

Health and Wellbeing Board

Wednesday, 13 December 2017

Appendices referred to in the following Agenda items:

- 6. Swindon's Transformation Plan for Children and Young People's Mental Health and Well Being - 2017 to 2020 – Appendix 1 (Pages 3 - 62)**
- 9. Dementia Joint Strategic Needs Assessment - 2017 Update – Appendix 1 (Pages 63 - 110)**
- 11. Swindon Substance Misuse Strategy 2017-2022 – Appendix 1 (Pages 111 - 132)**

Contact: Vicki Yull (Committee Officer), 01793 463603, vyull@swindon.gov.uk

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Swindon's Transformation Plan for Children and Young People's Mental Health and Well Being – 2017 to 2020

1. Introduction

- 1.1 Since the publication of the last Transformation Plan 2014/15, Swindon has seen an increase in demand for mental health services for children and young people in line with the national picture. During 16/17, our local mental health services received more than 3069 referrals for children and young people requiring targeted or specialist support, this is a 30% increase since 2014/15. A green paper is due to be published soon in relation to children and young people's mental health and education providers.
- 1.2 Professionals, particularly GPs and school staff, are telling us that there are more children and young people with emotional problems and mental ill health, with significant numbers exhibiting disruptive, withdrawn, anxious, depressed or other behaviour which may be related to an unmet mental health need.
- 1.3 Swindon has also seen a year on year increase of self-harm presentations to the Emergency Department at the Great Western Hospitals for young people in distress. Whilst a robust pathway is in place often ensuring an admission and mental health assessment, many are discharged following low-level interventions. Consequently, large numbers of these visits and admissions may have been avoided. The CCG now receives regular data in relation to these admissions and has established a mental health liaison worker post at the Great Western Hospital to support children and young people directly, staff in the wards and ensure a smooth transition into children and young people's community mental health services.
- 1.4 Emotional wellbeing and mental ill health is complex, and increased demand may be explained by a number of influencing factors including rising stress on families, parenting problems, poverty and disadvantage, educational pressures, bullying (including using social media), peer pressure and other social influences. Swindon's children and young people tell us that emotional health and well-being is a high priority for them. Many Swindon schools have also bought additional primary mental health support on a traded services basis to meet increased demand in educational settings. Many schools are concerned that with decreasing educational budgets, they are having to make tough decisions in terms of having to let go of pastoral support staff, such as school counsellors. These staff would normally help the school support pupils requiring lower level emotional and mental wellbeing interventions, preventing an escalation of need.

- 1.5 This increasing demand comes at a time when public sector resources are squeezed, resulting in a lack of investment in early help and prevention. Instead, limited resources are focused downstream at costly specialist services where problems have reached a crisis point. This is ethically and morally wrong but also makes no sense economically as research shows that addressing problems early on saves the taxpayer significant financial and societal costs down the line. Swindon has also seen a significant increase in the number of looked after children.
- 1.6 Nationally, there is a high-profile emphasis on this agenda with the Government committed to making tangible improvements in child and youth mental health services – including a requirement for local areas to develop and refresh transformation plans for children and young people’s mental health and wellbeing. This is supported by additional investment. During 2016/17, Swindon undertook a comprehensive Joint Strategic Needs Assessment to understand the local need more fully. This plan sets out how we aim to respond to future challenges for Swindon’s young people to ensure that their mental health and wellbeing needs are met.
- 1.7 Our outcomes to be achieved are:
- **Build resilience through promoting good mental health and wellbeing, prevention and early intervention across the Emotional and Mental Health pathway**
 - **Change how care is provided so that we have a needs-led not service led seamless Emotional and Mental Health pathway**
 - **Sustain a culture of continuous evidence-based improvement delivered by a workforce with the right skills-mix, competencies and experience who strive for excellent quality**
- 1.8 There is excellent partnership working already in place as well as mechanisms in place to really hear the voice of children and young people and therefore with additional funding providing the added impetus, the time is right for us to make a real difference.
- 1.9 The national Sustainability and Transformation Partnership (STP) places Swindon in partnership with Wiltshire and Bath & North-East Somerset (BaNES). A re-procurement of child and adolescent mental health services across the STP is currently in progress. The Five Year Forward View for the NHS highlights the need to improve prevention and strengthen provision by voluntary sector providers to enable a sustainable NHS. Throughout 2016/17 the Swindon CCG completed a strategic review of children’s services, which highlighted the need to

improve outcome data for children's and young people's emotional and mental health services across some services.

- 1.10 The STP Mental Health workstream has identified children and young people's mental health as a priority, focusing on transitions and the implementation of the mental health liaison model in all acute hospitals.
- 1.11 The recently published a Prevention Concordat for Better Mental Health acknowledges that prevention is better than cure, Swindon is currently establishing a strategic group to design and oversee its implementation.

2. Swindon ambitions and how they align to Future in Mind

- 2.1 Future in Mind and Local Transformation Plans reflect national ambitions for improving mental health and well-being of children and young people. The increased national investment in eating disorders has significantly enhanced the capacity of the implementation through the release of capacity in specialist CAMHS and the establishment of an STP-wide Eating Disorder Service. In Swindon, these ambitions have been fully informed by the findings of the Joint Strategic Needs Assessment for Children and Young People's Mental Health and Well-Being.
- 2.2 A needs assessment for children and young people with Special Educational Needs and Disabilities (SEND) is currently in development, with the findings informing service developments. A Children and Young People's Emotional Mental Health and Wellbeing (CYPEMHWB) Strategy sets out the implementation of this transformation plan.

- 2.3 Swindon is committed to the further development of services to address the full spectrum of need including children and young people who have particular vulnerability to mental health problems for e.g. those with learning disabilities, children looked after and care leavers, those at risk or in contact with the Youth Justice System, or who have been sexually abused and/or exploited.
- 2.4 As children and young people's emotional wellbeing and mental health affect all aspects of their lives, no one service alone will be able to meet their needs. There is a duty of cooperation placed on commissioners and services to work together to the benefit of children and young people to ensure that there are no service gaps.
- 2.5 Services will be planned and developed in collaboration with children, young people and those who care for them as well as providers, commissioners and other key partners. The following table demonstrates the alignment of local priorities and strategic planning to Future in Mind:

Future In Mind	Swindon's Strategic Commitments	Swindon's CCG Priorities
<p>1. Promoting resilience, prevention and early intervention</p>	<p>Health and Well-being Strategy 17 – 22</p> <p>Priority 4 Improved mental health, wellbeing and resilience for all. Priorities are to:</p> <ol style="list-style-type: none"> 1. Tackle Domestic Abuse and its impact on people's lives 2. Increase the opportunities, through effective pathways, for people with mental health problems to access support services and community facilities aimed at promoting recovery (including education, debt management, housing, leisure services, health promotion) 3. Promote positive mental health and recognise that mental health is everyone's business 4. Reduce the stigma and discrimination associated with mental ill health <p>One Swindon Priorities</p> <p>Priority 4 - Living independently, protected from harm, leading healthy lives and making a positive contribution.</p>	<p>Mission: The mission of NHS Swindon Clinical Commissioning Group is to optimise the health of the people of Swindon.</p> <p>Raising awareness and training for universal services providers in conjunction with early intervention</p> <p>Tackling stigma and raising awareness in children and young people</p>

Swindon's Early Help Strategy

Prevention - Children in Swindon have the best start in life and grow up in supportive, confident and resilient families and communities. Targeted early help will be offered where parents have lost confidence in their parenting ability or where relationships come under pressure, to support families to adapt to a potentially new situation. The support should be practical, direct, targeted support when parents most need help. Through support for families, children grow up safe, stable and healthy and make a contribution to their community.

<p>2. Improving access to support – a system without tiers</p>	<p>Swindon's Early Help Strategy</p> <ul style="list-style-type: none"> • Help children, young people and families build resilience and self-reliance to enable them to find their own solutions when problems develop • Ensure the right help is given at the right time and right place across all levels of service provision, to ensure earliest possible identification and prevention of escalation. • Deliver a much more co-ordinated response to cases requiring multi-agency and multi-disciplinary support below the thresholds for statutory intervention. • Improve the health, wellbeing and emotional resilience of vulnerable children and young people and families within Swindon 	<p>Objective 3 – Helping people to recover following illness to ensure people have the right care and support in the most efficient and appropriate care setting at the right time.</p> <p>Address waiting times, access to services and capacity within Early Help Services, targeted and specialist secondary care children and adolescent mental health services</p>
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	<p>The Swindon children's services position statement</p> <p>The Swindon Children's Services Position Statement March (2014) highlights the emphasis that Swindon has on early help and intervention. There is a focus on a range of interventions such as the Family Nurse Partnership and The Families Service, which has led to Swindon's Troubled Families initiative.</p>	<p>Objective 4 – Improving patient experience and safety through improving access, quality and safety of services.</p> <p>Improved Information sharing and referral pathways between all CYPSEMHW services</p> <p>Objective 5 – Reducing health inequalities through working with other partners.</p> <p>Prioritise Vulnerable Groups. Ensure access to mental health services for vulnerable children and young people including children in care, care leavers, young offenders, LGBTQ, children in need, children in poverty, children with parents</p>
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<p>3. Care for the most vulnerable</p>	<p>Health and Well- being Strategy 2017 – 22</p> <p>Outcome 3 - Improved health outcomes for disadvantaged and vulnerable communities (including adults with long term conditions, learning disabilities, physical disabilities or mental health problems and offenders)</p> <p>The local safeguarding children board's strategic business plan 2016 -19</p> <p>Highlights four areas of work:</p> <ul style="list-style-type: none"> • The journey of the child through safeguarding processes, • domestic abuse, • disabled children, • supporting improved effectiveness of joint safeguarding work between services for children and adults. • complex needs, and there is effective transition in to adult services for those young people who need continued support. Children are protected from harm. This focuses on children in need including disabled children and those with significant special educational needs and disabilities (SEND). 	<p>in prison, children using substance, children who are being sexual exploited and being sexual abused, children of parents who are with substance misuse issues or mental health problems</p> <p>Transition from CAMHS to Adult mental health services.</p> <p>Further implementation of the National Transition CQUIN regarding transition from CAMHS to AMHS needs to be developed to ensure the needs of those between 16 and 25 are met by CAMHS and Adult services in-line with best practice guidance highlighted in this needs assessment. This should include reviewing the transition and access to adult Early Intervention Services for those leaving CAMHS services at 18</p>
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<p>4. Accountability and transparency</p>	<p>Joint Commissioning arrangements in place with Swindon CCG and Swindon Borough Council – Section 75</p>	<p>Strengthen commissioning of mental health services undertaken by schools to ensure services are evidenced based, follow best practice</p> <p>Review residential placements: To work with social care and CAMHS to better understand the increasing complexity of cases requiring residential placements. This work should inform the commissioning of local support services and be fed into any wider work around market development with residential providers.</p>
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	<p>12</p>	<p>guidance and meet the needs of children and young people.</p> <p>Improve data collection and monitoring information. A minimum data set for TaMHS has been developed. Data quality needs to improve. An action plan is in place and monitored monthly.</p> <p>Strengthen Information sharing & referral pathways. Improve information sharing between many services: GPs and TaMHS, TaMHS and CAMHS, GWH and School Nurses, TaMHS/CAMHS and school nurses, Adult and Children's mental health services.</p>
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<p>5. Developing the workforce</p>	<p>Priorities 1, 2, 3, 4, 5, 8 and 12 all contain aspects of workforce development need across the STP.</p> <p>This includes;</p> <ul style="list-style-type: none"> • Continuous development and review of single point of access and staff mix. Working practice between CAMHS and TaMHS and Early Help Services. • Increase group work • Raise awareness and training for universal service providers • improve commissioning of mental health services in schools • Review of location of CAMHS services • Review the requirement for hospital liaison provision of Responsible Clinician • Transition from CAMHS to Adult Mental Health Services to meet the needs of 16 – 25 age group
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3. Swindon's Achievements

