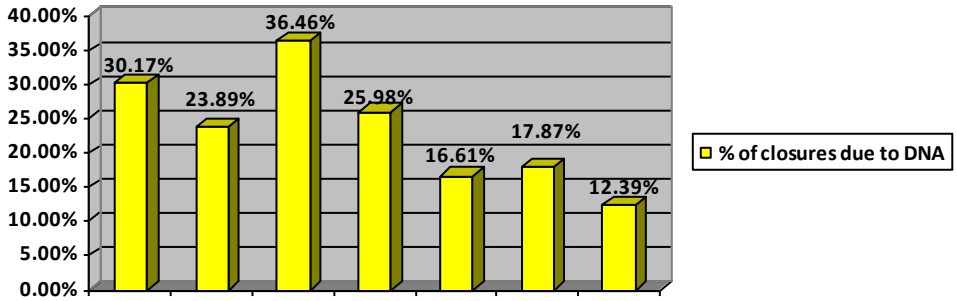




Discharges resulting from Post-Assessment DNA – Vale of Glamorgan

VALE	2009/10	2010/11	2011/12	2012/13 (To date)	2013/14	2014/15	2015/16 (up to and including Feb 16)
Number of closures due to DNA	175	161	249	185	105	121	43
% of closures due to DNA	30.17%	23.89%	36.46%	25.98%	16.61%	17.87%	12.39%



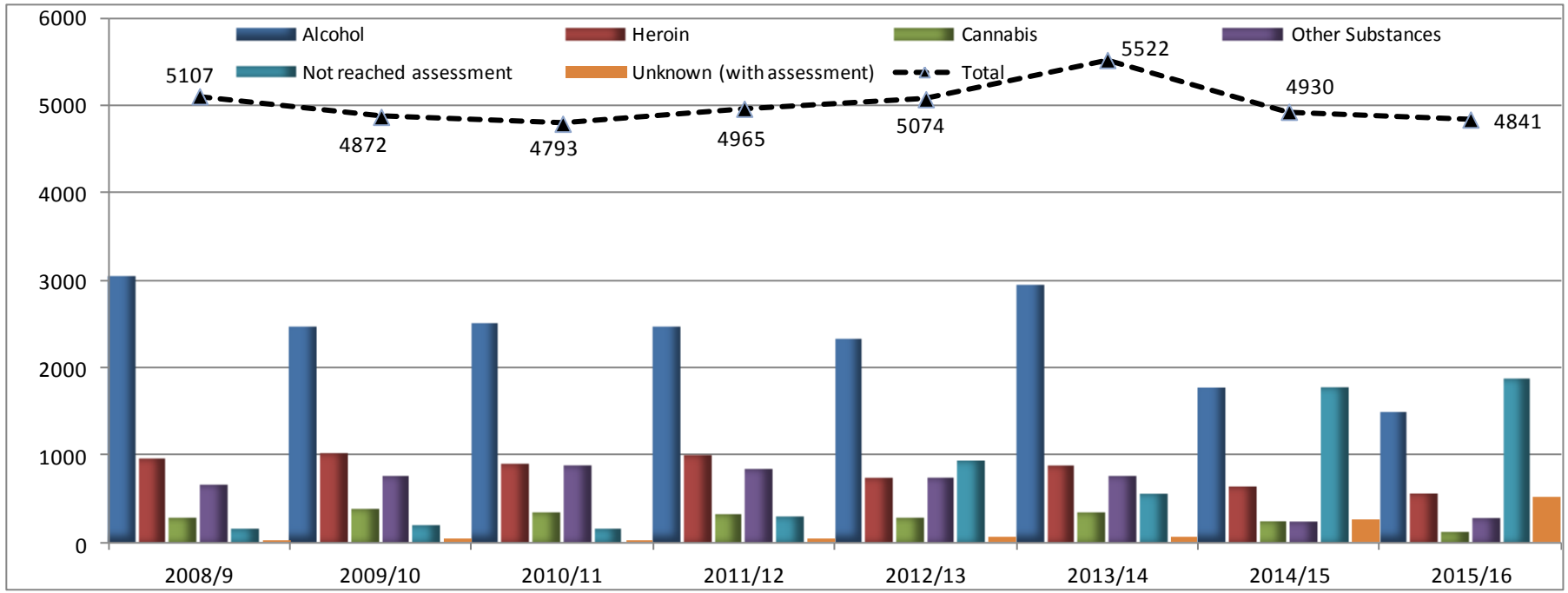


Referrals into services by primary substance

The table overleaf illustrates referrals into services, broken down by primary substance. These figures are taken from the Welsh National Database, and it should be noted that there is additional data on secondary substance, where levels of poly drug use can be assessed. Alcohol as well as the most common primary substance, is also the most common secondary substance for Cardiff and the Vale. It should be noted that the sharp decrease from 2013/14 to 2014/15 correlates with the introduction of EDAS and the resulting exclusion from the data of referrals that do not materialise.

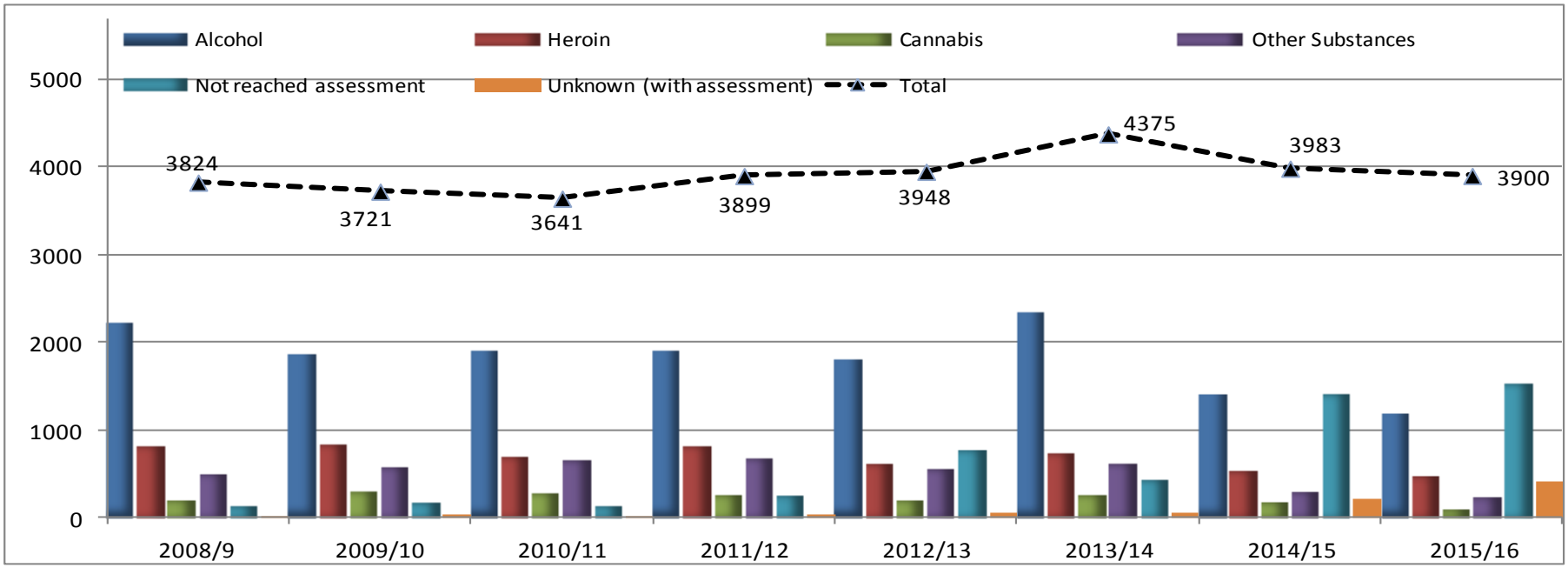
Referrals by Primary Substance – Cardiff and Vale Combined

2008/9		2009/10		2010/11		2011/12		2012/13		2013/14		2014/15		2015/16	
Alcohol	**3048**	Alcohol	**2470**	Alcohol	**2513**	Alcohol	**2465**	Alcohol	**2322**	Alcohol	**2933**	Alcohol	**1773**	Alcohol	**1486**
Heroin	**962**	Heroin	**1022**	Heroin	**900**	Heroin	**998**	Heroin	**730**	Heroin	**878**	Heroin	**639**	Heroin	**563**
Cannabis	**278**	Cannabis	**388**	Cannabis	**339**	Cannabis	**323**	Cannabis	**277**	Cannabis	**343**	Cannabis	**245**	Cannabis	**130**
Other substances	**658**	Other substances	**748**	Other substances	**867**	Other substances	**837**	Other substances	**742**	Other substances	**760**	Other substances	**249**	Other substances	**283**
Not Reached Assessment Yet	**155**	Not Reached Assessment Yet	**209**	Not Reached Assessment Yet	**154**	Not Reached Assessment Yet	**305**	Not Reached Assessment Yet	**936**	Not Reached Assessment Yet	**549**	Not Reached Assessment Yet	**1769**	Not Reached Assessment Yet	**1865**
Unknown (with assessment)	**6**	Unknown (with assessment)	**35**	Unknown (with assessment)	**20**	Unknown (with assessment)	**37**	Unknown (with assessment)	**67**	Unknown (with assessment)	**59**	Unknown (with assessment)	**255**	Unknown (with assessment)	**514**
Total	**5107**	**Total**	**4872**	**Total**	**4793**	**Total**	**4965**	**Total**	**5074**	**Total**	**5522**	**Total**	**4930**	**Total**	**4841**



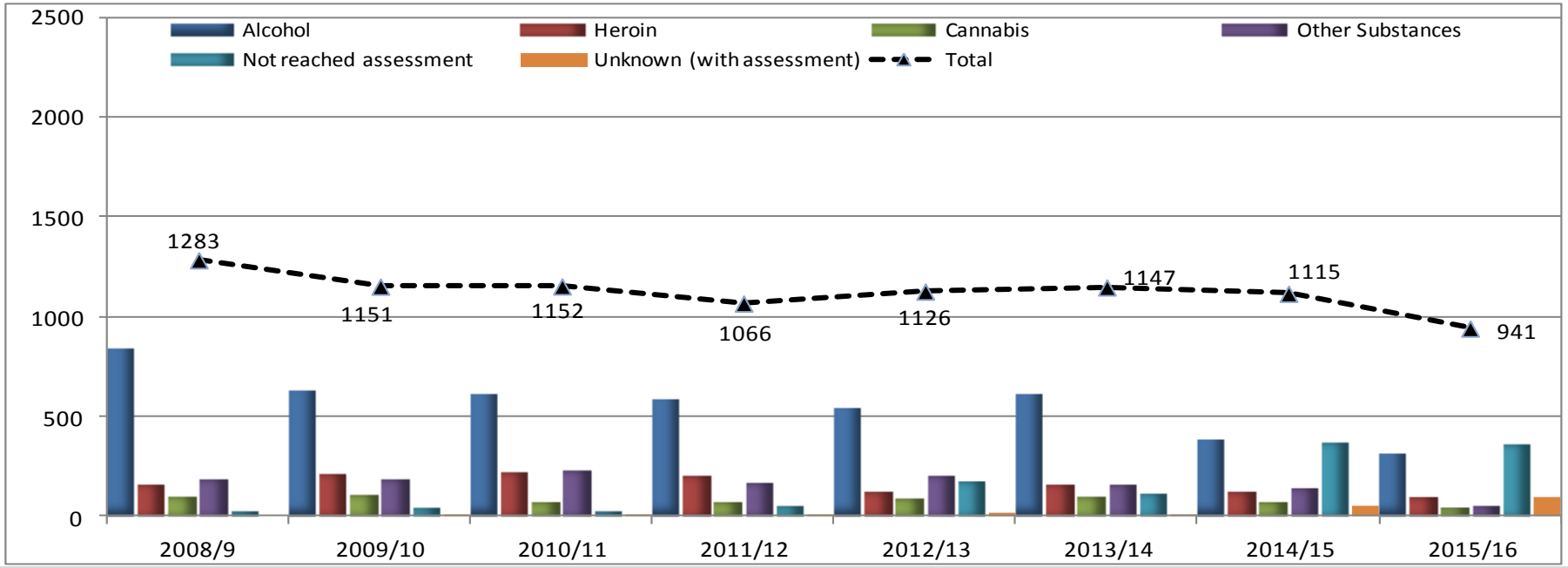
Referrals by Primary Substance – Cardiff

2008/9		2009/10		2010/11		2011/12		2012/13		2013/14		2014/15		2015/16	
Alcohol	**2217**	Alcohol	**1848**	Alcohol	**1902**	Alcohol	**1885**	Alcohol	**1787**	Alcohol	**2324**	Alcohol	**1392**	Alcohol	**1178**
Heroin	**804**	Heroin	**818**	Heroin	**682**	Heroin	**804**	Heroin	**606**	Heroin	**721**	Heroin	**523**	Heroin	**473**
Cannabis	**182**	Cannabis	**286**	Cannabis	**271**	Cannabis	**256**	Cannabis	**190**	Cannabis	**245**	Cannabis	**177**	Cannabis	**88**
Other substances	**481**	Other substances	**570**	Other substances	**642**	Other substances	**670**	Other substances	**547**	Other substances	**603**	Other substances	**282**	Other substances	**232**
Not Reached Assessment Yet	**134**	Not Reached Assessment Yet	**166**	Not Reached Assessment Yet	**127**	Not Reached Assessment Yet	**252**	Not Reached Assessment Yet	**764**	Not Reached Assessment Yet	**435**	Not Reached Assessment Yet	**1404**	Not Reached Assessment Yet	**1513**
Unknown (with assessment)	**6**	Unknown (with assessment)	**33**	Unknown (with assessment)	**17**	Unknown (with assessment)	**32**	Unknown (with assessment)	**54**	Unknown (with assessment)	**47**	Unknown (with assessment)	**205**	Unknown (with assessment)	**416**
Total	**3824**	**Total**	**3721**	**Total**	**3641**	**Total**	**3899**	**Total**	**3948**	**Total**	**4375**	**Total**	**3983**	**Total**	**3900**



Referrals by Primary Substance – Vale of Glamorgan

2008/9		2009/10		2010/11		2011/12		2012/13		2013/14		2014/15		2015/16	
Alcohol	**831**	Alcohol	**622**	Alcohol	**611**	Alcohol	**580**	Alcohol	**535**	Alcohol	**609**	Alcohol	**381**	Alcohol	**308**
Heroin	**158**	Heroin	**204**	Heroin	**218**	Heroin	**194**	Heroin	**124**	Heroin	**157**	Heroin	**116**	Heroin	**90**
Cannabis	**96**	Cannabis	**102**	Cannabis	**68**	Cannabis	**67**	Cannabis	**87**	Cannabis	**98**	Cannabis	**68**	Cannabis	**42**
Other substances	**177**	Other substances	**178**	Other substances	**225**	Other substances	**167**	Other substances	**195**	Other substances	**157**	Other substances	**135**	Other substances	**51**
Not Reached Assessment Yet	**21**	Not Reached Assessment Yet	**43**	Not Reached Assessment Yet	**27**	Not Reached Assessment Yet	**53**	Not Reached Assessment Yet	**172**	Not Reached Assessment Yet	**114**	Not Reached Assessment Yet	**365**	Not Reached Assessment Yet	**352**
Unknown (with assessment)	**0**	Unknown (with assessment)	**2**	Unknown (with assessment)	**3**	Unknown (with assessment)	**5**	Unknown (with assessment)	**13**	Unknown (with assessment)	**12**	Unknown (with assessment)	**50**	Unknown (with assessment)	**98**
Total	**1283**	**Total**	**1151**	**Total**	**1152**	**Total**	**1066**	**Total**	**1126**	**Total**	**1147**	**Total**	**1115**	**Total**	**941**



4 ASSESSMENT OF NEED AND PERFORMANCE - ANALYSIS

The findings of the needs assessment, coupled with the performance statistics from the national database enable a number of conclusions to be drawn to inform this commissioning strategy as follows:

- Gains that have been made in performance against KPIs have in some instances proved unsustainable. In particular, the improvements in waiting times secured in 2014-15 proved fragile, with a significant dip in performance in 2015-16, although this largely recovered towards the end of the year. Therefore, the APB will urgently need to undertake development work around business continuity, contingency management and risk management across the whole treatment system in order to increase the sustainability of any improvements in performance.

- Alcohol remains the most prevalent substance used. The focus of work going forward however has to be to address the settings and environments in which alcohol use and misuse is challenged and addressed. Developing generic public services, primary care settings and the wider health and social care system to enable the use of brief interventions, and the use of tools such as Making Every Contact Count (MECC) will be important tools in tackling alcohol use at a population level.

- Drug related deaths appear to be increasing, with data showing that the Vale of Glamorgan sustained a particularly high increase when compared to All-Wales data. The APB will need to implement robust systems that ensure that the lessons learned from the review of drug related deaths are implemented and continuously monitored across all commissioned services.

- There remains insufficient use of new aftercare provision, and the rate of treatment withdrawals as a reason for case closure remains high. Therefore, the APB will need to work with the aftercare service to establish a continuous presence and operational function within structured clinical treatment services in order to support the re-engagement of service users at risk of having their treatment withdrawn, and to

promote the capacity of the aftercare service to enable those in treatment to work towards moving out of clinical services and into aftercare.

- Referrals rates to treatment are showing a gradual decline. The APB are hopeful that this is a positive reflection of the impact of increased service availability in both open access and aftercare, with reports from service providers demonstrating that the numbers of individuals within the treatment system at any one time is significantly higher than at any point since the establishment of the SMAF funding in 2003. Whilst still early days, it does appear that the availability of early structured support in open access, and the capacity of aftercare services to reduce relapse is having an impact on the volume of demand on clinical treatment services.

Forecast planning

The increase in use of NPS predicted in the forecast of the previous strategy has largely come about. To this end the APB is conscious that an ongoing rise is to be expected, and that all services will need to ensure that they have the knowledge, skills and capacity to respond to NPS related treatment and support needs.

Substance use levels in older people are set to continue to rise as a consequence of having an ageing population. Commissioning decisions will need to respond to the necessity of age appropriate materials and approaches in the delivery of treatment and support.

There will be a significant rise in the population, particularly in Cardiff, as a result of the volume of residential development outlined in the Local Development Plans of the local authorities. There is an opportunity to ensure that the health and social care services for those localities have the necessary information and capacity to address substance use related needs.

Problematic alcohol remains the most frequent primary substance of referrals, and there continues to be no indication that this is likely to change. Services will therefore be designed to ensure that the needs of alcohol users are appropriately addressed.

COMMISSIONING ACTIONS

Based on the evidence gathered through the new needs assessment, the changing legislative and policy landscape, these are the new proposed commissioning priorities to be addressed through this strategy, and in line with the principles set out in section 1.

- *Reduce and mitigate the impacts of substance use on families;*
- *Develop aspiration, self-esteem and motivation in young people, as tools to increase resilience to substance use;*
- *Increase the numbers of service users in treatment able to move into aftercare and long term recovery;*
- *To re-engage those who disengage from treatment and support;*
- *Increase the extent to which primary care services can identify and respond to substance use and misuse;*
- *Increase the capacity of those in recovery to source, and self-sustain their own personal recovery support needs, making full use of the resources that the communities across the region can offer to support those in recovery;*
- *Improve the wellbeing and level of job satisfaction across the substance misuse workforce;*
- *Ensure that services provide an individualised and tailored response to peoples' needs;*
- *Lead on research and development to enhance the evidence base on which services operate, and encourage innovation in how services are designed and delivered, with service users at the centre of that design process;*
- *Enhance services such as education, employment and housing that protect the outcomes achieved through substance misuse interventions;*
- *Respond to the increasing demands resulting from a growing population across Cardiff and the Vale.*

In addition, the following priority areas remain relevant from the previous strategy:

- *Build sustainability into improvements made against the national waiting times target;*
- *Decrease alcohol related hospital admissions;*
- *Secure a decreasing trend in annual rates of drug related deaths, and non-fatal overdose;*
- *Ensure the capacity of services to meet the needs of those with protected characteristics.*

1. **Reduce and mitigate the impacts of substance use on families**

Synopsis:

As the evidence described under the principles section of this strategy illustrates, the quality of the childhood environment and experience has substantial impacts on health and lifestyle behaviours later on in life. With a renewed focus on addressing the underlying causes of substance use, the APB has selected to place family orientated services at the top of the priority list in this revised strategy.

Activity to date:

The APB has commissioned a family support service for a number of years. This has primarily focused on providing intervention and support to families that have children on the Children in Need or the Children at Risk registers, and where substance use is a significant contributing factor. The service has been highly successful with a high percentage of children within families supported coming of these registers.

The APB believe that through a process of redesign and development, this provision could be made available to a wider group of families in need. The board is also conscious that the grant funded component of services needs to clearly enhance and add to statutory functions – the development of the service will provide an opportunity to evaluate this factor.

The CRAFT programme has also been delivered as a component of this service, whereby carers and family members are trained to be able to provide the best possible support to their loved-ones who have a dependency on drugs or alcohol. The CRAFT programme remains a flagship project for the APB, and the best exemplar we have of co-production.

Commissioning actions: we will…

1) Re-design the APB-commissioned family support service in line with the latest early intervention and prevention evidence base, and to ensure a wider reach of service users is achieved.

2) Ensure synergy between the family support services, preventative services, youth services (including youth justice services), social work, and specialist addiction social workers.

3) Create a separation between the family support service and CRAFT for the purposes of each having their own defined set of outcomes.

4) Provide input into the local authority commissioned families first programmes, to ensure that these services are able to take actions that will have a preventative outcome with regards to substance use as well as a range of other harmful behaviours.

2. Develop aspiration, self-esteem and motivation in young people, as tools to increase resilience to substance use

Synopsis:

The evidenced outlined in this document clearly shows that young people with motivation, self-discipline and self-esteem are far more likely to avoid harmful behaviours including substance use, than if they were simply armed with the facts.

Activity to date:

The APB has a comprehensive young people's service called Switched On which focuses on supporting young people and professionals in environments focused on young people's services such as schools, pupil referral units and other youth service settings. One unique project delivered recently, and managed through switched on was the provision of substance misuse education sessions by medical undergraduate students with a particular interest in the field.

The unexpected low caseload levels of the previous tier 2 service resulted in a recommissioning exercise that places tier 2 young people's substance misuse support as one component of a much broader Emotional Wellbeing Service that will be able to provide interventions around mental health, self-esteem and emotional resilience as well as substance misuse.

The APB also oversees the provision of substance misuse functions into both Cardiff and Vale Youth Offending Services, and the provision of tier 3 substance misuse services for young people through the Young Person's Drug and Alcohol Service (YPDAS) that is based within CAMHS.

Commissioning actions: We will…

1. Oversee the effective implementation and delivery of the new broader Emotional Wellbeing Service.
2. Enable the substance misuse specialist function within the Youth Offending Services to become embedded as a resource for the youth offending service as a whole.
3. Support any expansion, or continuation of the programme of undergraduate medical students developing and delivering schools-based education programmes.
4. Enhance the universal services methodology to incorporate positive psychology, mindfulness and other similar approaches that increase the wellbeing and resilience of children and young people, as well as their knowledge.

3. Enable those in treatment to move into aftercare and long term recovery

Synopsis:

Treatment for substance use should always be considered a finite part of a much longer journey of recovery, rather than as the end point or goal. This should be fully understood by service users entering treatment and support. Admittedly, for some individuals, the length and nature of treatment will be longer and more intensive than for others. However, the APB does not accept that any service user should be resigned to remain in clinical treatment ad infinitum, with no prospect of recovery.

Whilst recovery may take many months, if not years, for some service users, the APB expects every member of staff working across substance misuse service to always have an ambition for recovery in mind and to capitalise on any opportunity to encourage that same ambition in the service users they support.

Activity to date:

The APB commissioned the new through-care, aftercare and recovery support service in 2013/14 in order to provide services with a clear and managed route for service users to move on from treatment in a planned and safe manner. However, the numbers of service users moving from treatment into aftercare remains low, and the number of cases closed as a result of treatment being withdrawn remains higher than the number referred on to aftercare support.

Commissioning actions: we will…

- Undertake workforce development with structured treatment services to ensure that care planning makes best use of through-care and aftercare services
- Establish joint working protocols, and care pathways with the criminal justice based Offender Interventions Service for seamless transition for service users
- Work with EDAS to ensure that expectations of recovery are appropriately communicated, and that the options for treatment pathways including aftercare and the full scale of service availability is discussed at first assessment.
- Set service targets for both joint working and onward referral.
- Develop a range of low intensity brief interventions for tier 1, which could be offered by a range of community services such as the 4 session brief motivational enhancement packages (alcohol, cannabis, amphetamines) designed by Cardiff and Vale staff for delivery by others under appropriate supervision to ensure fidelity to the intervention package.

4. To re-engage those who disengage from treatment and support

Synopsis:

As mentioned under the previous set of actions, the number of service users who have their treatment withdrawn, and their case closed is the highest in Wales. The APB fully understands and appreciates the governance implications for the provision of controlled

medication, and the need for prescribing to cease in the event of failure to contact the service user.

However, the population of Cardiff and the Vale is not vastly different from any other part of Wales and therefore there must be more effective ways of retaining service users in treatment, whilst retaining the necessary clinical governance procedures.

Activity to date:

Work has been completed to establish clear definitions around planned and unplanned case closures. The new open access and aftercare service have also delivered a marked improvement in planned closure rates. However, the unplanned closure rate in clinical services remains high. The APB also recognises that it is often those individuals with severe, enduring and complex needs that often disengage from services.

Commissioning actions: we will…

- Commission a new re-engagement function as part of the through-care and aftercare service that will be operationally imbedded in clinical treatment services, and that will engage and support service users identified as being at risk of having their treatment and support programme withdrawn.
- Meet with commissioners and providers from the APBs in Wales with the lowest levels of treatment withdrawals, and unplanned closures to determine any operational practice that can be implemented in Cardiff and the Vale.
- Work with providers to ensure the most effective treatment, care and support approach is available for service users who present with problematic and hazardous substance misuse, have extremely complex presentations, and high levels of comorbid health problems such as mental health, personality disorder, trauma and neurocognitive degeneration.

5. **Increase the extent to which primary care services can identify and respond to substance use and misuse**

Synopsis:

Primary care services are often the first port of call for individuals seeking advice and support in relation to their use of alcohol or other substances. GPs are often the first to be aware of a whole range of physical health issues that can be indicative of an underlying substance use problem. Substance misuse tends to sit largely outside of the General Medical Services (GMS) GP contract, but shared are schemes offer an enhanced method of delivering substance misuse treatment and support in primary care settings.

Activity to date:

Cardiff and Vale has a comprehensive and effective shared care service with a capacity of over 500 individuals being provided with treatment and support at any one time. In addition, the majority of GPs across Cardiff and the Vale have been trained in the delivery of Alcohol Brief Interventions (ABI).

However, it is also true that GP referrals account for over 70% of EDAS assessment appointments that result in a DNA. There are a number of opportunities to make bet use of primary care services, and to support GPS with an interest in managing substance use and addictions.

Commissioning actions: we will…

- Invest in primary care workforce development and training to increase the knowledge, awareness and skills of GPs in identifying and responding to substance use and misuse.
- Continue roll-out of the Alcohol Brief Interventions programme at an enhanced level for Cardiff and the Vale.
- Undertake a pilot project to determine the feasibility of a local alcohol shared care scheme in primary care.

- Establish a walk-in service within EDAS, and train GPs on effective screening that will enable them to sign-post rather formally refer service users when appropriate

6. **Increase the capacity of those in recovery to source, and self-sustain their recovery support needs, making full use of what the communities across the region can offer to support those in recovery**

   Synopsis:

   A discussed in detail, under the *Principles* section of this strategy, we do not have the resources to provide ongoing unlimited support for everyone who comes through treatment into aftercare and recovery. What is needed is a system of recovery support that equips individuals with the confidence and skills to lead their own recovery away from services, albeit knowing that services remain available if needed in the future.

   Activity to date:

   The recovery support service is an important component of the aftercare package across Cardiff and the Vale. In addition to commissioning this new provision there has been significant investment into buildings and premises to support recovery orientated activity and service delivery.

   Commissioning actions: we will…

   - Not prioritise the size of the recovery community / population as evidence in decision making for resource allocation, as this has the capacity to act as a disincentive to encouraging move-on into self-managed recovery away from services.
   - Set targets for planned closures from through-care, aftercare and recovery support, and build upon the role that volunteers can play in supporting this work.
   - Set targets for recovery service user engagement in generic community-based activity, including the Time Credits scheme, and similar provisions.

- Run a community resources event that will enable sign-up to sport, leisure and specialist interest clubs and groups for service users and carers from across substance misuse as well as other sectors such as general carer support networks and mental health service user and carer groups.
- Develop and maintain a directory of non-substance misuse specific community resources that can be accessed by all service users and carers.

7. Improve the wellbeing and level of job satisfaction across the substance misuse workforce

Synopsis:

Nursing Times (2013) reported in detail on research that clearly demonstrated a positive correlation between staff wellbeing and the patient experience of care. Also in 2013, Professor Jill Maben published her research in the Health Service Journal that demonstrated seven key areas that have the greatest impact on the wellbeing of health and social care staff in the workplace. These are:

- a good local team/work group climate;
- high levels of co-worker support;
- good job satisfaction;
- a good organisational climate;
- perceived organisational support;
- low emotional exhaustion; and
- supervisor support.

The APB is confident that all our services have high quality staff support systems in place. However, we must also remember that staff are having to deal with the emotional consequences of seeing service users who have achieved progress then lapse or relapse, as well as having to temper over ambition in service users with more achievable and realistic goals.

As outlined earlier, if the APB expects all staff to maintain positive expectations of recovery and improvement among all our service users, then we have an equal responsibility to ensure that the staff management, development and pastoral care arrangements are in place to enable that to happen.

Activity to date:

There has been a significant amount of staff training and development in areas such as dual diagnosis, and motivational interviewing with the STARS programme remaining an example of local best practice.

However, there has been less emphasis on providing staff with a safe environment to raise issues, discuss concerns, support and learn from each other, and engage in dialogue with commissioners.

Commissioning actions: we will….

- Implement the APB Workforce Development Plan with a view to ensuring that all staff receive information on implementing the *Five Ways of Wellbeing* for the benefit of themselves as well as for service users and carers.
- Provide structured opportunities on a regular basis for staff to discuss issues, raise concerns, and consider different ways of working in a safe and private environment.
- Implement a series of staff seminars and continuing professional development opportunities on a range of topics aimed at improving their knowledge and skills, keeping abreast of the latest developments in the field, and improving their personal wellbeing.
- Invest in administrative capacity in order to reduce the amount of clinical and professional staff time that is needed to carry out administrative tasks, and to free up time for sufficient ongoing training and supervision.

- Promote dignity at work for our staff, service users, and carers by investing in the quality of our estates so that every member of staff in every commissioned service is working in a healthy, safe and well planned environment that is conducive to their personal wellbeing.

8. Ensure that services provide an individualised and tailored response to peoples' needs

Synopsis:

This is an interesting area of development for the APB. Whilst we have no doubt that every service user in receipt of treatment and support has an individualised approach in response to their needs, we also face the challenge that the way services are set up deters certain groups of potential service users by default; therefore, they are not presenting in order to have their support needs considered and addressed.

Some of the groups that the evidence suggests are unlikely to contact specialist support includes older people, those without English as first language, professionals unwilling to attend a specialist substance misuse centre, and those working in the substance misuse field who may see a conflict of interest.

Clearly, our approach to the provision of support needs to be more inclusive, and less concentrated on specialist service premises.

Activity to date:

Our open access service has developed and delivered a distance approach for individuals unwilling to attend a specialist centre. This has been highly successful, and utilises methods such as workbooks, telephone consultations and outreach in order to meet the needs of the service users.

We have sought to increase the number of service users who have a contribution to their treatment, care and support from multiple organisations and services, but the level to which this occurs remains low.

Commissioning actions: we will…

- Provide commissioned services with targets to increase the level of interagency referral, and joint working to ensure that as broad a range of options are made available to those seeking support, beyond the traditional treatment-centre based approaches.
- Implement the Mental Health Measure (Part 2) approach to care and treatment planning across all commissioned substance misuse services, so that all service user care and treatment plans include the key headings of:
  - finance and money
  - accommodation
  - personal care and physical well-being
  - education and training
  - work and occupation
  - parenting or caring relationships
  - social, cultural or spiritual
  - medical and other forms of treatment including psychological interventions.
- Continue to develop and implement options for structured support that can be undertaken away from traditional specialist service environments, including the use of online and technological delivery mechanisms, and materials that can be used in the home environment.
- Develop and deliver a package of resources that is designed to assist older people with issues around the use of substances, particularly alcohol, as part of a broader support approach that addresses issues such as bereavement, social isolation, safety in the home, and managing the physical symptoms of ageing.
- Engage with key stakeholders with expert knowledge on older people such as Age Cymru and Age Connects, and the Over 50s forums to shape services for older people.

- Ensure that information regarding local service provision, advice on how to access to support and key harm reduction messages is available in a wide range of languages, is culturally appropriate, and widely distributed.
- Ensure that public health messages regarding alcohol use are age appropriate, and reflect the greater harmful effects of alcohol with increasing age.

9. Lead on research and development to enhance the evidence base on which services operate, and encourage innovation in how services are designed and delivered, with service users at the centre of that design process.

Synopsis:

The substance misuse evidence base is continually evolving. Recent trends include the rapid rise in the use of New Psychoactive Substances (NPS), increased awareness regarding the extent to which prescribed medications are being misused, and the emergence of new therapies such as Nalmafene for non-dependent alcohol users and new psychological therapies that are proving to enable lasting behavioural change.

Activity to date:

The APB has supported training and development in response to NPS, and has established a treatment and therapies sub group that considers the emerging evidence base across substance misuse in order to advise the board on how service interventions should develop.

Commissioning actions: we will…

- Enable the treatment and therapies group to lead a strategic response to the misuse of prescribed medications, working with primary care as the key prescribers.
- Explore and recommend the appropriate use of contingency management approaches to support treatment and aftercare programmes.
- Lead the field in creating a system of delivering and monitoring interventions and treatments for substance misuse, so that the most effective yet least resource

intensive, treatment is delivered to patients first; with stepping up to increasingly intensive/specialist services as clinically required in a timely fashion.

- Work with the Universal Service providers to develop and deliver a work programme aimed at the emerging NPS markets, and online purchasing of substances.
- Develop local care pathways and agreed intervention packages for individuals with Alcohol related Brain Damage (ARBD).
- Seek collaboration with the Universities in Cardiff to enhance our work programme, to provide learning opportunities for students, and to support research into the substance misuse field.

10. Respond proactively to the increasing population size of Cardiff and the Vale of Glamorgan

Synopsis:

The local Development Plans (LDPs) of the two local authorities and notably Cardiff include large scale housing developments, with several thousand additional homes planned over the next ten years, with some of the larger developments already well underway.

The APB can ensure that access to services for an increasing population is planned for at an early stage, and work towards equipping some of the generic service provision across the region with the ability to provide low threshold support whilst ensuring that information on access routes into specialist services is widely distributed.

Activity to date:

This is an area that the APB has not focused on to any great extent to date.

Commissioning actions: we will…

- Seek opportunities to include information of wellbeing, health and access to local services in new household information packs.

- Ensure information on local service provision is freely available through the primary care services that are based within, or close to, new housing developments.
- Ensure copies of local service directories, and advice on responding to substance use issues are provided to all Neighbourhood Watch (and similar) schemes.

And our commissioning priorities retained from the previous strategy are as follows:

11. Achieve and sustain the national target for waiting times

Synopsis:

The APB achieved the national target for waiting times in 2014/15 for the first time, but performance significantly dropped in 2015/16. Because the motivation to address substance use can be so fleeting, the APB recognises that having rapid access to treatment and support is a critical function of an effective treatment and support system.

Activity to date:

The APB established EDAS, the open access service and the aftercare services all with the objective of improving access times to services, and increasing service user momentum. Improvements however had proved difficult to sustain.

Commissioning actions: we will…

- Examine and determine the reason for increased waiting times in a climate of significantly lower referral rates.
- As mentioned, we will invest in additional administrative staff in order to free up more time across the clinical and professional workforce.
- Review the evidence and options for commissioning and implementing a rapid access low threshold prescribing service as a precursor to engaging in more intensive

structured treatment, noting that guidelines are that all prescribed treatment regimes are delivered in tandem with psychosocial interventions.

- Work with all services to increase service user momentum from treatment into through-care in order to maximise service capacity.
- Increasing the capacity of specialist substance misuse primary care services and the rate of onward referral from GP shared care into aftercare services.

12. Enhance services such as education, employment and housing that protect the outcomes achieved through substance misuse interventions.

Synopsis:

As described throughout this strategy, ensuring that service user and carer needs are met across a wide range of socio-economic areas is critical to achieving and sustaining successful outcomes from treatment and support services. On a very basic level, and following the prudent healthcare service line of thinking, the resource implications are extremely high when considering the impact that difficulties in housing, education and employment can have on the gains made in substance misuse services.

The APB recognises of course that the capacity of service users to address personal behaviour change will never be entirely lost, but we have to address the fact that the causes of lapse and relapse of wide, are varied and often outside the remit of substance misuse services to directly address.

This is where partnership working is at its most meaningful, and where the impact of the APB working across all organisations at a strategic level can have the greatest impact.

Activity to date:

Dual diagnosis research led by the APB for the national Effective Services for Vulnerable Groups work programme clearly demonstrated that the capacity for service users with multiple needs to effectively navigate a wide range of public services was critical to the success of their healthcare outcomes.

The APB has also been working increasingly closely with the Regional Collaboration Committee for the supporting people programme and is seeking to play an active role in the commissioning of accommodation services for substance misuse.

Commissioning actions: we will…

- Work with the aftercare service to develop and pilot a systems navigation role via our volunteer workforce that assists with wellbeing checks, signposting and advice across a range of socio-economic needs.
- Ensure that the APB is closely involved in the commissioning of substance misuse specific Supporting People accommodation contracts to enable alignment with community based services.
- Work with local authorities and housing service providers to ensure that accommodation needs of those in receipt of treatment and support are addressed effectively.
- Make full use of the Welsh Government commissioned Out Of Work Service (OOWS) in order to ensure that as many employment opportunities as possible are available to those recovering from substance use.
- Update all the APB online resources to incorporate a wide range of links to other services that support a broad range of needs

13. Decrease alcohol related hospital admissions

Synopsis:

The primary means by which this outcome can be achieved is through a wholescale reduction in overall alcohol consumption at a population level. The last 10 years have seen not only rises in alcohol related liver disease, and alcohol related cancers, but also a reduction in the average age at which these conditions are presenting.

As the needs assessment demonstrates, the cost of alcohol to the public sector is substantial, and far in excess of the economic revenue benefits from the alcohol industry. The APB needs to continue working to get clear unambiguous messages widely

communicated regarding the harms associated with excessive alcohol use, and to play its part in securing a cultural shift in the way alcohol is perceived and consumed across the population.

Activity to date:

The Alcohol Treatment Centre (ATC) has had a significant and measurable impact on the impact of alcohol on the Emergency Unit at peak times, as well as on the general safety of the night time economy in Cardiff. The service has evolved so that everyone who attends the centre now receives a follow-up visit or conversation with the Open Access service, with a number of individuals opting to access treatment and support as a result.

The APB has also funded and introduced breathalysers for use by door staff which, whilst not necessarily reducing alcohol consumption, have proven to dissipate potentially aggressive situations with intoxicated individuals attempting to access premises.

Finally, under the last commissioning strategy, the APB added to additional Liaison Nurse to the substance misuse support that is provided across our two district general hospitals.

Commissioning actions: we will…

- Invest in enhancing the Emergency Unit Psychiatric Liaison Team to enable substance misuse to be identified and addressed by all team members, including the completion of EDAS assessments in situ.
- Maintain provision of the Cardiff Alcohol Treatment Centre as a permanent function of the Cardiff Night Time Economy.
- Invest in public awareness and media opportunities to increase the profile of events such as Dry January.

- Work with the local authorities to ensure that the APB is integral to the process of developing the night time economies across Cardiff and the Vale and able to ensure inclusion of methods by which excessive alcohol consumption can be reduced.

14. Secure a decreasing trend in annual rates for drug and alcohol related deaths, and near misses / incidents of overdose.

Synopsis:

Tackling drug related deaths, and reducing the number of fatalities is a key responsibility of the board. It is recognised that very few fatal overdoses are not preceded by at least one non-fatal overdose and so capitalising on these events as an early warning, is an important measure in reducing the number of fatalities.

Activity to date:

The APB has taken on responsibility for reviewing drug related deaths, and ensuring that the findings of those reviews are applied to improve the quality and safety of our services. A working relationship to support this has also been established.

The APB also supports, and oversees the local delivery of the national naloxone scheme, ensuring that as many staff and service users and cares are trained in the use of naloxone in the event of opiate overdose.