Achievements 2016/17

- Establishment of the **Single Point of Access (SPA)**. The meeting discusses every referral to the service and ensures that no young person falls between services.
- **Improved** access to **ONTRAK** with the introduction of **self-referral**. This is a **process** whereby any young person can self-refer to the service. **ONTRAK** joined the SPA, ensuring the right people receive the right service at the right time. **245 initial contacts** delivered by **Ontrak**, leading to **132 interventions** (2016-17)
- **TAMHS** delivered 918 days of clinician's time in 49 schools.
- Roll out of Parenting project **TAMHS** Family Links and Talking Teens. **17** individuals trained in **Family Links Nurturing Programme** and **15** in Talking Teens. The initially programme achieved:
95 parents attended Talking Teens, **64** attended drop-in sessions, **235** attended Family Links Nursing Programmes, **14** slightly adapted Foster Parents **Family Links Nurturing Programme** rolled out
=Total 408 interventions

- Mental Health in Schools Award developed and piloted and is now available to all schools in Swindon. Award was reviewed by Children and Young People who developed the award logo.
- Mental health groups for boys/young men piloted in conjunction with the Public Mental Health Lead by the community health and wellbeing team. #Lads is a 6-week programme that aims to achieve the following outcomes:
 - a. Increase awareness of mental health and suicide prevention in young men
 - b. Increase awareness of overall health & wellbeing and healthy living in young men
 - c. Improvements in a participant's emotional wellbeing (Young Persons Wellbeing Assessment).
 - d. Creation of peer support networks through engagement in group activity
 - e. An opportunity for goal setting and a 3 month 'check in' session.
- Blue-ICE mobile app trialled by Oxford Health Foundation Trust: 40 girls and 4 boys average age 16 years (range 12-17) participated in the project. Feedback was overwhelmingly positive with 37/40 (93%) wanting to use BlueIce for the 12-week trial and 89% wanting to keep BlueIce at the end of the project. Data suggests that BlueIce has prevented 308 episodes of self-harm in 33 young people over a 14-week period, approximately 9 episodes per person. BlueIce helped 73% of young people who were self-harming to stop or to reduce their self-harming
- Improved access for Looked after Children through the Complex Case Consultation Clinic. CAMHS have received requests for 48 consultations for these vulnerable children.
- Newly developed HarmLess online resource available via Oxford Health Foundation Trust.

- 49 schools in Swindon are currently trading with Targeted Mental Health Services (TAMHS) which is providing bespoke packages to meet the emotional health & well-being needs of young people at the earliest opportunity and as identified in schools and Universal services. In addition, consultancy and training is provided to build capacity and resilience within Universal Services.
- Special School nursing provision – LD CAMHS currently provide a Clinical Specialist Nursing role to Uplands and Brimble Schools with bespoke treatment and care plans for children with serious physical health and learning disabilities. This enables children who would might not otherwise be able to access education be supported safely with regards to their serious and significant health needs.
- Improved working relations with CAMHS & Educational psychology particularly in relation to the Neurodevelopmental clinic.
- A consultation service between TAMHS, Health visitors, & Early Help staff – reducing referrals for under 5's, and speeding up the process of seeing younger children.
- Swindon LD CAMHS continue to accept referrals directly into the team but have also joined the SPA to ensure those young people with an LD can be assessed within the specialist service and can provide consultation to TaMHS and CAMHS.
- TaMHS and CAMHS are now carrying out joint assessments for young people with complex needs that might require intervention from either service. This avoids repeated assessment and unnecessary delays and provides quicker access to required treatment
- There is a CAMHS worker based within the YOT ensuring all young people who come into contact with this service are offered an assessment of their mental health and a target intervention from CAMHS. Staff in the YOT have access to CAMHS consultation and training.

- **Online CBT** is currently being offered to young people through CAMHS
- New service delivered within TAMHS to provide **Placement Support** for children, young people who are adopted or fostered. This post supports carers, provides training and helps prevent placement breakdown.
- **Reducing Mental Health Act Section 136 detentions** - an effective agreement with CAMHS and the police to reduce the number of Section 136 detentions applied to under 18's. Between June 15 and April 2017 only 4 under 18's were detained on a S136 in Swindon.
- A 0.86WTE post has been established at the **SARC** providing a **counselling service for those aged 13 to 16** years of age providing support for children who have experienced sexual assault. A CAMHS therapist has been embedded into the SARC to ensure all young people in contact with the service will have their emotional and mental health needs assessed and timely access to CAMHS will be facilitated to all who need it. ISVA's have access to CAMHS consultation and training.
- Based at Saltway Centre, a new **bereavement counselling service** provided by the Voluntary sector. **Treehouse** provides ongoing support to children and young people up to the age 18.
- **CAMHS OSCA delivers a 24/7** service for children and young people who present with a **mental health crisis**. There are an increasing number of visits to Emergency departments for deliberate self-harm by young people under 18, OSCA CAMH service can respond to this 7 days a week if required in an emergency and will see all young people under the age of 18 within 24 hours if presenting with deliberate self-harm.
- **CAMHS** are now offering a range of **group sessions** which includes **Emotional Wellbeing, ASD with**

anxiety and low mood, and Mindfulness

- A post for a **mental health liaison worker** based at GWH acute Trust will improve the experience of children and young people by ensuring swift access into community services and increasing staff confidence in dealing with children and young people admitted for self-harm or mental health.
- **ELSA – Joint funding** has been identified to roll out ELSA **to all schools in Swindon**. Each school will have access to training and ongoing supervision for 2 members of staff to help children regulate their emotions and recognise and manage those of other children.
- Raising **Awareness and Training. Swindon Mind** has delivered (or will have by March 18) **6 ASSIST Suicide Prevention courses in Swindon**. Mind have also delivered **Mental Health First Aid Training** and specifically qualified to deliver this in Schools. A member of Swindon Health and Wellbeing Team has trained as a **Connect 5 trainer** and has delivered Connect 5 training in House.
- **75 of 80** of schools engaged with the **Swindon Healthy schools programme**, supporting them to take a holistic, whole school approach to the emotional well-being and mental health needs of pupils.
- **TAMHS criteria review started in January** to ensure that the right young people are referred to the service and waiting times are reduced.
- **OSCA provide intensive support packages** that enable young people to be discharged in a timely way and

significantly reduces the length of stay as an in-patient, they are able to provide bespoke packages of care to support the young person and the family unit to enable care to be provided at home. The service also provides intensive support to avoid admission where possible with **wrap around care** to enhance the community treatment package and manage any risky behaviour.

- **A self-harm pack** has been produced with the help of young people who have contributed significant material to the information booklets for **young people and parents**. This will be given to all young people who present in the Emergency Department with deliberate self-harm and is intended to provide guidance for accessing help as well as self-help strategies to avoid future self-harming.
- Development of the **Joint Strategy Needs Analysis for Swindon**, an in-depth piece of work involving many children's service areas to review the provision and the gaps in services for **children with mental health and emotional well-being issues** across the area.
- **A multi-agency Transitions** working party is underway and has begun to identify actions and agreement to ensure successful, effective and seamless transitions for all young people across all services.
- **A multi-agency Crisis Care Concordat** has been operating successfully for most of the year and has completed a joint Operational Action plan with clear objectives that are agreed by all parties.
- **187 referrals** received by TEDS (specialist Eating Disorder service) launched Jan 2017.

4. Needs Assessment

4.1 During 2015 a CAMHS Needs Assessment was undertaken. The full needs assessment can be found embedded in Annex 1 in this bid, however below are some of the Key Findings from the needs assessment after which some of the data regarding the Health and Wellbeing of young people in Swindon has been reproduced.

4.2 Summary of key points

- 4.2.1 This Joint Strategic Needs Assessment has highlighted the increase in demand for Children and Adolescent Mental Health Services at all levels and also an increase in the complexity of those accessing services. There are waiting times for all CAMHS services, although those with urgent need are fast tracked through to the appropriate service. This does mean that those with identified but non-urgent needs may wait considerable time for assessment and treatment during which time their condition may deteriorate. The Service User consultation also highlighted that some young people wait a long time before they even seek help, so from recognising that there is a problem to accessing treatment can be a long time during which a simple mental health issue may have deteriorated into a more complex condition. Parents and carers also highlighted the need to address waiting times. The economic evaluation showed that group work can be very cost effective and may provide a solution to capacity issues within the service and earlier intervention. The Needs Assessment has highlighted that the complexity of those accessing services has led to an increase in the time young people remain in treatment. This relates not only accessing Targeted and specialist mental health services but also residential placements. The needs assessment estimated that there may be an additional 100 children and young people who require, but are not receiving a mental health service.
- 4.2.2 The TaMHS and specialist CAMHS services have distinct service provision but have also developed a good working relationship, with a daily clinic offering the single point of access to services and holding joint assessments with CAMHS to ensure those needing CAMHS receive the service they require. Currently CAMHS and TaMHS do not use the same risk assessment tools or information system, so sharing of information is limited and there may be duplication in the assessment process. The Single Point of Access ensures that no young people fall through the system and everybody received the right service. The service practitioners highlighted that there is still work to be done in order to provide a seamless transition between the CAMHS and TaMHS service and improve the joint working, part of which is to review referral criteria.
- 4.2.3 The needs assessment has highlighted some groups of children and young people who are at particular risk of developing mental health problems. These include, but are not restricted to children of parents with mental health problems and substance misuse, children in

care and care leavers, those who have suffered abuse, sexual abuse or exploitation, refugee and asylum seekers, those who have experienced bereavement or family breakdown, domestic violence, children in need and poverty and young carers. It is essential that in order to give these children the best chance of recovery access to treatment and information sharing should be prioritised.

Stakeholders highlighted concerns about the mental health of those leaving care and the difficulties that they face. The local Primary Care Psychology Service (LIFT) pointed out that this is often picked up later in their service and if left untreated can escalate to emergent personality disorder. An audit undertaken by LIFT showed that 48% of their clients had severe or moderate personality disorder. Personality disorder can often emerge from early attachment issues, leading to conduct disorder and then on to personality disorder. There are examples of good practice within the South West to intervene with those with emergent personality disorder to address these issues.

Those leaving care are at particular risk.

- 4.2.4 During the development of this needs assessment organisations in Swindon signed the mental health crisis care concordat. CAMHS services recognised the need to ensure out of hours services such as 111 are aware of pathways to access CAMHS out of hours. It is essential that children and young people in crisis receive an appropriate and timely response and those under section are taken to a place of safety for assessment. The Memorandum of Understanding (MOU) between Court Liaison and Diversion Services and CAMHS has recently been signed in February 2015. This should be monitored to ensure that this MOU is effective in supporting Young People. Other issues to improve crisis care include: ensuring seamless pathways between TaMHS and CAMHS; ensuring the appropriate skills mix of CAMHS staff with regard to Improving Access to Psychology Therapies and models of care; improving partnership working with GWH
- 4.2.5 Children's Services and CAMHS to ensure the needs of the patient are met on admission and discharge from hospital. There issues are being picked up and reviewed in the Crisis Care Concordat Action Plan so will not be included in the recommendations below but should be acknowledged as an important piece of work with regard to meeting the needs of children and young people with Mental Health conditions.
- 4.2.6 Eating disorders, specifically anorexia nervosa is the third most common chronic illness of adolescence and as the highest morbidity and mortality of all psychiatric disorders. Government has pledged additional funding to tackle waiting times for eating disorder services and governmental task groups have highlighted the difficulty of moving inpatient funding for eating disorders to outpatient treatment which has a better evidence base. The impact that social media has had on the increase in prevalence of eating disorders should be taken into account when tackling this issue. In Swindon eating disorders have been recognised as a significant issue and access to treatment and waiting time, as we have seen elsewhere is an issue.