Finally the APB is close to securing an information sharing agreement across all organisations, including the health board, police and ambulance services that will enable presumed consent for non-fatal overdoses on the grounds that an overdose represents significant risk of harm to the individual. Once in place, every non-fatal overdose will be followed up with harm reduction information, advice and the offer of treatment and support for those not accessing services, and a renewed focus on harm reduction and avoiding overdose for those in receipt of treatment.

Commissioning actions: we will…

- Increase the number of Naloxone distribution sites across Cardiff and the Vale.
- Ensure that all individuals who experience a non-fatal overdoses and not in treatment are followed up with information on harm reduction, advice, and an offer of access to treatment and support local services.
- Ensure that all individuals who experience a non-fatal overdose and who are in treatment are provided with additional harm reduction advice, and specific guidance on avoiding overdose in the future.
- Incorporate the implementation of all recommendations from local drug related death reviews into the APB contract monitoring system, with a rigorous process of follow-up to ensure that recommendations have been implemented.

15. Ensure the capacity of services to respond to the needs of individuals with protected characteristics

Synopsis:

Ensuring that our services reflect Protected Characteristics as defined in the equalities act, means that our commissioned services do not discriminate against, or inadvertently deter individuals, as a result of any of the nine following characteristics:

- Age
- Gender
- Race
- Gender reassignment
- Sexual orientation
- Same sex marriages / civil partnerships
- Religion and belief
- Disability
- Pregnancy and maternity

Activity to date:

Adhering to a requirement not to discriminate on the basis of any of these characteristics is a fundamental requirement of all commissioned services. As well as protected characteristics, the APB has also given particular consideration to certain vulnerable groups for whom substance use presents a particular risk. These include those who are homeless or roofless with links now in place between open access and homelessness services, and sex workers, where criminal justice treatment services have provided much needed rapid access to treatment and support. Other groups that require specific support include victims and perpetrators of domestic violence and abuse and looked-after children.

Commissioning actions: we will

- Ensure that vulnerability and protected characteristics are given he necessary weighting in priority during the assessment process.
- Ensure that treatment and support approaches are designed to respond to the specific needs of individuals with one or more protected characteristics, and require services to demonstrate through case studies how these specific needs are being met.
- Work towards increasing the representation of service users with protected characteristics engaged with our service user and carer involvement programmes.
- Identify and deliver substance misuse development and training for staff working in organisations and services specifically aimed at meeting the needs of protected characteristic groups.

ENABLING DELIVERY

INVOLVING SERVICES USERS, CARERS AND SIGNIFICANT CONCERNED OTHERS (CSOs)

Service user involvement has increased in frequency, structure and effectiveness under the first strategy. However, it has been recognised that a more structured and tiered approach to user involvement will offer a clearer path of engagement for those wanting to contribute to how services are commissioned and managed.

In response, the APB will establish a tiered Bronze, Silver and Gold set of training and development standards for service users that will increase their knowledge and skills in supporting the APB work programme, and that will facilitate greater involvement in activity such as financial decision making, and commissioning decisions.

Areas of development within these standards will include:

- Understanding the public sector, including the organisations, structures and partnerships across substance misuse.
- The chance to attend and observe a range of meetings and discussions to contextualise learning from the programme in practice.
- Understanding public sector finance, and the processes of objective financial decision making.
- Funded access to other relevant training to develop knowledge and abilities on subjects such as presentation, communication, negotiation and assertiveness.

The Bronze standard will be agreed and implemented by summer 2016, with service users achieving this standard being involved in developing and designing the silver standard, and then again those achieving that next level involved in developing the gold standard. All three levels will be operational by March 2017.

STRUCTURES AND GOVERNANCE

APB, Strategic Partnerships, and supporting structures

Annex 6 provides the agreed APB partnership structures, governance and operating arrangements for Cardiff and the Vale. In principle, the APB is responsible for decision making a strategic level on all substance misuse related business and the APB Commissioning and Finance Group is responsible for implementing the decisions of the Board.

Therefore, the Commissioning and Finance Group will have responsibility for the implementation of this strategy and has a lead on all substance misuse commissioning, performance and delivery.

The day-to-day delivery of the work programmes continues to sit with the APB Support Team. However, over the last few years it has become increasingly apparent that achieving successful outcomes in substance misuse can be largely dependent on the impact of other public service work programmes. Therefore, under this strategic approach, it is proposed the APB support tem will evolve into a substance misuse and wellbeing support team. This will provide a mandate that will enable team members to engage in wider work programmes that focus on poverty, social exclusion, tackling deprivation, and addressing many of the underlying causes that can lead to substance use alongside a range of other harmful behaviours.

Outcomes based commissioning

The APB will adopt an outcomes based commissioning policy for all future commissioning activity that will move away from specifying services, to stating the key outcomes that must be achieved through proposed service solutions.

All future service design, redesign and commissioning activity will follow the following format of requirements:

1. Proposed models of service must demonstrate how a set of primary outcomes for the service (agreed jointly by the APB and service users, carer and staff representatives) will be achieved and measured.
2. Proposed models of service should also include evidence on how a range of appropriate secondary outcomes will also be achieved and measured.
3. Proposed models of service must adhere to all legislation, policy and guidance relevant to the field.
4. Proposed models of service must be jointly designed and presented with representative users of the service.

Evidence based practice

Evidence based practice will underpin the specifications for all commissioned services. This will extend not only to services that are provided being consistent with best practice, but also ensuring a high degree of fidelity with evidence based models of service delivery for example in instances where a particular approach, or service, is proven to be effective only when combined with other services, such as the provision of detoxification with appropriate aftercare in place. The APB will develop a programme of evidence review and provider support in order to help services consider, and where appropriate increase, their level of adherence to the evidence base.

Governance and quality assurance

A range of needs around Governance, quality assurance and audit have been identified through the assessment of need and the service review. Minimum standards can be found for governance within the national core standards for substance misuse, which will be imbedded into all commissioning activity. The APB annually selects a number of the

national quality standards and all commissioned services submit comprehensive evidence in order to demonstrate compliance.

In addition, the APB will develop and implement of rolling programme of service audits that will be used as learning and development opportunities in order to identify areas of best practice and areas for improvement.

Finally, the APB established risk management processes under the last strategy and maintains an ongoing risk register which is reviewed at each board meeting. Under this new strategy, the board will also establish an information asset register, to ensure compliance with information governance and data protection legislation

Finance and Audit

At a time of austerity in public services, financial scrutiny and audit are more important than ever. The APB regularly secures cost savings each year as a result of the level of scrutiny applied to finance. Under the last strategy, APB member agencies agreed a financial risk sharing agreement, which follows an assumption of which agencies would be the responsible authorities for any one service it was mainstream, rather than grant funded.

However, the management of unanticipated slippage for budgets in year remains rather ad hoc and less strategic than should be the case. Therefore, the APB will seek to implement a planning and resource management system by March 2017 that provides a robust and more strategic approach to how unspent resources are allocated within any particular year. At the very least, this will include a commitment in each annual expenditure plan for the priority areas of service that will have additional resources targeted toward them, should they become available.

PERFORMANCE MANAGEMENT

Operational Performance Management Framework

The APB Commissioning and Finance Group maintain responsibility for operational performance management against commissioned substance misuse service contracts. The APB support team undertake quarterly contract monitoring forums that provide all services the opportunity to account for service delivery, performance and financial expenditure for the preceding quarter.

The national key performance indicators are imbedded into the contracts for all commissioned services and the APB is close to agreeing results based accountability (RBA) frameworks with all services, with only a small number outstanding for agreement. These final RBA frameworks will be agreed by the board by March 2017.

A significant work programme under the previous strategy has been to bring third sector commissioned services onto the PARIS information platform that the NHS addiction services use locally. The Open Access service is now operational on PARIS with the Aftercare service due to become operational by summer 2016. This represents a significant improvement in patient information flows, with all services being able to see the service user journey through the treatment system as a single record, rather than having multiple information sets on any one individual.

As part of the delivery of this commissioning strategy, the APB will seek to align the new criminal justice services contract with the single information system to improve seamlessness of provision.

Finally, as well as sustaining quarterly contract monitoring forums, the APB will undertake an annual service review with all commissioned providers, in order to undertake a more in-depth analysis of performance and delivery on a one-to-one basis.

Strategic Performance Management Framework

In addition to the comprehensive operational performance management framework, that enables the APB Commissioning and Finance Group to assess performance across the entire substance misuse programme, the Board itself requires a strategic performance framework that routinely considers performance against a selection of strategic or key indicators in order to gain an overall indication of the direction of travel. These strategic performance outcomes and indicators are suggested as follows:

Public Health and Communities:

- *Age, gender and ethnicity of individuals referred to services*
- *Alcohol related hospital admissions*
- *Drug related deaths*

Adult Treatment and Support (National KPIs)

- *Waiting Times*
- *DNA rates*
- *Planned closures*
- *TOP outcomes*

Children and Young People

- *Number of children and young people on the children and need or the children at risk registers due to parental substance use*

Criminal Justice

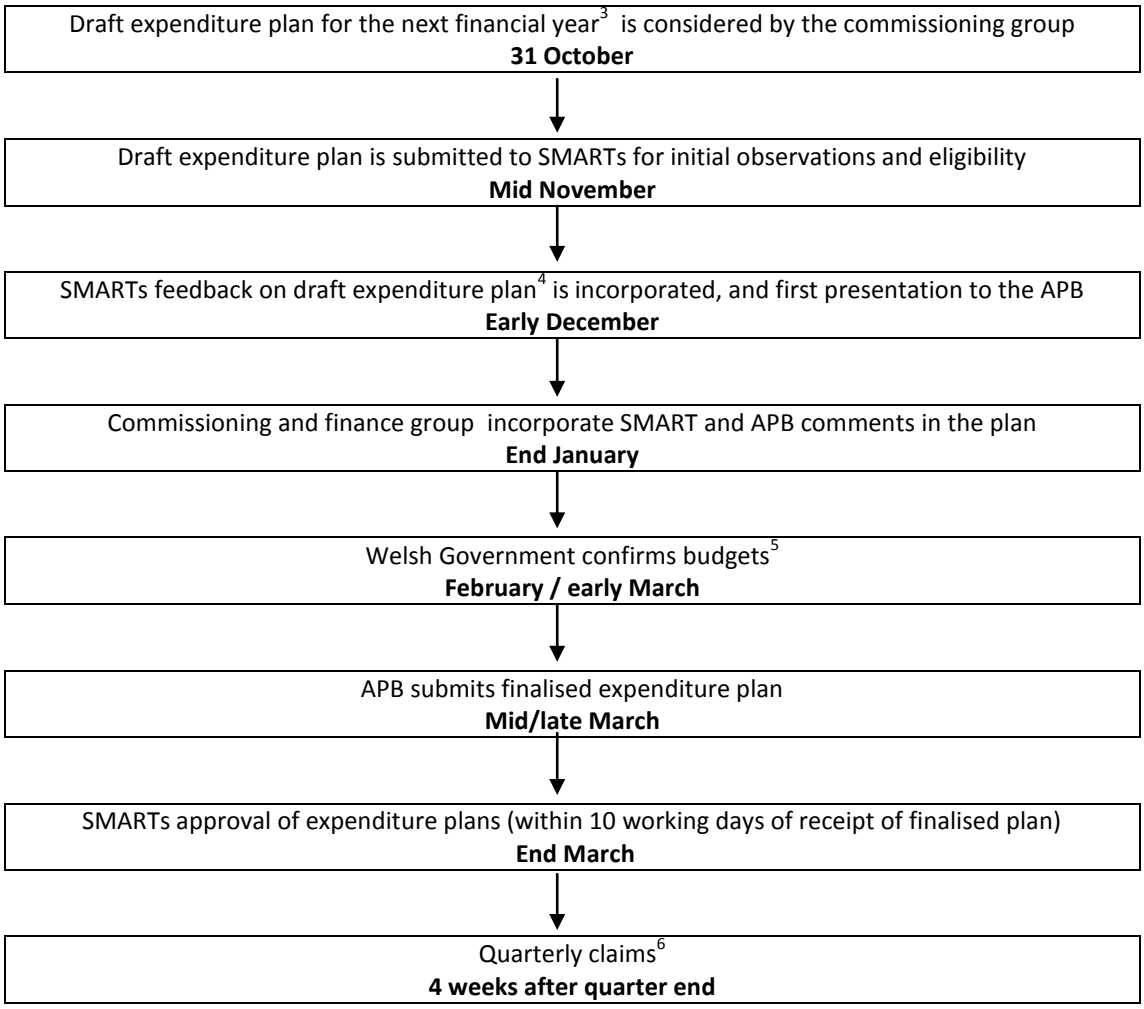
- *Re-offending rates for individuals in receipt of IOIS / IOM substance misuse treatment and support*
- *Level of violent crime within the night time economy*

The APB will publish performance data against each of these indicators in the annual report from 2016/17 onwards.

ANNUAL PLANNING CYCLE

Annual implementation planning and delivery

Welsh Government maintains the following planning cycle for SMAF grant funding which is adhered to each year by the APB. The key actions and dates for the annual commissioning and planning cycle are as follows:



[3] Draft expenditure plan will need to be drawn up against indicative budgets against the backdrop of an outcome based commissioning strategy. Plans should be prioritised so if there is an increase / decrease in budgets that these can be incorporated into plans at a later date if required

[4] SMART feedback at this stage will not give official approval to the expenditure plans but highlight areas where further information is required.

[5] This gives an indicative timescale to when we could expect Welsh Government approval of final SMAF allocations but is subject to change

[6] To note that for quarters 1 to 3 this is the final deadline and claims can be received earlier (following the quarter end) if the banker / APB support has ensured that all the relevant information is uploaded to the Online Funding Tool. In respect to quarter 4, central finance team in the substance misuse branch will give an **absolute deadline** for claims towards the end of the financial year. The date each year will be notified via the SMARTs mechanism

Annual APB Business Planning Cycle

Coupled with the expenditure planning cycle, the APB will undertake a number of routine actions each year that will enable ongoing gap analysis, assessment of need, and contract review. The review of performance for commissioned services is outlined in the performance management framework; however the following table outlines key events in the APBs annual business processes:

Task	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Issue annual confirmation of funding for existing contracts with terms and conditions												
APB Strategic performance review												
Delivery Group operational performance review												
Contract monitoring forum												
Contracted services annual reviews*												
Spend plan and Commissioning implementation plan consultation*												
Publication of new year's spend plan and implementation plan												
Publication of APB Chairs Annual Report												
APB Annual Stakeholder Conference*												

*Includes Service User, Carer, and CSO Involvement

ANNEX 1 – 2015 Comprehensive Needs Assessment

Substance Misuse Needs Assessment

Version: Final

Author: Christopher Jones

Contact: Chris.Jones6@wales.nhs.uk

Tel: 02920 336 234

Contents

- Skills Timing Intensity Relationships (STIR Project)
- Salvation Army Bridge Programme
- Clinical Treatment and Therapeutic Support
- Universal Services (Switched on, Volocity, Workforce Development)
- Up2U
- Family Support Services
- YPDAS

7. Care Pathways

- Analysis

8. Alcohol Treatment Centre

- Overview
- Attendances by Local Authority Area
- Age and Gender

9. Needle Exchange Programme

- Activity
- Naloxone Distribution and Replenishment

10. Alcohol Related Brian Damage

- Overview

11. Tier 4 Residential Rehabilitation

- Placements

12. Therapeutic Treatments

1. Introduction

This strategic health needs assessment has been produced on behalf of Cardiff and Vale Area Planning Board with a view to informing the refresh of the APB Substance Misuse Commissioning Strategy 2013-18.

2. Background

The Institute for Public Care (IPC) identifies four key stages in producing an effective commissioning plan (as depicted in the diagram below).

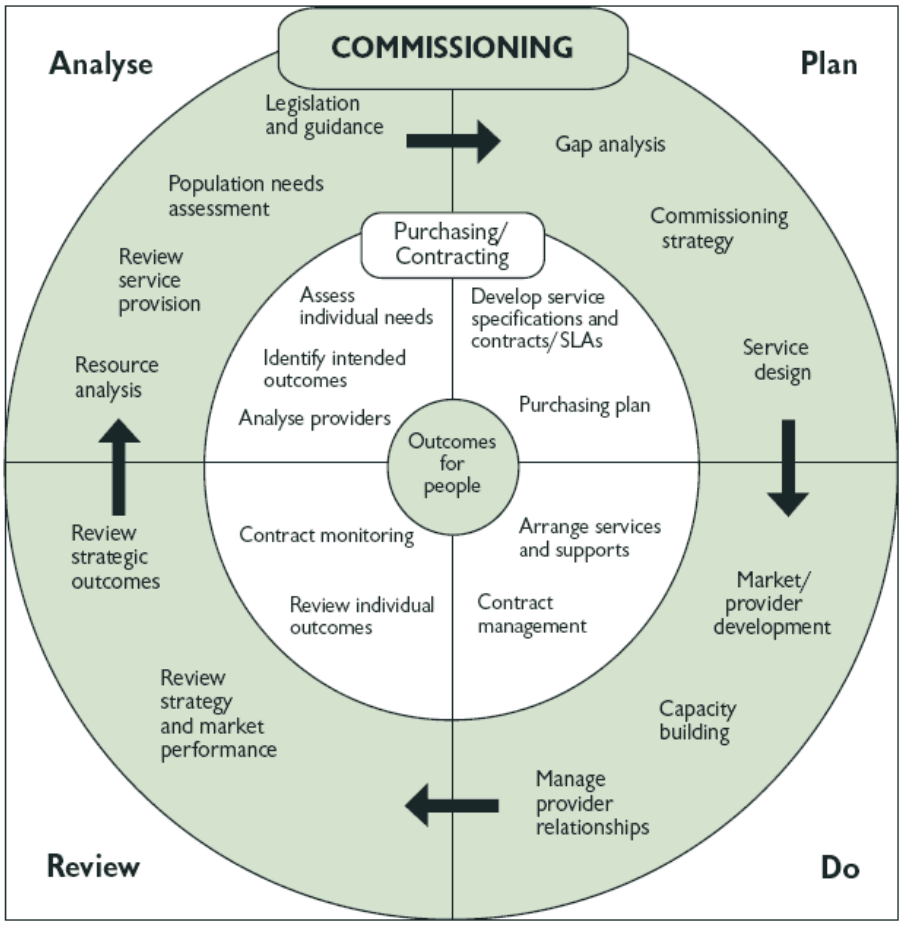


Figure 1: IPC Four Stage Model of Commissioning

For the purposes of this document, focus will centre within the 'Analyses' segment to critically appraise the following broad topic areas:

- Population Needs Assessment
- Review Service Provision
- Analyse Providers
- Resources analyses
- Assess individual needs
- Identify intended outcomes
- Legislation and guidance

In addition to these, consideration will also be given to other environmental factors such as healthcare inequalities and deprivation in exploring the widely publicised links to substance misuse.

3. Methodology

To enable an in-depth analyses which is balanced and well represented, quantitative data has been collected from a variety of sources including the Welsh National Database for Substance Misuse (WNDSM), PARIS healthcare system, NEO database, Census 2011, Welsh Index of Multiple Deprivation (WIMD) and the Public Health Wales Observatory.

Cardiff and Vale APB considers the views of young people, adult service users and carers as fundamental in critically appraising whether commissioned services are delivering quality outcomes for the local population. As such extensive consultation has been undertaken with these groups to identify any gaps in service provision through the use of forums and qualitative questionnaires.

4. Demographic Profile of Cardiff and Vale of Glamorgan

Understanding population change is imperative when forecasting future demands on healthcare services.

According to the latest mid-year estimates, there are currently 354,294 people living in Cardiff and 127,685 people inhabiting the Vale of Glamorgan (ons.gov.uk).

Of the total population in Cardiff, 174,278 are believed to be male and 180,016 female. A similar gender split can be seen in the Vale of Glamorgan where 62,070 are believed to be male and 65,615 female. However there is a stark contrast in age profile of people living in these areas.

Figure 1.1 overleaf, depicts the largest proportion of males **and** females living in Cardiff are aged between 20-24 years. However in the Vale the vast majority of males are aged 50-54 and females 45-49 years. There are two key factors which could explain such a disparity:

1. As recipient of best ‘UK city for quality of life 2015’, Cardiff is fast gaining a reputation as an upcoming area. As such the number of young professionals inhabiting and working in the city is continuing to increase.

2. Cardiff has a large university campus and student accommodation which is situated at multiple sites across the city. The student population is estimated to account for 10% of all residents living in the capital.

Population Count by Age and Gender

Percentage of population by age and sex, Cardiff & Vale UHB and Wales, 2014

	Cardiff & Vale UHB		Wales	
Age group	% Males	% Females	% Males	% Females
00-04	3.2	3.0	2.9	2.8
05-09	3.0	2.9	2.9	2.8
10-14	2.7	2.5	2.7	2.6
15-19	3.2	3.3	3.1	3.0
20-24	4.9	5.1	3.6	3.4
25-29	4.0	3.7	3.2	3.1
30-34	3.6	3.5	2.9	2.9
35-39	3.1	3.1	2.7	2.7
40-44	3.1	3.1	3.1	3.2
45-49	3.1	3.3	3.4	3.6
50-54	3.1	3.3	3.4	3.6
55-59	2.7	2.9	3.0	3.2
60-64	2.5	2.6	3.0	3.1
65-69	2.3	2.4	3.1	3.2
70-74	1.6	1.9	2.3	2.4
75-79	1.3	1.6	1.7	2.0
80-84	0.9	1.3	1.1	1.5
85-89	0.5	0.9	0.6	1.0
90+	0.2	0.6	0.3	0.7

Produced by Public Health Wales Observatory, using Mid-year Population Estimates (ONS)

Count of population by age and sex, Cardiff & Vale UHB and Wales, 2014

	Cardiff & Vale UHB		Wales	
Age group	Males	Females	Males	Females
00-04	15,628	14,616	91,079	86,596
05-09	14,324	14,121	90,296	86,028
10-14	12,809	12,126	84,933	80,158
15-19	15,587	15,777	97,095	91,352
20-24	23,743	24,511	112,027	105,551
25-29	19,225	17,848	97,544	94,557
30-34	17,486	16,851	90,870	91,202
35-39	14,972	14,871	83,293	84,454
40-44	15,027	15,103	96,215	100,341
45-49	14,987	15,975	106,600	111,213
50-54	14,973	15,891	105,862	109,796
55-59	13,216	13,746	94,304	98,390
60-64	11,887	12,344	91,683	95,850
65-69	10,894	11,715	94,316	98,517
70-74	7,771	8,944	70,022	75,593
75-79	6,070	7,869	53,177	61,432
80-84	4,334	6,260	35,321	47,503
85-89	2,355	4,215	18,707	31,334
90+	1,060	2,848	7,971	20,854

Produced by Public Health Wales Observatory, using Mid-year Population Estimates (ONS)

Source: ons.gov.uk, 2015

According to recent figures, the life expectancy of men living in the Vale of Glamorgan has increased from 74 to 79 years and for females 79 to 83 years. In contrast in Cardiff the life expectancy is slightly lower; males are expected to live approximately 78 years (formerly 73) whereas female life expectancy is now 78 years.

Referral Activity to Substance Misuse Services by Gender & Age

The Welsh National Database for Substance Misuse (WNDSM) reveals a slight increase (1.1%) in the combined number of young people aged 0-17 years referred to a substance misuse service between 2013/14 and 2014/15.

Whilst referral data provides a somewhat useful indication of prevalence activity, there were considerable changes to the technical architecture of the WNDSM in 2014 which means this data should not be considered in isolation.

Figure 1.3: Clients Referred by Age and Gender (Source: WNDSM)

Gender	Age	11-12		12-13		13-14		14-15	
		#	%	#	%	#	%	#	%
Male	0 - 17	85	1.72%	86	1.72%	120	2.25%	136	3.01%
	18 - 24	412	8.37%	369	7.42%	336	6.29%	270	5.97%
	25 - 39	1650	33.5%	1693	34.01%	1595	29.80%	1316	29.07%
	40 - 59	1102	22.37%	1201	24.12%	1417	26.50%	1245	27.51%
	60 - 79	106	2.15%	102	2.05%	149	2.79%	124	2.74%
	80 +	4	0.8%	5	0.10%	1	0.01%	1	0.02%
Total		**3359**	**68.19%**	**3456**	**69.42%**	**3618**	**67.64%**	**3092**	**68.32%**
Female	0 - 17	76	1.54%	51	1.02%	69	1.29%	74	1.63%
	18 - 24	205	4.16%	218	4.38%	152	2.84%	146	3.22%
	25 - 39	675	13.7%	626	12.58%	807	15.10%	620	13.70%
	40 - 59	552	11.2%	569	11.43%	632	11.80%	519	11.50%
	60 - 79	52	1.05%	56	1.12%	63	1.20%	72	1.60%
	80 +	5	0.10%	1	0.02%	3	0.05%	3	0.06%
Total		**1565**	**31.75%**	**1521**	**30.55%**	**1726**	**32.28%**	**1434**	**31.71%**

A continuing upward trend in young people aged 0-17 could potentially indicate the need for increased targeted prevention education within schools and youth settings with a view to alleviating rising numbers of young people referred to more structured tiered services later on. Kandel et al, (1997) suggest ‘adolescents who drink or use drugs have a more rapid progression from casual use to dependence, longer substance use careers, and a greater number of co-occurring psychiatric problems’.

According to Welsh Government’s population projections, ‘the number of children aged 0-15 (living in the Vale of Glamorgan) will peak at approximately 25,850 in 2023 before reducing to 21,893 in 2036 (valeofglamorgan.gov.uk).

Interestingly despite the population census suggesting a greater number of females are dwelling in Cardiff and the Vale of Glamorgan, the number of males referred to substance misuse services is consistently higher.

In 2014 Alcohol Concern identified a growing trend in the number of older people drinking alcohol in excess of recommended unit guidelines. As a result the APB commissioned the Wallich to conduct a comprehensive needs analysis via quantitative and qualitative feedback mechanisms with older people living in Cardiff and the Vale of Glamorgan.

Using a series of surveys and focus groups, data was sought in the following key areas:

- To gauge the number of older people consuming harmful or problematic amounts of alcohol
- To distinguish between numbers currently accessing services to those who are not
- To consult with healthcare professionals and practitioners to discover what they believe should be done to support the needs of this cohort of people and their families, e.g. educational awareness.

The report found approximately 16,902 older people are regularly consuming alcohol in excess of unit guidelines, to which there is a clear need for targeted information and awareness of services available. Of the total respondents who participated in the study, a large proportion were not engaged in any services seemingly due to embarrassment, denial or a lack of knowledge of where to get advice and support. Cultural norms also accounted for relaxed attitudes towards daily alcohol intake. As a result the following recommendations were suggested:

- Improve communication and service pathways
- Look to commissioning additional screening, interventions and specialist aftercare services
- Ongoing learning and development for staff to be flexible in response to older people's needs.
- Wider public health campaigns delivering targeted information to challenge traditional attitudes and existing cultures which trivialises drinking of alcohol.

Public Health Wales has been instrumental in delivering and promoting the use of Alcohol Brief Intervention (ABI) training to staff from statutory and third sector organisations. Since its launch in 2011, the national campaign has been widely

publicised and gained significant momentum with over 1722 professionals in receipt of training.

Screening tools such as ABI and the Alcohol Use Disorders Identification Test (AUDIT) are proven effective in determining the appropriate level of intervention required to minimise harm. For some people a brief alcohol intervention to flag up personal consumption versus unit guidelines is all that is needed, however for other people for which alcohol is more a dependency and entrenched in routine behaviour, a referral to a specialist substance misuse service could be a lifeline.

Generally speaking there are two cohorts of older people who misuse substances; those who begin misusing during adolescence and those who due to adverse changes in life events e.g. loss of partners, retirement or loneliness misuse later on. The Royal College of Psychiatrists, suggest the most effective way of identifying and engaging with these people is to target the places the older population frequent regularly e.g. primary care (A&E departments, GP practices and mental health services). Where possible; screening tools and assessments conducted in the home by a concerned significant other (CSO) are perceived to be more effective in gauging the complexity of substance use. “Research shows unpaid carers (family, friends and neighbours) provide around 70% of care in the community” (Public Health Wales Observatory, 2014).

According to a recent publication by ‘the adult population aged over 50 years are more susceptible to greater harm caused by lower level use of substances than young people’. Furthermore ‘acute alcohol withdrawal syndrome is more protracted and severe in older people than in younger people with drinking problems of equal severity’ (Welsh Government, 2014). As such it is considered safer and more effective to manage withdrawal in older people on a largely inpatient basis. The framework also advocates more can be done by APB’s in the context of service planning substance misuse provisions for older a people, particularly as life expectancy continues to rise.

‘In 2012/13 a total of 3783 people aged 50+ were referred for substance misuse treatment in Wales; of which 3266 of referrals were alcohol related’ (Welsh Government, 2014).

The Journal of Abnormal Psychology advocates ‘men are more likely than women to develop problematic use of alcohol whilst women are increasingly prone to misuse prescription medication such as sedatives, hypnotic and anxiolytic medication’ to treat anxiety (drugfree.org). Recommendations from the research which sampled over 43,000 adults concluded the need for gender specific prevention and treatment efforts’.

Primary Substance by Referral

Data extracted from the Welsh National Database of Substance Misuse (WNDSM) reveals primary substances in rank order of prevalence in Cardiff and Vale.

The following tables and graphs (overleaf) highlighted the 3 most popular substances have remained unchanged since 2008:

- Alcohol
- Heroin
- Cannabis

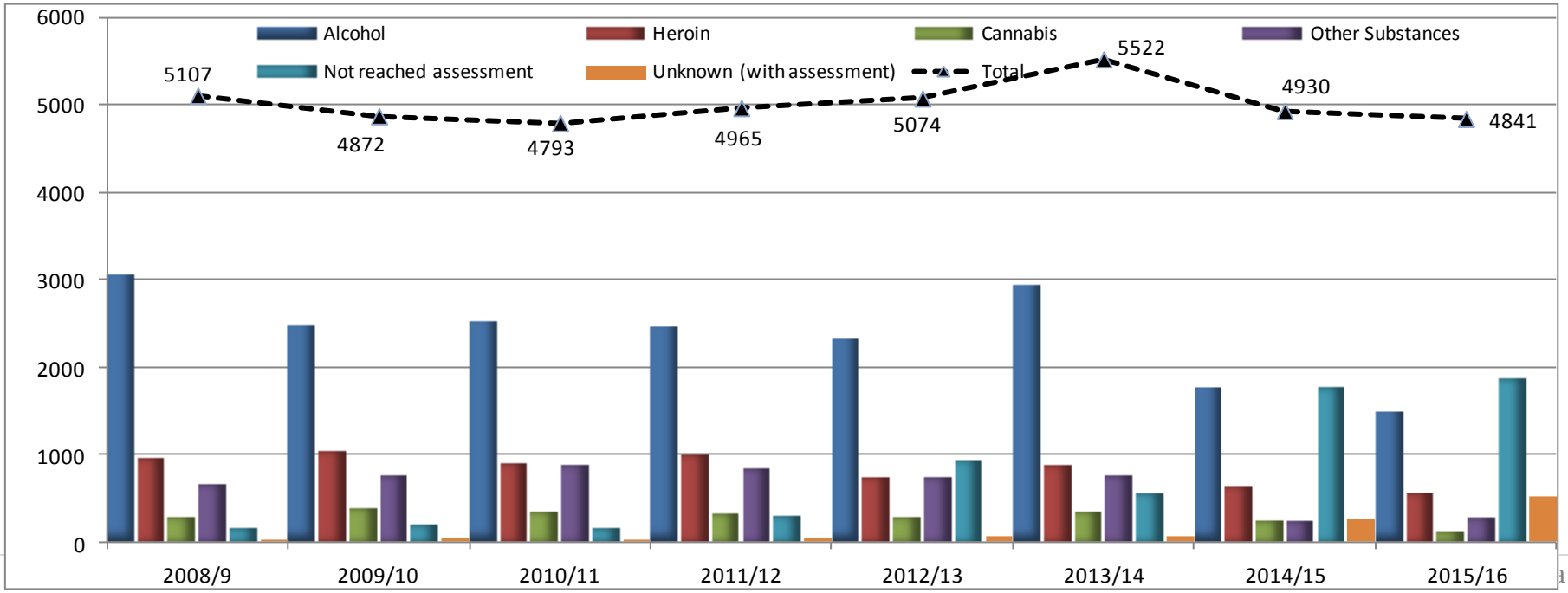
Whilst primary substance by referral is a useful indicator, there were a series of significant changes to the technical architecture of the national database which altered the way primary substances were recorded at the point of referral. As such I have included a broader data capture of referral activity spanning 2008 – 2015/16 to signify the impact of these changes over a greater period.

Please also note the introduction of the EDAS service in 2014/15 which is also likely to have influenced additional exception in the way data was recorded. Please bear in mind these caveats when drawing any conclusions from the data.
Sourcing additional information such as assessment data can be useful to:

1. To offset data quality issues.
2. To consider the possibility of inappropriate referrals (self or healthcare professionals lack of understanding and/or awareness of service provision eligibility).

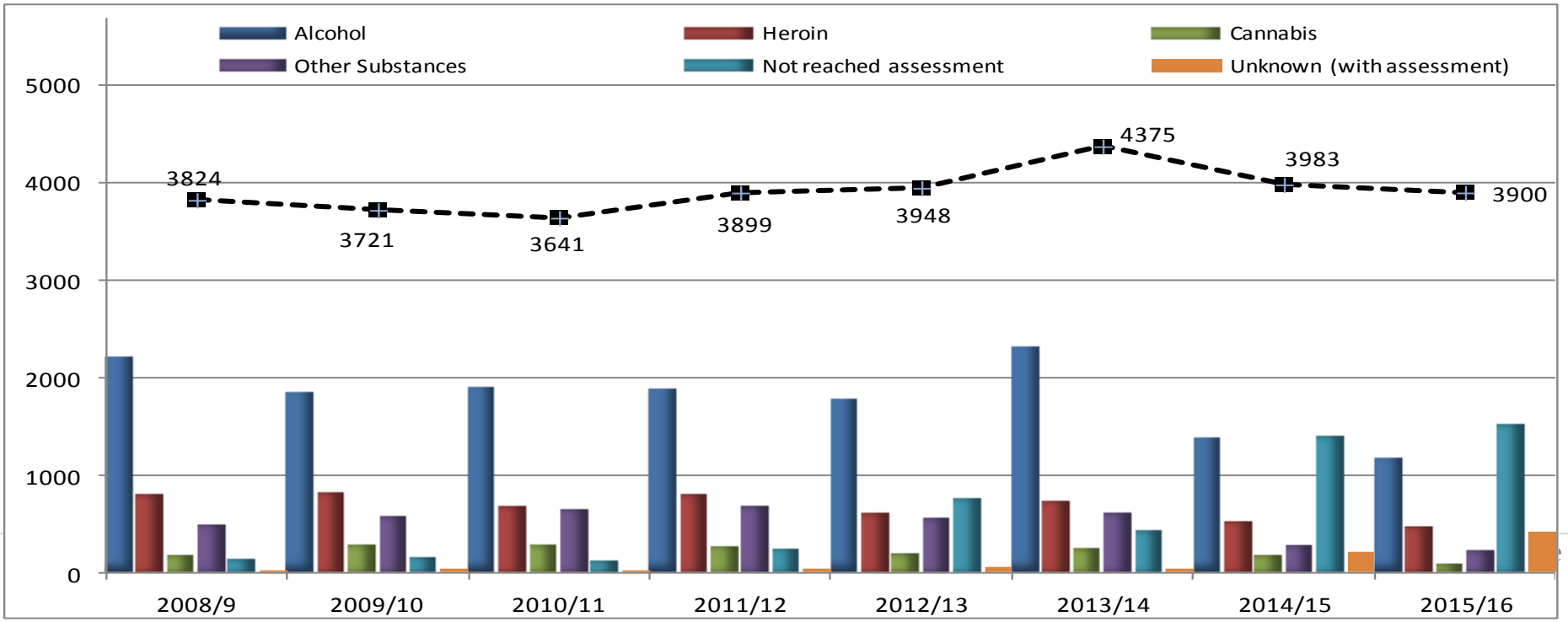
Referrals by Primary Substance – Cardiff and Vale Combined

2008/9		2009/10		2010/11		2011/12		2012/13		2013/14		2014/15		2015/16	
Alcohol	**3048**	Alcohol	**2470**	Alcohol	**2513**	Alcohol	**2465**	Alcohol	**2322**	Alcohol	**2933**	Alcohol	**1773**	Alcohol	**1486**
Heroin	**962**	Heroin	**1022**	Heroin	**900**	Heroin	**998**	Heroin	**730**	Heroin	**878**	Heroin	**639**	Heroin	**563**
Cannabis	**278**	Cannabis	**388**	Cannabis	**339**	Cannabis	**323**	Cannabis	**277**	Cannabis	**343**	Cannabis	**245**	Cannabis	**130**
Other substances	**658**	Other substances	**748**	Other substances	**867**	Other substances	**837**	Other substances	**742**	Other substances	**760**	Other substances	**249**	Other substances	**283**
Not Reached Assessment Yet	**155**	Not Reached Assessment Yet	**209**	Not Reached Assessment Yet	**154**	Not Reached Assessment Yet	**305**	Not Reached Assessment Yet	**936**	Not Reached Assessment Yet	**549**	Not Reached Assessment Yet	**1769**	Not Reached Assessment Yet	**1865**
Unknown (with assessment)	**6**	Unknown (with assessment)	**35**	Unknown (with assessment)	**20**	Unknown (with assessment)	**37**	Unknown (with assessment)	**67**	Unknown (with assessment)	**59**	Unknown (with assessment)	**255**	Unknown (with assessment)	**514**
Total	**5107**	**Total**	**4872**	**Total**	**4793**	**Total**	**4965**	**Total**	**5074**	**Total**	**5522**	**Total**	**4930**	**Total**	**4841**



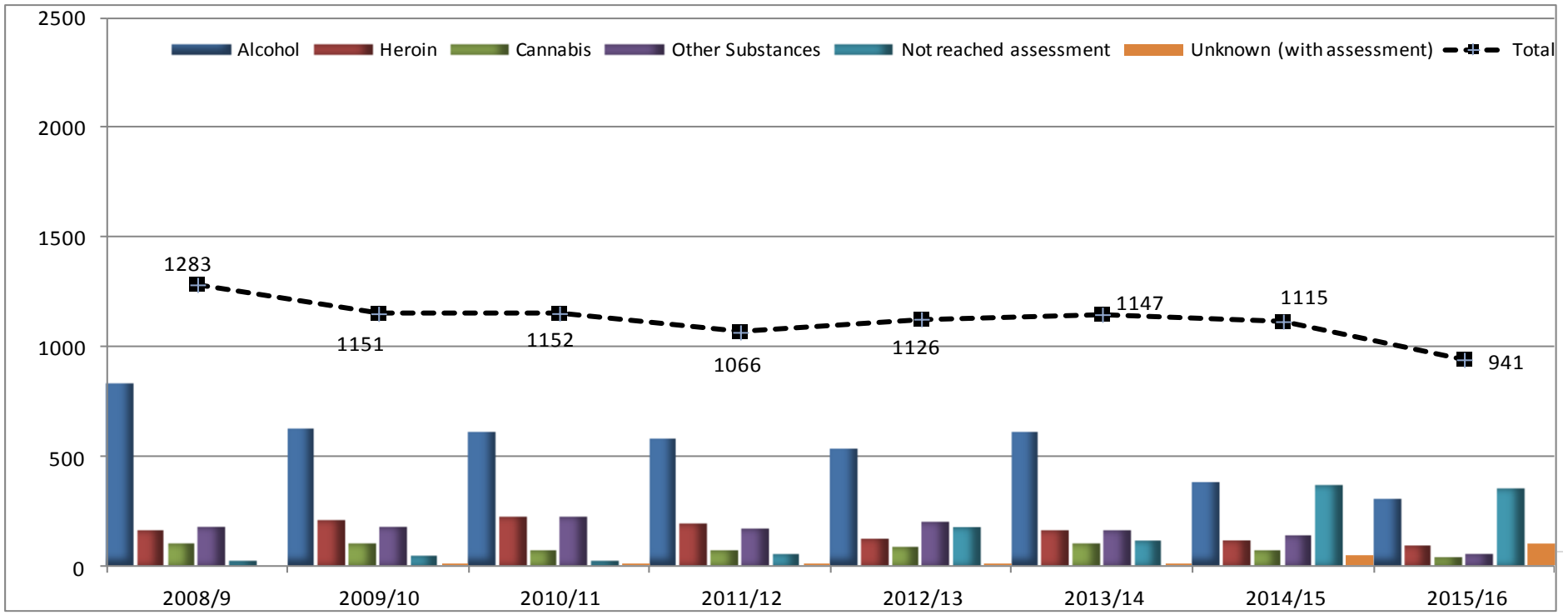
Referrals by Primary Substance – Cardiff

2008/9		2009/10		2010/11		2011/12		2012/13		2013/14		2014/15		2015/16	
Alcohol	**2217**	Alcohol	**1848**	Alcohol	**1902**	Alcohol	**1885**	Alcohol	**1787**	Alcohol	**2324**	Alcohol	**1392**	Alcohol	**1178**
Heroin	**804**	Heroin	**818**	Heroin	**682**	Heroin	**804**	Heroin	**606**	Heroin	**721**	Heroin	**523**	Heroin	**473**
Cannabis	**182**	Cannabis	**286**	Cannabis	**271**	Cannabis	**256**	Cannabis	**190**	Cannabis	**245**	Cannabis	**177**	Cannabis	**88**
Other substances	**481**	Other substances	**570**	Other substances	**642**	Other substances	**670**	Other substances	**547**	Other substances	**603**	Other substances	**282**	Other substances	**232**
Not Reached Assessment Yet	**134**	Not Reached Assessment Yet	**166**	Not Reached Assessment Yet	**127**	Not Reached Assessment Yet	**252**	Not Reached Assessment Yet	**764**	Not Reached Assessment Yet	**435**	Not Reached Assessment Yet	**1404**	Not Reached Assessment Yet	**1513**
Unknown (with assessment)	**6**	Unknown (with assessment)	**33**	Unknown (with assessment)	**17**	Unknown (with assessment)	**32**	Unknown (with assessment)	**54**	Unknown (with assessment)	**47**	Unknown (with assessment)	**205**	Unknown (with assessment)	**416**
Total	**3824**	**Total**	**3721**	**Total**	**3641**	**Total**	**3899**	**Total**	**3948**	**Total**	**4375**	**Total**	**3983**	**Total**	**3900**



Referrals by Primary Substance – Vale of Glamorgan

2008/9		2009/10		2010/11		2011/12		2012/13		2013/14		2014/15		2015/16	
Alcohol	**831**	Alcohol	**622**	Alcohol	**611**	Alcohol	**580**	Alcohol	**535**	Alcohol	**609**	Alcohol	**381**	Alcohol	**308**
Heroin	**158**	Heroin	**204**	Heroin	**218**	Heroin	**194**	Heroin	**124**	Heroin	**157**	Heroin	**116**	Heroin	**90**
Cannabis	**96**	Cannabis	**102**	Cannabis	**68**	Cannabis	**67**	Cannabis	**87**	Cannabis	**98**	Cannabis	**68**	Cannabis	**42**
Other substances	**177**	Other substances	**178**	Other substances	**225**	Other substances	**167**	Other substances	**195**	Other substances	**157**	Other substances	**135**	Other substances	**51**
Not Reached Assessment Yet	**21**	Not Reached Assessment Yet	**43**	Not Reached Assessment Yet	**27**	Not Reached Assessment Yet	**53**	Not Reached Assessment Yet	**172**	Not Reached Assessment Yet	**114**	Not Reached Assessment Yet	**365**	Not Reached Assessment Yet	**352**
Unknown (with assessment)	**0**	Unknown (with assessment)	**2**	Unknown (with assessment)	**3**	Unknown (with assessment)	**5**	Unknown (with assessment)	**13**	Unknown (with assessment)	**12**	Unknown (with assessment)	**50**	Unknown (with assessment)	**98**
Total	**1283**	**Total**	**1151**	**Total**	**1152**	**Total**	**1066**	**Total**	**1126**	**Total**	**1147**	**Total**	**1115**	**Total**	**941**



Assessment Activity

The following table depicts the number of assessments carried out by substance misuse services between 2011-2015.