- 4.2.7 In Swindon attendances and admissions for self-harm at GWH have increased year on year and are significantly higher than the national and regional rates. It has also been highlighted that there is no routine hospital liaison service for those under 18 years of age at GWH and the increase in attendances has sometimes had an effect on urgent provision by O S C A impacting on routine appointments. Information sharing between GWH and School Nursing service on those who have attended had ceased during the time that this needs assessment was undertaken but there are plans to reintroduce it. There is also a Quality Premium payment that has been agreed for Swindon to reduce attendance and admission for self-harm in Swindon. This should be done in line with best practice guidance and ensure that patients receive an effective and supportive experience when attending A&E.
- 4.2.8 Lack of information sharing between different partner organisations was also highlighted as detrimental to the service that children and young people receive. Various stakeholders during the consultation phase of the needs assessment highlighted the need for better information. This included information sharing between: GPs and TaMHS, TaMHS and CAMHS, GWH and School Nurses, TaMHS/CAMHS and School Nurses, and adult mental health services and CAMHS. This is key to making sure the needs of the most vulnerable are met, avoiding duplication of services and ensuring children and young people do not fall between the gaps in services.
- 4.2.9 Many stakeholders raised the need for additional training for staff working with children and young people with regard to mental health so they can gain knowledge and confidence to offer support. For universal services such as A&E, GPs, Paediatric services, schools, and youth services additional awareness, knowledge and understanding of mental health conditions and services may lead to more appropriate referrals and speed up access to services where appropriate. Raising awareness of local, national and on-line resources for schools, parents and professionals and sharing best practice between schools will enable more informed support to be offered. Recognising the difference between behavioural and mental health issues is key to this and will enable more appropriate interventions to be offered by a range of providers. Anti-bullying work is also key to preventing mental health problems and this has been recognised and acted upon in schools in Swindon. It is key to take a whole schools approach to mental health.
- 4.2.10 Associated with this is the need to tackle stigma regarding mental health services and raise awareness of the signs and symptoms for young people. Consultation with children and young people highlighted that many of them (56%) had never heard of CAMHS or TaMHS and many of them did not know where to turn for help and support. Alongside the resources mentioned above which are aimed at those working with or supporting young people, young people themselves require information and resources to find out more about their own mental health and emotional wellbeing. Parents and Carers also expressed the need to have more information on how and where to access support and information on what services were available. There is a need for an innovative programme of awareness raising should be developed building on the information gathered from the service users (and their parents/carers) for this report. This should include the use of social media, on-line resources; work in schools and better liaison and visibility of mental health services. Parity of esteem between physical and mental health service should be considered in conjunction with this.

- 4.2.11 The TaMHS traded service model, alongside the core service provision, offers many benefits for schools to be able to purchase bespoke services meeting the requirements of their pupils. It also gives opportunities to raise awareness and knowledge of mental health issues in schools. However, the disparate commissioning of a complex range of services makes it a challenge to evaluate service provision, demonstrate value for money, outcomes and effectiveness of interventions. During the needs assessment it has become obvious that the collection of data for the TaMHS service is key to quantifying service provision and outcomes and demonstrating to commissioners that the needs of the whole population including vulnerable groups and those who attend schools not commissioning TaMHS are met. Work has commenced on developing a minimum dataset. This should be done in conjunction with the national minimum dataset outlined in the transformation plans.
- 4.2.12 The visibility and accessibility of mental health services has been outlined above and aligned to this is the fact that Primary Care services are beginning to feel removed from the provision of mental health support for children and young people. In order to address this, the location of CAMHS/TaMHS services in primary care settings could be explored. Moving these services into community, locality or primary care settings such as GP practices could improve work relationships and breakdown some of the perceived inequity in traded service provision. Children and young people stated that they would like services to be more flexible and closer to home.
- 4.2.13 There was also recognition of the need to improve the transition of service users from CAMHS to adult mental health services (AMHS). This has been addressed through the introduction of a CQUIN between CAMHS and AMHS, which is now well embedded. As part of this needs assessment the CAMHS and AMHS services together with commissioners undertook a self-assessment of transition between services currently. This highlighted the need to: improve transition and operational policies and pathways; identifying transition champions in both services; ensure information is available to young people and their families/carers on the transition process; develop an audit and monitoring process to assess services against the standards; ensure data systems are in place to ensure safe transfer of data; provide joint training programmes and develop alternative care pathways for those who do not meet the AMHS threshold.
- Particular account should be given to those transitioning out of the CAMHS Early Intervention Service. In order to prevent future demand on services it is essential to ensure the needs of those between 16 and 25 years of age are met by CAMHS and Adult services in-line with best practice guidance highlighted in this needs assessment. This may include improving partnership working between CAMHS and LIFT.
- 4.2.14 Finally, it should be remembered that this needs assessment does not cover the needs of children under the age of 4 yrs. The mental health needs of this cohort will be picked up in the Early Years Needs Assessment and Perinatal mental health service review. Any recommendations from these two pieces of work should be considered in any strategy development or commissioning.

4.3 Population – overview and background

- 4.3.1 The total population registered with Swindon CCG aged 0 to 18 years inclusive in January 2016 was 54,222, while the figure for Swindon UA residents of this age-group in mid-2016 was 51,986.

4.3.2 As a guide, the ethnic breakdown for Swindon UA residents (aged under 25), at the 2011 Census was as follows:

	Under 25	% of total
White	55,372	86.4%
Asian/Asian British	4,822	7.5%
Mixed/multiple ethnic group	2619	4.1%
Black/African/Caribbean/Black British	987	1.5%
Other ethnic group	272	0.4%

4.3.3 SBC population projections suggest that between 2011 and 2031 the total Swindon UA population will increase from 209,709 to 265,430, that is by 26.6%. The same projections suggest that the Swindon UA population aged 0 to 18 years inclusive will increase from 49,083 to 58,273, that is by 18.7%.

4.3.4 The same projections suggest that the Swindon UA school-age population aged 5 to 18 years inclusive, will increase from 34,921 to 42,988 that is by 23.1%.

4.3.5 Office for National Statistics (ONS)'s own population projections suggest that these increases will be greater than increases in corresponding groups in the South West and England as a whole.

4.4 **Health and wellbeing indicators**

4.4.1 The level of child poverty is better with 15.9% of children under 16 living in poverty in Swindon than the England average (19.9%) (2014).

4.4.2 Percentage of children in low income families (children under 16), 16.3% in Swindon UA and 20.1% in England in 2014, with Swindon significantly better.

4.4.3 Infant Mortality, deaths in first year of life per 1,000 live births in 2013-2015, 3.0 in Swindon UA compared with 3.9 in England, so at

similar level.

- 4.4.4 Percentage of babies reaching full term in 2015 who were Low Birth Weight, 3.2% in Swindon UA compared with 2.8% in England, so at similar level.
- 4.4.5 Percentage of all babies, who were born to under 18s in 2015/2016, 0.8% in Swindon UA compared with 0.9%, so at similar level.
- 4.4.6 Percentage of all babies who were born to women aged 35+ years in 2015, 18.9% in Swindon UA compared with 21.1% in England, so Swindon was significantly lower.
- 4.4.7 2,929 babies born in Swindon UA in 2014.
- 4.4.8 General Fertility Rate in 2015, births per 1,000 females aged 15 to 44 years, 66.6 in Swindon UA, compared with 62.5 in England, so higher in Swindon.
- 4.4.9 Multiple births in 2015, per 1,000 women aged 15 to 44 years, 20.4 in Swindon UA compared with 16.0 in England, so at similar level.
- 4.4.10 Prevalence of overweight and obesity in children in reception class in 2015/2016, 21.1% in Swindon UA, compared with 22.1% in England so at a similar level.
- 4.4.11 Prevalence of overweight and obesity in Year 6 2015/2016, 32.6% in Swindon UA, compared with 34.2% in England, so at a similar level.
- 4.4.12 Teenage conceptions in 2015 per 1,000 females 15 to 17 years, 20.2 in Swindon UA compared with 20.8 in England, so at a similar level.
- 4.4.13 Children subject to a child protection plan with initial category of neglect per 10,000 children under 18 in 2016, 18.8 in Swindon UA compared with 19.8 in England, so at a similar level.
- 4.4.14 Children subject to a child protection plan with initial category of abuse per 10,000 children under 18, 29.8 in Swindon UA compared with 20.8 in England, so higher in Swindon.

- 4.4.15 Hospital admissions due to alcohol specific conditions in children under 18 per 100,000, in 2014/15, 43.1 in Swindon UA compared with 36.6 in England, so at similar levels.
- 4.4.16 Hospital admissions as a result of self-harm (10 to 24 years) 2015/2016, 275 in Swindon UA compared with 430.5 in England, so Swindon was worse than England.
- 4.4.17 There are 62 primary schools, 12 secondary schools and 7 special schools in Swindon. Further and higher education in the Swindon area is provided by New College, Oxford Brookes University and Swindon College.
- 4.4.18 Children achieving a good level of development at the end of Reception Year in 2015/2016, 68.8% in Swindon UA compared with 59.7% in England, so at a similar level.
- 4.4.19 Children achieving 5 GCSEs at A* to C including English and Maths in 2015/2016, 56.7% in Swindon UA compared with 57.8% in England, so at a similar level.
- 4.4.20 16 to 18 year olds not in Education or employment or training (NEET) in 2015, 4.0% in Swindon UA compared with 4.2% In England, so at a similar level.
- 4.4.21 Smoking prevalence at age 15 years in 2014/2015, 7.5% in Swindon UA and 8.2% in England, so at a similar level.

4.5 Numbers of children and young people affected by mental health problems

- 4.5.1 It should be noted that national prevalence data for children and young people's mental health problems is based on research undertaken some time ago (1996, 2004). This is the most up to date prevalence estimates. There are currently plans nationally to update these figures when this is completed the estimates below will be reviewed.

(We have updated the table using the Green *et al* (2005) prevalence rates and applying them to the latest appropriate population figures for Swindon UA and Swindon CCG.

Prevalence of clinically significant mental health disorders for children and young people aged 5 to 16. (Some children have more than one disorder)

Type of Condition	National Prevalence Rates	Estimated Nos for Swindon UA 2016	Estimated Nos for Swindon CCG registered Jan 2016.
Any disorder	10%	3,176	3,351
Emotional Disorder	4%	1,271	1,340
(ED Includes Anxiety disorder)	(3%)	(953)	(1,005)
(ED Includes Depressive Disorder)	(1%)	(318)	(335)
Conduct Disorder	6%	1,906	2,011
Hyperkinetic Disorder	2%	635	670

Less common disorders (e.g. autism, eating disorder, mutism).	1%	318	335
<i>Population base:</i>		31,764	33,510

4.6 Prevalence estimates⁴

Prevalence Indicator	Year	Swindon Nos	UA
Potential eating disorders in 16 to 24 year old age-group*	2013	2,885	
Attention Deficit Hyperactivity Disorder in 16 to 24 year old age-group*	2013	3,038	
Children under 17 years requiring Tier 3 CAMHS**	2012	880	
Children under 17 years requiring Tier 4 CAMHS**	2014	40	

* Public Health Profiles/Fingertips Children and Young Persons' mental health indicators. Latest data given

**presumably based on Kurtz report. Not clear what the prevalence rates are, so new data not given here.

Mental health disorders in childhood can have high levels of persistence:

- 25% of children with a diagnosable emotional disorder and 43% with a diagnosable conduct disorder still had the problem three years later according to a national study
- persistence rates in both cases were higher for children whose mothers had poor mental health (37% and 60% respectively)
- young people experiencing anxiety in childhood are 3.5 times more likely than others to suffer depression or anxiety disorders in adulthood.

Indicator	Period	Swindon Count
Prevalence of potential eating disorders among young people: Estimated number of 16 – 24 year	2013	2885
Prevalence of ADHD among young people: Estimated number of 16 – 24 year olds	2013	3038
Children who require Tier 3 ⁵ CAMHS: estimated number of Children <17	2012	880
Children who require Tier 4 ⁶ CAMHS: estimated number of children <17	2014	40

¹ <http://www.tobacoprofiles.info/profile/tobacco-control/data#page/1/gid/1938132886/pat/6/par/E12000009/ati/102/are/E06000030>

taken from the WAY survey

² Mental health of children and young people in Great Britain, 2004 Green et al Palgrave MacMillan 2005

³ Mental health of children and young people in Great Britain, 2004 Green et al Palgrave MacMillan 2005

⁴ <http://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh/data#gid/1938132753/pat/6/ati/102/page/1/par/E12000009/are/E06000030/iid/90826/age/217/sex/4>

⁵ Tier 3 CAMHS refers to Specialist Secondary Care Mental Health Services

⁶ Tier 4 CAMHS refers to Tertiary Care specialist inpatient Mental Health Services

*The prevalence estimates for those requiring CAMHS are defined as “estimates of the numbers of children aged 17 years and under who may experience mental health problems appropriate to a response from CAMHS in the local authority as per Kurtz, Z. (1996) Treating children well : a guide to using the evidence base in commissioning and managing services for the mental health of children and young people. London. Mental Health Foundation.”. The estimated prevalence rates in the Kurtz report are:

4.7 Health indicators⁷

Indicator	Period	Swindon UA rate	England rate	Swindon as compared with England
Child admissions for mental health (aged 0 to 17 years, per 100,000)	2015/2016	93.8	85.9	Similar
Child admissions due to alcohol-specific conditions (aged under 18 years, per 100,000)	2012/2013/2014/2015	43.1	36.6	Similar
Young people admissions due to substance misuse	2013/2014/2015/2016	156.0	95.4	Worse

(aged 15 to 24 years per 100,000)				
Child admissions for unintentional and deliberate injuries (aged 0 to 14 years, per 100,000)	2015 /2016	82.5	104.2	Better
Young people admissions for unintentional and deliberate injuries (aged 15 to 24, per 100,000)	2015/2016	169.6	134.1	Worse

Swindon's overall admission rate for mental health issues for those aged 0-17 is similar to the England rate. However, Swindon's admission rates for self-harm (15-24 year olds), alcohol specific conditions (under 18s) and admissions for substance misuse are higher than the England rates.

4.8 Self-harm and Mental Health Hospital admissions

10% of all hospital admissions for 0-18s were for mental health or self-harm codes:

Column Labels													
	2016/17												2016/17 Total
Row Labels	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Mental Health and Self Harm Dx													
Mental Health													
Percent	7.41%	6.86%	5.63%	10.37%	4.46%	6.37%	5.92%	5.35%	3.82%	5.37%	3.20%	7.25%	5.99%
Actuals	22	21	16	25	9	17	19	19	11	16	9	24	208
Self Harm													
Percent	3.70%	4.58%	4.93%	4.15%	1.98%	1.12%	2.80%	1.97%	3.47%	4.03%	4.27%	4.23%	3.46%
Actuals	11	14	14	10	4	3	9	7	10	12	12	14	120
Mental Health and Self Harm Dx													
Percent	11.11%	11.44%	10.56%	14.52%	6.44%	7.49%	8.72%	7.32%	7.29%	9.40%	7.47%	11.48%	9.45%
Mental Health and Self Harm Dx													
Actuals	33	35	30	35	13	20	28	26	21	28	21	38	328
Neither													
Percent	88.89%	88.56%	89.44%	85.48%	93.56%	92.51%	91.28%	92.68%	92.71%	90.60%	92.53%	88.52%	90.55%
Actuals	264	271	254	206	189	247	293	329	267	270	260	293	3143

Great Western Hospital report that there has been an increase in the number of Swindon GP registered patients, under 18s attending ED where self-harm is indicated. There were 328 children and young people who presented for either self-harm or mental health admission codes. This data is currently monitored bi-monthly through the recently re-established Paediatric Development Forum. The new Hospital Liaison Worker Post should start to impact on re-admission rates once in post.

4.9 Eating disorders

The Governmental Children and Young People's Mental Health and Wellbeing Taskforce report 2014 stated that Anorexia nervosa is the third most common chronic illness of adolescence and has the highest morbidity and mortality of all psychiatric disorders. Eating disorders is one of the, if not the most common, reason for CAMHS inpatients admissions. The best evidenced based treatments are

outpatient treatments¹.

In Swindon, there were three admissions for U19s for Eating Disorders in 16/17 in residential NHSE provision. These are cases where the eating disorder was the primary diagnosis associated with admission. The table below shows an increase in presentation of children and young people with Eating Disorders in the Swindon Acute trust:

Year	Nos with Eating D. as Primary Diagnosis	Nos with Eating D. Among Secondary Diagnoses	Nos with Eating D. as Diagnosis in any position
2014/2015	5	13	18
2015/2016	6	19	25
2016/2017	9	10	19
Total Period	20	42	62

Source: SUS Hospital Episodes.

¹ Dr Dasha Nicholls quoted in the Health Committee - Third Report

Children's and adolescents' mental health and CAMHS October 2014 <http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/342/34210.htm>

5. Engagement and Partnership Approach

5.1 What do children and young people think?

Consultation with children and young people was undertaken by STEP and the Youth Forum. Two groups of young people were consulted: group 1 had no experience of mental health services and group 2 had experienced either experience targeted or specialist services. Of those who had not received a mental health service only 19% had heard of CAMHS and 25% had heard of TaMHS. 56% had not heard of either service. Of those who had heard of these services 57% did not really know what sort of help they offered. Only 38% of respondents thought they would know who to ask for or how to get help if they felt they needed support from these services.

Of those who had received a service 35% reported that they had waited more than a year before seeking help. Once they did seek help 45% felt they did not receive help soon enough.

Both groups thought there should be more information available for them on mental health problems and local services and they felt there was still a stigma and lack of awareness of mental health problems and that services were not visible. Children and Young people would prefer services to be flexible and close to home.

5.2 What do parents and carers think?

The Parent and Carer consultation was undertaken by CAMHS and TaMHS services and generally parents and carers were very pleased with the service their charges received.

However, they did feel that waiting times were too long and interventions too short. They would have liked more sessions for the young person. They also would have liked better communication while they were waiting for the service. Generally they felt the services required additional resources to provide more information and cut waiting times.

5.3 Partners and Stakeholders

All schools in Swindon were invited to take part in a consultation exercise for the needs assessment which has been used to inform this bid.

The key findings from this consultation was that considerable work already going on in schools to support children and young people's mental health needs and that most schools had good links with the TaMHS service.

However, schools did report that they would like to see:

- Improved access to and communication with mental health services
- Increased funding for mental health
- Increased awareness of mental health issues to promote an open culture of mental health
- Improve training for staff and provide information for parents on what was available.
- A retained focus on anti-bullying

Other stakeholders consulted included:

- Designated Nurse (Children Looked After)
- Educational Psychology
- Healthwatch
- LIFT Psychology Service
- Mental Health Commissioners
- Parents and Carers (Consultation and ongoing participation through CAMHS and TaMHS)
- Primary Care
- ON TRAK Youth Counselling Service
- School Nurses
- STEP
- Swindon Sexual Assault Referral Centre
- TaMHS
- Third Sector providers NSPCC, Mediation Plus 5 – 18 Counselling Service, Cruse, Swindon Mentoring and Self-harm (SMASH)

➤ YOT

This bid was put together by a subgroup of the CAMHS Strategy Group which included: Commissioners (lead), Public Health, CAMHS and TAMHS service providers.

6. Governance

6.1 Swindon Clinical Commissioning Group is the lead commissioning organisation for CAMHS in Swindon and as lead commissioner; the CCG will be responsible for final sign off of the Plan before submission in October. The Lead Commissioner will be responsible for ensuring sign-off. Development of the Plan has required a partnership approach and therefore the developmental phase has been driven through the Health and Wellbeing Board infrastructure, reporting to the Joint Commissioning group (local co commissioning arrangement) and Mental Health Programme Board and with sign off delegated to the Chair by the Chair of the Health and Wellbeing Board. This has ensured coherence with Swindon's Health and Wellbeing Strategy.

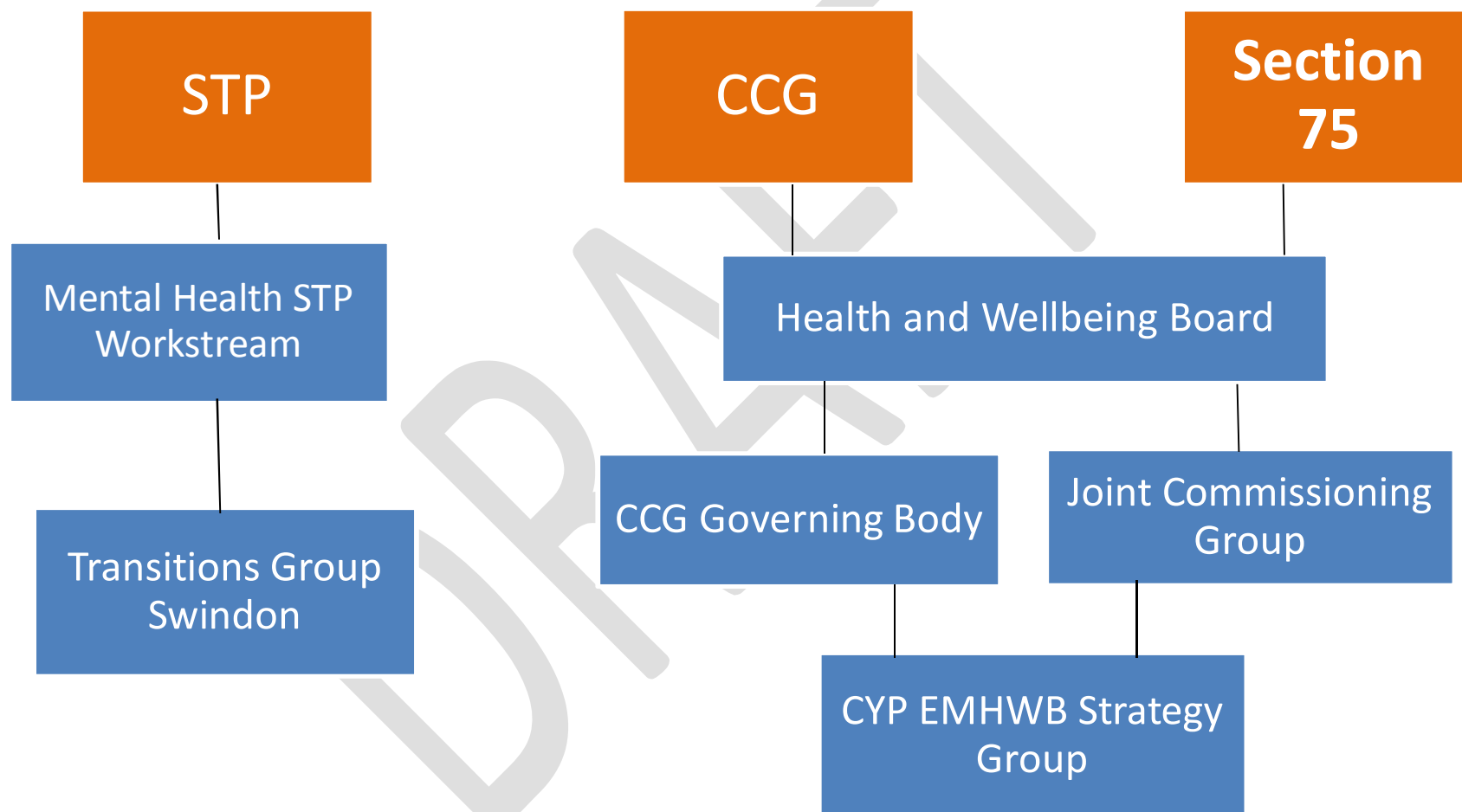
A multi-agency Children and Young People's Emotional, Mental Health and Wellbeing Strategy Group has been responsible for the initial review of services to date and the subsequent development of this Plan. Membership includes:

- YOT Service Manager, On-Track and U-Turn – Swindon Borough Council
- Children's Health Commissioning Lead, Swindon CCG
- Head of Early Help, Swindon Borough Council
- Mental Health Commissioning Lead, Public Health Team, Swindon Borough Council
- Operational Manager-Prevention & Specialist Services YOT, On-Trak & Uturn
- SENCO Dorcan Secondary School
- Service Manager, Healthwatch, Swindon

- Interim Service Manager, Oxford Health Foundation Trust
- Early Help Manager, TAMHS
- Head of Children and Families and Community Health Services, Swindon Borough Council
- Designated Nurse for Looked after Children, CCG
- Trust Assistant Principal (SEND), The Parks Academies Trust
- Senior Counsellor, Children's Services
- TAMHS Manager– Swindon Borough Council

The strategy group has reported to the governance structure throughout the review and development phase.