Gender	Age	14-15		13-15		12 - 13		11 - 12	
		#	%	#	%	#	%	#	%
Male	0 – 17	112	3.86	88	2.78%	55	1.85%	60	2.02%
	18 - 24	164	5.65	206	6.51%	239	8.07%	279	9.47%
	25 - 39	828	28.5	886	28.00%	1062	35.86%	995	33.77%
	40 - 59	802	27.6	870	27.50%	697	23.53%	637	21.62%
	60 - 79	78	2.69	75	2.37%	58	1.96%	57	1.94%
	80 +	0	0	0	0.00%	1	0.03%	1	0.03%
Total		**1984**	**68.3%**	**2125**	**67.16%**	**2112**	**71.3%**	**2029**	**68.85%**

Female	0 – 17	46	1.59%	51	1.61%	33	1.11%	62	2.1%
	18 -24	86	2.96%	83	2.62%	109	3.68%	121	4.11%
	25 - 39	402	13.80%	464	14.68%	368	12.42%	403	13.68%
	40 - 59	335	11.54%	396	12.50%	309	10.43%	295	10.01%
	60 - 79	50	1.72%	40	1.27%	30	1.01%	33	1.12%
	80 +	1	0.03%	3	0.09%	0	0.00%	2	0.07
Total		**920**	**31.7%**	**1037**	**32.77%**	**849**	**28.65%**	**916**	**31.09%**

2904 *Assessments carried out by substance misuse services in 2014-15*

8% *Decrease in comparison to the number of assessments carried out in 2013-14*

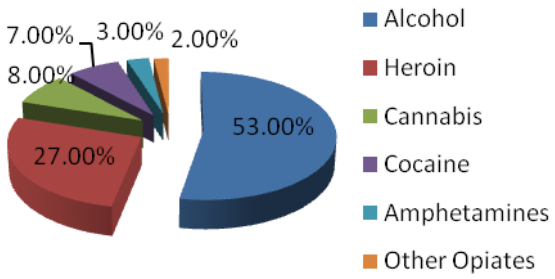
68% *of people who received a substance misuse assessments during 2014-15 were male*

1% *increase in the number of older people aged 60-80 receiving an assessment for drug and alcohol issues between 13/14 and 14/15*

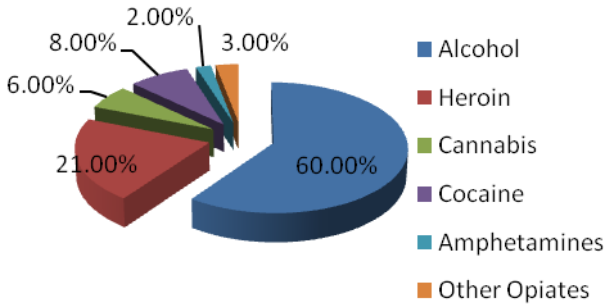
Primary Substance by Assessment

Primary Substance	2014 - 15		2013 - 14		2012 - 13		2011 - 12	
	#	%	#	%	#	%	#	%
Alcohol	1594	58%	1837	62.3%	1606	60%	1421	53%
Heroin	658	24%	594	20.1%	567	21%	727	27%
Cannabis	256	9%	213	7.2%	173	6%	210	8%
Cocaine	134	5%	149	5%	208	8%	202	7%
Amphetamines	54	2%	68	2.3%	50	2%	82	3%
Other Opiates	58	2%	83	2.8%	72	3%	58	2%
Total	**2754**	**100%**	**2944**	**100%**	**2676**	**100%**	**2700**	**100%**

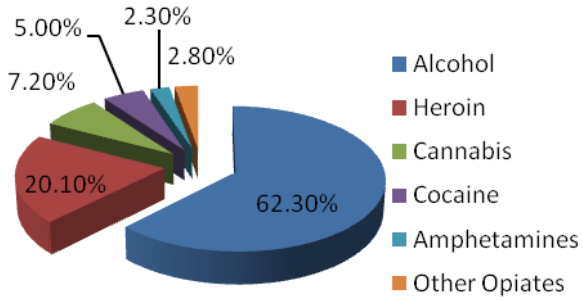
Primary Substance by Assessment 2011/12



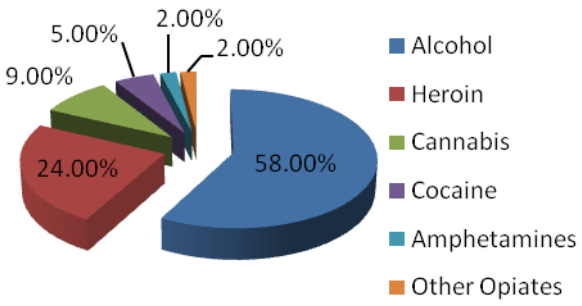
Primary Substance by Assessment 2012/13



Primary Substance by Assessment 2013/14



Primary Substance by Assessment 2014/15



Using data sourced from the Patient Episode Database for Wales, in 2014/15:

- Cardiff had a lower rate of alcohol misuse* per 100,000 of the population than many other Welsh authorities and comes out 2nd of the 22 authorities.

- Cardiff had a lower rate of drug misuse ** per 100,000 of the population than some other Welsh authorities and comes out 12th of the 22 authorities.

*as measured by alcohol specific hospital admissions (person based) crude rate per 100,000 based on mid-year population estimates ** as measured by drug related hospital admissions (person based) crude rate per 100,000 based on midyear population estimates

Ethnicity

'Knowledge of the demography of the minority ethnic population is a prerequisite for the understanding of health needs and outcomes. For those involved in planning the provision of services, health related or not, it is vitally important to understand these factors so that needs can be met appropriately' (Ethnicity in Wales, PHW Observatory).

The ethnic population in Wales is relatively small in proportion; often clustering in cities and urban areas. According to the 2011 census, 96.4% of residents living in the Vale of Glamorgan are White, 1.6% Asian/Asian British, 1.3% Mixed/Multiple ethnic group, 0.4% Black/African/Caribbean, Black British and 0.3% are of 'other ethnic group' (http://vale.infobasecymru.net).

Ethnic Group	Total	%
All usual residents	346,090	
White	293,114	**84.7%**
White: English/Welsh/Scottish/Northern Irish/British	277,798	80.3%
White: Irish	2,547	0.7%
White: Gypsy or Irish Traveller	521	0.2%
White: Other White	12,248	3.5%
Mixed/multiple ethnic groups	10,031	**2.9%**
Mixed/multiple ethnic groups: White and Black Caribbean	3,641	1.1%
Mixed/multiple ethnic groups: White and Black African	1,742	0.5%
Mixed/multiple ethnic groups: White and Asian	2,459	0.7%
Mixed/multiple ethnic groups: Other Mixed	2,189	0.6%
Asian/Asian British	27,885	**8%**
Asian/Asian British: Indian	7,886	2.3%
Asian/Asian British: Pakistani	6,354	1.8%
Asian/Asian British: Bangladeshi	4,838	1.4%
Asian/Asian British: Chinese	4,168	1.2%
Asian/Asian British: Other Asian	4,639	1.3%
Black/African/Caribbean/Black British	8,201	**2.4%**
Black/African/Caribbean/Black British: African	5,213	1.5%
Black/African/Caribbean/Black British: Caribbean	1,322	0.4%
Black/African/Caribbean/Black British: Other Black	1,666	0.5%
Other ethnic group	6,859	**1.9%**
Other ethnic group: Arab	4,707	1.4%
Other ethnic group: Any other ethnic group	2,152	0.6%

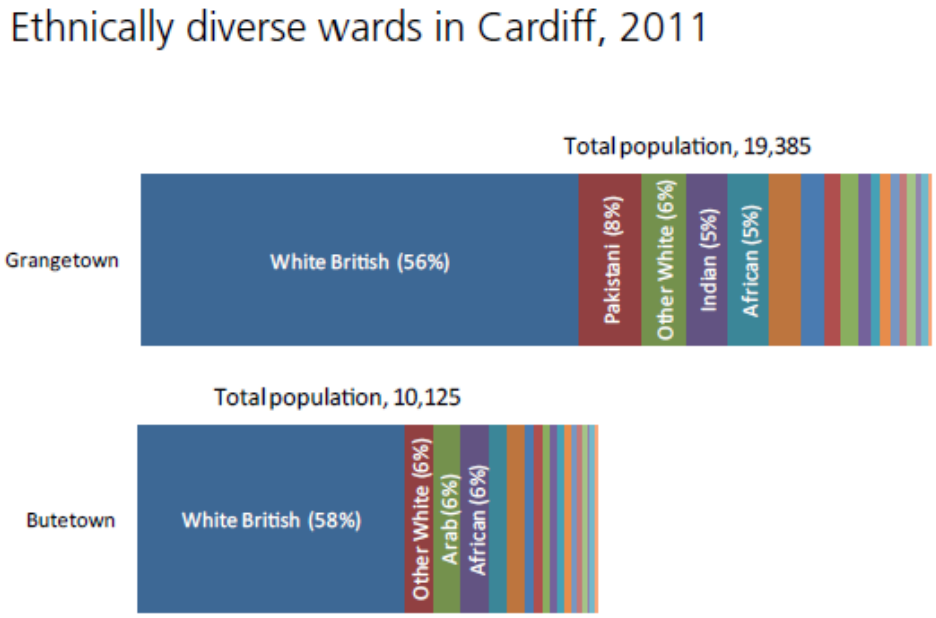
Source:
nomisweb.co.uk/census/2011/

In contrast Cardiff is typically more culturally diverse with more sub variations of ethnic minority groups.

A report published by the Centre on Dynamics of Ethnicity (CoDE) suggests Grangetown and Butetown are the most ethnically diverse wards in Cardiff.

As a general rule of thumb, diversity is determined by calculating how close a 'ward' or area is to having an equal number of residents from each ethnic group living in the area.

The following diagram shows Pakistani is the second largest group living in Grangetown whilst Indian, African and 'Other White' account for 6% independently in Butetown.



Source: ESRC Centre on Dynamics of Ethnicity (CoDE)

The Welsh National Database for Substance Misuse (WNDSM) reveals the proportion of people assessed by a substance misuse service, categorised by ethnic minority group:

Ethnic Origin	**14 - 15**		**13 – 14**		**12 - 13**		**11 - 12**	
	#	**%**	**#**	**%**	**#**	**%**	**#**	**%**
White	2269	91.6%	2682	92%	2393	92.4%	2240	89.7%
Mixed White & Black Caribbean	14	0.6%	25	0.9%	26	1.0%	55	2.2%
Mixed White & Black African	9	0.4%	10	0.3%	7	0.3%	13	0.52%
Mixed White & Asian	10	0.4%	5	0.2%	6	0.23%	22	0.9%
Any other mixed background	33	1.3%	47	1.6%	40	1.54%	32	1.3%
Asian British Indian	8	0.3%	11	0.4%	11	0.4%	15	0.6%
Asian British Pakistani	16	0.6%	7	0.2%	10	0.4%	17	0.7%
Asian British Bangladeshi	15	0.6%	14	0.5%	11	0.5%	9	0.4%
Other Asian Background	24	1%	16	0.5%	18	0.7%	18	0.7%

Black British Caribbean	9	0.4%	27	0.9%	18	0.7%	34	1.4%
Black British African	17	0.7%	41	1.4%	27	1.04%	24	1%
Other Balck Background	38	1.53%	19	0.7%	14	0.5%	9	0.4%
Chinese	0	0.00%	1	0.03%	0	0.00%	0	0.00%
Other Ethnic Group	15	0.6%	13	0.4%	10	0.4%	8	0.3%
Total	2477	100%	2918	100%	2591	100%	2496	100%

Whilst the data collectively reveals an increase of 0.32% in the number of people from all ethnic minority groups receiving an assessment, it does not specifically uncover the visible growing presence of the Polish and Czech-Roma community living in Cardiff.

A recent Community Needs Analysis exploring EU Roma Communities in Cardiff concluded that most statutory services and community development organisations find this cohort of people often challenging to engage due to cultural and language barriers. As such these groups are said to have adopted 'negative expectations of service providers'. According to a recent paper published by Welsh Government titled 'Review of Evidence of Inequalities in Access to Health Services in Wales and the UK' 'the sex of the GP or nurse may represent a barrier to access for Gypsy or Traveller people and language barriers among some BME groups may impede understanding of health advice'.

The following table represents the total number of people in receipt of structured treatment for drug or alcohol related issues. When combining the total of ethnic minority groups (excluding white) there is a reduction of 1.91% between 13/14 and 14/15. However these figures do not necessarily represent a reduction in the overall number of people misusing substances. In addition to data quality issues, a reduction could also illustrate the aforementioned barriers (cultural or lingual) preventing people in these minority groups from engaging with services. Furthermore it does not account for the number of people actively seeking online support.

To date of the 268 people who accessed support via 'breaking free online'; 1.92% were Mixed White & Black Caribbean, 0.64% Mixed White & Black African, 1.28% mixed, 0.64% Black African, 0.64% Asian Pakistani and 2.56% belonging to an 'other ethnic group'. It is critical for services to be culturally astute and flexible in service delivery to meet the changing demographics of its surrounding communities.

Clients Treated by Ethnic Origin	**14 - 15**		**13 - 14**		**12 – 13**		**11 - 12**	
	#	**%**	**#**	**%5**	**#**	**%**	**#**	**%**
White	973	89.2%	1490	91.1%	1821	91.1%	1989	89.4%
White & Black Caribbean	8	0.7%	14	0.95%	25	1.26%	46	2.07%
White & Black African	6	0.5%	9	0.6%	7	0.4%	12	0.5%
White & Asian	2	0.2%	3	0.2%	3	0.2%	23	1.03%
Any other mixed background	21	1.92%	28	1.71%	37	1.9%	33	1.5%
Asian British - Indian	3	0.27%	6	0.4%	12	0.6%	12	0.5%

Asian British - Pakistani	7	0.64%	3	0.2%	9	0.5%	17	0.8%
Asian British - Bangladeshi	9	0.08%	5	0.3%	8	0.4%	9	0.4%
Any other Asian background	18	1.65%	12	0.7%	16	0.8%	14	0.6%
Black/Black British - Caribbean	8	0.7%	20	1.2%	16	0.8%	36	1.6%
Black/Black British - African	6	0.5%	26	1.6%	23	1.2%	23	1.03%
Any other Black background	23	2.1%	12	0.7%	15	0.8%	7	0.3%
Chinese	0	0.00%	1	0.06%	0	0.00%	0	0.00%
Any other ethnic group	7	0.64%	6	0.4%	7	0.4%	4	0.2%
Total	**1091**	**100%**	**1635**	**100%**	**1999**	**100%**	**2225**	**100%**

Source: WNDSM

Welsh Language

According to the 2011 censes; of the 454,291 population believed to be living in Cardiff and the Vale of Glamorgan, only 11% (49,924) are able to speak Welsh whilst the majority 89% (404,367) is not able to converse using the native Welsh language.

A recent article published by the BBC details the decline of the Welsh language across Wales despite growing population numbers. Between 2013/14 and 2014/15 the number of Welsh speakers has reportedly declined from 582,000 to 562,000 however Cardiff is one of few areas in Wales to increase in number. 'There are more fluent Welsh speakers in Cardiff than there were 10 years ago – with the number in the capital having risen by 7,000' (bbc.co.uk, 2015).

The following table depicts the current capacity of commissioned substance misuse provisions to offer services in the Welsh language.

	Bilingual Assessment & Supporting materials?		**Welsh Speaking Member(s) of staff?**	
	Yes	No	Yes	No
Community Addiction Services (CAU)		✓		✓
Open Access and Engagement (OAE)	✓		✓ (1)	
EDAS	✓		✓ (1)	
Footsteps to Recovery		✓ Can be produced in Welsh if needed	✓ (1)	
Family Support Service	✓ Bilingual Materials		✓ (1)	

Salvation Army Bridge Programme	✓ Bilingual Materials		✓ (2)	
Switched on	✓ Bilingual Materials		✓ (1) admin	
Up2U		✓ Initial assessment not currently in Welsh Adaptations can be made if required	✓ (3) 2 FT 1 PT Barnado's staff can be called upon if needed	
YPDAS		✓ However some marketing materials are produced in Welsh		✓
STIR		✓	✓ (1)	
CADT Residential Rehabilitation		✓	✓	

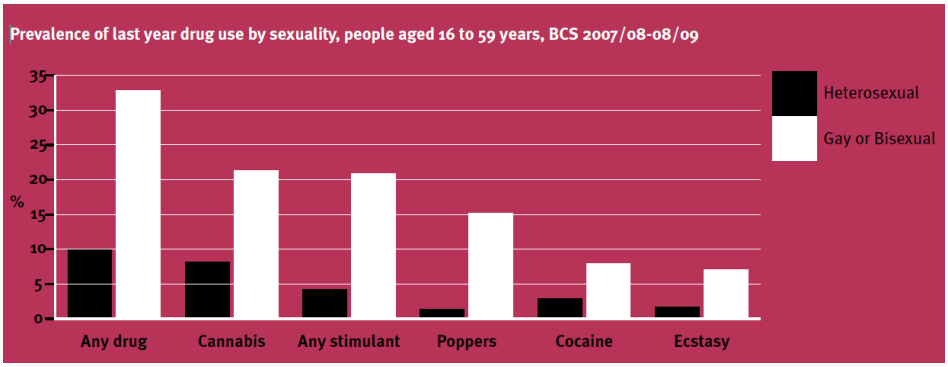
In spite of services making suitable adaptations to accommodate the linguistic needs of diverse communities, the aforementioned paper produced by Welsh Government acknowledges the challenges and 'discomfort (some people experience) with interpreters they do not know, preferring friends and family to interpret' which can 'compromise abilities to communicate sensitive information or emotions in an open manner'.

Additional Protected Characteristics

In the recent publication, 'Review of Evidence of Inequalities in Access to Health Services in Wales and the UK; Gender, Gender reassignment and sexual identity)' "Lesbian, Gay or Bisexual people have less confidence in their GPs than straight people and report poorer experiences of consultations". Furthermore a quarter of LGBT people feel they have no opportunity to disclose their sexual identity to healthcare professional or fear doing so. Despite more flexible attitudes towards this growing community in contemporary society, LGBT is still considered to be marginalised group 'at increased risk of recreational substance use' (UK Drug Policy Commission).

Unfortunately, imperative population data is lacking as to the proportion of people living in Wales who identify as belonging to the LGBT community.

The UK Drug Policy Commission undertook a study looking at LGBT and substance misuse behaviour on a national scale. The results of the survey revealed the most commonly misused substance by age (shown below).



The study concluded with some interesting findings:

- Sexual health and mental health services need greater knowledge and understanding of LGBT specific issues.
- Need for appropriate help and support in mainstream services.
- Specialist substance misuse services for LGBT are not sustainable
- Additional information is needed on effective treatment models and pathways for some of the drugs commonly used.
- More data is needed on barriers to access services in particular among different LGBT groups.

Inequalities and deprivation

The relationship between deprivation and substance misuse has been widely publicised in numerous research papers and epidemiology studies; as such it is a commonly accepted notion that those living in deprived communities are far more likely to misuse substances.

There are many concepts as to what constitutes ‘deprivation’ however put simply deprivation refers to ‘a lack of access to opportunities or resources which one would expect in society’ such as physical resources (food, shelter, clothing) or an inability to participate in society or normal social life within a community’ (WIMD, 2015).

The Welsh Index of Multiple Deprivation (WIMD) is considered to be the official and most reliable measurement of deprivation in ‘small areas where there is the highest concentration of several types of deprivation’ which include:

1. Income
2. Employment
3. Health
4. Education
5. Access to services
6. Community Safety
7. Physical Environment
8. Housing

Each of the above domains are weighted and combined to form an overall index of multiple deprivation. Areas with low scores are considered to be the most deprived and those with a higher figure - least deprived.

Whilst 'income' and 'employment' carry the largest weighting of relative deprivation, 'access to services' is not perceived to be as instrumental due to the increasing availability of outreach services and growing online support (see page 21). As such it should not be assumed that residents living in these areas are completely detached from help and support.

Revised figures published on August 12th 2015 reveal the most deprived area in Cardiff is Splott (4) followed by Trowbridge (13) and Ely (24).

Area	WIMD SCORE	Income	Employment	Health	Education	Access to services	Community Safety	Physical Environment	Housing
Splott	**4**	15	42	24	45	633	26	13	40
Trow-bridge	**13**	7	68	7	17	504	150	259	367
Ely	**24**	2	79	52	28	1644	243	1499	27

A full list of the WIMD rankings for Cardiff and Vale can be found in appendix 1.

The least deprived area in Cardiff is Cyncoed (1907) followed by Llanishen (1906) and Heath (1905) which all scored favourably in respect to average income, employment and education (as shown below).

Area	WIMD SCORE	Income	Employment	Health	Education	Access to services	Community Safety	Physical Environment	Housing
Cyncoed	**1907**	1893	1851	1872	1906	1616	1747	984	1824
Llanishen	**1906**	1801	1865	1901	1851	1581	1658	1374	1752
Heath	**1905**	1852	1808	1857	1849	1824	1894	895	1846

In the Vale of Glamorgan the most deprived area is Gibbonsdown (83) followed by Court (169) and Cadoc (178).

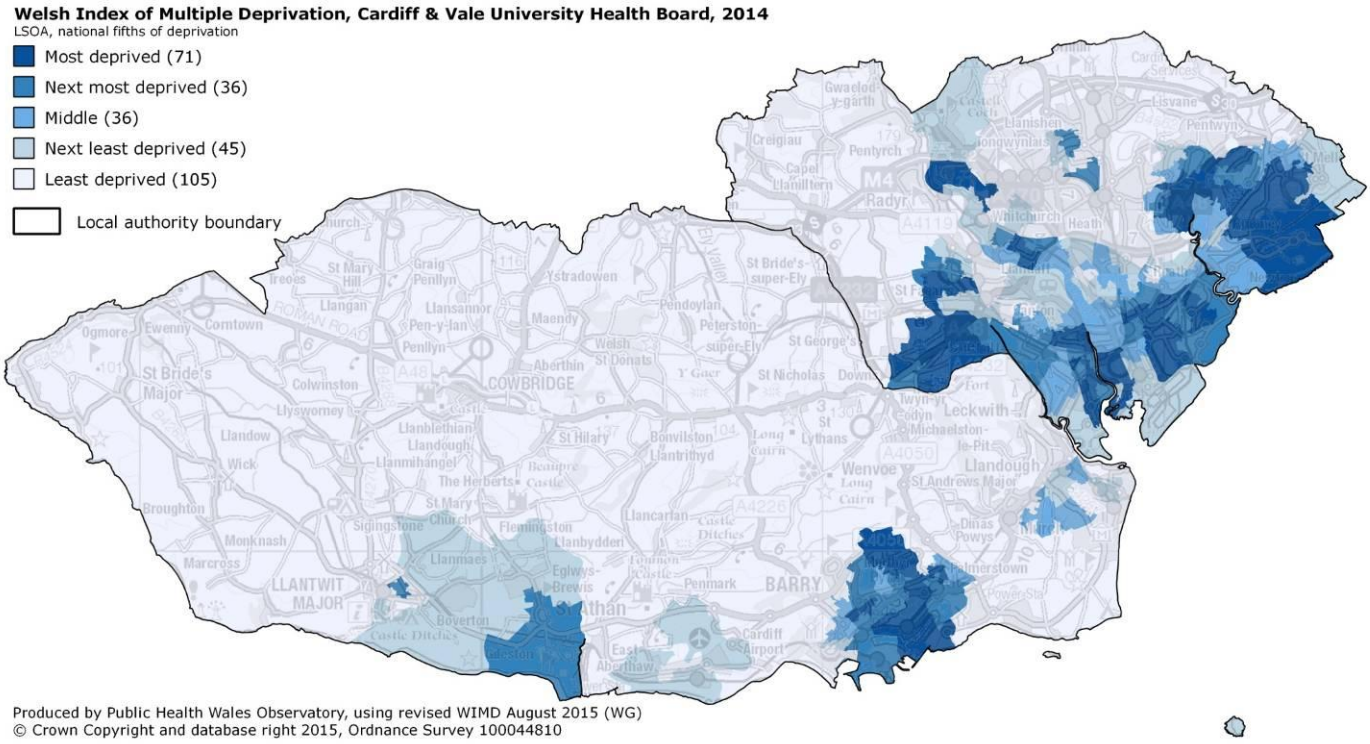
Area	WIMD	Income	Employment	Health	Education	Access to services	Community Safety	Physical Environment	Housing
Gibbo-nsdown	**83**	52	158	129	54	1402	147	818	172
Court	**169**	140	206	128	199	1619	185	409	441
Cadoc	**178**	217	184	325	335	819	44	121	186

The least deprived area in the Vale of Glamorgan is Dinas Powys (1881), Illtyd (1872) and Stanwell (1867).

Area	WIMD SCORE	Income	Employment	Health	Education	Access to services	Community Safety	Physical Environment	Housing
Dinas Powys	**1881**	1875	1839	1873	1897	1676	1416	617	1729
Illtyd	**1872**	1660	1716	1864	1660	1838	1187	1577	1724
Stanwell	**1867**	1754	1720	1703	1856	1882	1115	1216	1497

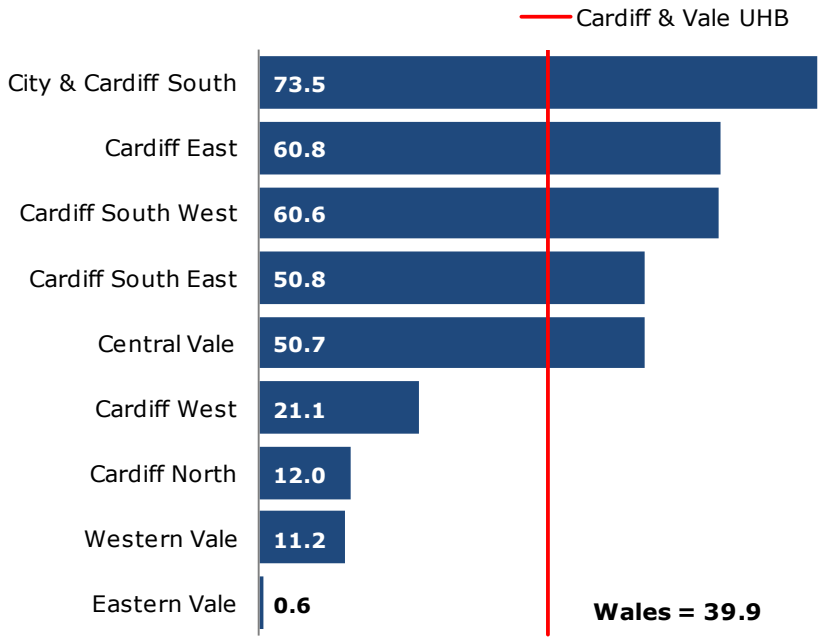
Whilst the WIMD provides a useful indication of local level inequalities, the data should not be used for cumulative comparison purposes in determining whether an area is more deprived than the previous year.

The following map visually plots the areas of greatest deprivation across C&V HB area.



Public Health Wales has identified large disparities in health life expectancy in Cardiff and Vale. According to observatory data, men and women living in the least deprived areas of C&V can expect to live in 'good health for approximately 21-23 years longer than those living in deprived communities'. Furthermore 'the inequality gap in life expectancy has slightly widened over the last ten years' rising from 8.6 to 9.2 years for men and 6.5 to 7.1 years for women' (Public Health Observatory, 2014).

Percentage of patients living in the 40% most deprived LSOAs in Wales (using Welsh Index of Multiple Deprivation 2014), GP Clusters in Cardiff & Vale UHB, 2014



Online Support and E-Learning

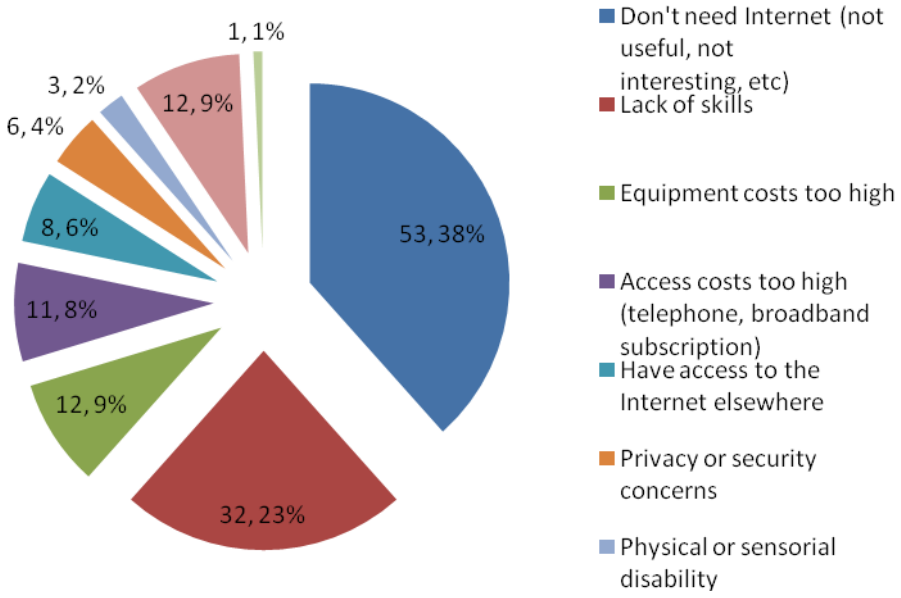
The Welsh Government published paper 'Reviewing Evidence of Inequalities in Access to Health Service in Wales and the UK' explores the challenges experienced by 'marginalised vulnerable groups' (homeless people, those fleeing from domestic abuse, lone parents) in accessing healthcare services. Reasons include but are not limited to:

- Lack of transport
- Cost of reaching services
- Difficulties finding alternative childcare

However the advancement of technology and the internet has revolutionised the way in which one accesses advice and support and provided services with an opportunity to communicate with these cohorts of people who would otherwise be hard to engage.

Since 2004 the number of households in the UK with internet access has increased significantly from 49% to 84% (Office for National Statistics, 2014).

Of the remaining population who do not have internet access the following reasons were identified:



Source: ONS.gov.uk

The rapid advancement in Information Technology has also seen the development of additional 'smart' devices such as mobile telephones, tablets and e-readers which means information is now readily available anywhere at any given time.

The following tables depict the growing popularity of these devices to access online materials by gender and age group and the reasoning for using the Internet to interact with public authorities or services.

Device source of obtaining information

	Age group						Sex		%
	16-24	**25-34**	**35-44**	**45-54**	**55-64**	**65+**	**Men**	**Women**	**All**
Mobile phone or Smartphone	87	86	78	62	41	11	62	55	**58**
Portable computer (e.g. laptop, tablet)	59	48	52	50	41	17	45	41	**43**
Other handheld device (e.g. PDA, MP3, e-book reader, games console)	22	20	22	14	12	3	16	14	**15**

Reasons for using the internet to interact with Public Authorities and Services %

	Age group						Sex		
	16-24	**25-34**	**35-44**	**45-54**	**55-64**	**65+**	**Men**	**Women**	**All**
Obtaining information from websites	34	38	45	49	41	21	40	34	**37**
Downloading official forms	29	31	35	36	31	16	33	25	**29**
Submitting completed forms	29	33	40	40	34	18	35	28	**32**
None of these	52	48	41	41	49	73	49	54	**52**

Source: ONS.gov.uk, 2014

The modest number of people downloading and submitting official forms online denotes a national increase in computer literacy, however despite this growing trend few people are accessing EDAS' online assessment prior to their initial appointment. A lack of awareness could be a contributory factor, as such additional marketing should increase uptake and reduce lengthy appointment times which in the process free administrative capacity.

Breaking Free Online

During 2011-2015 a total of 268 people have accessed online e-learning materials provided by 'Breaking Free Online' to address issues with substance misuse; of which 47.5% alcohol, 16.2% drugs and 36.3% for poly drug and alcohol use.

Alcohol is the most problematic substance (63.4%), followed by cannabis (10.9%), Heroin (6.41%) and cocaine (4.49%).

Demographic analysis reveals the majority of people accessing the online e-learning materials are of working age; 40-44 (17.3%), 30-34 (16.6%) and 45-49 (14.1%). A recent meta-analysis undertaken by Cook et al, (2014), looked at the effectiveness of 'e-therapy' and concluded 'middle aged adults (25-39) seemed to be more effectively treated than younger or older adults due to perceived increased computer literacy' (Barak et al, 2008). In contrast Spence et al, (2006) advocate internet therapy and 'web based CBT' are perfectly acceptable with families, anxious children and adults with mental health issues with dropout rates often minimal.

An early insight into the draft Cardiff and Vale UHB Alcohol Liver Disease Plan (ALDP) 2015, suggests a clear correlation between deprivation and alcohol specific mortality. 'Every week in Cardiff and the Vale of Glamorgan there are approximately 138 alcohol attributable hospital admissions'. Furthermore alcohol mortality rates for males living in the C&V UHB are the highest in Wales attributing 22 per 100,000 and

females 9 per 100,000 in comparison to the rest of Wales (based on figures recorded in 2010-12).

According to the ALDP, Prolonged heavy drinking over a sustained period of time could inevitably lead to alcohol related liver disease. 'In Cardiff and Vale, approximately 55 people die every year from alcohol-specific conditions, primarily from liver disease (82% of deaths in males and 81% in females).

In response to this growing area of concern, the ALDP makes a series of recommendations including:

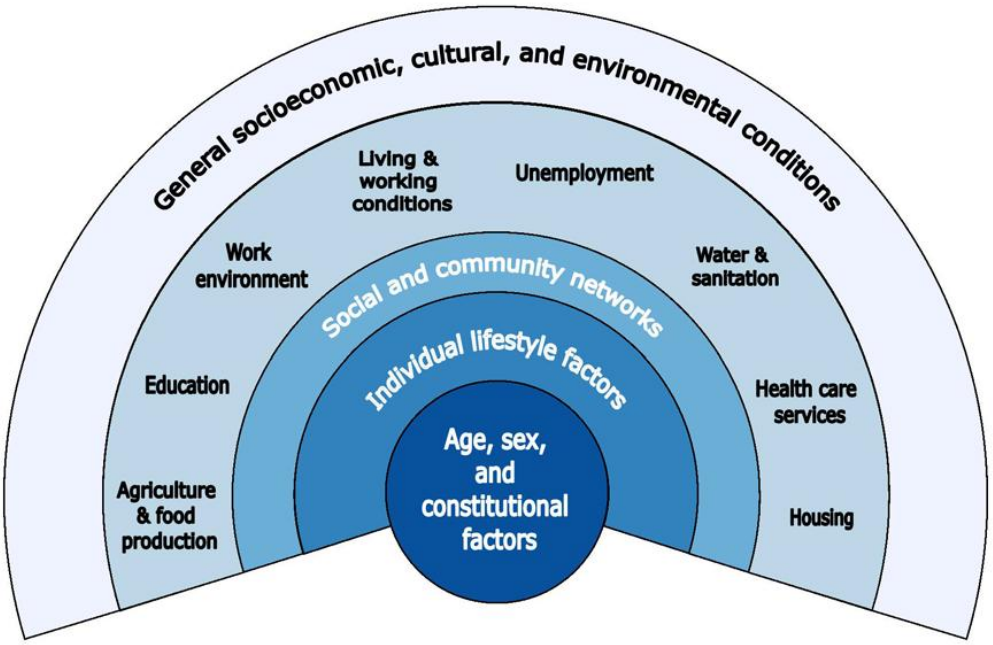
- Imposing a minimum costing of 50p per unit of alcohol
- Clear health warning labels on packaging
- Restrictions around accessibility and designated areas for purchasing alcohol
- Prohibiting the use of advertising and sponsorship of alcohol brands and beverages

According to a recent study undertaken by the NHS Information Service, people in executive professions are more likely to drink alcohol daily above recommended unit guidelines. 'In 2012, 17% of the adult population working in managerial and professional households had an alcoholic drink on five or more days in the past week, in comparison to 11% of adults in routine and manual households'. Furthermore households with a gross income in excess of £1000 per week are 'three times more likely to consume alcohol such as wines and spirits above unit guidelines, than those earning £200 per week who typically prefer to consume beers and lagers' (drugscope.org.uk).

In 2013/14 the Welsh Health Survey revealed 44% of adults living in Cardiff and the Vale of Glamorgan drink over recommended guidelines and 26% binge drink' (Cardiff and Vale UHB Liver Disease Plan, 2015).

In the academic paper 'Concepts and Principles for tackling social inequalities in health' Dahlgren & Whitehead (1991) identified a number of causal factors in contributing towards health inequalities and deprivation; some of which are 'non modifiable such as sex, age and other hereditary factors and some are changeable e.g. cultural or lifestyle conditions'.

Dahlgren & Whitehead (1991), 'Policies and strategies to Promote equity in health'



Dahlgren G, Whitehead M. *Policies and strategies to promote equity in health*. Stockholm: Institute for Future Studies; 1991.
Adapted by Public Health Wales Observatory

Cardiff and Vale APB is striving to demonstrate qualitative and sustainable outcomes for all clients. The APB has adopted the Results Based Accountability Framework for performance monitoring these socioeconomic, cultural and environmental conditions which encourage services to adopt a joined up approach to meet their client's holistic needs.