6.2 Governance Arrangements



Local Safeguarding Children's Board

6.3 Oversight of the delivery of the Swindon Transformation Plan

6.3.1 The Children's Emotional Mental Health and Wellbeing Strategy Group will be for implementation of the Transformation Plan and monitoring and review following implementation. This Group will be newly established, members have come together for a workshop to set priorities in this plan and a good working ethos has already been established. The CCG will organise and chair the meetings going forward. This group will meet at least six times a year to oversee the implementation of the plan. The CYPEMHWB Strategy Group will include/ seek advice from the following agencies (this may expand or change over time as plans develop):

- CCG
- Oxford Health Foundation Trust
- TAMHS
- Parent rep
- Swindon CAMHS young people's participation group and Swindon Ten to Eighteen Project (STEP)
- Children's Services (including Education and Youth Offending Service)
- Primary Care
- Paediatric services
- Public Health
- Schools and colleges
- Third sector
- Adult Mental Health Commissioners

6.4 Investment

6.4.1 Primary mental health services for children and young people in Swindon are provided by Swindon Borough Council through the Targeted Mental Health Service (TaMHS). This service is jointly funded by Swindon Clinical Commissioning Group and the Borough Council, and via traded services with schools. It is provided primarily through school based work but can offer community based

interventions elsewhere. The service offers assessment and brief interventions for children and young people with mild to moderate mental health need. TaMHS also offers consultation and training across universal services including schools. Specialist CAMHS and inpatient CAMHS in Swindon, are provided by Oxford Health NHS Foundation Trust. These services are funded by the CCG and NHS England respectively. Specialist CAMHS provide assessment and intervention for children and young people with moderate to severe mental health problems. This comprehensive service operates seven days a week with a community based outreach model, and full 24/7 on call for psychiatric emergencies. There is also a specialist Learning Disabilities CAMH service for young people with additional vulnerabilities. NHSE funds inpatient services for those with severe mental health need requiring 24-hour support and intervention.

6.4.2 At present, a re-procurement exercise is taking place across the STP with a contract start date of 1st of April 2018. Particular attention is being paid to outcomes reporting and monitoring, enabling children and young people to receive the right service in the right place at the right time, with children and young people playing an active part in the procurement. The commissioners are working closely together to ensure the development of a sustainable and flexible service model across the STP. A bespoke community eating disorder service was launched in January 2017.

6.4.3 The total Transformation Funding available for 2017/18 is £531,174k. (Source: Education Policy Institute)

	15/16	16/17	17/18 (plan)
	£'000	£'000	£'000
Eating Disorders	169	386	282
CAMHS - Tier 3	1,482	1,548	1,660
Learning Disabilities	347	347	347
MH Liaison Post at GWH		-	54
CBT Online		-	27
YOT post		-	29
Other		6	8
TAMHs service	104	153	185
CCG funded services via S75 with SBC	2,902	3,032	3,214
	5,004	5,472	5,806
Increase		468	334
% increase		9.4%	6.1%

- 6.4.4 In addition to the above providers, a number of other services are contracted to deliver emotional support and counselling for young people including On Trak Youth Counselling Service, Sexual Assault Referral Centre (SARC) and Letting the Future In (NSPCC). LIFT Psychology is also provided for 16 and 17 year olds by Avon & Wiltshire NHS Partnership Trust.

6.5 Structure and Organisation

6.5.1 Targeted Mental Health Services (TaMHS)

- 6.5.1.1 Targeted Mental Health Service sits in Swindon Borough Council's Integrated Locality Teams alongside those health staff (health visitors, school nurses, speech and language) who have been TUPED into the local authority under the Section 75 agreement. This is beneficial in providing all collated staff with additional consultation. The colocated staff include EWOs, educational psychologists, youth engagement workers and social workers. TaMHS is staffed by 16.9 whole time equivalent staff (wte) working across primary and secondary schools, and universal settings across Swindon delivering clinical assessment and brief interventions for mild to moderate mental health needs. Parenting packages are also provided as part of a holistic approach.
- 6.5.1.2 TaMHS also provides the Single Point of Access for children and young people's mental health need working closely with specialist CAMHS to ensure needs are met at the most appropriate part of the pathway. TaMHS also provides specialist placement support and consultation to adoption and support services in social care to prevent placement breakdown.
- 6.5.1.3 Traded services to schools include:
- Support and training for staff
 - Evidence based interventions with pupils eg Cognitive Behaviour Therapy
 - Group work in schools to tackle common issues such as anxiety
 - Self-referral system to nurture groups

6.6 Specialist CAMHS

6.1.1 Specialist CAMHS is staffed by 34.4 whole time equivalent staff (including clinicians, managers and administrators) and includes the following:

- Community CAMHS for children and young people 0-18 years with moderate to severe, complex and persistent mental health needs.
- Learning Disability CAMHS for those with a learning disability and mental health need.
- Outreach Service for Children and Adolescents (OSCA) is a community based 7 day a week service which targets those young people who may not have a clear mental health diagnosis, and are often less likely to engage with traditional CAMH services. It also provides wrap around support for those young people in CAMHS treatment who may be experiencing an acute episode. The service offers evidence based interventions, e.g. Dialectical Behavioural Therapy.
- Out of Hours service operates 24/7, 365 days a year staffed by Senior Mental Health Practitioners, Consultant Psychiatrists and Managers who collectively work with other professionals to ensure timely assessment of young people in a psychiatric emergency. This element of the service is strongly linked to the work of Swindon's Crisis Care Concordat Group.

6.7 CYP IAPT Programme

6.7.1 Swindon's specialist CAMHS provider, Oxford Health NHS Foundation Trust has been involved with the CYP IAPT programme since its conception and is currently the lead partner for the Oxford and Reading collaborative. As a result of participation in the programme, Oxford Health are now able to offer local children and young people access to a range of evidence-based/NICE approved treatments and interventions including:

Cognitive Behavioural Therapy (inc. Dialectical Behavioural Therapy and CBT-E, Multi-Family Therapy, Systemic Family Practice, Interpersonal Therapy)

At the heart of the CYP IAPT programme is the use of patient recorded, session by session outcome measurement to improve the quality and experience of services (called Routine Outcome Monitoring). This data is collected by all CAMHS clinicians.

Routine Outcome Monitoring (ROM) has already been rolled out to the Swindon CAMHS team and continues to be embedded in clinical practice. New outcome reporting criteria is currently being developed across the STP as part of the new contract.

6.8 Additional Services

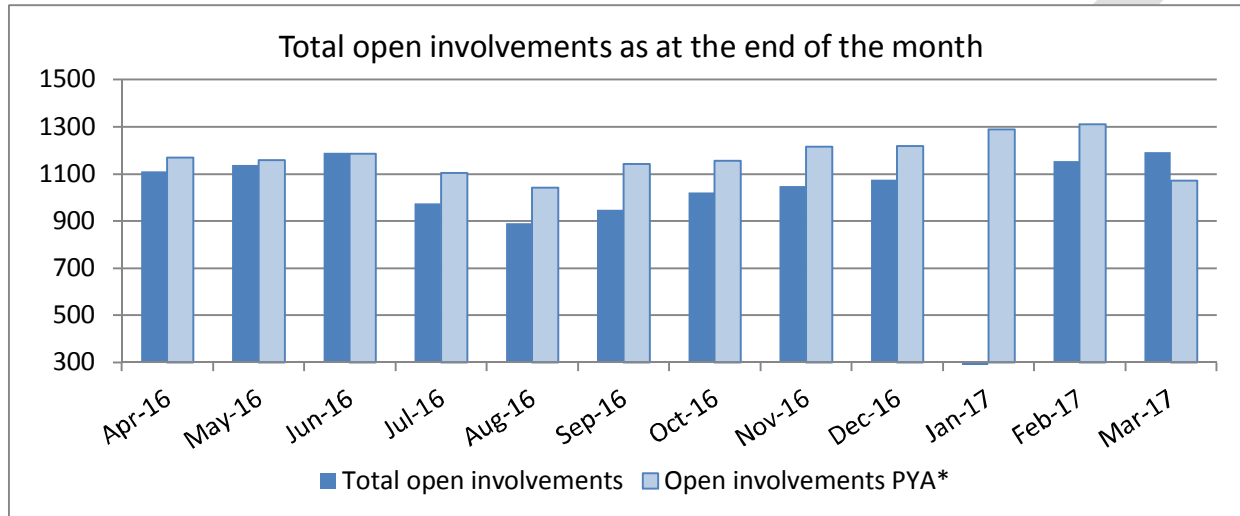
There are additional commissioned services provided for those young people over the age 14 years. These are as follows;

- Early Intervention Psychosis Service (16+)
- LIFT Psychology (16+)
- This is now Self Harmony at Swindon Mind
- Sexual Assault Referral Centre – counselling service

6.9 Performance Data

The Children's Health Commissioner is now receiving regular performance data from Swindon Borough Council.

6.9.1 TaMHS



New and Closing Involvements												
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
New involvements	182	172	174	132	73	200	181	194	136	264	185	236
<i>New involvements PYA</i>	131	143	159	149	82	214	171	200	136	195	195	193
New inv cumulative	182	354	528	660	733	933	1114	1308	1444	1708	1893	2129
<i>New inv PYA cumulative</i>	131	274	433	582	664	878	1049	1249	1385	1580	1775	1968
Closing involvements	144	145	123	343	158	142	95	166	109	165	149	200
<i>Closing involvements PYA</i>	121	155	130	232	144	114	157	140	133	125	174	432
Closing inv cumulative	144	289	412	755	913	1055	1150	1316	1425	1590	1739	1939
<i>Closing inv PYA cumulative</i>	121	276	406	638	782	896	1053	1193	1326	1451	1625	2057

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	16/17 YTD	15/16 YR
Referral to treatment time:														
Num starting treatment	102	84	83	23	13	123	94	74	50	155	81	121	1003	1028
Num within 18 wks of referral	93	78	73	18	12	114	83	67	40	140	76	104	898	854
% within 18 wks of referral	91.2%	92.9%	88.0%	78.3%	92.3%	92.7%	88.3%	90.5%	80.0%	90.3%	93.8%	86.0%	89.5%	83.1%

A new reporting dataset has now been agreed and this will mean that broken down waiting times data will be available from March 2017. The majority of referrals to TAMHS come from three sources. 48% were from GPs, 26% from Schools and 16% from Community Paediatricians. This excludes 16% of referrals from an unknown source.