The measurement of **Treatment Outcome Profile** (TOPs) provides a useful checkpoint to measure client attainment throughout their treatment journey. These are encompassed under the APB banner of 'Substance Reduced' and 'Improvements in Quality of Life'; both of which are National Indicators for all APB's to report to Welsh Government.

Using aggregated data extracted from the Welsh National Database for Substance Misuse (WNDSM), the following table summarises TOP performance benchmarked against All Wales performance.

Substance Reduced (TOP) **Target 67%**	**2014-15**		**2013-14**		**2012-13**		**2011- 12**	
Cardiff and Vale APB	1217	72.05 %	1090	71.06%	1031	66.30%	1011	64.97 %
All Wales	13948	73.83 %	12999	71.40%	10934	68.91%	10328	68.44 %

Quality of Life Improved (TOP) Target 56%	2014-15		2013-14		2012-13		2011- 12	
Cardiff and Vale APB	495	79.33%	319	58.11%	356	50.50%	495	53.11 %
All Wales	6040	65.58%	5168	58.23%	4438	55.33%	4721	57.78 %

These results reveal significant strides in performance between 2011- 2014/15 in respect to the number of clients reporting reduced substance use and 'Improved Quality of Life'. However recent figures for 2015/16 indicate a slight dip to 73% for the cumulative year to date. Initial investigation reveals this issue is echoed across each of the APB areas in Wales. It would appear that when questioned during TOP reviews and/or exits, fewer clients are reporting positive improvements due to increased financial hardship assumingly due to changes to welfare reform and the introduction of universal credit (see appendix A). Welsh Government is currently in the process of consultation with APB leads to find a suitable way forward. In the interim, issued guidance is to ensure staff undertaking assessment should remind clients that answers should be in reference to reduced or abstained substance misuse behaviour.

The following table denotes C&V APB performance across the other 3 national key performance indicators (KPI's), benchmarked against the All Wales performance.

KPI		2014-15		2013-14		2012-13		2011- 12	
DNA Post Assessment	C&V	633	19.99%	628	19.82%	1002	32.87%	1048	35.95%
	All Wales	3660	17.88%	3200	17.99%	4244	23.55%	5018	26.89%
Referral to Treatment	C&V	1011	81.27%	1336	75.87%	1654	74.27%	1735	69.54%
	All Wales	14862	87.37%	13536	88.22%	12705	84.93%	11832	82.14%
Planned Treatment Closures	C&V	622	50.82%	718	55.70%	887	50.40%	1125	56.96%
	All Wales	8465	67.93%	8043	72.26%	7274	64.31%	6775	62.14%

Market Analysis

Cardiff and Vale APB currently commission the following substance misuse services:

Adult Services	**Service Mapping**		
	Service Provider	Entry to Drug and Alcohol Services	**EDAS**
	Service Objectives:	1. Provide a professional referral system with prompt referral processing, service user engagement and appointment 2. Provide an engaging and open access environment , suitable for all service user 3. Provide a comprehensive assessment service for adult drug and alcohol service users 4. Provide a model of 'shared and informed decision making' which will invite service users to work together as active partners making choices about their care 5. Develop holistic initial engagement plans with service users and refer on to the most appropriate health and social care providers based on individual need and choice 6. Promote a recovery orientated integrated treatment system for adult drug and alcohol service users from the initial engagement on 7. Provide harm reduction advice and information and facilitate access to needle exchange/harm reduction programmes and referral to BBV services 8. Deliver low intensity brief psycho-social interventions to service users who do not require care planned structured treatment services 9. Provide time limited support for concerned significant others 10. Manage referrals and assessments to deliver expected waiting times	
	SMAF Expenditure 14/15: **Statutory:** **Other:**	**£ 24,431.32**	

	Areas Covered	Cardiff, Vale of Glamorgan			
	Referrals	**Total:** 2361	**Cardiff:** 1861	**Vale of Glamorgan:** 500	
	Assessments 2014-15	**Total:** 1237	**Cardiff:** 985	**Vale of Glamorgan:** 252	
	Onward Referrals	**Total: 1529**	CAU Cardiff: 582 CAU Vale: 132 CADT: 167 Social Work Cardiff: 20	Footsteps to Recovery: 91 Inroads Cardiff: 55 Inroads Vale: 13 Social Work Vale: 7 VADT: 74	IOIS Cardiff: 55 IOIS Vale: 13 OAE: 318 Recovery Cymru: 60
	Avg Referral to Treatment Time		**Cardiff:** 7.3 days	**Vale of Glamorgan**: 9.8 days	

The following table depicts the effectiveness of using text appointment alerts which are sent to clients with a view to reducing the number of failed attendances.

PARIS Appointment Booking System				
	Mobile Number Provided		**Mobile Number Not Provided**	
01/04/14 – 31/03/15				
DNA	862	40.76%	532	47.37%
Attended	1253	59.24%	591	52.63%
01/04/13 – 31/03/14				
DNA	950	40.46%	502	43.92%
Attended	1398	59.54%	641	56.08%
01/04/12 – 31/03/13				
DNA	296	34.34%	178	44.84%
Attended	566	65.66%	219	55.16%
01/04/11 – 31/03/12				
DNA	No Data Available			
Attended				

With the exception of self referrals, GP's are the second largest source of referrals to EDAS which result in DNA.

Using data sourced from Paris, the table below illustrates the volumes of GP referrals which resulted in DNA, split by locality area.

	Referrals	DNA	
		#	%
2014 – 2015			
Cardiff	476	239	50.2%
Vale of Glamorgan	216	92	42.6%
Total	**692**	**331**	**47.8%**
2013 – 2014			
Cardiff	545	280	51.4%
Vale of Glamorgan	197	84	42.6%
Total	**742**	**364**	**49%**
2012 – 2013			
Cardiff	213	99	46.5%
Vale of Glamorgan	76	30	39.5%
Total	**289**	**129**	**44.6%**
2011 – 2012	**No data available**		

GP surgeries in Cardiff are the greatest source of referrals from primary care and the largest proportion resulting in DNA.

The data suggests the need for increased targeted information to GP's around service eligibility criteria and potentially revisiting clinic times to ensure they are still convenient and accessible for people at most risk of DNA.

In 2014 the APB commissioned a unique telephone system which provides callers with a menu of options depending on their requirements. Option 1 connects the caller to the Open Access and Engagement service for general advice and support around drugs and alcohol. Option 2 diverts the caller to EDAS for a formal clinical needs assessment.

The rationale behind developing the telephone service is to provide individuals with greater flexibility around choosing the service most appropriate to their needs, hence alleviating undue service pressures associated with inappropriate referrals which result in unplanned discharges.

Adult Services	**Service Mapping**		
	Service Provider	Open Access & Engagement (OAE)	**TAITH**
	Service Objectives:	1. To engage with service users at the front end of the treatment system by offering open access low threshold support and drop in access for those at the pre-contemplative stage of the cycle of change. 2. To provide support to the EDAS single assessment service and to act as a member of the EDAS consortium 3. To provide structured, less structured and recovery orientated support services for individuals at tier 2 4. To proactively provide specialist support to those deemed hard to reach, engaging with communities who may find it difficult to access support as well as offering advice to those across the treatment system to enable working with such groups 5. To co-ordinate, manage and deliver needle exchange services across the locality (formerly provided by NHS services) 6. To provide operational specialist harm reduction services that meet an individual's need to use substances more safely, including access to needle exchange facilities, safer injecting advice, relapse prevention, and referral to blood borne virus screening & vaccination services 7. To work at reengaging those who disengage from treatment, and to provide interim support for those waiting to access structured treatment at Tier 3 8. To work towards reducing the number of drug related deaths, and increase positive outcomes for individuals and their families. 9. To provide peripatetic support for individuals dependent on need and monitor changing trends in drug use across both Cardiff and the Vale of Glamorgan 10. To support those with substance related issues who are homeless or at risk of being homeless with advocacy	

		support 11. Providing evidence based models of psychotherapeutic intervention in line with the most up to date evidence base including but not exclusive to, Motivational Enhancement Therapy, Overdose management, Relapse Prevention, Cognitive Behavioural Therapy, and Brief Interventions 12. To provide advice, information, direct interventions and/or onward referral in order to support a wide range of socio-economic needs of service users, including welfare and benefits advice, tenancy and housing support, and opportunities to engage in education, training, volunteering and employment 13. To educate and encourage service users to build recovery capital in the community from the outset of their treatment journey 14. Capitalising on opportunities to improve the financial resilience of the service through social enterprise
	SMAF Expenditure 14/15: **Statutory:** **Other :**	**£395,964.42** **If any additional funding stream, please specify**
	Areas Covered	**Cardiff,** • 30% occupancy in Cardiff premises • **Staff (per week):** Cardiff (Static) = 223 hours **Vale of Glamorgan (Barry)** • 100% occupancy in Vale • **Staff (per week):** Barry (Static) = 67 Hours
	Case Load 2014-15 **Maximum Case Load**	• Taith average around 20 structured cases per worker (capped at 30) however some staff may have 2 structured clients but see 60 individuals in a less structured environment e.g. workshops and other group activities.
	Referrals	**Please note the service was operational in July 2014. As such the following data refers to quarters 3 and 4 only.** **Cardiff:** **EDAS:** 177 **Self:** 166 **Vale of Glamorgan:** **EDAS:** 46 **Self:** 42 **Total:** **473** **Needle Exchange Transactions** **Cardiff:** 1723 **Vale:** 1381 **Total: 3104**
	Referral Sources	**Statutory Drug Service:** 1 **Non statutory Drug Service:** 30 **GP:** 2 **Self:** 76 **Community Mental Health Team:** 1 **Employment Service:** 1 **Unknown:** 240
	Assessments	**Assessments**: 334

	2014-15				
			Target	**Achieved**	
	Annual Performance 2014 – 15 **Source: WNDSM**	KPI 1: DNA Post Assessment	≤ 20	47	39.40%
		KPI 2: Referral to Treatment	≥ 80%	163	92.61%
		KPI 3: Substance Reduced (TOP)	≥ 67%	Not available	
		KPI 4: Improved Quality of Life (TOP)	≥ 56%	Not available	
		KPI 5: Planned Treatment Closures	≥ 72%	50	54.35%

Since it went operational in July 2014, the Open Access and Engagement Service delivered by TAITH has supported clients in making informed choices over their treatment options from its two branches in Nolton Road (Vale of Glamorgan) and Neville Street (Cardiff).

Services include:

- Needle Exchange.
- Psychosocial Interventions, Motivation/Miracle Letters, ITEP Mapping, Relapse Prevention.
- Harm Minimisation, Safer Injecting, Health and Well being, Nutrition, Wound care.
- Outreach for discretionary, mental health and disability issues.
- Re-engagement with clients who do not attend (Letters/Calls/Texts/Visits).
- Remote working – Email, Web based work, Postal.
- Group Work.
- Naloxone Training.
- BBV Testing, Spot testing.

- Support in the form of 1-1 / Group Discussion with concerned others.
- Advice and advocacy to Tier 1 services.

There are currently no waiting lists to access the structured elements of the open access service. Furthermore the treatment preparation group is well attended and positive in maintaining client engagement and motivation whilst clinical treatment options become available in the Community Addictions Unit.

Adult Services	**Service Mapping**		
	Service Provider	Footsteps to Recovery	SOLAS
	Service Objectives	1. Engaging with service users whilst still in receipt of tier 2, 3 & 4 treatment and support, through formalised joint working arrangements, in order to pave the way for future involvement with aftercare and recovery services. 2. Providing structured, less structured and recovery orientated support services for individuals leaving tier 2, 3 & 4 treatment and support services 3. Designing and implementing models of care aimed at sustaining treatment gains, reducing risk of relapse, and enabling service users to engage in recovery networks. 4. Providing effective models of psychotherapeutic intervention in line with the most up to date evidence base including but not exclusive to, Motivational Enhancement Therapy, Relapse Prevention, Cognitive Behavioural Therapy, and Brief Interventions 5. Providing socio-economic service interventions aimed at addressing welfare needs, education, training, work experience and employment needs of service users. 6. Providing a flexible model of aftercare planning that enables service users to develop and agree an aftercare and recovery plan that suits their circumstances, and meets their needs. 7. Establishing a recovery community that includes peer support networks, social engagement opportunities, diversionary activities, access to treatment and support when required, mutual aid, and opportunities for self-care. 8. Capitalising on opportunities to improve the financial resilience of the service through social enterprise	
	SMAF Expenditure 14-15: **Statutory:** **Other:**	**£325,254.34**	**Counselling: £44007.29**

	Areas Covered	**Cardiff** • 70% • 1 full time worker • 1 part time Cardiff (2 days) • No issues identified with the premises	**Vale of Glamorgan (Barry** • 30% • 1 part time Vale (3 days) • No issues identified with the premises

	Case Load 2014-15	• 2 key workers with an average of 8 clients allocated per worker. • The maximum number of clients per worker is 6 from any one cohort of the structured programme but staff can also be working with another 6-8 in 'preparation' phase or after completing the structured programme.					
	Referrals	**Please note the service was operational in July 2014. As such the following data refers to quarters 3 and 4 only.**					
	Total Referrals	**Total:** 397	**Cardiff:** 266	**Vale of Glamorgan:** 131			
	Referrals into Assessment Afternoons from External Agencies	**Total:** 114	**Cardiff:** 78	**Vale of Glamorgan:** 36			
	Referrals into Assessment Afternoons Internally (RC)	**Total:** 48	**Cardiff:** 37	**Vale of Glamorgan:** 11			
	New Recovery Community Members in Period	**Total:** 206	**Cardiff:** 135	**Vale of Glamorgan:** 71			
	New Recovery Community Volunteer in Period	**Total:** 29	**Cardiff:** 16	**Vale of Glamorgan:** 13			
	Assessments 2014-15 (as recorded on WNDSM)	**Total** 46	**Cardiff** 33	**Vale of Glamorgan** 13			
			Target	**Cardiff**		**Vale of Glamorgan**	
	Annual Performance	KPI 1: DNA Post Assessment;	≤ 20	8	53.33%	2	40%

	2014 – 15 **Source: WNDSM**	KPI 2: Referral to Treatment; Target	≥ 80%	35	94.59%	13	100%
		KPI 3: Substance Reduced (TOP)	≥ 67%	4	80%	3	60%
		KPI 4: Improved Quality of Life (TOP)	≥ 56%	6	60%	2	40%
		KPI 5: Planned Treatment Closures	≥ 72%	5	33.33%	2	50%

Adult Services	**Service Mapping**	**S**kills **T**iming **I**ntensity **R**elationships
	Service Provider	STIR
	Service Objectives	1. Engaging with service users whilst still in a custodial setting in order to ensure a smooth transition back into the community upon release. 2. The service will operate on an in-reach basis covering the prison estate in South Wales, and Eastwood Park for female prisoners, offering additional support to primary alcohol users. 3. Providing holistic support in a multi disciplinary setting to address the welfare needs, education, training, work experience and employment needs of service users. 4. The service offers a broad range of evidence based psycho social interventions as well as referral into other services as deemed necessary by a care plan, assessment of need, and client defined need.
	SMAF Expenditure 14-15: **Statutory:** **Other:**	**£110700.00**
	Areas Covered	Cardiff

	Case Load 2014-15	**Total:**				
	Referrals	98				
	Referral Sources	HMP Parc HMP Prescoed Probation	HMP Eastwood Park HMP Parc Self Referral	HMP Usk EDAS St Giles Trust	HMP Stafford ST Giles Trust	
	Total Assessments 2014-15	93				
				Target	**Achieved**	
	Annual Performance 2014–15 **Source: WNDSM**	KPI 1: DNA Post Assessment;		≤ 20	24	23.08%
		KPI 2: Referral to Treatment; Target		≥ 80%	15	88.24%
		KPI 3: Substance Reduced (TOP)		≥ 67%	0	0%
		KPI 4: Improved Quality of Life (TOP)		≥ 56%	0	0%
		KPI 5: Planned Treatment Closures		≥ 72%	14	56%

Adult Services	**Service Mapping**		
	Service Provider	Bridge Programme	**Salvation Army – TY Gobaith**
	Service Objectives	1. To engage with service users who are homeless or at risk of becoming homeless, and in need of substance misuse treatment within a supported accommodation environment. 2. To collaborate with the EDAS single assessment service to ensure seamless of provision with other elements of the substance misuse treatment system. 3. To collaborate with housing, accommodation support, and homelessness services 4. To develop a seamless and integrated interface with the APB commissioned Throughcare, Aftercare and Recovery Support service 5. To ensure that the full range of needs are met for those individuals accessing the service, including harm reduction services, advice and information, and referral on to other services 6. Providing evidence based models of psychotherapeutic intervention in line with the most up to date evidence base including but not exclusive to, Motivational Enhancement Therapy, Overdose management, Relapse	

		Prevention, Cognitive Behavioural Therapy, and Brief Interventions 7. To provide advice, information, direct interventions and/or onward referral in order to support a wide range of socio-economic needs of service users, including welfare and benefits advice, and opportunities to engage in education, training, volunteering and employment 8. To educate and encourage service users to build recovery capital in the community from the outset of their treatment journey 9. Capitalising on opportunities to improve the financial resilience of the service through social enterprise 10. As an Open College Network provider, some group sessions are mapped to qualifications which are accessible by all clients throughout the duration on the structured programme				
	SMAF Expenditure 14/15: **Statutory:** **Other:**	**£105,063.75.**				
	Areas Covered	Cardiff; no issues identified with the current premises				
	Case Load 2014-15	**Staff structure:** Programme coordinator x1 Nurse (CAU) x 1 Substance misuse workers x 3		Outreach worker x 1 Assistant support worker x 1		
	Maximum Case Load	19 beds across the programme This is an average of 6 clients per worker (max) and the outreach worker and assistant at times supporting 1.				
	Referrals	135 referrals between April 2014 - March 2015.				
	Referral Sources	Probation: 33 Self: 28 Prisons: 23 Gateway: 12 STIR: 8	Ty Gobaith: 4 IOIS: 4 EDAS: 3 HANR: 3	Shoreline: 3 Bus: 2 Huggard: 2 CAU: 1	CADT: 1 YMCA: 1 Sands: 1	
	Assessments 2014-15	96 have been assessed. (71% of total referred)				
				Target	**Achieved**	
	Annual Performance 2014-15	KPI 1: DNA Post Assessment;		≤ 20	Not reported	
		KPI 2: Referral to Treatment; Target		≥ 80%	18	100%

	Source: WNDSM	KPI 3: Substance Reduced (TOP)	≥ 67%	57	67.06%
		KPI 4: Improved Quality of Life (TOP)	≥ 56%	20	68.97%
		KPI 5: Planned Treatment Closures	≥ 72%	5	55.56%

Please note this service is unlikely to continue in its current format due to identified duplication with the new IOIS contract.

Adult Services	**Service Mapping**	**Clinical Treatment and Therapeutic Support**	
	Service Provider	Community Addictions Services	NHS
	Service Objectives	1. Provide clinically effective interventions in a range of settings suitable to clients needs. 2. Empower people to make positive changes in their drinking/drug taking. 3. Enable clients to become drug/alcohol free. 4. Enable clients to reduce consumption of drugs/alcohol. 5. Enable clients to stabilise their use of drugs/control their drinking. 6. Enable clients to reduce their range of poly drug use. 7. Work jointly with other agencies and other clinical areas within Cardiff and Vale University Local Health Board 8. Develop effective service user involvement throughout the Addictions Directorate Comprehensive assessment of clients' medical, social and psychological problems related to drugs and alcohol.	

	Service Objectives	10. Information, advice and support to significant others of those with substance misuse problems. 11. Motivational and other clinically effective counselling. 12. Relapse prevention interventions. 13. Structured two-week therapeutic day programme for early rehabilitation 14. Comprehensive home detoxification services to those clients who have been assessed and deemed suitable. 15. Specialist regional substance misuse treatment facility 16. Provide / co-ordinate an accessible needle exchange scheme offering a full range of paraphernalia, appropriate information on safer injecting, and monitor injecting technique 17. Substitute treatment programs within varying intensity psychosocial packages, including full key working, with multidisciplinary input, for those with complicated needs 18. Substance misuse liaison service within Cardiff and Vale University Health Board 19. A range of other evidence based pharmacological interventions within a wider treatment package 20. With GPs, a formal shared care scheme to provide substitute treatment for opiate dependent individuals 21. Provide tier 3 /4 input into other services, as commissioned <u>Primary Prevention</u> 1. The Addictions Directorate will work to reduce the spread of blood borne infections, and to reduce the risk of sexually transmitted diseases directly by: 2. Comprehensive needle exchange provision as stated above 3. Offering blood borne virus (BBV) testing to all clients of the service

		4. Offering Hepatitis B vaccination to all clients of the service 5. It is well known that many other interventions offered by the Addictions Directorate should positively impact on BBV risks <u>Drug related Deaths</u> The Addictions Directorate offers services directly aimed at reducing the risk of drug related deaths through overdose: 1. Overdose awareness 2. Naloxone provision with training, as commissioned 3. Cardiopulmonary resuscitation (CPR) 4. Other Addictions Directorate interventions are associated with reduced risk of drug related death. <u>Training of Others</u> The Addictions Directorate will: **1.** Provide working placements for other professionals. **2.** Provide formal training for generic service providers. **3.** Provide informal education and awareness raising through contacts with other professionals in all settings (e.g., routine correspondence and telephone advice). 4. Undertake joint working and liaison with other professionals.		
	SMAF Expenditure 14/15: **Statutory:** **Other:**	**£1,526,111.75**		
	Community Addictions Unit		**Target**	**Achieved**

				Cardiff E/W		**Vale of Glamorgan**	
	Annual Performance 2014 - 15	KPI 1: DNA Post Assessment;	≤ 20	181	55.69%	25	33.78%%
		KPI 2: Referral to Treatment; Target	≥ 80%	210	56.15%	51	53.13%
		KPI 3: Substance Reduced (TOP)	≥ 67%	680	72.19%	262	78.92%
		KPI 4: Improved Quality of Life (TOP)	≥ 56%	224	80%	73	76.84%
		KPI 5: Planned Treatment Closures	≥ 72%	85	29.11%	38	52.78%

	Referrals	**Cardiff (East and West)** 817	**Vale of Glamorgan** 198
	Assessments 2014-15	**Cardiff (East and West)** 455	**Vale of Glamorgan** 101
	Waiting Times	**Alcohol** • East 5 weeks • West 5 weeks • Vale 6 weeks	**Drug** • West 6 weeks • Vale 6 weeks • East 5 weeks

Substance Misuse Liaison Service

Referrals	**Received**	**Processed**	**Unmet Need**
	Qtr 1 = 161 Qtr 2 = 179 Qtr 3 = 223 Qtr 4 = 196	95 (60%) 150 (84%) 193 (87%) 160 (82%)	66 (40%) 29 (16%) 30 (13%) 36 (18%)

n g P	**Universal Services:**

	Service Mapping	**Switched on Volocity Workforce Development**
	Service Provider	**NewLink Wales, Public Health Wales, Cardiff &Vale University Health Board**
	Service Objectives	1. To ensure that the universal substance misuse related needs of the population of Cardiff and the Vale of Glamorgan are identified, quantified and adequately addressed. 2. To equip educational establishments with the necessary information, support and resources for the delivery of substance misuse education, information, advice and support services which are consistent with evidence of effectiveness. 3. To develop and implement a universal services workforce development programme that is aimed at equipping professionals from across all sectors with the capacity to identify, and effectively respond to any presenting issues that relate to substance use 4. To ensure that an evidence-based Cardiff and Vale-wide programme of substance use related health promotion, prevention and early intervention is established, delivered and effectively outcome assessed. 5. To implement a specialist workforce development programme that ensures that all staff working in the substance misuse field in Cardiff and the Vale is equipped with the latest evidence based knowledge, skills and capacity to be as effective as possible within their roles. 6. To identify, and respond to new skills and knowledge deficits, based on emerging evidence and research 7. To provide universal service support through training, information and signposting to key services and environments where individuals with elevated levels of risk are most likely to present at an early stage of their substance use, including acute health services, primary care, youth services, social services, and emergency services. 8. To provide an evidence-based system into the substance misuse field for individuals wishing to engage with the sector through a volunteer approach. 9. To develop volunteers skills, knowledge and competence to equip them with the ability to become the next paid workforce and address a shortfall in qualified front line workers.

	SMAF Expenditure 14/15: **Statutory:** **Other:**	**£330,489.92**	
	Areas Covered	Cardiff, Vale of Glamorgan	
	Switched on	No of schools, colleges, youth and community settings receiving training in substance misuse education	49
		Practitioners attending substance misuse education training	465
		Substance misuse education sessions delivered to young people	48
		Young people receiving targeted education sessions	833
		Individual users on Red Button website	6439
Universal Services	**Workforce Development**	Learners engaged in completing their qualification or accreditation	54
		Total number of people trained in Alcohol Brief Intervention (ABI)	360
		Courses commissioned from within Cardiff and Vale	11
	VOLocity	Volunteer applications received for VOLocity	141
		Volunteers starting a placement	38
		Volunteers completing the MILE training programme	35
	STARS	Participants receiving motivational interviewing (MI training)	214
		Motivational Interviewing courses delivered	37
		Participants receiving supervision	49

Children and Young People's Services

Service Mapping

Service Provider	Up2U	Barnardos
Service Objectives	1. Increase the number of young people in effective treatment, which has a positive impact on health and crime. 2. Incorporate provision of age appropriate substance misuse advice and information into the support programmes for vulnerable and diverse groups of children and young people aimed at reducing harm and risk, in collaboration with Tier 1 service providers. 3. To provide an accessible and appropriate range of substance misuse support services to support young people within the Cardiff and Vale of Glamorgan Youth Offending Teams (YOTs). 4. Where appropriate, and in consultation with tier 3 services, provide specialist harm reduction services that meet a young person's need to use substances more safely, including access to age appropriate needle exchange facilities, safer injecting advice, relapse prevention, referral for screening and vaccination against blood borne viruses 5. To provide support to universal and targeted children's services to ensure that all children and young people who are deemed at risk through persistent truancy, school exclusion or the criminal justice system are screened for substance misuse 6. To undertake comprehensive and holistic assessments for those children and young people who have been screened in universal or targeted services and deemed to have a substance misuse problem which requires specialist support 7. To develop a goal centered care plan for those children and young people whose needs indicate interventions at a specialist Tier 2 level ensuring the plan is shared with all relevant agencies and is coordinated and managed by a lead professional 8. To provide structured 1-2-1 and group based psychosocial interventions in line with the most up to date evidence base including but not exclusive to, Motivational Enhancement Therapy, Relapse Prevention, Cognitive	

		Behaviour Therapy, and Brief Interventions 9. To ensure that any concerns for a child or young person is acted upon in line with Local Safeguarding Children Board (LSCB) Procedures. 10. To work in partnership with adult services in order to identify and provide support to children and young people who are at risk through parental su2bstance misuse 11. To act as the gateway into the Tier 3 Young Person's Drug and Alcohol Service for all community based children's services ensuring that only the most appropriate referrals, which cannot be managed at a lower level, are referred on. 12. To ensure that, when appropriate, a young person is referred seamlessly into Tier 3 services where their needs are assessed as complex, where Co-morbidity is identified, where the age of the child or young person puts them at significant risk, or where pharmacological or residential support is required. Children and young people who require this level of service are defined as children in need; therefore their needs must be identified as part of the common assessment framework 13. To ensure, where possible and appropriate, that parents and carers of children and young people are involved in the assessment, care planning and interventions provided by the service, whilst adhering to organisational policy and guidance regarding confidentiality and consent 14. To establish, manage and quality assure transitional arrangements with adult services in order to plan a seamless transfer for a young person prior to their 18th birthday 15. To provide support to the parents or carers of the young person and refer on to more appropriate family support services where indicated by need	
	SMAF Expenditure 14-15: Statutory / Other:	£178,831.30	
	Areas Covered	Cardiff, Vale of Glamorgan	
	Referrals	66 (6 of which were inappropriate)	
	Assessments	63	
	Care Plans Developed	56	
	Total Outreach Sessions	Cardiff: 31	Vale of Glamorgan: 24

	Contacts Made with Young People via outreach	1012			
	Onward referrals	Total: 26	Tier 1: 1 Non substance misuse specific services: 7	Tier 3: 18	
			Target	**Achieved**	
	Annual Performance 2014 – 15 16+ only **Source: WNDSM**	KPI 1: DNA Post Assessment;	≤ 20	3	5.88%
		KPI 2: Referral to Treatment; Target	≥ 80%	45	97.83%
		KPI 3: Substance Reduced (TOP)	≥ 67%	14	93.33%
		KPI 4: Improved Quality of Life (TOP)	≥ 56%	8	80%
		KPI 5: Planned Treatment Closures	≥ 72%	32	91.43%

Children and Young People's Services

Service Mapping

Family Support Services

Service Provider	Family Support Service	Cardiff and Vale Local Authority
Service Objectives	1. To reduce the impact of parental difficulties including: substance misuse, mental health issues, domestic violence etc on parenting capacity. 2. To enable parents to develop and practise the skills of positive and effective parenting. 3. To encourage parents to develop greater self determination. 4. Parents are often aware of the difficulties their children face and welcome help in supporting them. 5. The service brings together the existing family support services across Cardiff and the Vale, with some additional responsibilities as follows: 6. Establish effective family support links with the IFSS Programme 7. Establish links with all SMAF funded CYP services and universal services	

		8. Provide substance misuse specialist intervention and support in relation to domestic violence and abuse. 9. Structured therapeutic support for families and the provision of CRAFT training to enable family members to better support the treatment and care programmes that service users within the family are engaged in. 10. To increase the numbers of carers, family members provided with advice, information and support. 11. To increase the number of service users involving their families in their treatment and support. 12. To increase the number of cases of DV/A where substance misuse advice, support and interventions are provided. 13. Reduce DNA rates 14. Increase treatment completion rates			
	SMAF Expenditure 14/15 **Statutory:** **Other:**	**£263,774.93**			
	Areas Covered	Cardiff, Vale of Glamorgan			
	Referrals **2014-15**	CRAFT **Qtr 1:** 37 **Qtr 3:** 28 **Qtr 2:** 49 **Qtr 4:** 19	Total **133**	Early Intervention Service **Qtr 1**: 4, **Qtr 2**: 14, **Qtr 3**: 7, **Qtr 4**: 4	Total **29**
	Allocations To Team	CRAFT **Qtr 1:** 36, **Qtr 2:** 42, **Qtr 3:** 25, **Qtr 4**: 14	Total**: 117**	Early Intervention Service **Qtr 1**: 4, **Qtr 2**: 11, **Qtr 3**: 4, **Qtr 4**: 4	Total: **23**
	Allocation to Support Workers	**Qtr 1:** 9, **Qtr 2**: 9, **Qtr 3:** 11, **Qtr 4:** 11	Total: **40**	Accessing Additional Services: **132**	

	Service Provider	**Young Person's Drug and Alcohol Services**			**Cwm Taff CAMHS**	
	Service Objectives	• Comprehensive assessment of substance misuse and mental health • Drugs and alcohol education • Harm reduction • Relapse prevention • Social skills training • Family work and parenting skills • Motivational Interviewing • Cognitive Behaviour Therapy based interventions • Liaison and consultation with other professionals				
	SMAF Expenditure 14/15 **Statutory:** **Other:**	**£85,623.00**				
	Areas Covered	Cardiff, Vale of Glamorgan				
	Referrals 2014-15	**Qtr 1** 23	**Qtr 2** 24	**Qtr 3** 22	**Qtr 4** 20	**Total** 89
	No of follow up appointments seen	**Qtr 1** 128	**Qtr 2** 157	**Qtr 3** 129	**Qtr 4** 60	**Total** 474

Care Pathway Analysis

The following care pathways map was produced by Cardiff and Vale APB Support team with a view to disseminating to primary care, (GP practices, A&E departments etc) and various health and wellbeing agency reception areas. The rationale for producing the map came from consultation with healthcare professionals and service users where two distinct themes emerged:

1. There was a clear lack of knowledge and awareness as to what services currently exist.
2. Of those people who had a partial knowledge of the services available, eligibility criteria and entry routes were unclear.

The brief guide (shown overleaf) provides key information for each of the services; from initial entry to throughcare, aftercare and recovery support. Whilst the positive intended outcome is to enable clients to make informed decisions over the most suitable intervention to meet their needs, it is also hoped the pathway will reduce the traffic of inappropriate referrals to services. This can often lead to undue service pressures and skewed performance data, particularly reflected in the DNA and unplanned exit rates.

As part of an ongoing commitment to enhance the communication strategy with stakeholders, the APB has commissioned two interactive websites (maintained by the APB support team), Twitter and a service user and carer forum to effectively engage with wider audiences.

In March 2015, the APB held a public seminar in City Hall to celebrate past and present achievements, best practice and to outline the strategic direction of future commissioning. The event was well attended by mixed audiences including service users and carers, to senior colleagues from partner agencies such as Welsh Government, Health Board, Police, Probation and representatives from the third sector council. The event was also a great opportunity to launch the newly commissioned Open Access services and Aftercare services.

Care Pathways

All services will work with you to create a care plan which will offer support with other needs including, housing, money, debt advice & sexual health

EDAS

For individuals wanting to access treatment for an alcohol or substance misuse issue

Single point of entry into alcohol and drug services

Assessment of need to refer to most appropriate substance misuse service

TAITH

For individuals looking for advice, support & information on alcohol or other substances, including how to address any issues.

Open and direct access to advice and information on drugs and alcohol through appointment or drop in.

Needle exchange, BBV testing and vaccination

CAU

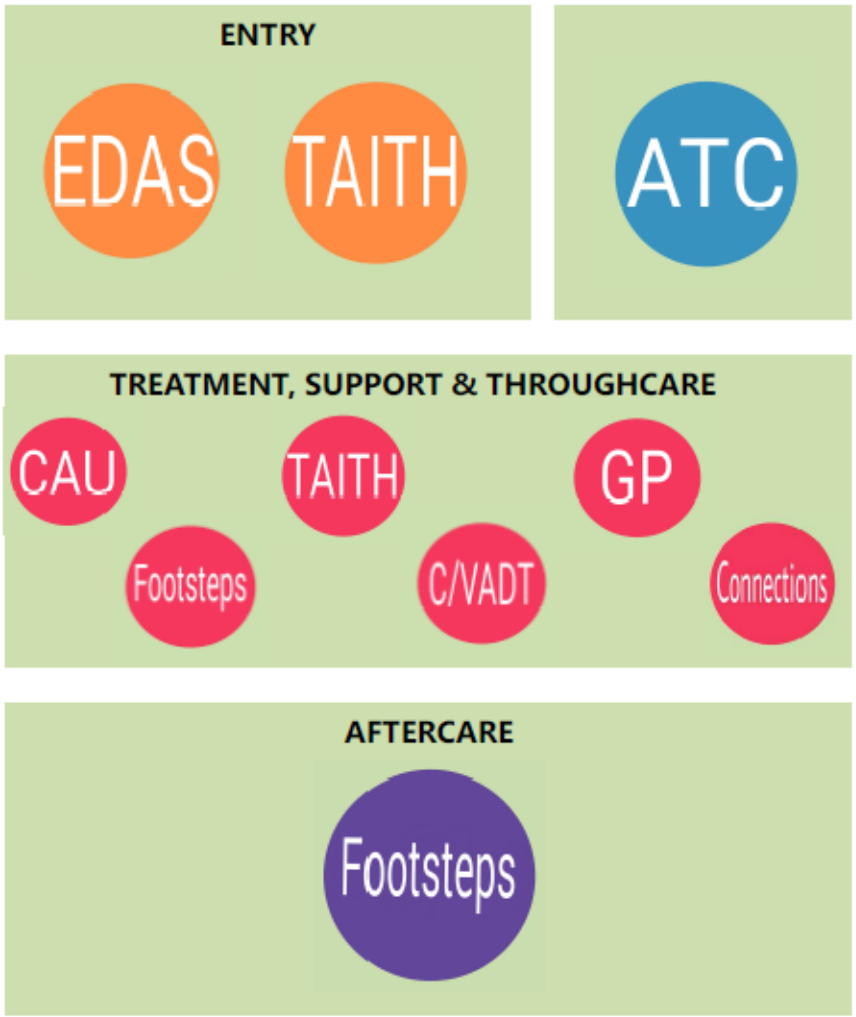
For individuals who require medical assistance in relation to their alcohol or drug issue.

Substitute & Maintenance Prescribing Programmes

Detoxification

Psychiatric Assessment

Health Screening and vaccination (HCV, HBV, HIV)



For more information on this pathway and other substance misuse services available in Cardiff & the Vale of Glamorgan please visit **www.cardiffandvaleapb.org**

APB

GP SHARED CARE

For individuals who have reached stability with their maintenance or substitute prescription programmes

Substitute or maintenance prescribing within primary care service.

Specialist check in appointments for on-going support.

CADT/VADT (Cardiff/Vale)

Assessment for rehabilitation, residential care and domiciliary support.

Connections (Cardiff/Vale)

Individual, couple and family structured counselling

ATC

Diverts individuals away from the Emergency Department who are acutely intoxicated.

FOOTSTEPS TO RECOVERY

For individuals who are ready to move on from treatment through Structured Programmes

On-going relapse prevention support

Support with transition out of services

Volunteering and Diversionary Activities & Recovery Community support

Cardiff & Vale APB

Achieving better substance misuse outcomes

Adult Commissioned Substance Misuse Service Guide

If you are under 18 and would like information about alcohol or drugs then please contact

0800 0232753

www.red-button.org

If you are over 18 and are concerned about your own or somebody else's substance use (inc. alcohol) then please contact;

0300 300 7000

The Bridge Programme

The Bridge programme is for those with substance misuse and accommodation (homeless status) issues.

Resettlement support with the ultimate aim of being resettled into suitable and stable accommodation.

BBV screening and Hepatitis B vaccination.

Psychosocial interventions access to substitute medication

Aftercare support

ASFAcarduf

ASFAcarduf is a forum for substance misuse service users across Cardiff & the Vale of Glamorgan. The forum collates thoughts and opinions of service users from a number of different services and feeds them back to both service providers and commissioners.

If you would like to get involved in ASFAcarduf then please visit our website;

www.**asfacarduf**.org

If you have a loved one who has issues with drugs or alcohol and feel that you need support you, contact one of the following organisations;

CRAFT: www.**ifstcandv**.org

Tearing Your Hair Out: **www.tearingyourhairout**.co.uk

Al Anon: www.**al-anonuk**.org.uk

Alcohol Treatment Centre

The Alcohol Treatment Centre (ATC) has derived from a pilot project supported through a consortium of providers including Cardiff Council, University Health Board, Wales Ambulance Trust, Police and Youth Justice Services.

Since it was launched in 2013/14, the ATC has been serving the night time economy in Cardiff City Centre on Friday and Saturday evenings through the provision of an emergency alcohol unit for people who are intoxicated and therefore considered a risk to themselves and/or others. The ATC operates on major event triage principles and is responsible for achieving the following broad objectives:

- Diversion of non-critical incidents away from the EU
- Provision of brief interventions
- Referral on to support services
- Provision of a safe environment for intoxicated individuals

In 2014/15, SMAF funding was reallocated in response to the need to maintain the ATC as a flagship service, whilst the RCF funding previously used to support the service has been cut. The total running costs are approximately £160,000 per annum, and the remainder is being met through member agency in-kind contributions and a small (£25,000) remaining RCF resource for the year.

The following analysis is sourced via the Cardiff and Vale UHB Emergency Department (ED) dataset. Please note only attendances where alcohol was reported as the 'initial complaint' are captured which is not a mandatory field and often completed by non clinical staff. As such the figures overleaf are likely to under represent the total number of attendances to the ATC.

The following data for 2013-2015 reveals whilst the majority of people accessing the ATC are Cardiff and Vale residents, a great proportion are 'out of area' potentially visiting the city due to its vibrant night time economy.

When looking exclusively at the number of Cardiff and Vale residents, the majority live in Cardiff South East (Splott, Adamstown, Plasnewydd, Gabalfa, Cathays) which are a mixture of deprived communities first areas and the latter synonymous with student accommodation. In the Vale of Glamorgan, most people live in 'Central Vale' (Barry, Wenvoe, Roose and St Athan).

There is no evident trend in regards to gender split as the proportion of males and females accessing the ATC differs however in respect to the age demographic, the majority of people are typically aged between 15-24 years.

2014/15

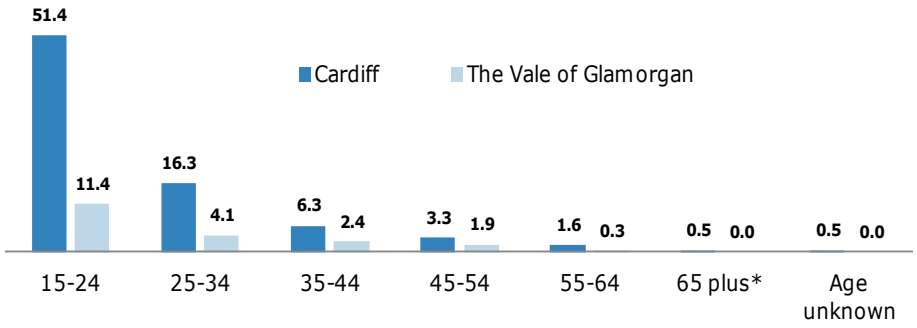
Attendances at the Alcohol Treatment Centre, counts and percentages, persons, by local authority area of residence, 2014/15

Local Authority	Number of attendances	Percentage of total attendances
Cardiff	294	31.5
The Vale of Glamorgan	74	7.9
Elsewhere in Wales	214	22.9
Resident in England	68	7.3
Residence not available*	284	30.4
Total	**934**	**100**

Attendances at the Alcohol Treatment Centre, Cardiff and Vale UHB, persons, by Neighbourhood management area of residence, 2014/15

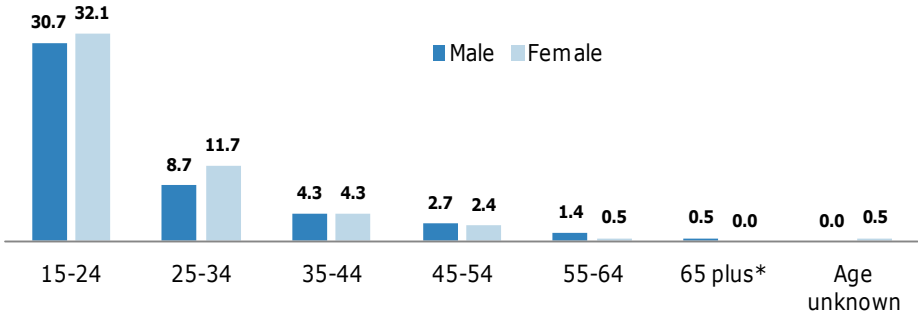
Neighbourhood	Number of attendances	Percentage of total attendances
City & Cardiff South	14	1.5
Cardiff East	33	3.5
Cardiff North	66	7.1
Cardiff South East	98	10.5
Cardiff South West	44	4.7
Cardiff West	39	4.2
Central Vale	36	3.9
Eastern Vale	25	2.7
Western Vale	13	1.4
Not resident in Cardiff and Vale/unknown*	566	60.6
Cardiff	**294**	31.5
The Vale of Glamorgan	**74**	7.9
Total attendances at ATC	**934**	**100**

Attendances to the Alcohol Treatment Centre, Cardiff and Vale UHB residents, percentages, all persons, age 15+, April 2014 - March 2015
Produced by Public Health Wales Observatory, using data supplied Cardiff & Vale UHB Information Services Department



*oldest age of attendance was 75 years in 2014/15

Attendances to the Alcohol Treatment Centre, Cardiff and Vale UHB residents, percentages, all persons, age 15+, April 2014 - March 2015
Produced by Public Health Wales Observatory, using data supplied Cardiff & Vale UHB Information Services Department



2013/14

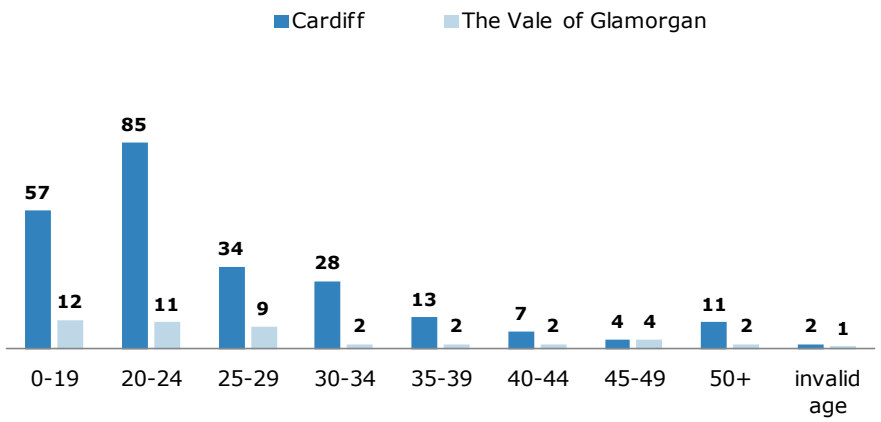
Local Authority	Number of attendances	Percentage of total attendances
Cardiff	241	33.2
The Vale of Glamorgan	45	6.2
Elsewhere in Wales	159	21.9
Resident in England	33	4.6
Residence not available*	247	34.1
Total	**725**	**100**

Counts of attendances at the Alcohol Treatment Centre, Cardiff and Vale UHB, persons, by Neighbourhood management area of residence, 2013/14

Neighbourhood	Number of attendances	Percentage of total attendances
City & Cardiff South	37	5.1
Cardiff East	19	2.6
Cardiff North	58	8.0
Cardiff South East	61	8.4
Cardiff South West	35	4.8
Cardiff West	31	4.3
Central Vale	26	3.6
Eastern Vale	14	1.9
Western Vale	5	0.7
Not resident in Cardiff and Vale/unknown*	439	60.6
Cardiff	**241**	33.2
The Vale of Glamorgan	**45**	6.2
Total attendances at ATC	**725**	**100**

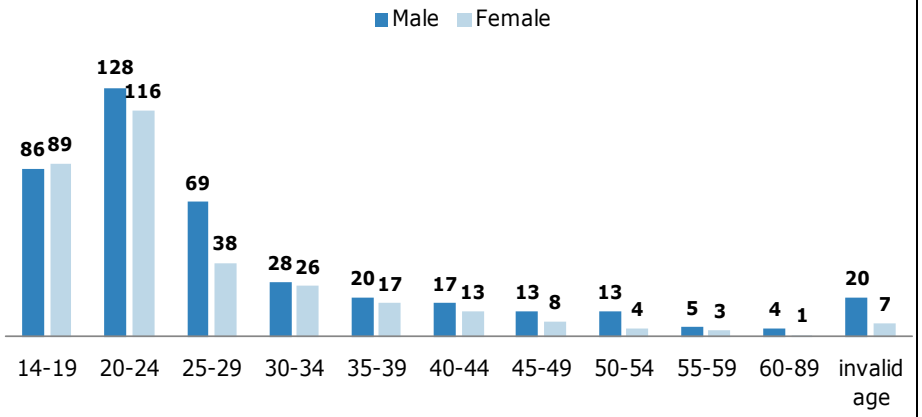
Attendances to the Alcohol Treatment Centre, Cardiff and Vale UHB residents, all persons, age- specific age groups, April 2013-March 2014

Produced by Public Health Wales Observatory, using data supplied by Cardiff and Vale UHB Information Services departm



Attendances to the Alcohol Treatment Centre, Cardiff and Vale UHB, all persons, age- specific age groups, April 2013-March 2014

Produced by Public Health Wales Observatory, using data supplied by Cardiff and Vale UHB Information Services department



All ATC data has been sourced via the Public Health Wales Observatory

Needle Syringe Activity

The following table demonstrates needle exchange transactions for the previous financial year (14/15) by agency (including participating pharmacies across Cardiff and the Vale of Glamorgan).

Site	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Total	Unique Client
602051A - St Mellons CF3 5UA	41	49	41	32	38	43	36	45	45	56	37	61	524	174
602381B - The Murch CF64 4QY	3	3	1	7	4	1	3	2	3	7	1	3	38	19
602421D - Park Crescent CF62 6HD	17	26	23	28	37	36	29	28	32	39	35	44	374	144
602514D - Caerau Lane CF5 5HQ	9	2	22	23	12	13	18	38	18	14	11	6	186	22
602514J - Pearns CF24 2OZ	39	58	68	79	76	72	73	43	48	57	42	46	701	114
602514K - Pearns CF5 4LJ	14	8	13	8	7	10	8	10	6	9	8	4	105	29
602735B - Woodville Road CF24 4EB	69	85	62	69	62	90	70	70	61	73	73	122	906	432
602807H - Lloyds CF5 4LL	40	75	55	64	63	52	40	11	3	18	0	0	421	125
602816L - Boots CF64 1YJ	2	6	5	19	14	13	10	9	21	15	19	28	161	46
602819B - Boots CF61 1XZ	14	5	15	11	13	23	14	6	3	8	7	6	125	32
602855M - Co-op CF10 5HR	24	18	21	19	18	20	24	21	14	28	26	25	258	153
CAU - CRI	180	192	193	113	46	143	215	158	135	173	166	198	1912	707
CAU - Newlands	36	38	56	38	22	14	0	0	0	0	0	1	205	127
Huggard	307	300	373	490	535	512	441	443	496	418	430	522	5267	784
Taith - Barry	218	237	205	272	260	304	286	220	203	223	247	264	2939	569
Taith - Cardiff	342	357	428	397	351	266	204	242	293	373	311	305	3869	1128
Ty Gobaith Salvation Army	0	0	0	0	0	0	0	2	0	1	16	6	25	8
Wallich CHT	4	4	2	6	5	8	15	5	3	11	2	3	68	21
Wallich Hostel Cardiff	51	37	42	58	62	38	65	43	41	34	22	58	551	45
Total	1410	1500	1625	1733	1625	1658	1551	1396	1425	1557	1453	1702	18635	4679

2013 - 14

Site	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Total	Unique Client
CAU - CRI	436	458	447	497	446	373	310	334	383	279	149	161	4273	1002
CAU - Newlands	45	39	65	71	53	44	41	39	15	36	38	45	531	303
Huggard	187	217	239	279	254	304	246	229	286	406	384	338	3369	504
Taith - Barry	234	237	204	246	260	246	201	193	186	245	188	228	2668	549
Taith - Cardiff	210	310	259	333	301	278	317	236	232	284	340	361	3461	1057
Ty Gobaith Salvation Army	0	103	27	15	11	22	16	4	7	3	0	10	218	62
Wallich CHT	27	29	34	26	17	36	17	11	2	4	3	6	212	41
Wallich Hostel Cardiff	42	43	44	60	56	53	19	16	5	21	25	41	425	48
Total	1181	1436	1319	1527	1398	1356	1167	1062	1116	1278	1127	1190	15157	3566

2012 - 13

Site	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Total	Unique Client
CAU - CRI	397	427	384	518	349	387	330	427	341	439	385	428	4812	1275
CAU - Newlands	18	19	20	40	6	0	79	44	38	44	47	29	384	232
Huggard	32	45	46	18	35	43	125	148	172	287	275	295	1521	305
Taith - Barry	115	186	200	189	208	164	140	141	145	165	203	227	2083	361
Taith - Cardiff	358	430	398	413	371	304	332	234	144	195	222	162	3563	957
Ty Gobaith Salvation Army	71	75	27	23	47	23	31	2	3	0	0	29	331	51
Wallich CHT	2	2	6	6	10	18	30	21	6	13	9	18	141	17
Wallich Hostel Cardiff	54	48	41	61	61	40	82	79	63	47	47	48	671	63
Total	1047	1232	1122	1268	1087	979	1149	1096	912	1190	1188	1236	13506	3261

2011 - 12

Site	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Total	Unique Client
CAU - CRI	263	315	375	378	331	555	385	548	346	361	396	412	4665	1370
CAU - Newlands	21	21	11	32	19	24	15	7	12	8	16	12	198	125
Huggard	0	0	0	9	67	76	47	34	60	49	43	36	421	118
Taith - Barry	153	168	190	158	203	185	180	144	127	114	113	74	1809	305
Taith - Cardiff	327	340	369	409	488	415	314	301	275	259	349	383	4229	1060
Ty Gobaith Salvation Army	45	73	24	56	65	49	18	16	37	50	49	74	556	72
Wallich CHT	0	0	0	11	5	6	2	2	7	12	5	3	53	14
Wallich Hostel Cardiff	0	0	0	24	56	69	98	59	122	50	26	37	541	41
Total	809	917	969	1077	1234	1379	1059	1111	986	903	997	1031	12472	3105

Naloxone Distribution and Replenishment

2014/15	Supply	Resupply	Total
Agency:			
Naloxone registry - CAU - Barry	12	66	78
Naloxone registry - CAU - Cardiff	102	65	167
Naloxone registry - HMP Cardiff	47	38	85
Naloxone registry - IOIS Cardiff and Vale	24	27	51
Grand Total	**185**	**196**	**381**

2013/14	Supply	Resupply	Total
Agency:			
Naloxone registry - CAU - Barry	17	14	31
Naloxone registry - CAU - Cardiff	79	51	130
Naloxone registry - HMP Cardiff	64	32	96
Naloxone registry - HMP Cardiff Professional	1		1
Naloxone registry - IOIS Cardiff and Vale	45	20	65
Grand Total	**206**	**117**	**323**

2012/13	Supply	Resupply	Total
Agency:			
Naloxone registry - CAU - Barry	8	8	16
Naloxone registry - CAU - Cardiff	54	32	86
Naloxone registry - HMP Cardiff	73	21	94
Naloxone registry - Huggard Centre	1	1	2
Naloxone registry – Taith Barry		1	1
Naloxone registry - Taith - Cardiff	11	4	15
Grand Total	**147**	**67**	**214**

2011/12	Supply	Resupply	Total
Agency			
Naloxone registry - CAU - Barry	19	8	27
Naloxone registry - CAU - Cardiff	53	34	87
Naloxone registry - HMP Cardiff	36	4	40
Naloxone registry - Huggard Centre	8	2	10
Naloxone registry - Taith - Barry	5	3	8
Naloxone registry - Taith - Cardiff	2	7	9
Naloxone registry - Wallich Hostel - Newport Rd	10	5	15
Grand Total	**133**	**63**	**196**

According to the latest figures published on the NEO database, 322 accessed naloxone training during 2014/15; a slight decline in comparison to the previous cumulative year which peaked at 420. The infancy of the NEO database as a reporting tool could potentially explain fewer numbers reported for 2012/13 (269) and 2011/12 (206).

Naloxone significantly reduces the risk of premature death by temporarily reversing the effects of a heroin overdose; thus providing ambulance services with a window of opportunity to perform life saving treatment. Take Home Naloxone (THN) kits are available throughout Wales, to all individuals at risk of opioid poisioning. They have reportedly been used successfully in 632 overdose cases since 2009' (PHW Observatory).

Recent data published by the Office of National Statistics (ONS) reveals the number of drug related deaths (113) in Wales has declined by 16% in comparison to the previous year and 30% since 2008; marking a 5 year consecutive downward trend.

In addition to the Harm Reduction & Recovery Group (which meets quarterly), Cardiff and Vale APB also coordinates ad-hoc Drug Related Death Panels to review recent fatalities with a view to deciphering 'lessons learned' and identifying any gaps in service provision. Despite its infancy, these meetings are well attended and open to all statutory and non statutory agencies; open to the individual in the events leading up to their death.

Alcohol Related Brain Damage

According to Boughy, (2007) traditionally, service provisions for patients with alcohol related brain injuries has been seemingly sparse, often resulting in patients being placed in 'inappropriate institutions' deemed unsuitable to their needs. The lack of appropriate care often aggravated pre existing conditions (Mental Welfare Commission, 2006). However due to recent developments in clinical practice and changing perceptions and attitudes 'Alcohol Related Brain Damage is now an accepted clinical term across the UK and Europe, founded through practical experience and incorporating the term 'alcohol related dementia' (Svanberg et al, 2000).

Welsh Government has demonstrated a continued commitment to enhancing accessibility to quality tier 4 services by investing £1 million of Substance Misuse Action Fund (SMAF) monies; ring fenced to supplement existing local health board and local authority budgets to offer tier 4 placements.

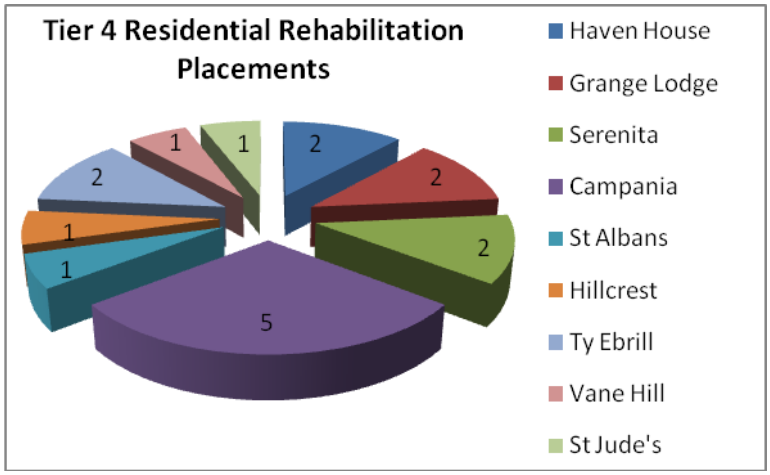
To facilitate informed decisions regarding treatment options, Welsh Government has recently issued a comprehensive guide detailing each Tier 4 service facility available across Wales and their respective costs.

There are 3 inpatient detoxification units in Wales offering withdrawal programmes for clients seeking tier 4 support for drug and/or alcohol dependency. These include the Adfer unit in Whitchurch hospital, Calon Lan Ward in NPT hospital and Hafen Wen. Each of these facilities provide substitution prescriptions, relapse prevention, psycho social interventions and stabilisations using substitute opioids.

For clients requiring more intensive 'round the clock' support there are 5 residential rehabilitation centres in Wales. NICE guidelines recommend these facilities are most

suitable for clients seeking long term abstinence who have 'significant comorbid physical, mental health or social problems' such as housing (Welsh Government Guide to Inpatient Detox and Residential Rehabilitation, 2015).

The following graph and table overleaf depicts the number of placements to residential rehabilitation facilities for 2010-2015.



For the last several years, Cardiff and Vale APB has also apportioned £42,577.50 to the Salvation Army Bridge Programme for delivery of residential preparation, detoxification and aftercare services. By utilising Tier 4 ring fenced and generic SMAF resources the following objectives are to being achieved:

- Increased treatment completion rates
- Decreased DNA rates
- Reduce the average number of previous treatment episodes among new referrals

Cardiff and Vale residents placed within a Tier 4 Residential Rehabilitation Service

***Cost per person, per week*

	Placement	Duration	2010-11	2011-12	2012-13	2013-14	2014-15
Pre 2010	Haven House	From 18/10/04	£386.30	£390.20	£390.20	£390.20	£432.50
	Grange Lodge	From 01/08/08	£458.54	£486.00	£501.00	£525.00	£550.00
2010-11	Serenita	From 13/09/10	£720.00	£727.20	£727.20	£727.20	£727.20
	Campania	From 09/04/10	£720.00	£727.20	£750.00	£750.00	£750.00
2011-12	Campania	From 28/02/12			£750.00	£750.00	£750.00
2012-13	St Albans	07/05/12 - 21/08/12			£752.72		
	Campania	From 22/08/12			£750.00	£750.00	£750.00
	Campania	17/09/12 - 02/11/14			£750.00	£750.00	£750.00
	Hillcrest	From 01/06/12			N/K	N/K	N/K
	Serenita	17/01/13 - 06/05/14			£750.00	£750.00	£750.00
2013-14	Campania	09/08/13 - 09/07/14				£750.00	£750.00
	Ty Ebrill	From 21/01/14				£650.00	£650.00
2014-15	Grange Lodge	From 03/11/14					£550.00
	Haven House	26/03/15 - 30/06/15					£620.00
	Vane Hill	From 09/07/14					£750.00
	St Jude's	From 02/03/14				£487.10	£496.84
	Ty Ebrill	From 06/05/14					£650.00

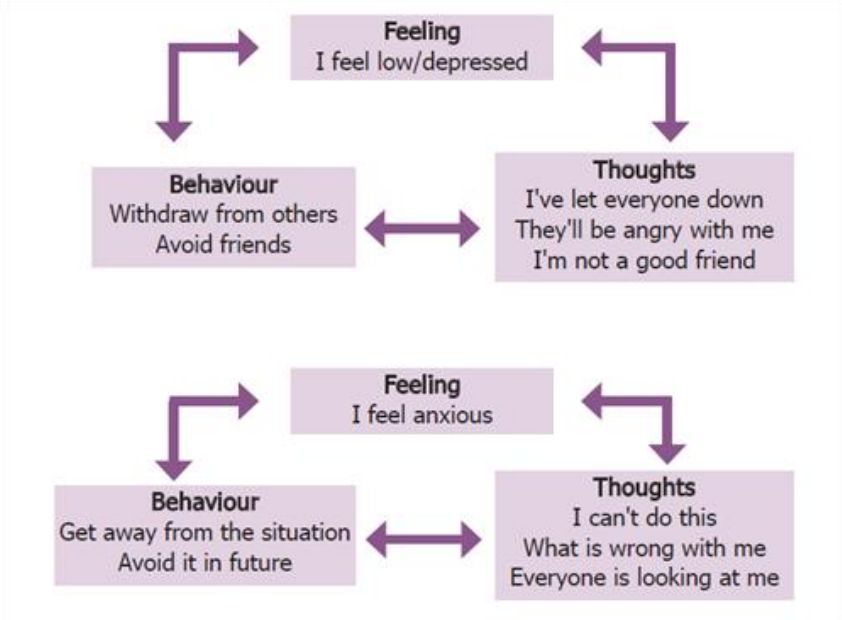
Source: CADT, 2015

Therapeutic Treatments

Cognitive Behavioural Therapy

Over recent years the use of therapeutic interventions such as Cognitive Behavioural Therapies (CBT) has gained increasing popularity by clinicians and healthcare practitioners in supporting clients with anxiety, depression and other physical and mental health related issues - including substance misuse. The principles and practices of CBT can be offered as a primary therapeutic intervention or in conjunction with several others depending on the complexity of the client's needs.

CBT is most widely regarded as a 'talking therapy'; encouraging individuals to eradicate negative thoughts, feelings and beliefs which are considered to be 'interconnected' and ultimately influence behaviour, as depicted in the graphical illustration below:



Source: mind.org.uk

The goal of CBT within a substance misuse context is to increase client resilience and ability to develop effective coping strategies through self preservation in order to detect cravings early and identify harms associated with continued drug or alcohol use on quality of life and the implications this has on health.

The use of CBT is widely available in Cardiff and Vale APB across the majority of commissioned adult and children and young people's services; as such the number of staff trained in delivering CBT is steadily increasing. However Kouimtsidis et al (2007) suggest CBT is not 'simplistic' and 'requires regular training and supervision in order to be effective'. In the book 'Cognitive-Behavioural Therapy in the Treatment of Addiction'; Kouimtsidis et all (2007) also identify overlap of several therapeutic treatment therapies with CBT including motivational interviewing (MI) and the relapse prevention model, particularly in the use of different words to describe similar concepts.

Positive Psychology

"Positive Psychology is the scientific study of the strengths and virtues that enable individuals and communities to thrive. The field is founded on the belief that people want to lead meaningful and fulfilling lives, to cultivate what is best within themselves, and to enhance their experiences of love, work, and play", (*Positive* Psychology Centre at the University of Pennsylvania*).*

Initially developed by Abraham Maslow et al, positive psychology is perceived to be a relatively novel form of psychology which encourages clients to focus on the positive influences in their life such as character strengths, optimism and 'constructive institutions' to achieve positive emotional and mental wellbeing. Peterson et al categorises happiness in three broad domains, pleasure, engagement and meaning.

According to this school of thought, clients are far more likely to make positive and sustainable changes in their lives if they are empowered by achievable tangible goals to strive for. Furthermore addiction is a 'behavioural disorder and even the most entrenched behaviours can be changed' (psychologytoday.com). However there is limited conclusive evidence available to suggest positive psychology has been effective in supporting the recovery of cohorts of people affected by addiction or substance misuse. According to Duckworth et al (2005) 'very little empirical research has explored the role of positive emotions and of strengths in prevention and treatment'.

Legislation and Guidance

Cardiff and Vale APB takes every precaution to ensure services are commissioned based on robust and transparent tendering processes. Each of the services commissioned by the APB is subject to operate within the parameters of legislative policies and guidance defined by Welsh Government in the delivery of all interventions. The following is not an exhaustive list however depicts some of the core mandatory guidance services must adhere to in order to provide the necessary assurances to the APB in regards to quality of service and duty of care:

- National Substance Misuse Strategy: Working Together to Reduce Harm (2008-18)
- Welsh Government Substance Misuse Treatment Framework - Open Access, Personal Development, Support and Aftercare
- Welsh Government Substance Misuse Treatment Framework - Carers and Families of Substance Misusers
- Welsh Government: Core Standards for Substance Misuse. WAG (2010)
- Drug Misuse & Dependence: UK Guidelines on Clinical Management (2007)

- Safeguarding Children: Working Together under the Children Act (2004), WAG (2007)
- Protection of Vulnerable Adults (POVA)
- Social Services & Wellbeing Act (2014)
- Wellbeing of Future Generations Act (2015)

Staff Consultation

To ensure the needs of all staff were considered, a questionnaire consisting of 10 questions was carefully selected to glean information on a number of topic areas including effective communication mechanisms and feedback on current and future commissioning. Responses were invited from all staff irrespective of commissioning status, with a view to encouraging a detailed and well represented response.

To maximise uptake questionnaires were available in hard copy as well as online via Survey Monkey ™ to provide additional flexibility. A detailed summary of received responses is included in appendix b.

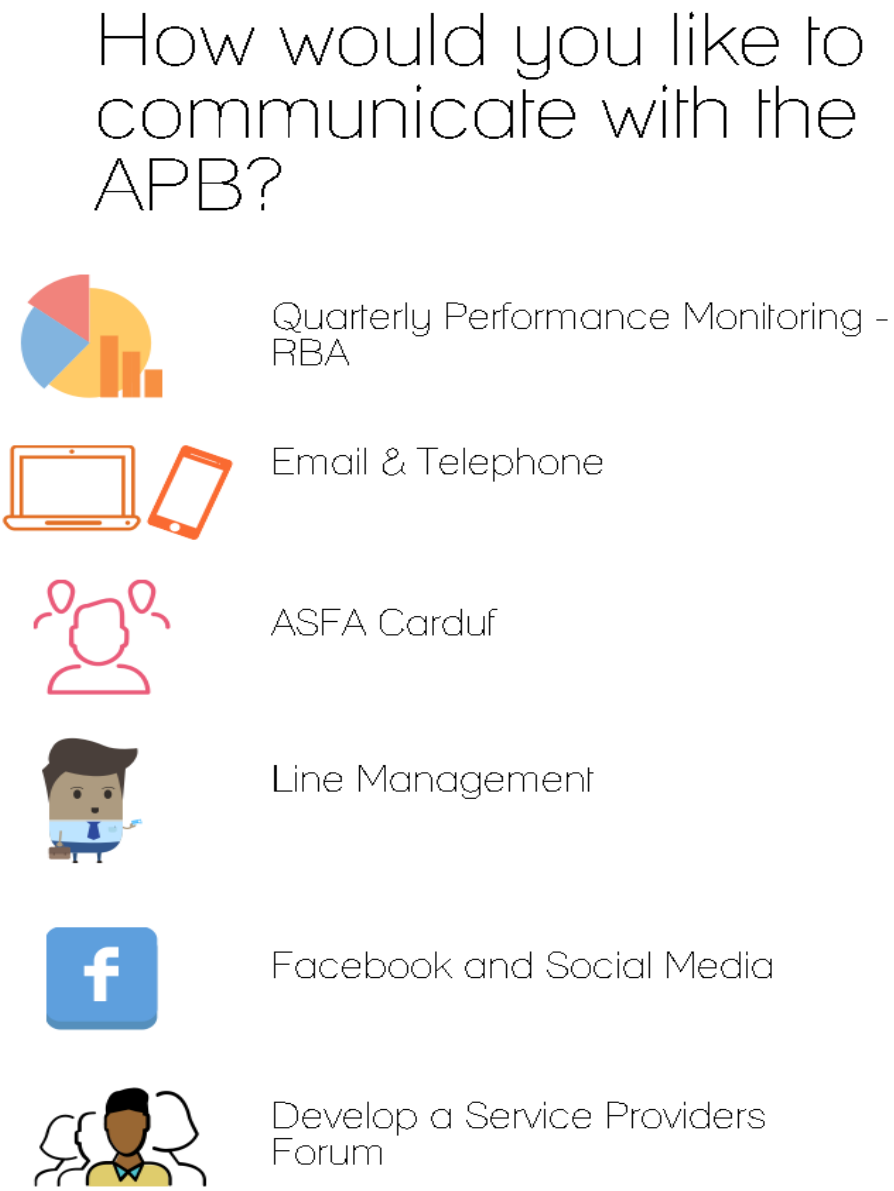
A total of 46 staff completed the survey; of which 20 worked collectively across Cardiff and the Vale of Glamorgan, 25 in Cardiff alone, 0 in the Vale and 1 respondent skipped the question. The majority of staff work with adults (32), 12 combined adults and CYP and 2 with CYP only. 45.7% (7) work within the third sector, (7) 15.2% statutory sector, (7) 15.2% both third and statutory sector and (11) 23.9% skipped the question.

The following chart summarises staff attitudes towards capacity, resources and confidence in making referrals:

Of the 46 respondents, the majority of people 85% (39) said they have access to learning and development opportunities applicable to their role, 3 disagreed and 4 skipped the question.

On the whole, most staff (92%) appeared to have a reasonable understanding of the roles and responsibilities of the Area Planning Board, 5.2% of people were unsure, 2.6% of people 'had not heard about the APB' and 8 skipped the question. Most staff (63%) had an awareness of the service user forum otherwise referred to as 'ASFA Carduf', however 17% had not and 20% skipped the question.

The following visuals represent some of the preferred communication mechanisms staff favour to contact the APB as well as suggestions for improving attendance at ASFAcarduf user forum.



How can we improve attendance at ASFA Carduf?

Virtual Participation
Video Conferencing

Recovery Community
Involvement

Greater Accessibility
Rotation of Venue's across C&V

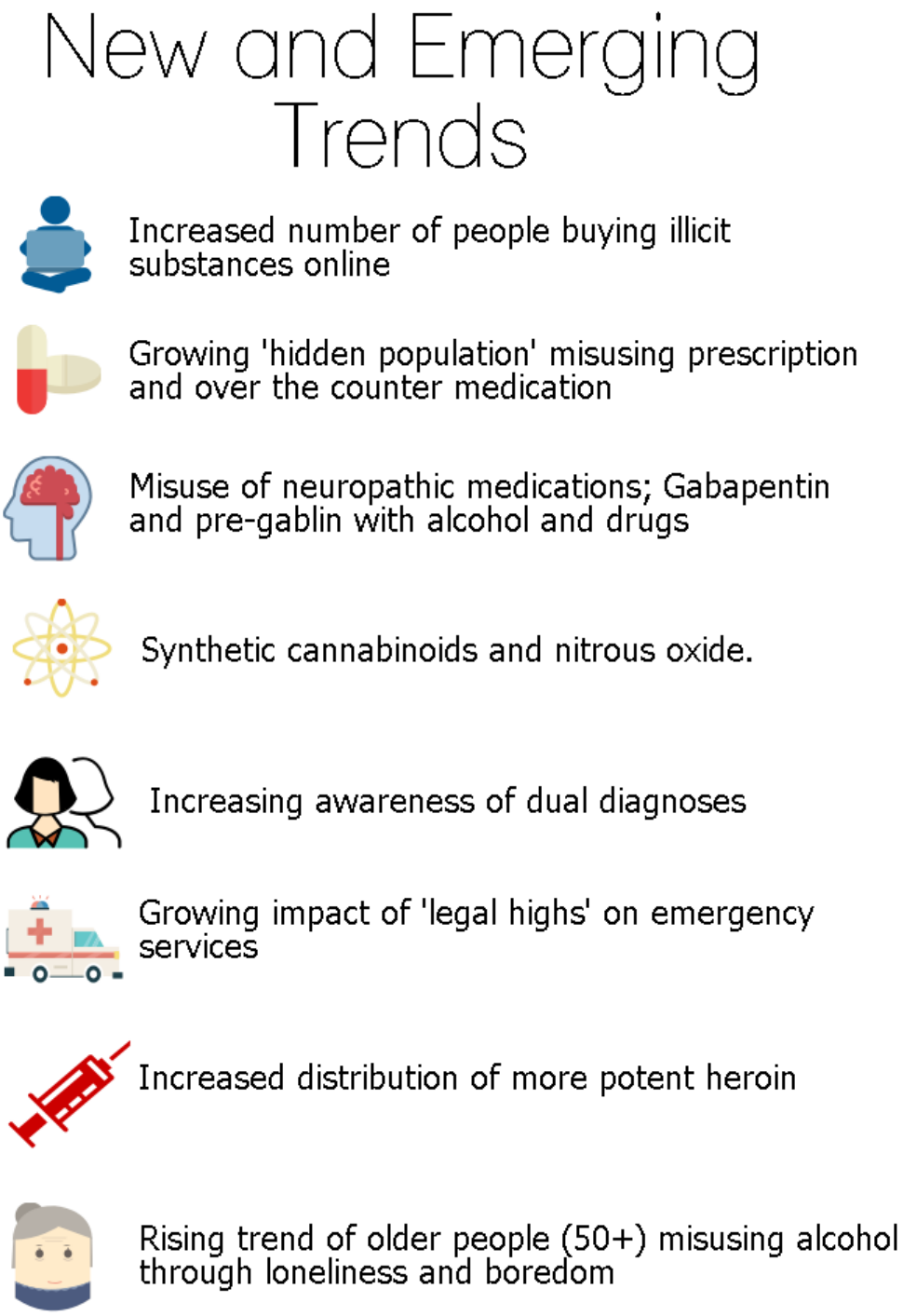
Newsletter
regularly circulated

Avoid Duplication
with other meetings

Additional Advertising
and awareness raising

Objective
& Solution Focussed

Due to the changing nature of substance use, frontline staff and practitioners were asked to identify new and emerging trends which the APB should be sighted on.



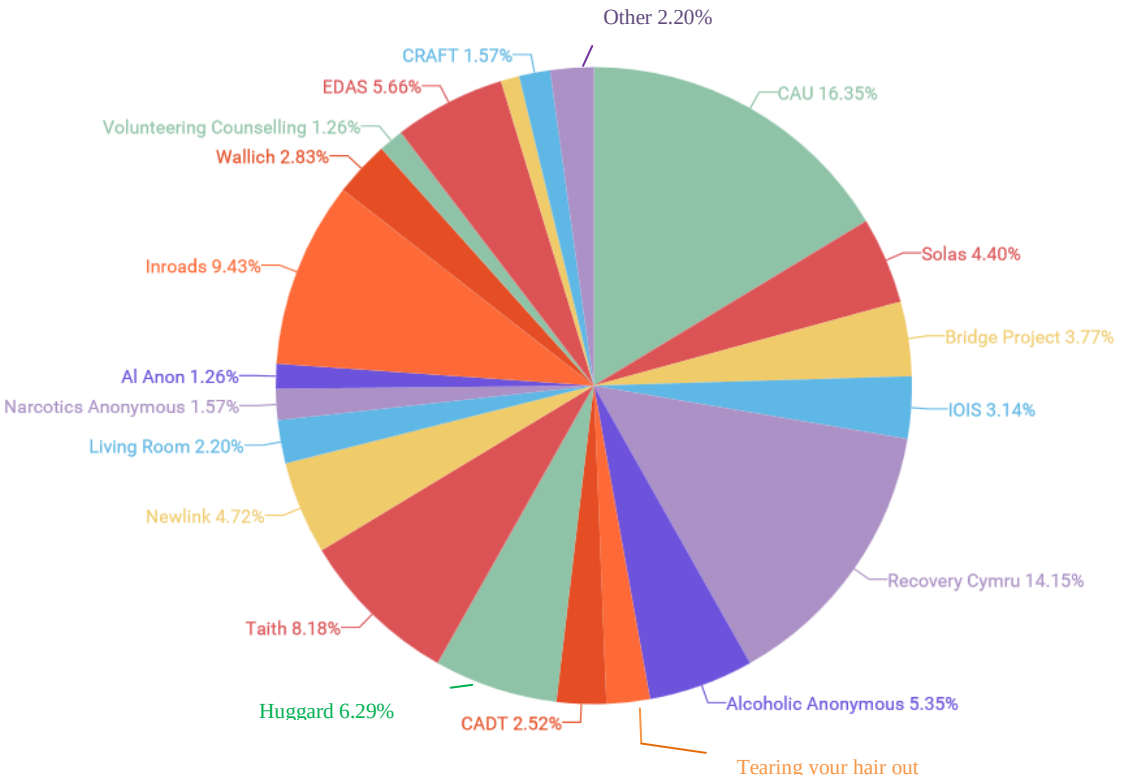
The vast majority of these trends appear to be warranted and reflected using prevalence data (previously documented in chapter 1).

Service User & Carers Consultation

Service users and carers (past and present) were invited to reflect on their involvement with substance misuse provisions across Cardiff and Vale of Glamorgan and share their experiences.

Using a similar format to the staff consultation, 10 questions were compiled into a short questionnaire which was distributed to substance misuse provisions and other health and wellbeing services across Cardiff and Vale. Survey Monkey™ was once again adopted for those seeking assurances as to discretion and anonymity.
A total of 130 respondents participated in the exercise; of which 98 said they lived in Cardiff and 28 in the Vale of Glamorgan.

Of responses received the majority of service users or carers have had some engagement with the Community Addictions Unit (16.4%), Recovery Cymru (14%), Inroads (9.4%) and Taith (8.1%). The following graphic depicts the other agencies which clients frequent.

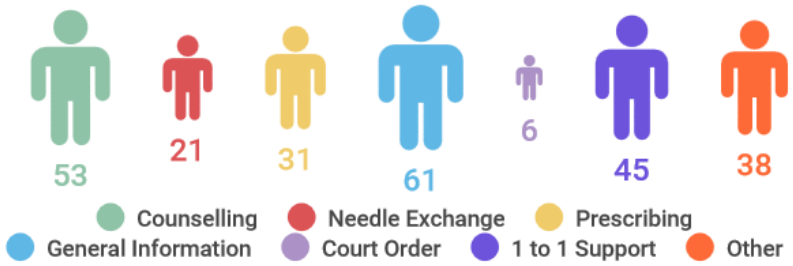


Source: info.gram

Of the total service users and carers surveyed, the most prevalent primary substance and reason for contacting a specialist service is alcohol (40%) followed by opiates (25.7%), Cannabis (10.9%), stimulants (10.4%) and 5.7% 'Other'. Despite the increasing popularity of Novel Psychoactive Substances, only 5.2% reported this as the primary cause for contact with substance misuse services.

The following graphic demonstrates the type of intervention and/or reasoning for contacting a specialised substance misuse agency.

Counselling	53
Needle Exchange	21
Prescribing	31
General Information	61
Court Order	6
1 to 1 Support	45
Other	



Of those engaged with services, the majority (62.9%) rated the support they received to address their substance misuse issues as ‘very positive’, 26.6% ‘positive’, 5.6% ‘neutral’, 3.25% ‘negative’ and 1.61% ‘very negative’.

Many of the surveyed participants had additional holistic needs (denoted below):

The fact that so many of the respondents had additional holistic needs which require one or more specialist service, signifies the importance of partnership working and cross agency communication in order to facilitate informed signposting and onward referrals.

The APB sought to discover what proportion of people felt respected by their key worker or healthcare practitioner. A total of 129 respondents completed this

question, of which 90.6% felt either very positive or positive that they were respected, 6.9% were neutral and 2.2% did not feel respected.

In regards to rating experiences with substance misuse services, of 123 respondents, 54.4% (67) of people felt very positive, 28.4% (35) positive and 12.3% (15) neutral. However sadly 4.87% (6) felt the service received was less than satisfactory. The following extracts highlight some of the key themes of service satisfaction:

Positive 	"Knowledge of steroids is more than other needle exchanges I have used". "I am not judged on my past addictive behaviour" "Everyone that deals with me is very helpful" "Can't fault the service other than length of time to access the service following referral" "I feel that what I say is actually listened to".	**Negative** 	"No Doctor has enough time for you. They only have 10 minutes and they are not specialist enough". "I would like to see the transgender community included in these services". "When substance misuse overlaps with mental health issues then help falters".

Interestingly the survey revealed the most common reasons for failed attendances are memory loss, intoxication, accessibility issues and for some people the whole experience can seem 'too daunting'. However some people did respond to say that increased flexibility of service operating times to meet individual needs had improved their attendance.

Finally the APB wanted to know how many people had an awareness of the ASFA Carduf Forum. Of a total of 124 responses, 79 (63.7%) were aware of the forum, whilst 45 (36.2%) were not.

Conclusion & Further Recommendations

The rationale for undertaking this health needs assessment has been to underpin the refresh of the Substance Misuse Commissioning Strategy and to facilitate the Area Planning Board to make informed decisions in the context of future planning. Although this document is somewhat limited in respect to implementing any actions, it is useful to highlight priority areas to commissioners nonetheless.