Key	
	Improved by 3 bands
	Improved by 2 bands
	Improved by 1 band
	Remained within the band
	Declined by 1 band
	Declined by 2 bands
	Declined by 3 bands

% of closed involvements in the YTD that have...	
...improved by 1+ bands	32.4%
...remained in the same band	54.1%
...declined by 1+ band	13.5%

SDQ Score Before and After Matrix - Year to Date (1st April 2016 to 31st March 2017)						
This table shows the % of closed involvements in each SDQ band before and after the involvement.			SDQ Score after TaMHS involvement			
			Normal	Borderline		Abnormal
			0 to 14 (Close to Average)	15 to 17 (Slightly Raised/ Slightly Lowered)	18 to 19 (High/ Low)	20 to 40 (Very High/ Very Low)
SDQ Score before TaMHS involvement	Normal	0 to 14 (Close to Average)	21.8%	1.5%	1.5%	3.0%
	Borderline	15 to 17 (Slightly Raised/ Slightly Lowered)	5.3%	4.5%	1.5%	4.5%
		18 to 19 (High/ Low)	5.3%	1.5%	1.5%	1.5%
	Abnormal	20 to 40 (Very High/ Very Low)	6.0%	6.0%	8.3%	26.3%

6.9.2 Specialist CAMHS

Patients first seen in 2016-17

CAMHS Team	Grand Total
CAMHS S ED Caseload	26
CAMHS S Neuro Developmental Caseload	47
CAMHS S Swindon Caseload	386
CAMHS S Swindon FTC	4
CAMHS S Swindon Referrals	1
CAMHS S OSCA Caseload	238
CAMHS S Swindon LD Caseload	63
CAMHS S Swindon LD Neuro Development	9
CAMHS S Swindon LD School Nurse Caseload	37
TOTAL Swindon	811

All referrals come via the Single Point of Access (SPA).

Swindon children and young can self re-refer to CAMHS within 1 year after being discharged. Figures for re-referral 2016-17 were:

CAMHS team	Number
CAMHS S Neuro Developmental Caseload	4
CAMHS S OSCA Caseload	16
CAMHS S Swindon Caseload	32
CAMHS S Swindon LD Caseload	6
Grand Total	58

6.9.3 CAMHS Waiting Times 2016/17

CAMHS Waiting Times

Emergency referrals seen within 24 hours	Urgent referrals seen within 7 days	Routine referrals seen within 4 weeks	Routine referrals seen within 8 weeks	Routine referrals seen with 18 weeks
100%	100%	42%	76%	100%

6.9.10 Mash referrals from CAMHS and TaMHS

There is a good referral flow from both CAMHS and TAMHS into the Multi-Agency Safeguarding Hub (MASH), with 46 referrals made by CAMHS and 27 by TaMHS.

7.0 Current Workforce

Swindon CAMHS – workforce information, no's of staff inc. whole time equivalents, skills and capabilities

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Snapshot (taken Oct 2017)	Whole Time Equivalents & Headcount (includes managers and admin staff)	Roles	Skills
TaMHS	16.9 WTE	Registered Mental Nurses (RMNs); Occupational Therapists; Social Workers and Mental Health Practitioners; Community Support Workers; Admin staff.	The team employs 3 senior clinical practitioners, with one of these providing specialist support to looked after children's placements. 7 clinical practitioners and 9 outreach workers.

Specialist CAMHS	34.42 WTE	<p>Clinical Team Managers; Consultant Child & Adolescent Psychiatrists; Clinical Psychologists, Systemic Family Therapists; Child Psychotherapists; Registered Mental Nurses (RMNs); Occupational Therapists; Social Workers with mental health training; and admin staff.</p>	<p>All team managers have a professional clinical background and current registration.</p> <p>IAPT principles of service user engagement, evidenced-based practice and routine outcome monitoring have been rolled out and embedded across all teams.</p> <p>Staff are trained to work with vulnerable and disadvantaged groups (e.g. learning disabilities and looked after children) and deliver the following evidence-based therapies:</p> <ul style="list-style-type: none"> - Eating disorders e.g. CBT – E, Multi Family Therapy (MFT) - Systemic Family Practice (SFP) - Interpersonal Therapy (IPT) - Cognitive Behavioural Therapy (CBT) - Dialectical Behaviour Therapy (DBT) - Other therapies e.g. Drama Therapy etc <p>All staff are registered with relevant regulatory bodies and subject to professional codes of conduct. For re-registration or validation, all staff need to demonstrate continuing professional development for fitness to practice. This means their professional training is managed via a governance framework and their training needs are reviewed annually by Oxford Health NHS Foundation Trust.</p>
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Outreach Service for Children and Adolescents (OSCA)	Included in Specialist CAMHS figure above.	Clinical Team Manager; Consultant Child & Adolescent Psychiatrist; Systemic Family Therapist; Senior Mental Health Practitioners (RMNs/Occupational Therapists/Social Workers); and Community Support Workers.	As above
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8. Investment and Spend

8.1 Spending Approach

The five year budget would be fully utilised to deliver the outcomes of Swindon's Transformation Plan. Commissioners would work with providers across the CAMHS pathway to ensure that the funding is directed to meet the improvements that are needed and intended through the CAMHS Transformation funding.

- A service model that is focussed on building resilience, capability and capacity across the CAMHS pathway
- Strengthening of consultation and liaison
- Improved communication between families and delivery partners
- Improved information (published pathways, service offer and self-help options)
- Developing a tier less model where no child or young person doesn't receive a service
- Prevention – earlier help, on-line info, self help
- Better support to families and young people whilst waiting for first appointment and supported step down

8.2

How Services will be Different

- Reduced waiting times and improving access
- Services receive better quality and more appropriate referrals
- Prioritising support to some of our most vulnerable children (Looked after Children, Learning Disability, Autistic Spectrum Disorder, fostered and adopted children, young people who have been sexually exploited and/or abused)
- Seamless transitions to adult services
- Further development of Evidenced Based Service; providing evidence-based, NICE-approved and CYP IAPT standard therapies such as CBT, IPT, SFT and Family Therapy.
- Self-referral by children and young people to TAMHS
- Increased capacity across the system including the voluntary sector to meet growing need
- Improved use of data for service improvement and development
- Use of technology to improve access and self help
- Strong partnerships across the system, reducing duplication and improving service quality
- Improved information sharing and collaboration
- Building on the integration of Children's, Families and Community Health Services
- Increase partnership working with key stakeholders
- Further development of partnership working with third Sector to increase overall capacity

My preference would be for the table on P53:

1. Quote £282k instead of £169,238

2. I don't recognise the £40k so I think it better to remove and replace with your business case overrider for the moment in case someone then thinks we are putting more money in that we may not have agreed. I checked with Greg and he agrees as is not sure what it is
3. 5 I would change £53,846 to £54k

I would add a comment somewhere that says something like

The CCG will be considering business cases for new investment proposals as well as reviewing the evaluations of existing non-recurrently funded investments before finalising its investments for 18/19. Any investment for 18/19 will need to be approved in line with the CCG's scheme of financial delegation and will be considered along with other operational requirements.

Outcomes	What We are Going to Do	2017/18 CCG Planned Funding
1. Continue to invest in an evidence based Eating Disorder Service	<ul style="list-style-type: none"> • Eating Disorder investment will increase capacity in specialist CAMHS. • Joint single point of access (routine and urgent) with TaMHS and Specialist CAMHS 	£282,000

<p>2. Build resilience through promoting good mental health and wellbeing, prevention and early intervention across the CAMHS pathway</p>	<ul style="list-style-type: none"> • Continue to promote resilient parents, good perinatal mental health and attachment, strengthening our perinatal and infant mental health service. • Working with schools and universal services to promote evidence-based practice (ELSA); resilience; national/local resources; improve early identification and early intervention; raise awareness and expertise and tackle stigma by using participation and co-production • Focusing on the most vulnerable by providing relevant parenting support courses- co-funded between the CCG and funded by SBC* • Roll-out mental health training to schools by Swindon MIND 	<p>£17,000</p>
<p>3. Change how care is provided so that we have a needs-led not service led seamless CAMHS pathway</p>	<ul style="list-style-type: none"> • Continue to develop a tierless treatment system • Develop self-referrals for TaMHS • Continue to invest in early intervention, e.g. Ontrak to reduce waiting times and escalation of higher level need • Purchase Kooth online resource to offer alternative treatment options 	<p>Separate needs-led business cases to be presented</p>

4. Sustain a culture of continuous evidence- based improvement delivered by a workforce with the right skills-mix, competencies and experience who strive	<ul style="list-style-type: none"> • Developing structures that support staff in all areas of the children's workforce. • Regular reviews of the evidence-base, cost-effectiveness of interventions and the skills and competency mix of staff are underway to ensure efficient response and demonstrable sustainable outcomes alongside relevant KPIs. • Build on the CYP IAPT model, perinatal roles, universal up- skilling and reviews within targeted and specialist mental health services. 	Separate needs-led business cases to be presented
5. Development of Paediatric Liaison relating to Deliberate Self Harm and Chronic conditions	<ul style="list-style-type: none"> • Continue to invest in a Mental Health Liaison Worker at Great Western Hospital 	£54,000
<i>Grand Total</i>		£ 353,000 + separate business cases+ £74,000 SBC contribution

8.4 **24/7 liaison mental health services in emergency departments (EDs)**

Swindon recognises the need to enhance current provision of psychiatric liaison services in ED, particularly in relation to CAMHS Services. Further iterations of our transformation plans will include details of how we plan to enhance and build on our current outreach service to ensure the needs of Children and Young People are met.

8.5 **Perinatal Mental Health**

Work is in progress to review and develop roles within an integrated pathway in Swindon. Further work will need to be undertaken and is being led by the Adult Mental Health Commissioner in the CCG with all partners and stakeholder across both children's and adult's services.

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Swindon Dementia Needs Assessment 2017 - Update

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Executive Summary

This report is an update of the 2013 Joint Strategic Needs Assessment (JSNA) for dementia in Swindon (available at <http://www.swindonjsna.co.uk/dna/dementia-needs-assessment>) and should be read together with the latter, which gives more background and context on the issue. The aim of this update report is to inform the priorities and future strategy of the Dementia Steering Group and other stakeholders, by understanding the current epidemiology of dementia in Swindon and future need.

Main findings

- Dementia is a clinical syndrome (i.e. a group of symptoms) rather than a specific disease, in which there is a decline in cognitive function severe enough to interfere with daily life and function. There are many possible causes and types of dementia. It is estimated that about 80% of dementia cases are caused by either Alzheimer's disease or vascular lesions in vascular dementia, or a combination of both types of pathology.
- Dementia affects people differently depending on the type of dementia, stage of illness (mild, moderate or severe) and individual. People with mild dementia can live independently and cope well with day-to-day living.
- Locally, a multi-agency Swindon Dementia Strategy for the period 2014-2019 was developed based on the 2013 dementia JSNA. The 12 priorities set out in this strategy are largely based on those of the 2009 National Dementia Strategy, and include improving public and professional awareness of dementia and reducing stigma, improving timely diagnosis and treatment of dementia, and developing services that support people to maximise their independence.
- Swindon Borough Council serves a resident population of 217,905 people. In all, 33,733 of people (15.5% of the population) are aged 65 years or more. BME groups accounted for 8% of all people aged 65 years or over in the 2011 Census. Life expectancy in Swindon UA from 2013 to 2015 inclusive was 79.6 years for males and 82.8 years for females. The difference in life expectancy between the most deprived group and the least deprived group was 8 years less for males and 4 years less for females during the period 2013-2015.

Who is affected?