Whilst the top 3 prevalent substances in Cardiff and Vale of Glamorgan remain unchanged (Alcohol, Cannabis and Heroin) since the previous commissioning strategy was published, the demographic profile of the region has changed considerably. Recent prevalence data alludes to a growing older population (65+) and rising life expectancy (78-83 years); however this too highlighted local level inequalities and disparities in deprivation (healthcare, access to services, education and employment). Furthermore the gap between local level inequalities and deprivation is likely to widen with reference to the introduction of universal credit and the Welfare Reform Act (see appendix A).

The Wallich Alcohol Study revealed a growing number of older people drinking alcohol in excess of national guidelines (approximately 16,902) due to perceived isolation, relaxed entrenched cultural norms and lack of awareness of information and/or service provisions. It is therefore fundamental that services are geared towards older people in the context of appropriate marketing and communication and the need to work holistically with non specialist substance misuse services which older people are likely to frequent, e.g. GP surgeries. Where possible, outreach services would benefit this cohort of clients who are otherwise hard to engage.

Since 2004 the number of households in the UK with internet access has increased by 35% (Office for National Statistics, 2014). The latest figures published by ‘Breaking Free Online’ reveal 264 people have accessed e-learning for help with drug and/or alcohol issues; which is a continuing growing trend with those seeking discretionary support or reduced accessibility to services. The internet is continuing to revolutionise services capacity to communicate targeted information to large cohorts of people in a reasonably cost effective way. A recommendation would therefore be to look to new innovative technology and social media in the delivery of therapeutic interventions and structured support within the home.

Therapeutic interventions and other new and emerging treatment therapies (e.g. positive psychology) are gaining considerable recognition by academics and practitioners alike and seem to be well received by service users in receipt of these. However due to the relative infancies in a substance misuse context, data is inconclusive to justify long term effectiveness. Despite this the APB may want to consider allocating some of its Substance Misuse Action Fund (SMAF) monies to pilot these new and emerging therapies and continue to monitor effectiveness as

part of standardised performance monitoring arrangements. In doing so a blanket approach to staff competencies through formal accredited training is recommended to ensure quality and fidelity to the treatment model.

This needs assessment also highlighted the need for more robust data collection systems (which at present are not sustainable) and increased training with frontline staff around technical reporting to the Welsh National Database for Substance Misuse (WNDSM). At present some providers are triple keying data to multiple systems or manually recording activity which is complex and time consuming for the individual.

In January 2016, a number of third sector and non statutory organisations will be moving across to the PARIS information system for case managing clients. The perceived benefits associated with consolidating all providers on one standalone system are:

- Strengthened data quality
- Seamless management of patient care
- Identifying a number of holistic needs
- Ethical Storage solutions of comprehensive assessments, case notes, care plans and risk assessments (AUDIT and ASSIST) etc.

The feedback from service users and staff revealed more could potentially be done in regards to acknowledging the needs of marginalised groups (LGBT, disabled and BME communities) and the requisite for increased efficiencies within addiction services to reduce waiting times between referral and assessment. Furthermore greater enhancement of outreach and re-engagement could maintain the motivation of service users seeking to reduce their substance misuse and improve their quality of life whilst waiting to commence structured clinical treatment.

Despite these areas for development, it was pleasing to see the majority of feedback in relation to current services was positive by staff and service users. Staff highlighted that capacity was limited in some areas however training opportunities were mostly readily available to enhance personal development and services capabilities. It was also satisfying to hear the Open Access and Engagement Service and Throughcare Aftercare and Recovery Support services (commissioned by the APB in 2014) has been well received by clients in regards to modest referral and assessment activity and offered clients additional treatment options.

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Needs Assessment - Appendix A

Contributory Factors to Health Inequalities and Deprivation *Source: Cardiff.gov.uk*	**The Budget 16-17 Highlights** *Source: independent.co.uk*
Bedroom Tax From April 2013, if you live in a council or housing association home and have one or more 'spare' bedrooms your Housing Benefit may be reduced. Children are expected to share a bedroom. If you have one 'spare' bedroom your Housing Benefit will reduce by at least 14%. If you have two or more spare bedrooms your Housing Benefit will reduce by at least 25%. **Universal Credit** Universal Credit is a new single payment for people who are looking for work or on a low income. It will replace income-based jobseekers allowance, income related employment and support allowance, income support, child tax credits, working tax credits and housing benefit. **Benefits Cap** A limit (known as the Benefit Cap) has been introduced by Westminster Government to the total amount of benefit that working age people can receive. Income from housing benefit, carers allowance, child benefit, child tax credit, jobseekers allowance and income support amongst others will be assessed. Income will be capped at £350 a week for single adults and £500 a week for couples and families.	**Benefits** For those aged 18-21, they must "earn or learn" and will lose their automatic entitlement to housing benefits. From 2017, all working parents of three and four year olds must work if they want universal benefit, but also get 30 hours of free childcare each week, up from 15 hours. **Welfare Reform** The cap on benefits will be cut from £26,000 to £20,000 for anyone living outside of London Working-age benefits will be frozen for four years, including tax credits and housing benefit. Maternity payments will be excluded from the freeze. Rent payments for social housing will be cut by 1pc per year for each of the next four years. Working benefits will be stripped from those who are not disabled and have no children, and will be withdrawn at a faster pace as a claimant's earnings rise. **Child Benefit** Tax credit and universal credit support to be limited to first two children from April 2017 (excluding triplets etc) Housing benefit will also be affected by removing family premium for new children from April 2016.

ANNEX 2: Cardiff and Vale APB Workforce Development Plan

Background

The APB is setting out its vision and ambitions for workforce development across the substance misuse sector as an integral component of the commissioning strategy. The board has agreed that this needs to encompass the full breadth of workforce capacity and development including the integration of coproduction and the use of volunteer workforce, the effective use of continuous training and development and to articulate the responsibilities of organisations in relation to workforce.

Vision

The substance misuse workforce across Cardiff and the Vale of Glamorgan will develop and evolve in a manner that ensures that managers, staff, service users, carers, volunteers and community members all have clearly defined roles, are enabled to maximise their knowledge, skills and competencies, and are treated with equity, dignity and respect as contributors to the collaborative delivery of services.

Aims

- To have a highly skilled, well developed, motivated and competent paid workforce that is enhanced through contributions from volunteers, community members, carers, family members and through self-care by service users.
- For Cardiff and Vale to establish and sustain a reputation for an outstanding substance misuse workforce.
- For all staff and volunteers to have clear direction and support in their professional development.
- For the Cardiff and Vale substance misuse sector to become an exemplar of co-production alongside other prudent healthcare principles.
- For the broader health, social care and public sector workforce across Cardiff and Vale to have a high degree of knowledge, awareness, competence and confidence in

identifying and appropriately responding to substance use related issues in their own areas of service delivery.

Objectives

- Commissioned services will develop and publish their commitment to the role of staff, service users, carers and family members, volunteers and community members in the delivery of their services.
- All commissioned services will develop a strategy and action plan to maximise the impact of co-production within their services. This may be done in partnership across a number of providers, or as a system wide collaborative, as the basis for an APB co-production strategy.
- Commissioners and service providers will establish tools and mechanisms to promote and increase the participant role of service users in the delivery of their own treatment, care and support.
- All commissioned services will undertake self-assessment of their workforce, and workforce development strategies, the results of which will be quality assured by the APB through its contract monitoring systems.
- Service providers will establish a substance misuse Continuing Professional Development (CPD) framework that reflects the latest evidence and best practice in the field, delivers on new and emerging responsibilities in substance misuse, and enables staff members to develop and capitalise on their individual strengths and interests.
- Commissioners and providers will establish opportunities to incentivise voluntary participation in the sector, including access to training and development opportunities and sharing volunteer contribution and support across disciplines.
- Commissioners will establish mechanisms and environments that enable staff to innovate, communicate and collaborate in a manner that ensures equity of involvement across different roles and levels of seniority.

Recommended actions

Commissioned services will develop and publish their commitment to the role of staff, service users, carers and family members, volunteers and community members in the delivery of their services.

- Service managers, staff, service users and family members should undertake development work to articulate the contribution to treatment, care and support that can be made by different groups of individuals.
- Contributions to treatment care and support from different groups of individuals should be clearly aligned to the care pathways for the service, with information and literature developed and provided to all stakeholders routinely.
- Initial care and treatment plan development with service users should include discussions regarding the role of carers and family members, the extent to which self-care is a viable option, and agreement on how this will be monitored and enhanced going forward.
- Commissioned services should have a published policy on the involvement of volunteers, peer mentors and community members in contributing to the delivery of services.

All commissioned services will develop a strategy and action plan to maximise the impact of co-production within their services. This may be done in partnership across a number of providers, or as a system wide collaborative, as the basis for an APB co-production strategy.

- Service managers and staff should consider all service delivery functions in light of co-production opportunities, and establish mechanisms to deliver on those opportunities in a way that accounts for effective risk management and governance.
- All frontline staff should receive basic awareness training on the dynamics and patient-professional relationship in an effective co-produced service. This should include methods to introduce the concept and ideals of coproduction to service users

and carers, and structuring of care plan templates to ensure that opportunities for self-care and user and carer contribution are embedded in service delivery.

- Commissioners will expand existing service user and carer engagement, consultation and satisfaction survey activities to assess the extent to which co-production is being realised at an operational levels, and to which there is increasing equity in the professional-patient relationship.

Commissioners and service providers will establish tools and mechanisms to promote and increase the participant role of service users and carers in the delivery of their own treatment, care and support

- Commissioners will identify examples of effective practice in user and carer participation at a national and international level, and draw together a toolkit for providers based on the available evidence.
- Provider care and treatment plan audits and user surveys will be sued to determine the extent of user participation in line with the published resource.
- The commissioner service user forum will act as the overseeing forum for the user and carer participation work programme.

All commissioned services will undertake self-assessment of their workforce, and workforce development strategies, the results of which will be quality assured by the APB through its workforce development contract

- Commissioners will advise on the availability of appropriate workforce development assessment tools.
- Commissioned services will carry out self-assessment, and use the results to draw up a workforce improvement plan, in line with the aims and objectives of this document.

- The fidelity of the self-assessment will be quality assured through the commissioner's workforce development contract[7].
- Providers will be encouraged to undertake workforce development in collaboration with partner agencies, using opportunities such as shadowing, temporary role switching, secondment and joint meetings relating to frontline business, in order to enhance education and training opportunities.

Service providers will establish a substance misuse Continuing Professional Development (CPD) framework that reflects the latest evidence and best practice in the field, delivers on new and emerging responsibilities in substance misuse, and enables staff members to develop and capitalise on their individual strengths and interests.

- All commissioned services will draw up their framework that includes the organisations mandatory training requirements, and the full range of education, training and development opportunities available to staff, peer mentors, volunteers, and community members.
- CPD frameworks will need to create demarcation between different levels of training and development to differentiate between what is routinely expected as a minimum of those participating in service delivery, through to the opportunities for individual staff to develop expertise and specialism in specific areas of service.

Commissioners and providers will establish opportunities to incentivise voluntary participation in the sector, including access to training and development opportunities, and sharing volunteer contribution and support across disciplines

- Commissioners will establish resources to support training, education and development for unpaid staff as a means of encouraging participation, and maximising the benefit of these roles.
- Commissioners will develop and publish a volunteer involvement action plan

[7] Currently a component of the APB Universal Services Package

- Service provider CPD frameworks and plans will include a mandatory requirement to promote the use of peer mentors and volunteers in service delivery.

Commissioners will establish mechanisms and environments that enable staff to innovate, communicate, and collaborate in a manner that ensures equity of involvement across different roles and levels of seniority

- Commissioners will develop, promote and manage staff engagement forums, and a range of mechanisms by which suggestions for improved ways of working can be made considered.
- The APB Treatment, Therapies and Clinical Governance group will programme-manage the development and application of innovative practice.
- Commissioners will establish multi-agency Action Learning Sets (ALS) in order to promote effective and innovative practice, to include volunteers, peer mentors, community members, service users and carers.

ANNEX 3: Cardiff and Vale APB Capital and Estates Strategy

1.1. Background and Introduction

"A strategy is the most effective route to a desirable outcome, or future state, using available means" (Dr. Max McKeown, International Strategist, at the Seren Group AGM. September 2015)

1.1.1. The Welsh Government has included a level of capital funding in the annual Substance Misuse Action Fund allocation since its inception in 2003. A wide range of investments have been undertaken using this resource including the purchase of leases, premises, equipment and hardware, as well as the completion of renovation, maintenance and repairs.

1.1.2. This chapter illustrates how the management and delivery of the capital programme integrates with the other aspects of the commissioning strategy, and the overall substance misuse work programme.

1.2. Vision

1.2.1. For substance misuse the outcome or vision in relation to capital investment is as follows:

"All service users, carers will have access to commissioned services which are delivered in high quality environments that are fit for purpose, that address a broad spectrum of physical accessibility needs, that enable anonymity, and that promote service user dignity and respect. Those services will make best use of current, new and emerging technologies and equipment to improve service user and carer outcomes. In pursuing this outcome, opportunities to disaggregate delivery to a local level and into a variety of settings will be actioned. Where possible, opportunities for Return on Investment (ROI) will be identified and pursued. "

1.3. Values and principles

1.3.1. Whilst the means are clearly available to the APB to achieve its outcomes and future position for estates in terms of access to capital funding, as well as other resources, it is important that the strategy, or the route by which this achieve, does not compromise the values and principles of the partnership, or its member organisations.

1.3.2. This strategic approach attempts to consolidate the position of the APB, whilst incorporating lessons that have been learned in the management of capital over the last few years, and addressing a range of issues and concerns that have been considered and discussed by the board. As a result, the following values and principles are set out to inform and guide all future estates development.

1.3.3. Statement of values and principles

1.3.3.1. In line with the newly applied State Aid rules by Welsh Government the APB will no longer financially support the purchase of premises that are owned outside of the statutory sector. The availability of such premises as an asset in future tender submissions and their presence on organisations' balance sheets clearly creates a competitive advantage that contravenes state aid guidance.

1.3.3.2. The APB will support the redesign and redevelopment of existing premises already owned outside of the statutory sector if doing so;

A) Clearly meets a gap in service, or an unmet need set out in the commissioning strategy, and
B) Does not increase the commercial value of those premises to a level that breaches the first commitment set out above.

1.3.3.3. The APB will continue to invest in capital requirements of all substance misuse action fund (SMAF) commissioned services in relation to equipment, maintenance

and repairs in order to sustain and promote quality and innovation across service provision.

1.3.3.4. The APB will support capital investment into social enterprise projects undertaken by SMAF commissioned services that are based on robust business models, and which are likely to yield a reasonable Return on Investment (ROI) back into community services during the lifespan of the contracts in place.

1.3.3.5. The APB will support and finance the purchase of leases for services that have been successfully commissioned through the APBs standard procurement processes. Leases will be established that mirror the length of contract, and will include an obligation for transfer in the eventuality of a different service provider taking on responsibility for delivery of services either during the course of, or at the end of, those contracts.

PART 2 - Scope of the APB agreement for the use of capital funding

2.1 Lease maintenance

2.1.1. The Cardiff and Vale APB will renew leases for the delivery of substance misuse services that are based within the statutory sector. The APB will also fund the continuation of leases for commissioned services that are funded through either the SMAF, or the resources for the IOIS criminal justice treatment services, with lease longevity that parallels the length of the respective contracts.

2.1.2. The APB will support investment into leases for non-commissioned services, where this enables continued provision of service capacity that meets a recognised gap in the range of SMAF commissioned services.

2.2. Procurement of premises for statutory services

2.2.1. The Cardiff and Vale APB will acquire and develop premises for better and more effective delivery of substance misuse services within the statutory sector. This includes NHS, local authority, probation, police and NOMS based services.

2.2.2. The APB will support the acquisition and development of multi-agency premises where a statutory organisation is able to take lead responsibility and ownership of the site.

2.2.3. The APB will seek to invest capital in premises of generic statutory services in order to enhance their ability and capacity to increasingly address substance misuse services, such as GP practices, community health centres, and community pharmacies.

2.3. Maintenance, equipment, and repairs

2.3.1. The APB will continue to support capital proposals for the maintenance and repair of existing premises, and the purchase of capital-eligible equipment, for all statutory substance misuse service, all SMAF commissioned service, and all non-commissioned services that are able to strongly evidence that the investment will improve the quality or capacity of the local substance misuse treatment and support system, and that can evidence that the state aid requirement of not providing a competitive advantage can be proven.

2.3.2. The list of eligible proposals extends to include general maintenance and repairs, furniture and furnishings, IT and hardware, and equipment of direct benefit to service users such as the service user minibus, or methadone dispensing machines.

2.4. Premises redevelopment

2.4.1. The APB will support the redevelopment of existing premises that are used to deliver statutory substance misuse services, and SMAF commissioned services if improved service quality or capacity can be evidenced as a primary outcome.

2.4.2. The board will also support the redevelopment of premises owned outside of the statutory sector if doing so improves the capacity or quality of a service that meets a recognised gap in the range of SMAF commissioned services, and that the state aid rule of not providing a competitive advantage can be proven.

2.4.3. Examples will include the alteration of space within existing premises to improve capacity, or quality of services, investing in improving access to comply with the Disability Discrimination Act, or the conversion of existing space into facilities such as a service user IT suite to improve outcomes for service users.

2.5. Social Enterprise

2.5.1. The APB will support capital investment in order to develop and enable social enterprise that is either led by a statutory partner, or by a SMAF commissioned service in order to further deliver the outcomes that the provider has been commissioned to achieve.

2.5.2. The APB will ensure that any Return on Investment (RoI) resulting from social enterprise that has received SMAF Capital or Revenue funding will be allocated and managed in the same manner as any other SMAF resources.

2.5.3. Examples of social enterprise include a range of small businesses, particularly within the service and retail industries.

PART 3 - Current estates and resulting commitments

3.1 Existing Estate

The imbedded document provides an itinerary of the current substance misuse estate.

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3.2. Lease maintenance commitments

3.2.1. Those leases that the APB is currently committed to maintaining are as follows:

- Newlands Street Barry – Provision of NHS substance misuse services.

- 2-10 Holton Road, Barry - Provision of TAITH (SMAF commissioned open access services), IOIS services, and EDAS single assessment service for the Vale of Glamorgan.

- Harlech Court – Provision of IOIS services for Cardiff.

- 54/56 Newport Road – Provision of EDAS for Cardiff.

- Meridian Court – Provision of a base for SMAF commissioned universal services and Tier 2 CYP substance misuse services.

- Recovery Cymru, Barry – provision in part of the SMAF funded aftercare service.

- Recovery Cymru, Cardiff – AS ABOVE.

PART 4: Long Term Commitments

4.1. Flagship Project 1: Cardiff Royal Infirmary – a new Addiction and Recovery Centre for Cardiff and Vale and for Wales

4.1.1. The APB is committed to developing a multi-agency, multi-function addiction and recovery centre for Cardiff and Vale. The existing Cardiff NHS addiction service premises are no longer fit for purpose, and the service requires relocation. The royal infirmary has been selected for a number of reasons including the following:

- There is a long tradition of addiction services on this site and so the service user population will be familiar with attending this location.

- The site has sufficient capacity to meet all requirement, alongside further expansion at a later date if required.
- The site is central has ease of access to the city centre and all public transport networks.
- The range of other services provided within the CRI footprint will go a long way towards de-stigmatising substance misuse and addition services.
- The range of other services provided within the CRI footprint will afford opportunities for shared service user resources and economies of scale such as shared access to IT, welfare and benefits advice, access to sexual health services, and access to mental health services.

4.1.2. The full scope of the APBs ambition for services within the royal infirmary includes the following:

- EDAS single assessment
- Recovery service engagement (3rd sector)
- TAITH open access services (3rd sector)
- Criminal justice treatment and liaison
- Community detoxification
- Onsite methadone and buprenorphine dispensing
- Clinical Psychiatry
- Clinical Psychology
- Dual diagnosis support
- Primary care liaison and support
- Throughcare and aftercare
- University medical school teaching facilities (Faculties of Medicine, Psychiatry, Psychology and Mental Health)
- Substance misuse resource centre – journals, key texts, IT facilities, teaching materials etc.
- Partnership meeting facilities

4.2. Flagship Project 2: Establishing a subsidiary independent company for the management of capital assets.

4.2.1. This strategy proposes the potential merit of establishing an independent limited company as a not-for-profit organisation and a subsidiary of one of the APB statutory partner agencies.

4.2.2. There are already examples locally and across the UK of this model, with Salisbury NHS foundation trust creating Odstock Ltd to oversee the marketing and promotion of its Functional Electronic Stimulation service and Inclusion Substance Misuse service that was set up as a subsidiary company of South Staffordshire and Shropshire NHS Trust in order to secure out of area contracts as well as generating income for reinvestment into local services.

4.2.3. For the purposes of this Estates Strategy, the proposal is to research the potential for such a company to be established that could be the owner of capital assets such as premises and equipment, for use by any organisation nominated by the APB. This would ensure the ability to transfer the use of assets in line with changes in contracted organisations. It would also enable ownership of projects such as social enterprise that receive APB capital funding – ensuring that any proceeds from such ventures are available to the board for reinvestment.

4.2.4. Establishing a company would offer the board a range of future innovations and options such as financing research programmes in the field of addiction, dependency and behavioural change, and brokering alliances between service providers for collaborative delivery. However, the first a primary function would be to enable ownership of capital assets in a way that prevents giving competitive advantage to local service providers, and thereby negating the risk of breaching state aid regulations. It is clear a given that such a company would have mandate not to deliver, or compete for the delivery of, any services directly that require capital investment; hence the suggestions around research and brokerage.

ANNEX 4: Cardiff and Vale APB Expenditure Plan 2016-17

Contract / SLA ID	Service	Service Package Value	2016/17 SMAF Single Contract Value	2015/16 SMAF level and difference for reference	Ring fenced	Service Spec / SLA in place	Comment
	Alcohol Treatment Centre					**NA**	**No Service Specification required – operational policy is in place**
	Generic SMAF	£23,000					**Funding has reduced from 2015-16 due to member agency contributions being secured**
	Ring Fenced SMAF						
	TOTAL	**£23,000**	**£23,000**	**£83,045 (-£60,045)**			
ATC-2	**Residential Accommodation Support Service**					✓	**Bridge Programme – residential (Hostel) preparation, detoxification and aftercare**
	Generic SMAF	£34,845					
	Ring Fenced SMAF	£85,155			**Tier 4**		*Reflects that this service is entirely residential in the model of delivery, and targets the homeless population as a particularly vulnerable group. Funding has increased to meet the methadone costs of prescribed service users going through detoxification. This has been a recurrent cost pressure on the delivery model that requires a permanent solution.*
	TOTAL	**£120,000**	**£120,000**	**£106,125 (+£13,875)**			
	Commissioning support and Service user engagement					**NA**	**No Service Specification Required.**
	Generic SMAF	£150,000					*Cardiff and Vale budgets for commissioning support, governance support~~,~~ and the budget for service user engagement and support.*
	Ring Fenced SMAF	£					
	TOTAL	**£**	**£150,000**	**£150,000 No change**			

Contract / SLA ID	Service	Service Package Value	2016/17 SMAF Single Contract Value	2015/16 SMAF level and difference for reference	Ring fenced	Service Spec / SLA in place	Comment
	Systems information service					**NA**	**No Service Specification Required.**
	Generic SMAF	£42,575					*Substance misuse systems information management service. Budget has increased as a result of all external service providers going onto the PARIS system. SMAF now contributes to the cost of 0.3wte of a developer in the UHB corporate PARIS team to manage the data and resolve all technical issues with data validity and reporting.*
	Ring Fenced SMAF	£					
	TOTAL	**£**	**£42,575**	**£40,000 (+£2,575)**			
ATC-4	**Clinical Treatment and Therapeutic Support Service**						
	Generic SMAF	£1,408,445					▪ *NHS primary care services including shared care services, pharmacy dispensing and supervised consumption.* ▪ *NHS secondary care community addiction services.* ▪ *District General Hospital Liaison service.* ▪ *Substance misuse specialist support to HMP Cardiff healthcare team.* *Funding has been increased in 2016-17 for the following:* ▪ *An increase (~~X~~x1 band 7 nurse) to the Emergency Unit Psychiatric Liaison Team in order to equip the entire team with substance misuse capacity, including the ability to complete EDAS assessments in the unit.* ▪ *Meeting the cost differential between an existing post and a pharmacy technician role to staff the onsite dispensing service, thereby freeing up significant qualified nurse time from dispensing activity.*
	Ring Fenced SMAF	£57,675					*NHS tertiary care (Tier 4) In-patient detoxification – this resource will be used within the detoxification ward in order to pilot clinical management approaches for individuals with an alcohol related brain injury requiring detoxification.*
	TOTAL	**£1,466,120**	**£1,466,120**	**£1,403,785 (+£62,335)**			

Contract / SLA ID	Service	Service Package Value	2016/17 SMAF Single Contract Value	2015/16 SMAF level and difference for reference	Ring fenced	Service Spec / SLA in place	Comment
ATC-1	**Open Access Engagement and Low Threshold Support Service**					✓	**Contract awarded with start date of 01/04/2014**
	Generic SMAF	£488,175					*SMAF funding for the OAE service package including an element of the previous NHS allocation for the previous of Needle Exchange Services.* *Funding has increased in order to provide additional workers alongside EDAS to facilitate immediate referral for low threshold support needs, and to support OAE service support to the alcohol treatment centre.*
	UHB Ring Fenced Resources	£139,655					*UHB funding from the NHS ring fenced allocation – earmarked specifically for at least the needle exchange component of the service, given the statutory requirement for the provision of this element.*
	TOTAL	**£627,830**	**£488,175**	**£446,175 (+£42,000)**			
ATC-3a	**Hidden Harm Service (Formerly Family Support)**					✓	
	Generic SMAF	-					
	Ring Fenced SMAF	£135,843			**CYP**		*Reconstituted service to reflect the evolved nature of delivery – this is now a dedicated hidden harm service that provides interventions and support to families where young people are actually, or at risk of, being adversely affected by parental substance use.*
	TOTAL	**£135,843**	**£135,843**	**NA – previously merged with CRAFT**			
ATC-3b	**CRAFT carer support service (Formerly Family Support)**					✓	
	Generic SMAF	£130,652					*CRAFT programme as a distinct component of the previous family support service – this encapsulates current policy drivers such as prudent healthcare, and co-production.*
	Ring Fenced SMAF	-					
	TOTAL	**£130,652**	**£130,652**	**NA – previously merged with Hidden Harm**			

Contract / SLA ID	Service	Service Package Value	2016/17 SMAF Single Contract Value	2015/16 SMAF level and difference for reference	Ring fenced	Service Spec / SLA in place	Comment
ATC-5	**Through-care, Aftercare and Recovery Support Service**					✓	
	Generic SMAF	£404,351					*SMAF resources for the Throughcare, Aftercare and Recovery Support service package.*
	Ring Fenced SMAF	£49,140			**Counselling**		*The ringfenced counselling budget that is embedded in the Aftercare service is now directly aligned to the delivery of the Options Counselling service.* *The budget for the package has been increased by £80,000 in order to develop and implement a new re-engagement service that will address the APB priority of increasing panned discharges, and reducing DNA rates. This will work alongside statutory addiction services in order to target service users identified as being at risk of disengagement.*
	UHB Ring Fenced Resources	£72,845					*UHB funding from the NHS ring fenced allocation.*
	TOTAL	**£526,336**	**£453,491**	**£370,755 (+£82,736)**			
ATSLA-1	**Single Point of Entry Service**					✓	**Service level agreement in place – specification enshrined in EDAS Operational Policy**
	Generic SMAF	£47,000					*Funding has increased by £25,000 in order to provide additional administrative support, and thereby free up the time of assessors that is currently taken up by completing of administration work.*
	Ring Fenced SMAF	£-					
	TOTAL	**£**	**£47,000**	**£25,000 (+£22,000)**			
CJC-2	**Enhanced substance misuse and criminal justice service**					✓	**This service has been decommissioned as the full range of interventions provided are now incorporated into the recently commissioned Offender Intervention Service that is funded through the PCC and NOMS.** **Retained in the 2016-17 expenditure plan for reference.**
	Generic SMAF	£-					
	Ring Fenced SMAF	£-					
	TOTAL	**£-**	**£-**	**£110,700 (-£110,700)**			

Contract / SLA ID	Service	Service Package Value	2016/17 SMAF Single Contract Value	2015/16 SMAF level and difference for reference	Ring fenced	Service Spec / SLA in place	Comment
PHCC-1	**Universal Services and Workforce Development Contract**					✓	**New service specification agreed on 01/11/2014, and implementation underway for all new arrangements to be in place by 01/04/2014.**
	Generic SMAF	£254,246					*Incorporates SMEAS, CYP education and information service, the volunteer programme, STARS, and the workforce development budget. Increase is to the workforce development component for Primary Care Development and training.*
	Ring Fenced SMAF	£128,984			**CYP**		*Incorporates the enhanced SMEAS, the BME youth service, purchasing and co-ordination of resources, and funding for public health / health promotion campaigns.*
	UHB Ring Fenced Resources	£70,770			**OOWS**		*UHB funded volunteer training and workforce development programmes.*
	TOTAL	**£454,000**	**£383,230**	**£372,002 (+£11,228)**			
CYPC-1a	**Emotional Wellbeing Service**					✓	**New service tendered in 2016, and operating against a new service specification.**
	Generic SMAF	£					
	Ring Fenced SMAF	£100,000			**CYP**		*Performance difficulties with the previous Tier 2 service for children and young people have led to a service redesign exercise throughout 2015. It has become apparent that substance misuse in Uunder 18s rarely occurs in isolation, and is frequently concurrent with low level mental health needs, complex behaviours, and needs around esteem and coping with adversity.* *As a result, a decision has been made to integrate Tier 2 CYP substance misuse service with a new Emotional Wellbeing service that will act as an assessment and triage service for CAMHS as well as dealing with substance misuse alongside a broad range of mental health and wellbeing needs in-house. Resource levels are lower, as the YOS substance misuse service will continue as a separate strand, and substantial economies of scale are available by integrating substance misuse with broader wellbeing needs.*
	UHB Ring Fenced Resources	£200,000					
	TOTAL	**£300,000**	**£100,000**	**£186,974 (-£86,974)**			
CYPC-1b	**YOS Substance Misuse**					✓	
	UHB Ring Fenced Resources	£63,026	£-				*Whilst no longer within a SMAF contract, this has been retained for reference so that the funding streams can be tracked from previous years.*
	TOTAL	**£63,026**		**NA**			

Contract / SLA ID	Service	Service Package Value	2016/17 SMAF Single Contract Value	2015/16 SMAF level and difference for reference	Ring fenced	Service Spec / SLA in place	Comment
CYPC-2	**Tier 3 CYP Treatment and Support Service**					✓	**New service specification has been developed as part of the UHB corporate review and re-commission of all CAMHS services.**
	Generic SMAF	£					
	Ring Fenced SMAF	£85,623			**CYP**		*Includes the existing YPDAS funding, and the new investment from 2012/13 for medical consultant support.*
	UHB Ring Fenced Resources	£81,456					*UHB funding for CAMHS substance misuse nurses, and YOS Specialist Support CAMHS Nurses.*
	TOTAL	**£167,079**	**£85,623**	**£85,623 No change**			
CJC-2	**Residential placements**					✓	
	Generic SMAF	£-					
	Ring Fenced SMAF	£-	20,970		**Tier 4**		*Maintained from 2015-16.*
	TOTAL	**£-**	**£20,970**	**£20,970 No change**			
	TOTAL PROPOSED 2016-17 SMAF EXPENDITURE		**£3,646,679**	**£3,646,679**			

Annex 5: Cardiff and Vale APB Structures and Governance Framework

Background

The Cardiff and Vale APB is required to have a robust set of corporate governance structures in place in order to meet its obligations under the National Core Standards for Substance Misuse. This document provides a first draft of those structures, some of which are newly developed and others of which have been reviewed since their inception in March 2012.

Certain aspects are not contained here (Communication and consultation systems) as these will be incorporated into the APB communication strategy currently under development

PART 1: Board Business Structures

- Code of conduct based on the Nolan Principles
- Terms of reference
- Membership
- Roles and Responsibilities
- Structures diagram
- Induction programme for members

PART 2: Systems and Processes

- Register of interests
- Management audit framework
- Performance Management system

PART 3: Risk Management

- Risk assessment
- Risk register
- Statement of internal control
- Emergency planning systems and contingency management plan

PART 4: Financial Governance

- Shared financial risk protocol
- Financial Audit

PART 1: Board Business Structures

Cardiff and Vale Substance Misuse Area Planning Board (APB)
Organizational Code of Conduct

This code of conduct makes explicit the principles, values and standards that guide the decisions, procedures and systems of the Cardiff and Vale Area Planning Board (APB). The objective of the code is to develop a values-based organisation and a values-driven code, to promote a culture that encourages officers, partners and stakeholders to internalise the principle of integrity and practice it.

Officers, partners and stakeholders, hereafter referred to as the constituents, are required to take all reasonable steps to comply with the requirements set out in the Code of Conduct. This applies to all business associated with the offices, planning and delivery of work within the remit of the Cardiff and Vale APB. Breaches of the Code are to be reported to the Chair of the Area Planning Board. It is the aim of the APB to resolve most complaints through informal negotiation ('Conciliation'). Failing that, it is the responsibility of the Chair of the APB to act to ensure firm, prompt and fair action, in conjunction with senior managers and/or trustees of the appropriate employing organisation.

Principles

The Area Planning Board aim to maintain the highest standards of professional endeavour, integrity, confidentiality, financial propriety and personal conduct;

It is an expectation of the APB that the primary constituents of this conduct are to:

i. Deal honestly and fairly in business with employers, employees, clients, fellow professionals, other professions and the public;

ii. Respect the customs, practices and codes of clients, employers, colleagues, fellow professionals and other professions;

iii. Take all reasonable care to ensure employment best practice, including giving no cause for complaint of unfair discrimination on any grounds and ensures fairness, equality and above all values diversity in all dealings;

iv. Work within the legal and regulatory frameworks affecting the delivery of substance misuse services;

v. Treat fellow constituents with courtesy;

vi. Respect and abide by this Code and encourage others to do the same.

Fundamental to good practice are:

Integrity

- Honest and responsible regard for the public interest;
- Checking the reliability and accuracy of information before dissemination;
- Never knowingly misleading clients, employers, employees, colleagues and fellow professionals about the nature of representation or what can be competently delivered and achieved;
- Supporting the values of the Area Planning Board by bringing to the attention of the APB examples of malpractice and unprofessional conduct.

Competence

- Being aware of the limitations of professional competence: without limiting realistic scope for development, being willing to accept or delegate only that work for which practitioners are suitably skilled and experienced;
- Where appropriate, collaborating on projects to ensure the necessary skill base.

Transparency and avoiding conflicts of interest

- Disclosing to employers, clients or potential clients any financial interest in a service provider/supplier being recommended or engaged;
- Declaring conflicts of interest (or circumstances which may give rise to them) in writing to the APB as soon as they arise;
- Ensuring that services provided are costed and accounted for in a manner that conforms to accepted business practice and ethics.

Confidentiality

- Safeguarding the confidences of present and former clients and employers;
- Being careful to avoid using confidential and 'insider' information to the disadvantage or prejudice of clients and employers, or to self-advantage of any kind;
- Not disclosing confidential information unless specific permission has been granted or the public interest is at stake or if required by law.

Maintaining professional standards

- Constituents are encouraged to spread positive awareness of the work of the APB where practicable.
- Implement mechanisms, where applicable, to ensure practitioners have current professional registration.
- Sharing information on good practice with constituents and, equally, referring perceived examples of poor practice to the APB.

Interpreting the Code

In the interpretation of this code, the Laws of the Land shall apply. Compliance with the code will be monitored by performance management and monitoring of service level agreements, where the code, with a stated expectation of compliance by service providers and commissioners, will be an addendum.

This code of conduct is not intended to supersede or replace an individual's professional codes of conduct.
To ensure compliance with this Code of Conduct, Cardiff and Vale Area Planning Board requires that all constituents review the Code of Conduct and acknowledge their understanding and adherence in writing on an annual basis on the attached form.

Commitment to the
Cardiff and Vale Area Planning Board
Code of Conduct

I acknowledge that I have received a copy of the Code of Conduct dated _____ ("the Code"), and that I have read the Code and that I understand it. I will comply with the Code. If I learn that there has been a violation of the Code, I will contact the Chair of the Area Planning Board. I acknowledge that the Code is not a contract and that nothing in the Code is intended to change the traditional relationship of employment-at-will.

Dated: _____

_____

Constituent's Signature

_____

Constituent's Name (Please Print)

_____

Employing Organisation

Template for reporting breaches of the Cardiff and Vale APB Code of Conduct:

Definition: A Breach of one or more provisions within the Code occurs in situations where there is clear evidence that an individual or organization has demonstrated non-observance of the Code in conducting themselves or their organization in a manner that can be associated with APB business.

This includes the delivery of commissioned services, representing the APB or its commissioned services, or supporting the APB work programme.

Report submitted by:

Date of submission:

Reporting Organisation:

Circumstances of Breach e.g. Date of occurrence, nature of breach, reasons (where known) for breach	
Public / Commission reaction / Impact on reputation (if any)	
Details of any action taken at source	

Cardiff and Vale Area Planning Board Memorandum of Understanding

Including Terms of Reference, Membership and Roles and Responsibilities

Aim of the APB

The aim of the **Cardiff and Vale Area Planning Board** is to bring together representatives of the responsible authorities and organizations who share the responsibility of developing, delivering and improving, efficient and effective substance misuse services across Cardiff and the Vale of Glamorgan to pursue the objectives of the APB.

Objectives of the APB

- Develop partnership working arrangements at a regional level.
- Strategic management of the financial resources used to commission and provide substance misuse services.
- Ensure that the Core Standards for Substance Misuse and other relevant standards are embedded in all service planning and delivery systems with appropriate arrangements in place for performance management and review.
- Improvement planning to respond to the audit and performance assessment of commissioned services for substance misuse.
- Ensure all funded services form part of an integrated care pathway based upon national guidance.
- Monitor the impact of the Welsh Assembly Government's Substance Misuse Strategy across Cardiff and Vale.
- Ensure that arrangements are in place to receive, consider and act on performance management data.
- Identify the breadth of substance misuse issues where working on a regional basis will be cost effective and provide a better platform for engagement with service providers or users.

Membership of the APB

Membership of the APB is to consist of:

Organisation	**Members**
Local Health Board	Dr Sharon Hopkins, Executive Director of Public Health (Chair)
Cardiff Local Authority	Tony Young –Director of Health and Social Care
Vale Local Authority	Hayley Selway – Director of Housing
Vale Local Authority	Rachel Evans – Director of Children and Family Services
South Wales Police	Divisional Commander (Eastern Division) Divisional Commander (Central Division) Gareth Hopkins, Regional Lead, Offender Interventions Service, Office of the Police and Crime Commissioner
Wales Probation Trust	Peter Greenhill – Head of Local Delivery (Cardiff and Vale)
National Offender Management Service (NOMS)	Emma Wools, Director for Offender Interventions
Third Sector	David Poole, Cardiff Third Sector Council
APB Delivery Group Chair	Melanie Wilkey – Head of Outcomes Based Commissioning, Cardiff and Vale UHB
Treatment, Therapies and Clinical Governance Group Chair	*On rotation*
Welsh Government	*In attendance*
APB Support Team	*In attendance*

The role of APB members

APB members are expected to:

a) Contribute to the implementation, monitoring and evaluation of the Area Planning Board work programme, commissioning strategy and any related action plans.

b) Show commitment to working towards the priorities set out in the All Wales Substance Misuse Implementation Plan

c) If required, act as a 'champion' or lead on a given area of activity.

d) Be an active link (which includes communication and reporting) between the APB and the member's organisation.

e) Be active ambassadors for the APB.

f) Promote equality of opportunity in the work of the APB and constructively challenge discriminatory practice.

g) Represent their organisation at board meetings.

h) Contribute to meetings in accordance with such authority or delegation as is given to representatives by their organisations.

i) Contribute to the APB by participating in personal learning and development and activities and engaging in any performance management system that the APB decides to use.

Chairperson and Vice-Chairperson of APB

a) A Chairperson and Vice-Chairperson shall be elected annually from amongst the members of the APB. The Chairperson and Vice-Chairperson are required to be senior representatives of one of the Responsible Authorities.

b) The Vice-Chairperson is responsible for the duties of the Chairperson in his/her absence and should report all developments to the Chairperson.

Role of the Chairperson of the APB

The Chairperson of the APB is expected to:

a) Chair the APB meetings in an impartial and inclusive manner and ensure that its business is conducted properly.

b) Ensure that all participants are fully involved and encouraged to contribute to discussion at the APB meetings.

c) Ensure that meetings of the APB are planned and run effectively in an open and transparent manner and are guided by the APB aims and objectives.