- In this JSNA update, prevalence has been estimated by applying prevalence rates from the Dementia UK Report (2014), which were estimated by an expert consensus panel (the Delphi consensus method), to ONS population figures.
- It was estimated that there were about 2,316 people over the age of 65 living with dementia within local authority boundaries in Swindon in 2016, and about 140 living with early onset dementia. This equates to about 1.8% of all those aged 30+ in the borough. This estimated prevalence rate is 3 times higher than the recorded prevalence in 2015/2016 for all ages of 0.6% (based on 1,395 cases on Swindon CCG registers).
- Actual numbers were estimated to be highest amongst those aged 80-89. At ward level, the estimates suggested that St Margaret and South Marston, Blunsdon and Highworth, and Wroughton and Wichelstowe had the highest numbers of people with dementia, which is not surprising as these wards have higher numbers of older people living there.
- Severity of disease is important to take into account as it indicates the potential level of care needed. Even with over 2,000 people in Swindon estimated to have dementia, nearly two thirds of these are estimated to be mild cases (1,283) and so would be able to function independently in a community that is sympathetic and supportive.

- Estimates suggest that 1,405 people with late onset dementia live in the community. The dementia population in care homes in 2016 in Swindon was estimated to lie between a maximum of 885 people and a minimum of about 610.
- Based on national incidence proportion figures, derived from the Cognitive Function and Ageing Study, it was estimated that, in 2016, 216 men and 383 women (599 persons in all) aged 65 years or more in Swindon UA developed dementia.
- There is little evidence for a direct link between deprivation and dementia. However many of the risk factors are more prevalent in more deprived areas.

Who is most at risk?

- Recent research (July 2017) from the Lancet Commission on Dementia Prevention, Intervention and Care identified that there are risk factors for dementia throughout the life course and tackling those which are modifiable would delay or prevent a third of dementia cases. Addressing modifiable risk factors for dementia would involve focusing on reducing hypertension, childhood education, exercise, maintaining social engagement, reducing smoking and management of hearing loss, depression, diabetes, and obesity.
- The Lancet Commission also found that nearly 85% of costs are related to family and social, rather than medical, care. In addition, the paper highlighted that recent studies in the USA, UK, Sweden, the Netherlands and Canada have found a lower incidence of dementia than expected.
- Age is an obvious risk factor for dementia; it is estimated that risk doubles for every additional 5 years after the age of 30, although it starts very low. According to 2016 population estimates, 15.5% of the Swindon population are aged 65 or over (33,733 people). With estimates of the number of people with dementia at around the 2,300 mark, this means that currently there are approximately 31,000 people aged 65 or over who do not have the disease.
- NICE guidance recommends that hypertension, diabetes and high cholesterol be identified and treated in middle age to reduce problems in later life. In Swindon, as of March 31st 2016, there were 31,729 people (13.7% of the CCG registered population) recorded as having hypertension and 12,924 people (7.1% of the population, only people aged 17 or over) recorded as having diabetes (7.1%, only people aged 17 years or over). Diabetes UK data suggest that a further 830 people in Swindon may have undiagnosed diabetes.
- Modifiable lifestyle risk factors for dementia include smoking, excessive alcohol consumption and having excess weight. Risk factors for early onset dementia (people who are under 65) include alcohol abuse, traumatic brain injury (although evidence for this is mixed), HIV and other neurological illnesses. It is estimated that about 10% of dementia cases in younger people are alcohol related.

Primary, Secondary and Social Care

- This chapter explores the services that people with dementia may access in their journey from diagnosis to end of life care – however it is not a comprehensive service review and rather focuses on updating data in the 2013 JSNA. There is currently no cure for dementia, although there are medical and psychosocial interventions which can help people to maintain independence. Because there is no cure, demand for social care can be significant particularly at the severe stage of the illness.
- The pathway for dementia care usually starts when someone approaches their GP with concern about their memory and is then referred to the memory clinic for assessment. Estimates suggest that people wait up to 3 years to see their GP after first noticing symptoms. In Swindon, the estimated diagnosis rate among people aged 65+ years with dementia is 64%, which is slightly lower than the national rate of 67.9%.

- Regarding medical interventions to reduce dementia symptoms, NICE recommends AChE inhibitors including Donepezil, Galantamine and Rivastigmine for mild to moderate Alzheimer's disease and Memantine for moderate or severe Alzheimer's disease. In Swindon, the number of items prescribed for all of these drugs, except Galantamine, has risen each year over the period 2013/2014-2016/2017. However, overall costs have come down in this period, as generic (unbranded) versions of these drugs have become available. This pattern mirrors that observed for England as a whole for the same period.
- Over the three year period from 2014/2015-2016/2017, there were 2,887 hospital admissions (representing 1,574 individual persons) with dementia coded in any diagnosis position (as either primary diagnosis or any of twelve secondary diagnoses). The number of admissions rose year-on-year, from 828 in 2014/2015 to 970 in 2015/2016 to 1,089 in 2016/2017.
- Dementia was comparatively rare as a primary diagnosis (2.7% of the total number of admissions). For admissions with a secondary diagnosis of dementia, the most frequently occurring primary diagnoses were urinary tract infections, pneumonia and problems related to falling.
- Social care provides crucial support for some people with dementia to maintain their independence and 'live well' with their condition. Swindon Borough Council commission both mental health support and community based services, including day services, domiciliary care, respite, and nursing care either at home, in the community or in residential care.
- In general the cost of adult social care services is substantial. According to the national NASCIS system, expenditure for people aged 65+ years in 2015/2016 in Swindon UA represented approximately 40% of the total gross expenditure on adult social care services.

What does the future look like?

- The number of people aged 65 and over is predicted to increase by over 20,000 over the next 15 years to nearly 55,000.
- According to POPPI (Projecting Older People Information System) numbers of people with dementia are estimated to increase by about 2000 by 2030 reflecting the increase in population of those over 65 and that age is the greatest risk factor for dementia.
- Data from POPPI predicts significant increases in the number of older people living alone over the next 20 years. However older people living alone is not necessarily a marker of increased dementia or demand for services as it may encourage people to maintain independence.
- The Alzheimer's Society estimated the formal and informal cost (i.e. unpaid carers) of dementia based on 2012/13 costs. This shows that costs depend on the severity of dementia, and that costs are highest for people with severe dementia in the community due to the high estimate of cost of informal care.

1. Introduction and Context

- This report is an update of the 2013 Joint Strategic Needs Assessment (JSNA) for dementia in Swindon and should be read together with the latter, which gives more background and context on the issue. The aim of this update report is to inform the priorities and future strategy of the Dementia Steering Group, by understanding the current epidemiology of dementia in Swindon and future need.
- Dementia is a clinical syndrome (i.e. a group of symptoms) rather than a specific disease, in which there is a decline in cognitive function severe enough to interfere with daily life and function. There are many possible causes and corresponding types of dementia. It is estimated that about 80% of dementia cases are caused by either Alzheimer's disease or vascular lesions in vascular dementia, or a combination of both types of pathology.
- Dementia affects people differently depending on the type of dementia, stage of illness (mild, moderate or severe) and individual. People with mild dementia can live independently and cope well with day-to-day living.
- Locally, a multi-agency Swindon Dementia Strategy for the period 2014-2019 was developed based on the 2013 dementia JSNA. The 12 priorities set out in this strategy are largely based on those of the 2009 National Dementia Strategy, and include improving public and professional awareness of dementia and reducing stigma, improving timely diagnosis and treatment of dementia, and developing services that support people to maximise their independence.
- Swindon Borough Council serves a resident population of 217,905 people. In all, 33,733 of people (15.5% of the population) are aged 65 years or more. BME groups accounted for 8% of all people aged 65 years or over in the 2011 Census.
- Life expectancy in Swindon UA from 2013 to 2015 inclusive was 79.6 years for males and 82.8 years for females. The difference in life expectancy between the most deprived group and the least deprived group was 8 years less for males and 4 years less for females during the period 2013-2015.

Introduction

In 2013 a Joint Strategic Needs Assessment (JSNA) for dementia in Swindon was completed. This document set out knowledge about dementia at the time, including the prevalence and incidence of dementia based on available data and research. Four years on our knowledge about dementia, its risk factors, and what is effective in supporting people has improved, although there is no available cure as yet. This update report should be read together with the full 2013 JSNA, which gives more background and context. This report provides current estimates and insight into the scale of dementia in Swindon.

A JSNA is a process for understanding the current and future health and wellbeing needs of the local population. This involves gathering different types of information, interpreting it and pointing to the priorities for improving health and wellbeing in Swindon. Understanding Swindon's changing population, the factors that affect health and wellbeing, the town's assets and the implications for future services are important in setting priorities and planning future services.

The objectives for this JSNA update are:

- To inform the priorities and future strategy of the Dementia Steering Group
- To provide current incidence and prevalence data for dementia in Swindon
- To describe the population at risk of dementia in Swindon based on current knowledge and identified risk factors
- To understand future population projections for Swindon and what this may mean in terms of the needs of local people and demand for services

Dementia

Dementia causes damage to the brain resulting in a progressive decline in more than one area of function, including memory, reasoning, communication skills and the skills needed to carry out daily activities. In medical terms, dementia can be defined in terms of both clinical aetiology and diagnosis and / or severity, but is a broad umbrella term often used to cover a number of diseases which have different causes and symptoms. The main types of dementia are¹;

- **Dementia due to Alzheimer's disease**, in which small clumps of protein develop and accumulate around brain cells and disrupt the normal working of the brain – usually a gradual onset.
- **Vascular dementia**, in which problems with blood circulation result in parts of the brain not receiving enough blood and oxygen – can have a sudden onset, often after a stroke or series of strokes.
- **Dementia with Lewy bodies**, in which abnormal structures, known as Lewy bodies, develop inside the brain.
- **Fronto-temporal dementia**, in which the frontal and temporal lobes of the brain begin to shrink. This is rare and tends to affect younger people.

In terms of severity, it is generally categorised as mild, moderate or severe based on a psychometric test assessment². The distinctions between these categories are not always clearly defined.

According to a general dementia needs assessment produced by the HCNA Group³, the characteristics defining each level of severity are:

- Mild – impairment of attention and memory, forgetting recent information, occasional confusion, able to cope with daily routine, but needing help with changes to routine
- Moderate – amnesia for recent events, disoriented about time and place, very poor reasoning and understanding of events, dependent on others for help with personal care and daily routine
- Severe – speech incoherent, unable to recognise close relatives, incontinence, completely dependent on others for personal care.

There is also a descriptive term used known as Mild Cognitive Impairment⁴ which is not part of the dementia diagnosis, but recognises that for some people as they get older they may have mild problems with memory and recall, which may or may not be an early sign of dementia. MCI can affect people of any age as a result of stress, depression or another physical condition and usually involves only memory loss rather than affecting a range of cognitive functions.

It is estimated that about 80% of dementia cases are caused by either Alzheimer's disease or vascular dementia, or a combination of both – however people can have pathological damage in the brain without having cognitive impairment. Dementia can also be the result of an underlying neurological illness such as Parkinson's disease.

In terms of day to day living with dementia;

- Many people with mild dementia live independently and lead active, fulfilled lives
- Difficulty retaining memories of recent events is often one of the first symptoms, but this depends on the type of dementia
- There is no common journey for people with dementia – it affects everyone differently

- Some apparent symptoms of dementia in later stages (e.g. aggression, disorientation, paranoia) can be a response to the illness rather than part of the prognosis, although some people do have behavioural and psychological symptoms.

National Policy

Dementia is a national priority - the Department of Health has given a Government commitment to improving the care and experience of people with dementia and their carers, via a focus on awareness, early diagnosis and appropriate treatment⁵. This approach was set out in the National Dementia Strategy (NDS) in 2009 and was followed up in 2012 by a personal dementia challenge set by the Prime Minister David Cameron. The Prime Minister's "Challenge on Dementia 2020", published in February 2015, sets out what the Government wants to see in place by 2020 in order for England to be:

- the best country in the world for dementia care and support and for people with dementia, their carers and families to live in
- the best place in the world in which to undertake research into dementia and neurodegenerative diseases.

In 2015, an implementation plan to 2020 was published focusing on 4 themes: risk reduction, health and care, awareness and social action, and research.