Nominated substitutes at APB Meetings

a) A member of the APB may nominate another person to attend a meeting in his or her place. The member must give notice to the secretariat providing details of the person nominated prior to the start of the meeting.

b) Any person nominated to attend APB meetings on behalf of a member, must be authorised by his or her organisation to act on behalf of the member at APB meetings.

c) Information and papers relating to APB meetings will be expected to be made available by the secretariat to nominated substitutes.

d) Nominated substitutes should not attend more than two consecutive meetings in the place of a member of the APB.

APB procedures

Meetings

a) Decisions at all meetings of the APB will be taken by consensus wherever possible. A question may be decided by vote, in which case, a majority decision is required from those present and voting. In the case of an equal number of votes, the Chairperson will retain the casting vote.

b) A member/ nominated substitute of the APB will cease to be a member upon:

- Notifying his or her resignation to the APB or
- Ceasing to be a member or officer of the representative organisation or
- The representative organisation having given written notification to the APB, of the member's withdrawal from the APB
- Failing to attend, without good reason and having sent an apology in advance, for three consecutive meetings of the APB.

c) Should the APB consider the need to review the membership of an individual representative or organisation, the member will have the right to be heard by the APB. Expulsion from the APB for good and sufficient reason, must be supported by a two-thirds majority of those present and voting at the meeting.

d) The APB will undertake a formal annual review of:

1. the membership of the APB.
2. the sufficiency of the constituent organisations / sectors represented on the APB.

Notice and frequency of meetings

a) The APB will meet at least quarterly.

b) Any five members of the APB can call for a special meeting. Such requisition, made to the secretariat, must specify the nature of the matter requiring consideration and the notices summoning the meeting must contain details of the matter to be discussed. The meeting must be notified to members by the secretariat and must take place within 21 days of its notification.

Agenda

a) The secretariat (APB Support Team) will email all members at least 3 weeks in advance of the meeting to request details of any matter they wish to be included on the agenda. Members should respond with any items within 1 week of email notification.

b) The chairperson should approve the agenda in advance of it being issued.

Administrative matters

a) The agenda and related papers will normally be circulated by email 7 days in advance except in cases of urgency when 3 days notice will be given.

b) Minutes of APB meetings will be taken by the secretariat and will be agreed at the following meeting.

c) Minutes will include a list of those attending and of apologies received, along with decisions made and actions arising.

d) Minutes will be made available to the wider community, in appropriate and accessible formats. It is noted that there may be exceptions to this depending on the nature of discussion.

Information Sharing

a) Sharing information is part of good communication and is vital to the delivery and planning of substance misuse services. The APB should develop or adopt an existing information sharing protocol covering the use of both depersonalised and personalised data. The latter will be particularly pertinent in the development of integrated care pathways. N.B. The Department of Health has produced a code of practice for NHS staff that addresses confidentiality issues. Voluntary and private drug and alcohol treatment services may also find this code useful to inform their own policies. The document 'Confidentiality: NHS Code of Practice can be found on the Department of Health website at www.dh.gov.uk

b) Members of the APB and any subgroups are required to comply with the law governing the sharing of information in relation to the reduction of crime and disorder, namely regulations made under section 17A of the Crime and Disorder Act 1998.

Quorate meetings

For APB meetings to be quorate at least one third of the current members must be present.

Dealing with disputes

a) The APB will consider any concerns or criticisms that a member may have in relation to the role or functioning of the APB and it will be within the discretion of the APB to resolve any issues by consensus and if appropriate by majority vote.

b) The Welsh Assembly Government may, in exceptional circumstances, determine appropriate action in relation to outstanding issues which have not been resolved by the APB under paragraph (a) above.

Financial / management arrangements

a) The APB will be required to nominate one of the Responsible Authorities to administer specific funding streams on its behalf.

b) The APB will be allocated the top sliced LHB funding for substance misuse services and the SMAF capital and revenue budgets. Agreement on all expenditure will be decided by the APB, under the advisement of the APB Delivery Group.

c) Other budgets will be held by stakeholders and pooled as appropriate.

Accountability Arrangements of the APB

a) The Responsible Authorities, as members of the APB, will be held to account for the progress of the work of the APB through their own organisational performance management frameworks.

b) The Chairperson of the APB will retain responsibility for the governance arrangements of the APB.

c) The Chief Executive of the Health Board will be accountable for adhering to the NHS performance management framework and will retain responsibility for clinical governance.

d) Community Safety Partnerships as an entity will remain responsible for reporting on the statutory KPIs already in existence for substance misuse services.

e) The APB will report to the Minister for Health and Social Services through the Welsh Government Substance Misuse Branch.

Equality

The APB must, in undertaking its aims and objectives, be committed to fair and equal treatment, in accordance with the law and recognising the value of diversity.

Advisors and staff

a) Papers produced for the purposes of the APB shall be made available by the secretariat to the:

(i) The APB Support Team Manager, who:

- can contribute to meetings
- will be expected to advise on the considered direction of the APB

(ii) Advisors (Welsh Government)

b) The APB Support Team Manager and / or Welsh Government Advisors will:

- Advise Responsible Authorities and their partners on the development and implementation of their local / regional commissioning strategies; including the development of service specifications, costings and performance monitoring indicators.
- Provide advice on planning, performance and resource management issues including performance against the new core standards and the Key Performance Indicators for substance misuse.
- Advise on good practice.
- Review and monitor the progress of the APB in the delivery of the Welsh Government Substance Misuse Strategy.
- Work with partners to ensure compliance with the reporting requirements of the WNDSM and the TOP; this includes identifying data quality issues and facilitating resolution.
- Advise partners, senior management and Ministers on the resolution of performance issues.

Subgroups

a) It is appropriate for the APB to set up sub groups to consider areas of interest within the remit of the APB. The objectives and life span of any sub group should be recorded in the APB minutes.

b) Specific sub groups should have an agreed mechanism to report back to the APB, the outcomes of which can then be recorded within the APB minutes.

c) Any subgroup established by the APB must comply with the provisions of this memorandum of understanding except where otherwise provided.

Membership of Subgroups

a) Membership of each subgroup shall include wide representation from the agencies that can provide expertise or have specific work or personal interests in the subgroup's area of work including, where appropriate, disadvantaged or hard to reach groups.

b) Each subgroup will appoint a chairperson and vice-chairperson from amongst its members. If this group is a standing sub group this will be undertaken annually. In the case of task and finish groups this will be agreed at the commencement of the task and finish group.

c) In the event that a subgroup member is unable to attend a meeting, the member should ask an appropriate substitute to attend in his/her place.

d) A member of each subgroup may, by prior agreement with the chairperson, invite non-members to attend meetings to provide information and/or guidance on specific issues.

e) Sub groups will work towards having appropriate service user, carer and family representation at regular meetings or special events.

Meetings

a) Each subgroup will meet at least four times per year at regular intervals.

b) Meetings will be held at suitable times and at venues which are accessible and comply with the requirements for the Disability Discrimination Act.

c) Additional meetings may be arranged as necessary with the prior agreement of the Chairperson.

d) The Chairperson will determine the agenda for the all meetings.

e) Minutes will be made available to the wider community, in appropriate and accessible formats. It is noted that there may be exceptions to this depending on the nature of discussion.

Reporting Procedures

a) Each subgroup will report back to the APB as agreed on inception of group.

b) The Chairperson may attend meetings of the APB as and when appropriate to report on any specific matters arising.

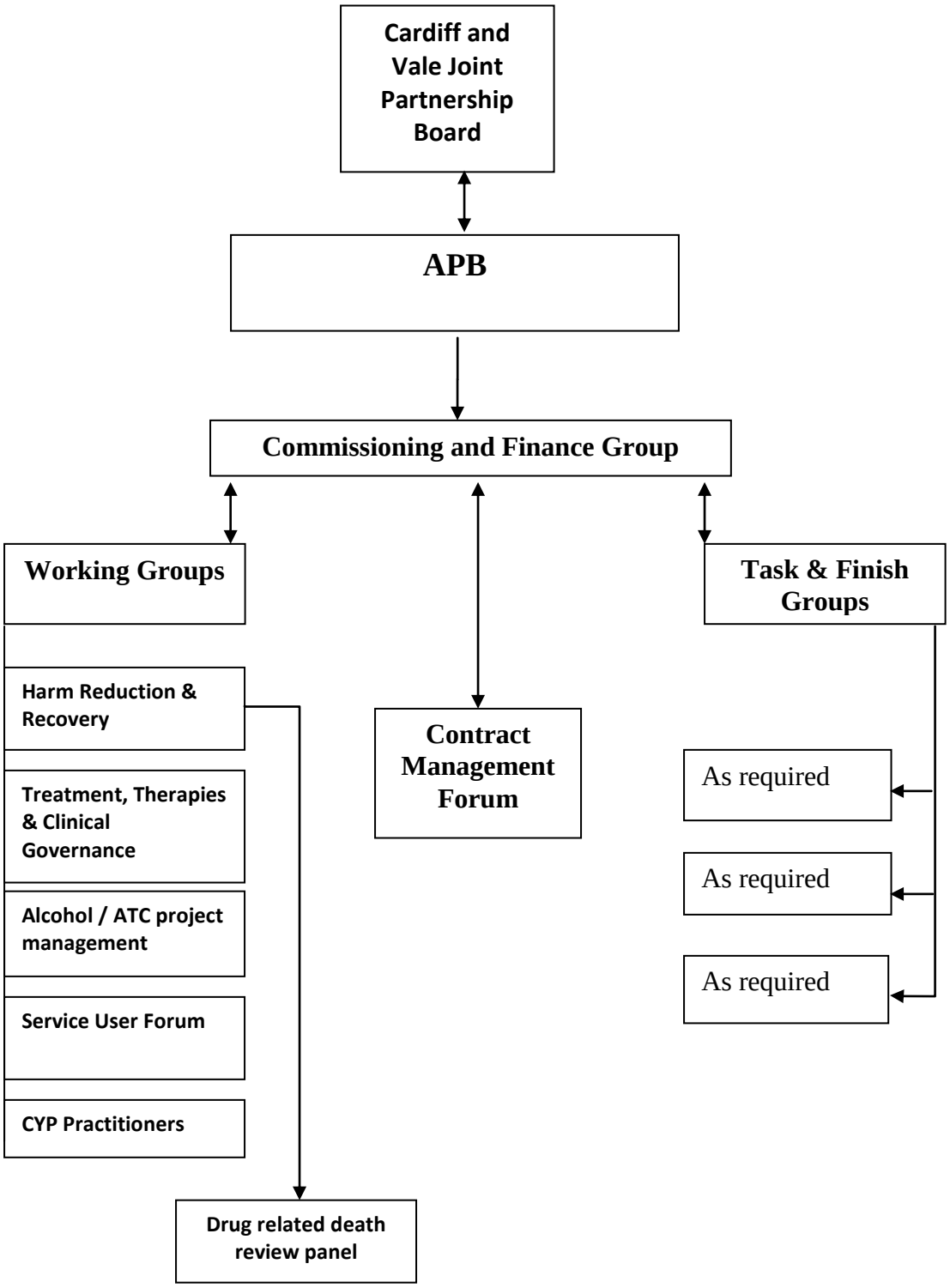
Review of this memorandum of understanding

a) This memorandum of understanding will be reviewed and updated by the APB at least annually.

b) Any APB or subgroup member can make proposals to the APB regarding proposed changes to the memorandum of understanding at any time.

c) The APB will agree by majority on any changes to this memorandum of understanding.

CARDIFF AND VALE APB SUPPORT STUCTURE



Roles and Responsibilities

APB
To oversee and programme manage the following workstreams:

Governance, accountability and scrutiny

- Ensure that the work programme and business processes for substance misuse are consistent with those of the member agencies of the board.
- Ensure that the decision making processes for the board are transparent, based on robust evidence, and are open to scrutiny.
- Maintain the confidence of member agencies in the capacity of the APB to deliver the substance misuse agenda on their behalf.
- Ensure that the quality and governance arrangements of APB commissioned services are of a consistently high standard.
- Oversee the communications programme for the APB as a means of delivering assurance on the board's business processes and procedures.
- Ensure that the national core standards for substance misuse relevant to APB governance, accountability, and conduct are achieved and sustained.
- Manage the membership and attendance of the board, ensuring that the APB is effectively represented at regional and national groups.

Performance

- Maintain oversight of performance against national and local key performance indicators and targets using the principles of Results Based Accountability (RBA).
- Consider the options and advice of the APB delivery group, to agree courses of action to address and improve poor, or insufficient, levels of performance.
- Promote and share the achievement of high levels of performance; both across Cardiff and the Vale and at a national level.
- Consider and act upon issues of performance within the wider public services sector that may have an impact on substance misuse.
- Ensure that member agencies and partnerships are sighted on the performance of substance misuse as a priority area of service at a strategic level.
- Receive and consider a strategic performance report at each meeting.

Finance

- Maintain oversight of all the APB responsible funding streams.
- Ensure that financial governance frameworks are satisfactory to all partner agencies.
- Consider the broader impact of APB financial allocations on mainstream service provision, and strategic direction.
- Consider and agree the prioritisation of APB-funded areas of service, to inform the commissioning and financial allocation responsibilities of the APB Delivery Group.
- Consider and approve annual spending plans, on the advice and recommendations of the APB Delivery Group.
- Facilitate better and more integrated service development between APB funded services, and other partnership and member agency funded services.
- Receive and consider a financial statement and report at each meeting.

Progress and delivery

- Maintain oversight of delivery across the APB work programme.
- Oversee the strategic integration of the substance misuse agenda within the work programmes of agencies across Cardiff and the Vale.
- Oversee the strategic integration of the substance misuse agenda across the multi-agency partnerships in place across Cardiff and the Vale.
- Consider the impacts of the wider health, social care, public service delivery and criminal justice agendas on the work of the APB, and identify opportunities for more effective, or more efficient delivery in the broader context of public services and partnership working.
- Consider the longer term strategic direction for substance misuse to inform current or shorter term service development.
- Consider and agree the annual substance misuse work programme at the start of each financial year.
- Regularly consider and review the identification and management of risks to the delivery of the work programme.
- Ensure an effective interface between the delivery of the APB work programme and the mainstream delivery of other partnership and member agency agendas.
- Receive and consider a progress and delivery report at each meeting.

APB Commissioning and Finance Group

- Managing and overseeing the operational delivery of the APB work programme.
- Implementing the Board's decisions around scrutiny, governance and assurance across the APBs responsibilities.
- Considering, preparing, and presenting for board approval, resource allocation schedules to deliver the APBs objectives.
- Commissioning the development of new services, and redesigning existing services.
- Overseeing the performance monitoring and performance management of APB responsible services.
- Ensuring the quality, governance and adherence to standards of APB funded services
- Identifying, managing and mitigating emerging risks to the delivery of the APB work programme.
- Overseeing the operational interaction of substance misuse with other agency and partnership agendas.
- Reporting to the APB against each of its work streams.
- Managing the network of working groups, forums and task and finish groups.

Working Groups

- To be responsible for a specific strand of the APB work programme.
- To report on progress to the APB delivery group.
- To ensure comprehensive and appropriate engagement from relevant stakeholders.
- To ensure that progress is in line with the overall strategic direction of the APB.
- To apply the principles of RBA to quantify progress and delivery.
- To maintain oversight of risks to delivery and to advise the APB delivery group of current or emerging risks and options to reduce or eliminate those risks.

Task and Finish Groups

- To be responsible for delivering a specific element or outcome from the APB work programme.
- To report on progress to the APB delivery group or one of its working groups.

- To ensure comprehensive and appropriate engagement from relevant stakeholders.
- To ensure that progress is in line with the overall strategic direction of the APB, and in line with the specification for the specific task.
- To apply the principles of RBA to quantify progress and delivery.
- To maintain oversight of risks to delivery, and to advise the APB delivery group or working group, of current or emerging risks, and options to reduce, or eliminate those risks.
- To ensure appropriate exit strategies and evaluation mechanisms are in place to provide closure to the specific task.

APB Member Induction Programme

As part of its corporate governance structures, Cardiff and Vale APB has agreed a series of activities, meetings and key documents that combine to form a comprehensive induction programme for new members. As a new member to the board, you are asked to complete the induction programme according to the identified timescales. The whole programme is designed to be completed in the first 9 months of your membership and once completed the signed checklist should be returned to the APB support team – contact details at the end.

NB: All referenced documents will be supplied to you electronically by the APB support team

FIRST THREE MONTHS OF MEMBERSHIP

Meetings

- ☐ **Introductory meeting with the APB Chair**
- ☐ **Introductory meeting with the APB support team**
- ☐ **Attendance at your first APB Meeting**

Reading

- ☐ **Cardiff and Vale APB Substance Misuse Commissioning Strategy (2013-18)**
- ☐ **National Substance Misuse Strategy for Wales: 2008-18**
- ☐ **Cardiff and Vale APB Governance Framework**
- ☐ **Welsh Government Guidance on the establishment of Area Planning Boards (Revised)**
- ☐ **Current APB Annual Business Plan**
- ☐ **Minutes from the previous x2 APB meetings and x2 Delivery Group meetings**

FIRST NINE MONTHS OF MEMBERSHIP

Meetings

- ☐ **Attendance at an APB Delivery Group Meeting**
- ☐ **Attendance at relevant APB working group meetings**
- ☐ **Attendance at an APB Contract Management Forum Meeting**

Reading

- ☐ **Relevant Welsh Government substance misuse treatment frameworks**
- ☐ **National Core Standards for Substance Misuse**
- ☐ **The most recent Cardiff and Vale APB Annual Report**
- ☐ **The most recent edition of the APB newsletter – "Substance Misuse in Brief"**

NAME…….

ORGANISATION……

DATE PROGRAMME COMMENCED……

DATE PROGRAMME COMPLETED……

SIGNED……

On completion of the induction programme, please fill in your details in the space above, sign and return to:

Conrad Eydmann
Head of Partnership Strategy and Commissioning
Cardiff and Vale APB
C/o Cardiff and Vale Public Health Team
Whitchurch Hospital
Park Road
Cardiff
CF14 7XB

Conrad.eydmann@wales.nhs.uk

PART 2: Systems and Processes

REGISTER OF INTERESTS

This Register of Interests includes all interests declared by Board members, sub group members and employees of Cardiff and Vale Substance Misuse Area Planning Board (the APB). In accordance with the Welsh Government National Core Standards for Substance Misuse, the APB's chair (via the APB Support Team Manager) must be informed of any interest which may lead to a conflict with the interests of the APB and the public for whom they have commission services in relation to a decision to be made by the APB, or its supporting structures, that needs to be included in the Register within 28 days of the individual becoming aware of the potential for a conflict. Updates to the register will be undertaken twice yearly within APB meetings. The Register will be updated regularly (at no more than 3 monthly intervals).

Interests that must be declared (whether such interests are those of the individual themselves or of a family member, close friend or other acquaintance of the individual) include:

- roles and responsibilities held within commissioned services;
- directorships, including non-executive directorships, held in private companies or PLCs;
- ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the APB;
- shareholdings (more than 5%) of companies in the field of substance misuse;
- a position of authority in an organisation (e.g. charity or voluntary organisation) in the field of substance misuse;
- any connection with a voluntary or other organisation contracting for Substance Misuse Action Fund supported services;
- research funding/grants that may be received by the individual or any organisation in which they have an interest or role;
- any other role or relationship which the public could perceive would impair or otherwise influence the individual's judgment or actions in their role within the APB.

Cardiff and Vale Substance Misuse Area Planning Board (APB)
Register of Interests

Name	Date	Position/ Role	Potential or actual area where interest could occur	Action taken to mitigate risk	Comments

Management Audit Framework

The Audit of APB business has been designed to closely align with the roles and responsibilities of the board. The framework below sets out the audit framework to be completed each year. The results of the management audit and any associated actions will be published in the APB annual report for that same year:

Subject Area	Audit actions	Data Sources
APB Business	a) Review of APB governance framework	Framework
	b) Audit of APB and sub group member attendance	Minutes
	c) Audit of meeting action completion rates	Minutes
	d) Audit of actions taken under code of conduct breaches	Breach reports
	e) Assessment of Welsh Government satisfaction with APB progress	Annual WG monitoring visit
Performance	a) Audit of performance measurement systems	Quarterly lead provider reports
	b) Spot check of WNDSM data accuracy	WNDSM
	c) Assessment of performance at a national level	WG APB Dashboard and associated data
Finance	a) Internal audit of all SMAF expenditure	Quarterly lead provider finance reports
	b) Grant receiving agency external audit of SMAF capital and revenue expenditure	Contract holder ledgers
		WG capital monitoring visits
Delivery	a) Audit of service delivery	Quarterly lead provider delivery reports
	b) Audit of APB programme delivery	Audit against APB annual business plan
HR	a) Audit of completion rates for APB induction programme	Completed induction forms
	b) Review of APB support team performance	Staff PADRs
Risk Management	a) Audit of annual risk register, and implementation of mitigating actions	Risk register for the year
	b) Audit of all serious and untoward incidents and follow-up actions	SUI Log

PERFORMANCE MANAGEMENT

The APB performance management framework, should be considered against the performance indicators contained in the Substance Misuse Commissioning Strategy

Performance measurement and analysis

Data recruitment

Data will be obtained to inform progress against each of the National and Local performance indicators from the following sources:

- School health survey
- Welsh health survey
- UHB hospital admissions data
- Police crime data
- IOIS performance information systems
- Local service provider performance information systems
- Welsh National Database for Substance Misuse (WNDSM)
- Service user surveys
- Local resident surveys
- Geographical information systems (GIS)

Data Analysis

The analysis of performance for each indicator will include the following:

- Performance dashboard diagram showing the overall trend for the year to date.
- A table highlighting;
    - Actual performance for the period
    - Level and percentage change since the last report
    - Degree of variance from target
- Narrative – the story behind the data.

Additional data analysis products will include the following:

- Revised unit cost data based on service capacity and performance reports.
- Geographical Information System (GIS) mapping of indicator performance distributions.
- Suites of performance indicator reports for specific population cohorts, such as individuals of a certain age, gender, ethnicity, those using specific substances, or from a specific location of residence.

Performance reporting

Reports will be compiled and distributed by the APB support team. The following reports will be produced as routine:

1. Monthly reports (by 21st of the following month)
2. Quarterly Reports (within four weeks of the quarter's end)
3. Annual Report (by 31st May of the following year)

1. Monthly reports

Incorporating all monthly reported indicators, these reports will primarily be used by the APB support team and partner agencies in order to monitor day to day progress. A menu of performance indicators will be published and circulated to all stakeholders. Stakeholders will be able to request production of a monthly electronic bespoke report made up of those indicators that have the most relevance to their area of work.

Monthly reports will also be used to monitor the impact of any performance improvement activity that is underway, and will be considered, reviewed and signed off by the performance management subgroup of the APB Delivery Group.

A separate standardised monthly performance report will be produced against the national KPIs.

2. Quarterly reports

Quarterly reports will constitute the primary performance reporting mechanism to the APB Delivery Group, and to the APB itself. The quarterly reports will include the following four categories of indicators:

- An assessment of NKPI performance
- Acknowledgement of those indicators where a greater improvement has been achieved that expected during the quarter
- An alert to those indicators with declining performance levels
- Monitoring progress against indicators for which performance improvement actions are underway

3. Annual report

The annual performance report will incorporate the key elements of the results of monthly and quarterly reports through the year, as well as those indicators that are only collected on an annual basis. This will include a report against the NKPIs for the year, and a comprehensive annual performance report for each indicator will be incorporated into an annex to the report.

The annual performance report will constitute a key component of the APB Chairs annual report on the work of the Board.

Performance improvement

There will be an obligation on the APB delivery group to deliver performance improvement plans against any static or decreasing levels of performance. A secondary responsibility will be actions to accelerate levels of improvement that are insufficient to meet targets.

Performance improvement will, for the most part, be indicator specific, and will follow the 4 by 4 methodology (i.e. 4 people and 4 meetings). The following outline provides the fundamental components of any performance improvement plan:

Issue analysis (Meeting 1)

- Determining specific trends within the performance data.
- Identifying the causes and determinants of current performance levels.
- Identifying issues within single agencies, within multiple agencies and between agencies that are, or may be, contributing to performance levels.

Action planning (Meeting 1 and 2)

- Agreeing key actions that can be undertaken to address the causes of poor performance.
- Agreeing targets and expectations as a result of actions – defining what improvement will look like.
- Ensuring that proposed actions are consistent with the evidence base.
- Assigning accountability for delivery for each action or task.
- Agreeing timescales.

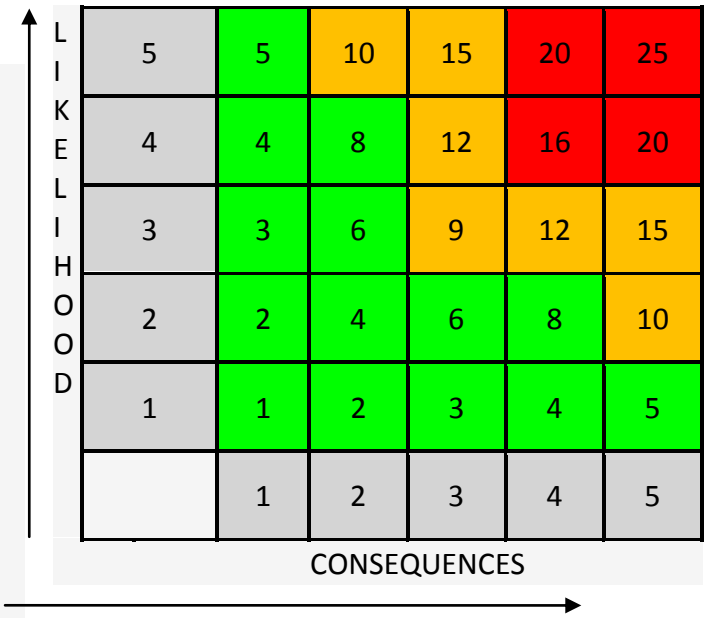
Monitoring (Meeting 3 and 4)

- Recruiting and analysing ongoing performance data.
- Midway monitoring meeting, to ensure that the desired improvement are beginning to materialise.
- Final monitoring meeting to establish the extent of improvements achieved, and to build ongoing sustainability into any changes to service delivery that have been implemented.

PART 3: Risk Management

Risk Assessment

Cardiff and Vale APB: 5x5 Risk Matrix



Risk Rating

Low (1-8)
Medium (9-15)
High (16-25)

Cardiff and Vale APB Risk Register

Section 1: Actual risks identified

Risk identifier / name	Nature of the risk	Risk Rating	Mitigating actions, including named lead and timescales per action	Date of review

Section 2: Potential risks identified

Risk identifier	Nature of the potential risk	Risk of occurrence	Likely Risk Rating if the risk occurs	Mitigating actions, including named lead and timescales per action	Date of review

Section 3: Ongoing monitoring of risks that have been mitigated / closed risks

Risk identifier	Initial risk rating	Final risk rating	Risk of re-occurrence	Ongoing monitoring actions, including named lead	Date of review

Statement of internal control

To be supplied by City and County of Cardiff as SMAF grant recipient

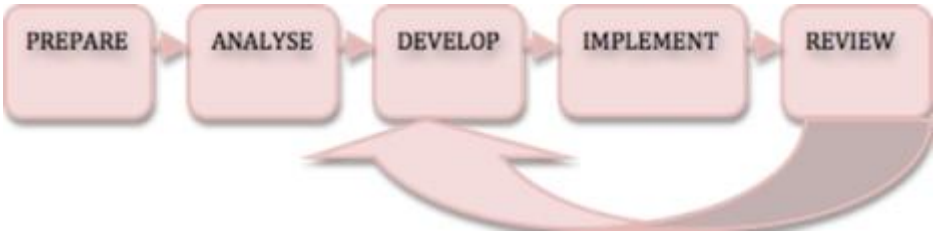
Emergency planning systems and Contingency Management Plan (CMP)

Contingency planning aims to prepare the APB and its member agencies to respond well to an emergency or serious incident, and either mitigate, or manage potential impacts. Developing a contingency plan involves making decisions in advance about the management of human and financial resources, coordination and communications procedures, and being aware of a range of technical and logistical responses. Such planning is a management tool, involving all sectors, which can help ensure timely and effective provision of the most appropriate response when an incident occurs. Time spent in contingency planning equals time saved when an incident occurs. Effective contingency planning should lead to timely and effective responses.

The contingency planning process can basically be broken down into three simple questions:
• What is going to happen?
• What are we going to do about it?
• What can we do ahead of time to get prepared?

The approach outlined here will enable the APB and its support structures to think through these questions in a systematic way. Contingency planning is most often undertaken when there is a specific threat or hazard; exactly how that threat will actually impact is unknown. Developing scenarios is a good way of thinking through the possible impacts. On the basis of sensible scenarios it is possible to develop a plan that sets out the scale of the response and the resources needed.

The development of an APB response to the need for contingency planning is broken down into five main steps, shown in the diagram below.



In order to be relevant and useful, contingency plans must be a collaborative effort. They must also be linked to the plans, systems or processes of each of the constituent member agencies on the board at all levels – operational, managerial and senior / executive management level.

CMP STEP 1: Prepare

The most likely adverse incidents that could occur within the remit of the APB have been identified below. These have been grouped in line with the APB business management processes i.e. in terms of performance, finance and delivery. By its nature, the delivery section contains substantially larger numbers of potential risks, and will need to be regularly updated as and when either new risks are identified, or unforeseen incidents occur.

Performance

Potential issue
Significant change in performance level among commissioned services
Significant change in trend among the wider population, linked to substance use
Evidence of inaccuracy in performance information

Finance

Potential issue
Unforeseen significant overspend or under spend against SMAF allocations
Evidence of inappropriate use of financial resources
Unforeseen reductions in funding allocations that support commissioned services

Delivery

Potential issue
Newly identified risk to the service user population e.g. contaminated substances
Serious and Untoward Incidents within commissioned services
Serious and untoward incidents within the community that are attributable to substance misuse related issues; e.g. discarded injecting equipment or a rise in drug related overdose and death
Disruption to commissioned services e.g. temporary such as high volumes of sickness and absence or permanent such as insolvency of providers
Allegations and/or evidence of poor or risky practice
Complaints from service users, carers, staff and the general public in relation to the conduct of frontline service delivery

CMP STEP 2: Analyse

In this section, the impacts of the listed issues, and the data and information required to quantify a potential incident is outlined. This is the information that will enable the APB and its support team to assess any incident in question, and develop an appropriate response.

Performance

Potential issue	Impact(s)	Evidence required
Significant change in performance level among commissioned services	• Poorer capacity and quality of commissioned services	• Provider performance data • WNDSM Data • Service user feedback
Significant change in trends among the wider population, linked to substance use e.g. EU attendance rates	• Increased health inequity • Decreased capacity for services to respond to demand	• Population data • Wider service performance and activity data
Evidence of inaccuracy in performance information	• Weakness in the evidence supporting financial allocation, and APB decision making • Failure to understand the true picture of service delivery in practice	• Provider performance data • WNDSM Data • Service user feedback

Finance

Potential issue	Impact(s)	Evidence Required
Unforeseen significant overspend or under spend against SMAF allocations	• Financial risk transferred to APB member agencies • Finances allocated according to capacity to incur expenditure, rather than against evidence of greatest need	• Service provider and contract holder budget reports • Financial forecast outturns
Evidence of inappropriate use of financial resources by commissioned services	• Leal implications for contracted services • Disassociation between commissioning intentions and services provided • APB open to challenge by Welsh Government, with financial risk falling to member agencies	• Internal and external financial audit • Scrutiny of provider expenditure reports
Unforeseen reductions in funding allocations that support commissioned services	• Loss of critical services • Inability for service capacity to meet demand • Need for transparent	• Welsh Government SMAF allocations

	and accountable decision making in order to prioritize the retention of services	

Delivery

Potential issue	Impact(s)	Evidence required
Newly identified risk to the service user population e.g. contaminated substances	• Serious incidents, and significant harm to the service user population	• CMO / National alerts • Alerts from out of area • Local provider and service use reports
Serious and Untoward Incidents within commissioned services	• Significant harm to service users, carers or staff • Service delivery model may have an inherent risk that could result in re-occurrence	• SUI reports – mandated in SMAF terms and conditions to be notified to the APB within 2 working days • Whistle blowing
Serious and untoward incidents within the community that are attributable to substance misuse related issues; e.g. discarded injecting equipment or a rise in drug related overdose and death	• Significant risk of harm to service users, carers, staff and the general public	• Statutory agency reports • Local provider and service use reports • Public feedback and responses
Disruption to commissioned services e.g. temporary such as high volumes of sickness and absence or permanent such as insolvency of providers	• Short term breaches of governance such as excessive caseloads • Discontinuation of treatment, care and support to service users	• Service provider reports and notifications
Allegations and/or evidence of poor or risky practice	• Actual, or significant risk of, harm to service users, carers, and/or staff	• Notifications to the APB • Whistle blowing
Complaints from service users, carers, staff and the general public in relation to the conduct of frontline service	• Potential indicator of poor practice • Opportunity to identify areas for service improvement	• Complaints registers • Communications via the APB Feedback Email address • Direct complaints

Potential issue	Impact(s)	Evidence required
delivery		

CMP STEP 3: Develop

In this step, the most usual and recognized effective responses to each of the issue are listed. This provides the basis of agreeing the actions needed to underpin the APB response in the event of an incident occurring, and forms the main structure of an incident response plan.

Performance

Potential issue	Responses	Lead
Significant change in performance level among commissioned services	• Assessment of the validity of performance information • Triangulation of multiple data sources to confirm validity • Service provider consultation to identify causal factors	APB Systems Information Officer
Significant change in trend among the wider population, linked to substance use	• Assessment of the validity of performance information • Triangulation of multiple data sources to confirm validity • Research to identify causal factors	APB Systems Information Officer Head of substance misuse
Evidence of inaccuracy in performance information	• Assessment of the validity of performance information • Identification of true performance levels as evidenced through validated data	APB Systems Information Officer

Finance

Potential issue	Responses	Lead
Unforeseen significant overspend or under spend against SMAF allocations	• Quantify financial position with the provider • Identify the legal position with regards to contracts and service level agreements	Head of substance misuse APB Finance Officer
Evidence of inappropriate use of financial resources	• Scrutiny of ledgers and audit reports • Determination of any illegality	APB Chair, supported by APB Finance Officer
Unforeseen reductions in funding allocations	• Prioritization of the APB schedule of commissioned services,	APB Delivery Group Chair,

that support commissioned services	including consultation with service providers, users and carers	supported by Head of substance misuse

Delivery

Potential issue	Responses	Lead
Newly identified risk to the service user population e.g. contaminated substances	• Clarification of the nature and extent of the risk • Identification of the populations at risk • Considering and agreeing the content and communication routes of information for cascade	Head of substance misuse
Serious and Untoward Incidents within commissioned services	• Application of the UHB Serious and Untoward Incident procedures H:\APB Development' Governance\Incident	APB Clinical Governance Lead & Head of substance misuse
Serious and untoward incidents within the community that are attributable to substance misuse related issues; e.g. discarded injecting equipment or a rise in drug related overdose and death	• Clarification of the nature and extent of the incident • Application of due process according to the APB member agency with statutory responsibility for responding to incidents of that nature	Head of substance misuse
Disruption to commissioned services e.g. temporary such as high volumes of sickness and absence or permanent such as insolvency of providers	• Clarification of the nature and extent of the issue • Assessment of the longevity of the position and the risk to service users • Identification of mitigating responses e.g. negotiation for alternative provision with other services, or the provision of non-recurrent resources to address staff deficiencies	Delivery Group Chair, supported by the Head of substance misuse
Allegations and/or evidence of poor or high risk practice	• Assessment of the need for statutory investigation e.g. safeguarding • Follow due process in relation to statutory obligations • Recruitment and scrutiny of	APB Clinical Governance Lead, supported by Head of substance

Potential issue	Responses	Lead
	evidence • Agree any mandate for changes in practice for commissioned services • Agree any mandate for changes in practice under the statutory responsibility of the relevant APB member agency, for non-commissioned services	misuse
Complaints from service users, carers, staff and the general public in relation to the conduct of frontline service delivery	• Clarification of the nature and extent of the issue • Establish the perspective of the service provider whilst protecting the service user identity • Agree the terms of a provider-led investigation • Determine whether the results of the investigation, and any subsequent actions are satisfactory to the complainant • Agree and implement further actions that are appropriate, evidence based and proportionate	APB Service User Lead Officer (Users and carers) Head of substance misuse (Staff and general public)

CMP STEP 4: Implement (I.e. Incident Response)

The identification of potential risks, the appropriate analysis tasks, and the correct preparation steps (i.e. steps 1-3) will be continuously updated and reviewed. In the event of an incident, step 4 forms the starting point.

For the implementation of the Contingency Management Plan, the following steps are to be followed in order

ACTION	LEAD	COMMUNICATION	RESULT
On receipt of notification of an actual or suspected incident, the appropriate actions identified under STEP 2 to analyse the position to be completed. This should be completed in the same working day as the notification.	As defined in STEP 2 In the event of an incident of a new nature, the Head of Substance Misuse has the default responsibility for undertaking the analysis	On completion of analysis, and determination of the validity of the incident an email alert is automatically sent to the **APB Chair, APB Vice Chair, Delivery Group Chair** and **representatives of those organizations** whose statutory responsibilities incorporate incidents	Key members of the APB and delivery group are quickly cognizant of the nature of the incident, and of the response being taken.

ACTION	LEAD	COMMUNICATION	RESULT
		of this nature	
Following analysis, the Incident Lead prepares an outline of the responses recommended for the APB to take in relation to the incident	As above i.e. Incident Lead	Where possible, the recommended course of action should be included in the communication to the APB members outlined above	APB members are sufficiently informed to agree the appropriate course of action
APB members to agree the suggested course of action, with any additions or amendments	Notified APB Members	Confirmation back to the Incident Lead to proceed.	Actions taken are with the full knowledge and agreement of key APB members
Incident Lead implements the agreed response actions	Incident Lead	All communications required within the agreed actions e.g. information alert cascades, formal letters / emails on behalf of the APB etc	Implementation of an incident-appropriate response
Incident Lead monitors impact of actions, and ascertains whether a satisfactory resolution has been achieved	Incident Lead	Further communications in line with required actions to ensure the incident is resolved. Further communication with notified APB members on progress, and any unforeseen difficulties in resolution	Agreed actions achieve resolution of the incident. APB members are briefed on progress
Incident Lead undertakes any further actions required	Incident Lead	Further communications in line with additional actions needed to ensure the incident is resolved. Further communication with notified APB	Incident is resolved

ACTION	LEAD	COMMUNICATION	RESULT
		members on progress, and resolution	
Incident Lead completes an incident report and resolution form	Incident Lead	Involved APB members are sent a copy of a completed incident report and resolution form	APB members are assured on incident resolution
Incident Closure	APB Chair	Signed incident report and resolution form is returned to the Incident Lead	The necessary information is in place to enable, review to commence

Cardiff and Vale APB Incident Report and Resolution Form

Date and Time of incident notification received ……..

Name of Incident Lead ……

Describe the nature of the incident

Describe the actions taken to analyse and validate the incident

Confirm date and time of APB member notification ……

List of APB members notified

1) _____
2) _____
3) _____
4) _____
5) _____

Describe the actions taken in response to the incident, and the results of those actions:

Outline how and when the incident was determined as resolved

APB Chair Signature – confirming that this incident has been correctly managed, responded to, and resolved

……

DATE ……

STEP 5: Review

Following any major incident that triggers implementation of the CMP, the following two stages are required to ensure that the incident response system for the APB is continuously learning and improving, as well as reducing, where possible, the likelihood of similar incidents occurring in future.

1. Identifying lessons learned

The APB Delivery Group is required to undertake a review of all incidents that trigger the use of the CMP system. The group is tasked with undertaking a comprehensive analysis of the incident, the responses, the resolution, and the outcome.

Using the results of their review, the Delivery Group are tasked with making recommendations to the APB on any aspect on the CMP process as it related to the incident in question. In order to assist this process, the Delivery Group should consider the following questions as a guideline:

- Did the incident come to the attention of the APB quickly enough, and in the correct manner?
- Was the right person identified as Incident Lead?
- How robust was the analysis and validation of the incident?
- How effective and appropriate were the communications?
- Was the course of action taken appropriate, measured, evidence based, and proportionate?
- Was the resolution of the incident satisfactory?
- Are there any alternative means of resolution that should have been considered?
- Were there any barriers to resolution, and how could they have been overcome?
- Are there any other key points that the APB should consider in the event of a similar incident occurring?

The result of this exercise will be an incident review report submitted to the APB by the Delivery Group.

2. Updating the CMP

On consideration of the Delivery Group incident review report, the APB should agree any additions and amendments to the "Prepare", "Analyse" and "Develop" sections of the Contingency Management Plan in order to ensure that lessons

learned are imbedded in future responses. The board should also consider amendments and improvements to STEP 4 incident response procedures as a result of the recommendations of the Delivery Group

The CMP in its entirety should be reviewed by the APB once every 2 years (i.e. every 8 meetings).

The CMP should be considered and agreed by the internal governance structures of the APB member agencies.

PART 4: Financial Governance

CARDIFF AND VALE SUBSTANCE MISUSE AREA PLANNING BOARD (APB)

Financial Risk Sharing and Audit Agreement

DRAFT (Version 1.1)

1. Description and Purpose of Agreement

1.1 The overarching strategic aim of this agreement is:-

- To ensure that the financial risk associated with APB responsible budgets are appropriately apportioned and shared between the partner agencies of the Board.
- To provide clarity with regards to how APB financial risk should be identified, monitored and mitigated.
- To provide close alignment between the allocation of financial risk and the statutory responsibilities of the partner agencies.

1.2 This will enable all members of the APB to:

- Clearly understand their roles and responsibilities in relation to APB finances
- Proactively monitor the identification and mitigation of financial risk to their organisation
- Support financial transparency and effective financial management of services for which risk is assigned to their organisation

2. Principles

2.1 The principles that underpin this agreement are as follows:-

- Financial risk should be aligned to statutory service responsibilities i.e. the risks associated with each of the APB commissioned packages of care or capital development projects should be aligned according the nature of the service being provided, and where the statutory responsibility for a service of that nature would normally lie.

- The weighting of financial risk between the two local authorities mirrors the weighting of funding allocation between those localities, as set out by the revised national substance misuse funding formula

- The allocation of financial risk will be revised annually, and clearly identified in the annual APB expenditure plan. Agreement of this plan by the board, and its subsequent submission to the Welsh Government for consideration, constitutes agreement to the risks as outlined.

2.2 The Grant Recipient is the City and County of Cardiff Local Authority

2.3 Each commissioned lead provider holds all financial risks associated with employed staff within the service package, overspends against contracted service values, and the use of financial resources for purposes not within their contracted agreements or Service Level Agreements without the prior consent of the APB. These financial standards will be included in all local terms and conditions issued with annual grant agreements.

2.4 Payments will not be made until signed terms and conditions have been received by the APB Finance Officer, and the service provider can evidence expenditure associated with contracted service delivery.

3. Current Schedule of Service Packages, and Allocated Risk

3.1 The table below outlines the full schedule of SMAF commissioned services as proposed from April 1st 2014.

Service Package	Value (2014/15)	Lead Provider	Contract Holder	Allocation of financial risk (2014/15)
Universal Services	£369,086	Public Health Wales	CCC	C&V UHB (50%) VG-CBC (11%) CCC (39%)
CYP Tier 2 service	£186,974	Barnardos	C&V UHB	C&V UHB (100%)
CYP Tier 3 CAMHS-based service	£85,623	Cwm Taf UHB	CCC	C&V UHB (50%) VG-CBC (11%)

				CCC (39%)
Enforcement support	£25,000	Both local authorities + South Wales Police	CCC	VG-CBC (40%) CCC (40%) SWP (20%)
Commissioning Support & Service User Engagement	£150,000	Both local authorities and Cardiff & Vale UHB	CCC	C&V UHB (65%) VG-CBC (30%) CCC (5%)
Systems Information Service	£40,000	C&V UHB	CCC	C&V UHB (100%)
Clinical treatment and therapeutic support service	£1,397,661	C&V UHB	CCC	C&V UHB (100%)
Family Support Service	£263,855	CCC	CCC	VG-CBC (22%) CCC (78%)
Open Access and Engagement Service	£467,345	TBC	C&V UHB	C&V UHB (100%)
Throughcare, Aftercare and Recovery Support Service	£367,155	TBC	C&V UHB	C&V UHB (100%)
Residential Accommodation Support Service	£106,135	Salvation Army	CCC	CCC (100%)
Enhanced CJS service	£105,000	CCC	CCC	Wales Probation Trust (25%) South Wales Police (25%) VG-CBC (11%) CCC (39%)
Residential Rehabilitation Budget	£52,845	CCC	CCC	VG-CBC (22%) CCC (78%)
EDAS – assessment service	£25,000	C&V UHB	CCC	C&V UHB (50%) VG-CBC (11%) CCC (39%)
Community Support Service	£5000	Various	CCC	C&V UHB (50%) VG-CBC (11%) CCC (39%)

4. Identification, management and mitigation of financial risk

4.1 Financial Monitoring and Audit

- The grant recipient (currently City and County of Cardiff Local Authority) is responsible for the annual external audit of the Substance Misuse Action Fund revenue and capital allocations.

- The grant recipient is responsible for ensuring that the local grant terms and conditions are structured in such a way as to satisfy those audit requirements.

- Each lead provider is responsible for ensuring the completion of the appropriate level of annual audit for all aspects of service delivery and associated expenditure within the package, to the standards required by the Welsh Government terms and conditions of grant, via the local terms and conditions of grant.

- The grant recipient has autonomous authority in authorising, or withholding payment of grant dependent on whether local terms and conditions of grant have been satisfied.

- The APB support team is responsible for monitoring the expenditure of resources for each service package, and the associated delivery of services through the APB contract monitoring forum. This will take place at least quarterly for each commissioned service.

4.2 Financial Risk Register

- The APB support team is responsible for maintaining a financial risk register that provides the board and its delivery group with a quarterly assessment of the following:
    - Expenditure to date
    - Forecast expenditure to the end of the financial year
    - Actual variances in expenditure and an assessment of the level of risk posed
    - Mitigating actions to address actual variances
    - Potential variances in expenditure both over and under budgeted levels, with an assessment of the likelihood of their occurrence
    - Mitigating actions to address potential variances in expenditure
    - Results of mitigating actions from previous quarterly assessments

5. Financial Management Systems and Processes

1.1 The Quarterly APB contract management forum meetings will include a comprehensive quarterly finance report from each of the commissioned packages of care. These reports will adhere to standards of format and content determined by the grant receiving agency.

1.2 Contract monitoring forum meetings will be timed so as to enable an up-to-date financial report to be available for every APB meeting.

1.3 Where a third party, separate from the grant receiving agency, holds the contract for a package of care, the support team will determine the performance and expenditure reporting requirements that must be

associated with the contract, to ensure adherence to grant terms and conditions. Where possible this should extend to enabling access to the relevant financial systems and ledgers to the APB finance officer, and systems information officer, for the purposes of scrutiny.

1.4 All contract holding agencies, and lead provider agencies (as listed in the schedule above) must nominate a single individual to act as the point of contact with regards to finance, and grant issues.

1.5 All APB support staff annual performance reviews will incorporate a mandatory assessment of their performance in relation to financial management, including the identification of further training and development needs associated with public sector finance.

6. Risk Sharing Agreement Review

6.1 Any alteration to the value or scope of a commissioned service during the course of a financial year can only be agreed with the consent of the APB representatives from those organisations that hold the financial risk for the service package in question.

6.2 This Risk Sharing Agreement, and the apportionment of risk against the service schedule, will be reviewed annually as part of the December APB meeting. This will be undertaken in tandem with the board's consideration and agreement of the SMAF expenditure plan for the following financial year.

Annex 6: Responses to the Commissioning Strategy Consultation, and APB responses

Source	Summary Comments		Fully Accepted	Partially Accepted	Rejected	Rationale for Decision
	Page/Action					
Vale Youth Offending Service		• The strategy is very well written and evidenced and I would support the principles contained within it.	✓			Noted
	Pg. 11 – 1	• Redesign family Support Services – how does this link to work being undertaken with YOS and preventative services?	✓			The redesign process will include an assessment of interdependencies across all related services
		• Look at how your expansion of commissioned services beyond CIN and CP could increase capacity in delivery of preventative services.	✓			Agreed – there is a generic focus in the strategy on prevention and early intervention
	Pg. 12 – 2	• Enable the S/M specialist functions within YOS to become embedded as a resource for the service as a whole.	✓			The YOS substance misuse provision will remain as an integrated component of the Youth Offending Teams and not as a separate entity.
		• 'APB looking to incorporate YOS service into EWS service' - What is meant by the statement as we would not wish to dilute the services to the YOS?		✓		EWB will become a key interdependent provision for YOS across a range of substance use and mental wellbeing needs
	Pg. 15/16	• DNA Rates for EDAS – Do you know whether people were dropping out of the service as they did not feel supported to attend, people		✓		Relatively high DNA rates are a common factor in the substance misuse sector. The rate has been decreasing, with the APB now

Source	Summary Comments		Fully Accepted	Partially Accepted	Rejected	Rationale for Decision
		with issues with dependency, anxiety who may be using substances as a coping mechanism may not have the ability to make the volunteers/peers as support if recognised as an issue.				repeatedly exceeding the national target of less than 20%. However, moving to a walk-in delivery model for EDAS should see this decline further.
	Pg. 16/17	• Agree that it is necessary to build in exit strategies for people otherwise they become dependent on services. • This is an opportunity to explore use of volunteers.	✓			Noted
	Pg. 21	• Links to older people, not sure if it would be useful to link to the Over 50 Forum	✓			The Over 50 forum, along with stakeholders such as Age Cymru will be central to the development of service and support for older people
	Pg. 24	• Will there be access to any psychological therapies alongside the low threshold prescribing service, or is this designed to be a holding mechanism whilst waiting to get into therapies?	✓			Yes – clinical guidelines recommend that no prescribed intervention is delivered in the absence of supporting therapies.

Source	Summary Comments		Fully Accepted	Partially Accepted	Rejected	Rationale for Decision
	Page/Action					
NewLink Wales		• How can we apply a segmentation model to peer support - working on some shared principles with social marketing? If we pair "survivors" (people who are generally disengaged in health behaviours and low down on the IMD) and pair them with "fighters" (the people who succeed anyway).		✓		This approach would fit comfortably with the existing design of the aftercare service. However it would need careful monitoring and evaluation to determine the added value, and improved outcomes for service users and peers.
		• I agree that re-engagement is a priority – will there be a contingency Management budget for this? There's loads of evidence saying this approach works but nobody ever wants to fund it properly and therefore it's rarely used.		✓		Agreeing the use of contingency management is something the Treatment, Therapies and clinical Governance group for the APB need to advise on. The dilemma is incentivising sustained treatment for disengaged individuals whilst others are on a waiting list.
		• I was encouraged to see such a focus on family interventions – with there be resources for this?	✓			The resources are already in place with the APB family Support Service / Hidden Harm contract
		• I agree that RBA is the best way to performance manage, however I'd like us to bring back KPI's – charities have to use these a part of legal compliance in our financial reporting so it would be better for everyone if we planned this out together so everyone can use the info.	✓			Happy for RBA frameworks to include KPIs within the suite of measures.

Source	Summary Comments		Fully Accepted	Partially Accepted	Rejected	Rationale for Decision
		• I agree that we can't commission services for people indefinitely, but we still need to keep room for self-definition of recovery and for people to engage with RC, Living Room and Nu Hi (and others) on their own terms.		✓		Agreed, but self-defined and self-sourced support including AA / NA and other providers should be formulated by individual services users, rather than set-out by commissioners. We do not dispute the role that non-commissioned serviced play, but neither should the APB try and exercise influence of the design and delivery of those services
		• There are unmet needs in the LGBT and diverse ethnic populations in Cardiff & Vale.	✓			Open access and outreach services will be working towards improving their interface with hard-to-reach and vulnerable groups

Source	Summary Comments		Fully Accepted	Partially Accepted	Rejected	Rationale for Decision
	Page/Action					
		• Need for increased integration between the Local Authorities, Cardiff and Vale UHB and the APB in relation to substance misuse which did not always come across in the commissioning strategy.		✓		Whilst the focus of the strategy is on grant-funded and commissioned services, these are designed and developed in the broader context of health, local government and criminal justice substance misuse provision. The membership of the board and its commissioning group reflect this.
		• Use of the word 'Service User'. The Social Services and Wellbeing (Wales) Act 2014 and the Wellbeing of Future Generations (Wales) 2015 both focus on person-centred solutions. The suggestion was that service user should either be replaced with 'people', 'person' or with 'citizen'.			✓	The term service user is the preferred choice in the substance misuse sector, and creates alignment and affinity with the national and UK-wide substance misuse service user movement. If feedback from service users was for a change in terminology, then this would be taken into consideration.
Cardiff Health and Social Care Network response		• Consistency of terminology; 'Substance misuse' and 'substance use' were mentioned in different places in the document. What is the difference between substance use and substance misuse? • If there is a difference this should be made clear in the final document. If there is no difference then just one term should be used	✓			Substance use relates to the use of substances such as recreational alcohol consumption, whereas misuse essentially means use at a level that causes, or is likely to cause, some degree of harm to the individual or others.

Source	Summary Comments		Fully Accepted	Partially Accepted	Rejected	Rationale for Decision
		to limit any confusion.				
C3SC Cardiff Third Sector Council Cyngor Trydydd Sector Caerdydd		• The commissioning strategy seems to focus only on adults, how will this be linked across to Children's services and is there a separate strategy for those services?			✓	There is a strong focus on early intervention and prevention services, family support services and hidden harm – these are the areas of substance misuse services for children and young people that have the highest level of priority for the term of this strategy
		• Will this commissioning strategy lead to procurement? Could it lead to pilots and innovation rather than the more traditional route? Does it open up the opportunities for thinking around developing services differently in a collaborative and co-productive manner? This would be a shift in thinking which would be welcomed by the third sector.	✓			The strategy will lead to outcomes-based commissioning and procurement. We already have services such as our aftercare service delivered as a third sector consortium. The outcomes approach is entirely focus on fostering creativity and innovation among providers and service users.

Source	Summary Comments		Fully Accepted	Partially Accepted	Rejected	Rationale for Decision
	Page/Action					
Cardiff Health and Social Care Network response C3SC Cardiff Third Sector Council Cyngor Trydydd Sector Caerdydd		• Not all of the existing services that are provided for people with substance misuse were included in the data, just the existing commissioned services		✓		The activity levels relate to commissioned services as this is where we have the most data. Service needs more broadly looked at a population level rather than on commissioned services alone.
		• How integrated this strategy is with other statutory sector areas that fund substance misuse services and support, such as the Supporting People Programme funded projects.	✓			All related services such as criminal justice services, statutory services, supporting people are represented at the APB and/or commissioning group.
		• Staff engagement as well as person engagement was raised as an important element of increasing job satisfaction and personal development.	✓			Agreed
	Action 8.	• *"Ensure that services provide an individualised and tailored response to people's needs"* • The Network thought that this needs to link more closely to commissioning action 9.		✓		It is true that achieving this might be better achieved if linked to a R&D programme, but the commissioning intention is to use the existing known methods such as care planning in line with the mental health measure, to ensure that all service users' needs in the broadest sense are assessed and planned for.

Source	Summary Comments		Fully Accepted	Partially Accepted	Rejected	Rationale for Decision
	Action 9.	• There is already a lot of research and innovation that is happening elsewhere. There is a need to learn from best practice from elsewhere. • A suggestion was made that instead of beginning the action with "lead on" it should be "Contribute to research…."		✓		The APB accepts that best practice elsewhere needs to be considered and introduced where appropriate. However, the board is ambitious in leading in addressing some of the current knowledge and research gaps – particularly in how this translates into operational practice. For example, we are leading at an international level in addressing alcohol in the night time economy with the Cardiff alcohol treatment centre, and will be the first APB in Wales to address sub-optimal prescribing dosages in practice.
	Action 10.	• The inclusion of housing was received positively. However, the lack of any mention of engagement with Housing Associations as a referral source and a useful link to prevention and early intervention services was identified as missing under this part of the commissioning strategy.	✓			Agreed – this will be addressed in the final draft

Source	Summary Comments		Fully Accepted	Partially Accepted	Rejected	Rationale for Decision
	Page/Action					
Cardiff Health and Social Care Network response C3SC Cardiff Third Sector Council Cyngor Trydydd Sector Caerdydd	Action 14.	• Why is the focus on drug use and not alcohol use as well?			✓	Welsh government have set the mandate for APB responsibilities on Drug Related Deaths. The national policy decisions on the management of alcohol related deaths have not yet been agreed.
		• High expectation on Service users, carers etc to the benefit of the APB. Whilst it is acknowledged that the aim is to achieve these improvements this does not clearly come through the strategy as it is currently written.		✓		This is synonymous with co-production and prudent healthcare; however it should be noted that the APBs intention is that this is to the benefit of service users rather than the APB. Putting users and carers at the heart of service design is crucial in ensuring effective engagement and positive outcomes.
		• Service user training: • What training will be provided for each level? • Level of involvement is it a step up or can someone go direct to Gold? • These individuals are experts from experience, how will this be acknowledged? • The expertise is from experience, the training needs to enable this expertise to be used in innovative ways and not to limit	✓			All the points raised will be taken into consideration as the training is developed. The levels are incremental, and each requires completion before moving on to the next.

Source	Summary Comments		Fully Accepted	Partially Accepted	Rejected	Rationale for Decision
		innovation and individualism. • Confusion as to what each of the different tiers represented				
		• Outcomes based commissioning was perceived as a positive step forward. There are already some really good examples of outcomes based commissioning that the APB can learn; Mental Health services in Camden (listed by the New Economic Foundation) was mentioned as an example by one of the attendees at the Network meeting.	✓			The New Economics Foundation training programme, and the Camden experience has informed both this strategy, and current OBC work such as the development of the new re-engagement service.

Source	Summary Comments		Fully Accepted	Partially Accepted	Rejected	Rationale for Decision
	Page/Action					
		• Understanding and impact of ACE research. It would be good for this to be recognised in workforce development and also meaningful joint working with other sectors as people leave the treatment system.	✓			The findings of the ACE work will inform all aspects of the APB work programme going forward
		• **Overcoming the causes / consequences of substance misuse -** We need to explore the role, involvement, investment and joint working with generic health and social care services; as well as mental health services in this approach. We strongly advocate that the APB commissioning strategy directly includes this.		✓		As well as through this document there are other vehicles for this work such as the APB dual diagnosis action plan that is currently under development, and the management of mental health and addiction across the plans for all health and social care services.
Recovery Cymru		• How does the substance misuse sector work meaningfully with other sectors to ensure the recovery capital needed for sustaining change is available and people are equipped to self manage it…?	✓			Programmes such as time banking / time credits, volunteering, the new Welsh Government Out Of Work support service and the APB programme to make use of community assets will all contribute to this.
		• While recognising the immense achievement of fully implementing Throughcare, aftercare and recovery support into the treatment system, we also need to have a longer term plan re: increasing demand on this part of the	✓			As above – with finite resources, the use of community assets and resources will be critical to providing sufficient capacity long term

Source	Summary Comments		Fully Accepted	Partially Accepted	Rejected	Rationale for Decision
		system				
		• We need to recognise the need for sustained/appropriate-to-demand investment in the latter parts of the treatment system before we can expect people to move on from these support mechanisms without returning to treatment/support.		✓		Agreed, however it should be recognised that the APB investment into aftercare has increased from £40,000 in 2012 to £500,000 currently. The board will need to see robust evidence of the reduced relapse rates and lower numbers returning to treatment as a result of this investment, before putting additional resources into this part of the system.
		• We are concerned about the prospect of 'setting targets for planned closures from Throughcare, aftercare and recovery support' for **all** parts of the footsteps model because this directly contradicts the philosophy of and evidence base for ongoing peer recovery support.			✓	Planned closure from a commissioned service does not equate to discontinued support. It merely reflects the fact that a service user has moved on from one level of recovery support to another.

Source	Summary Comments		Accepted	Partially	Rejected	Rationale for Decision
	Page/Action		✓	Accepted	✓	
Recovery Cymru Recovery Cymru		We support the notion that the size of the recovery community should not be the main influencing factor in decision making for resource allocation. However, the population of the recovery community that fall within the following categories should be: • Actively leaving treatment programmes (especially, Pine Ward; CAU; Taith; Shared Care) • Preparing to access the structured aftercare programme • Leaving the structured aftercare programmes • Those identified with entrenched substance misuse history; long engagement in treatment; very low recovery capital (and therefore, higher need) • Those in crisis which will put their sustained recovery at risk • Actively managing relapse in the community		✓		The availability of recovery support should not be limited to individuals who have gone through a pathway that we have prescribed for them, or who fall within a set of definitions. The evidence suggests that over 35% of individuals in long term sustained recovery in the community will have achieved this without any access to services or support. This has very little bearing on resource allocation – the cost of one 16 week residential placement would provide community based recovery support for many more individuals. Resources are targeted according to need, and not volumes. They are also targeted on the evidence of successful outcomes, and not activity levels.
		We support and would like to assist with: • Engaging with community based resources • Time banking	✓			Agreed

Source	Summary Comments		Accepted	Partially	Rejected	Rationale for Decision
		• Community resources event and asset mapping • A directory on non-substance misuse specific community resources				

Source	Summary Comments		Fully Accepted	Partially Accepted	Rejected	Rationale for Decision
	Page/Action					
Recovery Cymru **Sarah Vaile**		• Increasing capacity of user-led mutual aid approaches to recovery Ideas for exploration: • Genuine community integration and community group partnerships • Investing in peer volunteers and leaders – a sustainable approach to delivering ongoing peer support as and when it is needed • 'local' non centre-based peer support available across Cardiff and the vale • Ongoing support and mutual aid in a rural setting • RC would like to see the specific needs of **peer support workers** addressed in future work		✓		Any and all developments of this nature can be considered if there is a robust enough evidence base to support them.

Source	Summary Comments		Fully Accepted	Partially Accepted	Rejected	Rationale for Decision
Recovery Cymru		streams.				
		• Appropriate **investment in peer leaders / facilitators is essential** to ensure the sustainable peer model is possible and most effective.	✓			As mentioned – resources to this sector have increased 10 fold in the last 4 years. The APB is now keen to see the impacts and outcomes.
		• Peers leaders / recovery champions should be involved in (piloting a systems navigation role), as well as utilising the new OOW service. A specific pilot project could be set up linked to the ideas above re: moving on from the recovery community.	✓			Agreed – the APB has noted that local providers have won the contract for the OOWS for Cardiff and the Vale.
		RC would like to undertake analysis of 'Footsteppers' to date to evidence how the model does / can support: • Preparing to leave treatment • Preparing to access the structured programme • Support programme for sustaining changes made while in treatment and the structured programme • Moving on from intense recovery community support.	✓			This needs to be completed as part of the evaluation of the contract.

Source	Summary Comments		Fully Accepted	Partially Accepted	Rejected	Rationale for Decision
		• Sustaining longer term change without or with minimal ongoing support				
		• There needs to be better joint working protocols between treatment and aftercare; should be facilitated by the new re-engagement posts.	✓			The APB will be evaluating this function for any model of re-engagement that is presented back to us.

Source	Summary Comments		Fully Accepted	Partially Accepted	Rejected	Rationale for Decision
	Page/Action					
Dr Robert Kidd and Dr Pam Roberts; Cardiff and Vale UHB - Psychology		• The Commissioning Strategy 2016-20 as a whole would benefit from more clearly articulating a stepped model of care for psycho-social interventions. • Cardiff & Vale APB should aspire to lead the field in creating a system of delivering and monitoring interventions and treatments for substance misuse, so that the most effective yet least resource intensive, treatment is delivered to patients first; with stepping up to increasingly intensive/specialist services as clinically required in a timely fashion.	✓			This will be incorporated into the final draft
		• The APB might consider a stepped care model of psycho-social provision paralleling developments in thinking about the provision of psychological therapies in Wales (the Matrix Cymru) across a range of severity: E.g. Tier 4 Inpatient/Residential, Tier 3 Highly Specialist/Complex Care, tier 2 High Intensity, tier 1 low intensity, tier 0 primary care & public health promotion.	✓			This will be incorporated into the final draft
		• A stepped care model also would clarify the training needs of staff working at different tiers	✓	✓	✓	This will be incorporated into the final draft

		and the supervision requirements needed.				
Source	**Summary Comments**		**Fully Accepted**	**Partially Accepted**	**Reject ed**	**Rationale for Decision**
	Page/Action					
Dr Robert Kidd and Dr Pam Roberts; Cardiff and Vale UHB - Psychology		• A range of low intensity brief interventions should be developed for tier 1, which could be offered by a range of community services. Examples of this are the 4 session brief motivational enhancement packages (alcohol, cannabis, amphetamines) designed by Cardiff & Vale staff for delivery by others under appropriate supervision to ensure fidelity to the intervention package.	✓			Agreed – this can be undertaken as part of the development of both EDAS and open access services
	Page 29	• The APB should develop a position regarding how NICE clinical guidance 115 for harmful drinking and alcohol dependence should be provided at scale (possibly through group provision) within the Cardiff & Vale area.		✓		Agreed –this is currently delivered through the open access service, but the APB can ensure a review against the NICE guidelines
		• Limited reference throughout the strategy of Service users with the most problematic and hazardous substance misuse, clients who have extremely complex presentations, with high level of comorbid health problems such as mental health, personality disorder, trauma and neurocognitive degeneration, will require interventions of longer length.		✓		This group of service users has been traditionally most prioritised in service commissioning since the inception of grant funding – currently 50% of funding is allocated to treatment for service users with complex needs. However, the APB accepts that services for substance related neurocognitive degenerative disorders require further

						development
	Page 14	• This again suggests that a move to a more bio-psycho-social model of care is needed and that intervention providers will have to address psycho-social treatment targets consequently.	✓			Agreed – the APB is moving to a position that no treatment intervention should be provided in the absence of appropriate psycho-social therapeutic support
		• One aspect of the strategy which requires further development is the need for ongoing training and supervision, particularly if service providers are to be drawn from voluntary and/or relatively inexperienced staff.	✓			Agreed – the workforce development component will be strengthened in relation to CPD as well as staff wellbeing

Source	Summary Comments		Fully Accepted	Partially Accepted	Rejected	Rationale for Decision
	Page/Action					
Dr Neil Jones; Community Addictions Unit (CAU)		• Document is long, lacks references – 'UHB Shaping Our Future Wellbeing Strategy 2015-2025' suggested as useful example to consider		✓		Agreed that additional cross-referencing with member agency strategies would be helpful
		• Questions around data validity			✓	Need specific examples to be reviewed – the data in the needs assessment is all published data from source
		• Challenges remain in the treatment provision – key principles are not covered in the strategy		✓		

Source	Summary Comments		Fully Accepted	Partially Accepted	Rejected	Rationale for Decision
		• No reference to wider aspects of substance misuse, PH measures, availability, local licensing, planning		✓		Agreed, however substance misuse services have a direct impact on a multitude of public service areas. The APB id closely engaged with the night time economy strategies, in the assessment of licensing applications, and in informing the overall public health work programme. However, as a commissioning strategy, there are few commissioning decisions that would be fundamentally altered as a direct consequence of these areas of service, and the importance is a focus on what service development is achievable over the next four years.
		• No aspirations for the C&V population around alcohol and drug use	✓			Agreed – the final draft will articulate the aspirations of the APB for the population
		• Little reference to any national strategies that may give greater context		✓		Whilst not directly referenced, there is substantial read-across between this document and both the national substance misuse strategy, the treatment frameworks, and the draft three year delivery plan for 2016-19.
		• Executive summary is not a summary of the document as a whole – principles presented		✓		This will be reviewed with the comment in mind

Source	Summary Comments		Fully Accepted	Partially Accepted	Rejected	Rationale for Decision
		appear muddled and contradictory				
		• Useful to acknowledge some people sit beyond help and support due to limited treatment places, decisions not to fund some interventions, withdrawal of certain funding streams	✓			Agreed
		• Caution in the use of the word 'research' in context to "We should be constantly researching and developing better and more effective ways of securing sustainable outcomes for our service users and carers"		✓		The APB is committed to ensuring that services have the opportunity to introduce innovation coupled with effective monitoring and evaluation to improve services and outcomes. Whilst it is not research in the sense of methods such as a controlled trial, we do hope to generate evidence that adds to the knowledge base for substance misuse
		• We should work with academic departments and bodies to involve ourselves in good quality research	✓			Agreed
		• Little evidence to suggest text messaging service has reduce DNA rates in EDAS		✓		Whilst the impact on DNA rates may not be substantial, it does provide for a better quality service, and as a methods of improving communication options for service users be sustained and rolled out

Source	Summary Comments		Fully Accepted	Partially Accepted	Rejected	Rationale for Decision
						where possible.
		• No feedback or evaluation on the loss of CADT counselling service – no APB risk assessment			✓	This was managed on the APB risk register throughout the process of managing the withdrawal of this service. The resulting new service configuration is all that can be achieved in the light of the austerity measures that local government have been subject to.
		• Evaluation of ACEs and introduction of Piling's Life Project may prove difficult		✓		This does present challenges as a much longer term piece of work, but the APB is committed to the underlying principle of challenging the causes of substance misuse and not just the consequences.
		• Need for discussion around impact of future intended changes in local services, unemployment, sickness benefits etc on drivers of substance misuse	✓			Agreed, although this needs to take place in the broader public services arena, as these drivers will have consequences across a broad spectrum of public services.
		• The APB may wish to consider the other sections of the Mental Health Measure, with particular attention to co morbidity	✓			Agreed – the APB are currently developing a joint dual diagnosis action plan with the Mental Health Partnership Board
		• Clarity needed around when a 'generic service' may be considered under the umbrella of Substance misuse services (including substance misuse funding)		✓		Agreed in that the capacity of generic services has a direct influence on the outcomes of substance misuse services. The APB commissioning group is the

Source	Summary Comments		Fully Accepted	Partially Accepted	Rejected	Rationale for Decision
						environment in which the wider public services impacts are considered and addressed.
		• Mindful of references to specific groups in context to peer mentoring which may lead to personal upset for some	✓			Agreed – the strategy will be adjusted to be less specific
		• Useful to liaise with CADT social work service team who have expertise in the use of generic services to develop substance misuse recovery plans	✓			Agreed
		• You may wish to use your conference to encourage partnership with / investment in substance misuse services by other service areas	✓			Agreed
		• Services need to be aware of the greater harmful affect of alcohol with increasing age. The public health messages given to older people needs to be very clear	✓			Agreed – we will be learning from a range of projects and initiatives that are being delivered specifically aimed at alcohol use among older people
		• Wallich Study should not be assumed as indicative of older people not accessing treatment		✓		Agreed, although the findings suggest a much higher level of alcohol use across older people that can be assumed from referral data. We will complete a local database and WNDSM referral

Source	Summary Comments		Fully Accepted	Partially Accepted	Rejected	Rationale for Decision
						analysis for the over 50s and the over 60s to inform any service developments in this area.
		• Acknowledge lacking data to support outreach services for older people	✓			Agreed – this will be built into future data collection mechanisms
		• The issues of older people using recovery services and the recovery community is worth exploring	✓			Agreed – some early examples in Taith may be replicated elsewhere if we can distil the key components of a successful service model
		• Older populations of drug users also needs to be considered	✓			Agreed
		• The use of the POM and OTC medications needs to be considered	✓			Agreed, although partly covered under action point 9
		• Useful to know whether Breaking Free Online users are returning to the package? Recommendation Breaking Free online resource is available anonymously		✓		We will investigate this with BFoL
		• Usefulness of WEDINOS should be considered for needs assessment		✓		Unsure about this, other than ensuring that open access and outreach services are better informed regarding any changing trends in drug use – particularly in terms of NPS

Source	Summary Comments		Fully Accepted	Partially Accepted	Rejected	Rationale for Decision
		• References to Positive Psychology is a possible opportunity and not an assessed need		✓		The assessed need is for interventions that improve overall wellbeing so as to increase the likelihood of long term recovery. Also to increase staff wellbeing. Positive Psychology is suggested as an evidenced based approach that can achieve this.
		• Is the significant ongoing investment made by the UHB, understood by the APB in mapping treatment costs?	✓			Yes, as the APB is required to sign-off the UHB mainstream expenditure on substance misuse services to Welsh Government each year.
		• The APB may wish to consider the potential threat to the PARIS system with planned changes to community systems at a Wales wide level		✓		This will be managed in terms of mitigating risks where possible. The decision to move to the national system is far beyond the remit and scope of the APB.
		• ASSIST and AUDIT are not risk assessments; both are basic WHO screening tools	✓			Agreed – the document will be amended to reflect this.
	Page 21 Paragraphs 2/3	• Regarding Efficiency and Service Provision; this is not evidenced in this document yet also appears as a sentence in the Exec summary		✓		There is substantial evidence to this effect – WNDSM data shows that waiting times have increased whilst referral rates have decreased, and the level of investment in treatment an support services has increased. If there are no efficiencies to be

Source	Summary Comments		Fully Accepted	Partially Accepted	Rejected	Rationale for Decision
						made, then the factors that have contributed to this apparent paradox need to be fully understood.
		• References to changes to interpretation of national definitions (WNDSM) needs to be acknowledged, also these changes makes historic KPI comparison meaningless		✓		This is understood, but the revision of definitions is intended to reflect a truer picture of operational service delivery. The limitations this introduces with regards to historical comparisons are understood.
		• May want to look at numbers being referred on to other services	✓			Agreed
		• In context to Post Assessment DNA discharge; data analysis needs to be careful since EDAS WNDSM data does not reflect assessment treatment journeys		✓		WNDSM provides data on all treatment journeys that have an assessment. Others can be identified and reported on, but do not contribute to the KPI data.
		• Referral numbers have not dropped, should not be reported as doing so and the conclusions should be withdrawn			✓	They have according to WNDSM data – this is for the treatment system as a whole across Cardiff and the Vale. We recognise that this may not be the experience for individual service providers.
		• No reference to waiting times for treatment			✓	All KPI performance data, including waiting times has been taken into consideration

Source	Summary Comments		Fully Accepted	Partially Accepted	Rejected	Rationale for Decision
		• Useful to have a comparison of national performance with other areas		✓		This can be difficult. We do have a national performance dashboard where the 7 APBs performance levels can be considered alongside each other. However, the treatment systems are so different in each locality, that we are never comparing like with like. Cardiff and Vale APB believe that it is much more beneficial to compare our current performance levels with previous levels to determine the trajectory of any changes. However, it is also acknowledged that local service practice in APBs with particularly high performance levels need to be examined, with any transferable practices considered for use locally.
		• It is important not to confuse hazardous and harmful alcohol use vs alcohol dependence. You may also wish to consider the large SIPS study around IBA provision, and cost effective options for reaching target populations	✓			Agreed – this will be considered going forward
		• Greater use of Buprenorphine containing		✓		Agreed – although as an overarching commissioning

Source	Summary Comments		Fully Accepted	Partially Accepted	Rejected	Rationale for Decision
		products may also be worth considering				strategy for substance misuse, this would sit in more detail in the work programme for the treatment and therapies group. It may however be beneficial to commit to a review of prescribing therapies generally.
		• What does WNDSM tell you about treatment numbers, I think it is important to include this info if you have it.	✓			Agreed – implementation of the strategy will fully account for the number of separately identifiable individuals in the treatment system as shown on WNDSM
		• Need to acknowledge ban of New Psychoactive Substances – this is the primary reason for their use by many people (see Mixmag questionnaire)		✓		Agreed, and covered in commissioning priority 9
		• Greater connection of services is needed, between unscheduled care – mental and physical, and drug services	✓			Agreed – APB is now investing into the EU psychiatric liaison team,
		• You may want to include the rise of illicit diazepam and trends in prescribed drug misuse – e.g. Pregabalin	✓			Covered in commissioning priority 9
		• Useful to understand the actual and expected increase in dwellings and try and map		✓		Agreed, but this should not be a piece of work delivered solely

Source	Summary Comments		Fully Accepted	Partially Accepted	Rejected	Rationale for Decision
		expected changes in referral and treatment numbers				through the APB work stream. The increasing population will have a broad range of health, socio-economic and social care related needs, and the APB wil ensure that the generic public sector work to assess this incorporates substance misuse.
		• The rise of painkiller problems – maybe included in the section on NPS / drug trends in addition to other prescribed medications – Pregabalin and Gabapentin	✓			Agreed, and covered in commissioning priority 9
		• Need to include info on ageing opioid user, complex alcohol user, polydrug user, 'chemsex'		✓		Agreed – we can ensure that the prioritisation of service to address alcohol use in older people also accounts for all substance use and misuse
	Commissioning Actions	• The exec summary needs to reflect 'Reduce and mitigate impact of substance on families'	✓			Agreed – the summary will be updated to reflect all the commissioning priorities
	Action 1	• The importance of positive substance misuse treatment should not be forgotten as bringing improved parenting • APB needs to understand the social worker post within the CAU in the management of		✓		Agreed – although the level of detail needs to be considered in the context of an overarching strategy, we can reflect the important of social services, and the relationship between effective treatment and effective parenting

Source	Summary Comments		Fully Accepted	Partially Accepted	Rejected	Rationale for Decision
		pregnant women and families				
	Action 2	• You cannot use medical students to routinely deliver services. "Have you discussed this with the Medical school?"		✓		This programme was conceived, designed and delivered by medical students, with support provided by the Switched On substance misuse education service. We will reflect the need to encourage and support this initiative, rather than develop any dependency on it.
	Action 3	• Important not to mandate time limited opioid substitution also some alcohol treatments are not usually time limited • The APB may want to discuss with providers what it judges to be acceptable change constituting some form of recovery		✓		Agreed, although the document has been carefully worded not to include any time limitations on any treatment – rather the emphasis is on capitalising on any and every opportunity to enable service users to progress in their recovery. We also are committed to the national recovery framework in that recovery is defined by the service users, and not the services or commissioners.
	Action 4	• These changes have been resisted by our clinical services to date. We would urge the APB to refer this matter to Welsh Government and NWIS. Attempts to re-categorise discharges or manipulate systems primarily to reduce a number rather than to		✓		The APB and Welsh Government support the concept that where a service user is clearly not ready or prepared for the rigour of a clinical treatment programme, then a safe and planned withdrawal of service with onward referral to a more appropriate level of intervention

Source	Summary Comments		Fully Accepted	Partially Accepted	Rejected	Rationale for Decision
		improve services should be resisted.				and support is the best course of action. The re-engagement service is intended to try and turn this around for resistant service users before the point where treatment withdrawal and onward referral becomes the only option.
	Action 5	• Check DNA rates for GP's and EDAS referrals • Would like to see a mention of Nalmafene and its place within primary care		✓		DNA rates for GP referrals to EDAS is readily available, and is informing the process of redevelopment of EDAS. Nalamefen is covered under point 9.
	Action 6	• Setting targets for use of generic facilities may prove difficult, the measurement of performance even more so		✓		The APB is looking at targets around volunteering hours delivered outside of the sector. We would only be seeking one or to indicators to determine an increasing trend in access to generic community resources.
	Action 7	• Would like to see the APB to look at research into effects of short term commissioning cycles are not great for staff wellbeing			✓	This is a function and consequence of the public sector – not just substance misuse. The grant funding presents difficulties in recurrent commitment, but affords a substantial degree of protection for the money to remain in substance misuse. The need to ensure staff wellbeing is in part a recognition of the consequences

Source	Summary Comments		Fully Accepted	Partially Accepted	Rejected	Rationale for Decision
						that short term public funding cycles can have across all sectors.
	Action 8	• We would expect to see sharing of materials used with service users, for the good of all service users in the treatment system, and this could be part of service specifications	✓			Agreed
	Action 9	• Need for splitting of research and service development into different points		✓		These are separated in the commissioning actions, with research clearly lying within the final action.
	Action 11	Suggests a lack of understanding of some of the inherent issues. Treatment systems with more elements tend to have more potential for rare limiting steps. • Referral rates have increased since the demise of the CADT service • Nalmefene has a licence for dependent individuals – who do not have significant withdrawals. It is not licenced for non-dependent drinkers.	✓		✓	WNDSM clearly shows a reduction in referral rates from 2013-14 to 2015-16 in the order of 1000 fewer referrals Agree that we need to be specific regarding the service user cohort appropriate for Nalmafene. These specifics will lies in the project plan, rather than the commissioning strategy
	Action 12	• It maybe relevant to mention some of the reduced facilities available in education etc. • Do we need to mention the lack of some		✓		Agreed,, but not necessarily within the parameters of this strategy. The APB needs to influence the development of a broad range of services that impact on substance

Source	Summary Comments		Fully Accepted	Partially Accepted	Rejected	Rationale for Decision
		housing options in the Vale? • Some of these interventions, especially housing may also mitigate the harms of substance use.				misuse service users including housing, education, employment and social care. This strategy can be used to articulate the need for improved joint and partnership working across public services through the APB, rather than addressing service deficits that are not specifically substance misuse
	Action 13	• Initiatives to reduce alcohol use are likely to impact on hospital admissions but influence on readmission is likely to be difficult to measure	✓			Agreed – the alcohol group for the APB will be considering the best means of measuring and monitoring this aspect of service
	Action 15	• It maybe worthwhile considering the difference between protected characteristics and priority groups • You may want to ensure services collect info on the protected characteristics	✓			Agreed – although the focus on protected characteristics relates to equitable access to services that accounts for their specific needs. Prioritisation once in service is entirely down to the operational governance arrangements for the service providers. Performance monitoring will be updated to include protected characteristics.