This is also within the context of strategies on end of life care, dignity in care, adult social care, carers and mental health overall. A House of Commons Briefing Paper on dementia policy, services and statistics gives more detail on UK Government activity to date and that which is planned for the future (<http://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN07007>).

NICE (National Institute for Health and Care Excellence) has published new or updated guidance on dementia over the last few years:

- CG42 is a clinical guideline on supporting people with dementia and their carers in health and social care which was updated in September 2016 (<https://www.nice.org.uk/guidance/cg42>).
- NG16 focuses on dementia, disability and frailty in later life, as well as on mid-life approaches to delay or prevent onset and was published in October 2015 (<https://www.nice.org.uk/guidance/ng16>).
- Quality Standards (QS30) on dementia, independence and wellbeing were produced in April 2013 (<https://www.nice.org.uk/guidance/qs30>).
- Three summaries relating to medication were published in 2015 on low-dose antipsychotics (<https://www.nice.org.uk/advice/ktt7>), and management of aggression, agitation and behavioural disturbances in dementia with carbamazepine (<https://www.nice.org.uk/advice/esuom40/chapter/Key-points-from-the-evidence>) and valproate preparations (<https://www.nice.org.uk/advice/esuom41/chapter/Key-points-from-the-evidence>).
- New guidelines on dementia specifically, on assessment, management and support for people living with dementia and their carers - are being developed (<https://www.nice.org.uk/guidance/indevelopment/gid-cgwave0792>) and are due for publication in June 2018.

Local Context

Following on from the last Dementia JSNA in Swindon, a multi-agency Swindon Dementia Strategy for the period 2014-2019 was developed (<http://www.swindonjsna.co.uk/dna/dementia-needs-assessment>). This has 12 priorities, largely based on the national strategy, which are outlined below

- 1: Improve public and professional awareness of dementia and reduce stigma
- 2: Improve timely diagnosis and treatment of dementia
- 3: Increase access to a range of flexible day, home based and residential respite options

- 4: Develop services that support people to maximise their independence
 - 5: Increase community clinical support for patients experiencing dementia
 - 6: Improve the skills and competencies of the workforce
 - 7: Improve access to support and advice following diagnosis for people with dementia and their carers
 - 8: Reduce avoidable hospital and care home admissions and decrease hospital length of stay
 - 9: Ensure that the needs of younger people with dementia are addressed
 - 10: Improve the quality of dementia care in care homes and hospitals
 - 11: Improve end of life care for people with dementia
 - 12: Safeguard people living with dementia
- The Great Western Hospital also have a dementia strategy which was refreshed in 2017.

A Snapshot of Swindon⁶

Swindon Borough Council (Swindon UA) serves a resident population of 217,905 people (ONS population estimates for mid-2016), with broadly similar numbers of men (108,651) and women (109,254). In all, 33,733 people (15.5% of the population) are aged 65 years or more, with 15,033 (6.9%) aged 75 years or more, and 4,508 (2.1%) aged 85 years or over. Swindon continues to grow - its population expanded by 16% in the decade between the 2001 and 2011 censuses, which was the highest growth rate in South West England. The NHS Swindon CCG registered population at 230,844 (people registered with a Swindon CCG GP) is larger than the Swindon UA population, but the age-sex profiles of the two populations are broadly similar.

(Population figures for Swindon can vary depending on the geographical boundary considered. For example, Watchfield and Shrivenham ward contributes to the CCG population, but comes under Oxfordshire rather than Swindon Borough Council. Also, some patients registered with Swindon CCG live outside Swindon UA and Watchfield and Shrivenham. Most figures in this report relate to the Swindon UA resident population, but the population being considered will be referenced in the text as appropriate.)

The proportion of people in Swindon who reported being from a non-White British group in the 2011 Census was 15.4% (32,128 people). The largest Black and Minority Ethnic (BME) group was Asian/Asian British at 5.9%, closely followed by White non-British people (mainly Europeans) at 5.2%. At present, BME groups in Swindon UA are relatively young. BME groups accounted for 8% of all people aged 65 years or over in the 2011 Census, but in younger age-groups, the proportion was higher - at 10% of people aged 50 to 64 years, 18% of people aged 16 to 49 years and 18% of people aged 0 to 15 years. The Asian/Asian British Group was at its greatest extent (8%) in people aged 0 to 15 years and in people aged 16 to 49 years, but it made up only 2% of the population aged 65 years or over. It would therefore be wise always to view age-group together with ethnic group, when considering matters of ethnicity in the population.

The overall deprivation score for Swindon UA on the Indices of Multiple Deprivation 2015 was 17.9, which was lower than the score for England as a whole of 21.8. At the same time, 16.3% of children are estimated to live in low income families in Swindon, which again is better than the figure for England of 20.1% (deprivation figures from Health Profile 2016). Although Swindon is less deprived than the average Upper Tier Local Authority, the levels of deprivation vary considerably across the town, and many different grades of affluence and poverty are present within the population.

The table below shows, using 2015 population figures, the number and proportion of people aged 65 years or over in each of ten groups in Swindon UA, according to level of deprivation based on the IMD 2015. In total, 4,340 people aged 65 years or more were categorised as being in the two most deprived groups (Groups 1 and 2), but this represents only 13.1% of the 65+ population. In fact, 15,597 people, or nearly half, of this age-group, were categorised as being in the three least deprived groups (Groups 8, 9 and 10.)

Table 1: Swindon UA population in 2015 aged 65+ years by ten groups (decile groups) according to deprivation. (Deprivation in Swindon UA, as derived from Symphony Model 2015. 1= Most Deprived Group.)

Group of Deprivation	Population aged 65+	Percentage of all people aged 65+ in this group
1 (Most deprived)	1,555	4.7%
2	2,785	8.4%
3	2,421	7.3%
4	2,107	6.4%
5	2,385	7.2%
6	2,580	7.8%
7	3,636	11%
8	8,331	25.2%
9	5,398	16.3%
10 (Least deprived)	1,868	5.6%
All	33,066	-

Life expectancy in Swindon UA from 2013 to 2015 inclusive was 79.6 years for males and 82.8 years for females. The Slope Index of Inequality (from ONS) is a standard method of establishing the difference in life expectancy between segments of a population. It divides a population into ten equal groupings according to level of deprivation, plots the life expectancy of each group graphically and then draws a line of best fit through these values. In Swindon UA the difference in life expectancy between the most deprived group and the least deprived group according to this method was 8.0 years less for males and 4.0 years less for females (from 2013 to 2015.)

2. Population – who is affected?

- There is no conclusive diagnostic test for dementia, apart from post-mortem examination of brain tissue, which makes it difficult to measure the number of people with dementia. In this JSNA update, prevalence has been estimated by applying prevalence rates from the Dementia UK Report (2014), which were estimated by an expert consensus panel (the Delphi consensus method), to ONS population figures.
- It was estimated that there were about 2,316 people over the age of 65 living with dementia within local authority boundaries in Swindon in 2016, and about 140 living with early onset dementia. This equates to about 1.8% of all those aged 30+ in the borough. This estimated prevalence rate is 3 times higher than the recorded prevalence in 2015/2016 for all ages of 0.6% (based on 1,395 cases on Swindon CCG registers).
- Actual numbers were estimated to be highest amongst those aged 80-89. At ward level, the estimates suggested that St Margaret and South Marston, Blunsdon and Highworth, and Wroughton and Wichelstowe had the highest numbers of people with dementia, which is not surprising as these wards have higher numbers of older people living there.
- Severity of disease is important to take into account as it indicates the potential level of care needed. Even with over 2,000 people in Swindon estimated to have dementia, nearly two thirds of these are estimated to be mild cases (1,283) and so would be able to function independently in a community that is sympathetic and supportive.
- Estimates suggest that 1,405 people with late onset dementia live in the community. The dementia population in care homes in 2016 in Swindon was estimated to lie between a maximum of 885 people and a minimum of about 610.
- Based on national incidence proportion figures, derived from the Cognitive Function and Ageing Study, it was estimated that, in 2016, 216 men and 383 women (599 persons in all) aged 65 years or more in Swindon UA developed dementia.
- There is little evidence for a direct link between deprivation and dementia. However many of the risk factors (see chapter 4) are more prevalent in more deprived areas.

Introduction

Measuring the number of people with dementia is difficult. Whilst there are a number of different official sources, data from each depends on which interpretation of dementia diagnosis is used. There is no conclusive diagnostic test apart from post-mortem examination of brain tissue. However, for many people, diagnosis is based on behaviour and an ability to cope or not with daily activities. Formally, NICE guidance requires a mental health assessment which includes⁷:

- a detailed history from the patient and carer
- cognitive tests and an assessment of symptoms
- medical examination to exclude reversible causes of cognitive impairment such as depression, infection, adverse medication reaction or drug/alcohol abuse;
- brain imaging (either via a CT (computerised tomography) or MRI (magnetic resonance imaging) scan).

Official statistics identify those people who have been through this process (for example Quality Outcomes Framework (QOF) data¹ records all those on a register of patients with dementia held at a GP surgery, and all those who are reviewed regularly). However people may cope for a long time at home or with the support of family and friends, or there may be waiting lists for an official diagnosis: both of which may disguise the true prevalence.

In 2014, the Dementia UK organisation updated the consensus estimates developed in 2007. These are derived by a Delphi consensus method (used to estimate prevalence that you can't measure directly. The Delphi consensus process involved a preliminary review of all the available evidence, which was then submitted to an expert panel. The panel reviewed the evidence and used their judgment to estimate prevalence. After a second round of reviews (during which the panel could re-adjust their estimations in light of the anonymised responses of other experts) an average was calculated from the individual responses of the panel, which formed the basis for the estimations of prevalence published.

For this updated JSNA, prevalence has been estimated by applying consensus prevalence rates from the Dementia UK Report (2014) to ONS population figures.

Prevalence

Based on estimated prevalence rates from the Dementia UK Report (2014) consensus exercise, there were about 2,316 people over the age of 65 living with dementia in Swindon in 2016 within local authority boundaries, and about 140 living with early onset dementia. This equates to about 1.8% of all those aged 30+ in the borough. Using the CCG registered population figure, this estimate increases to 2,390 in the over 65 age-group and 145 for early onset dementia.

Table 1: Expected prevalence of late onset dementia by age and gender in 2016 in the UK and in Swindon UA

	Estimated prevalence derived by Delphi consensus method of late onset dementia in the UK by age and gender (%)			Estimated numbers of people living with dementia in Swindon UA (derived by applying consensus prevalence rates to Swindon UA population in 2016)		
Age (years)	Male	Female	Overall	Male	Female	Overall
65-69	1.5	1.8	1.7	78	99	176
70-74	3.1	3	3	119	127	245
75-79	5.3	6.6	6	147	211	359
80-84	10.3	11.7	11.1	206	298	503
85-89	15.1	20.2	18.3	177	355	532
90-94	22.6	33	29.9	98	270	368
95+	28.8	44.2	41.1	24	109	132
TOTAL				848	1469	2316

Sources: Dementia UK 2014, ONS.

Note: Expected numbers are rounded up to whole numbers within each cell and so do not appear to sum to the totals.

¹ The advantages of QOF are that robust and accurate data is available for those people on the register and they will have had a formal diagnosis. Its disadvantages are that it can be a more accurate reflection of the effect or interest of a GP practice in targeting a particular group of people rather than of the true prevalence in an area, that it also reflects the make-up of the local population, for example if that population is predominantly constituted of older people, and that it reflects only those aspects of care that are measurable.

Table 2: Estimated total numbers of people living with dementia and estimated total prevalence of dementia for Swindon

	Number with early onset dementia	Number with late onset dementia	Total estimated number with dementia	Prevalence of dementia among those aged 30+ ⁸	Prevalence of late onset dementia among those aged 65+
Swindon (local authority boundary)	140	2316	2456	1.7%	6.9%
Swindon (CCG registered population)	145	2390	2535	1.7%	6.9%

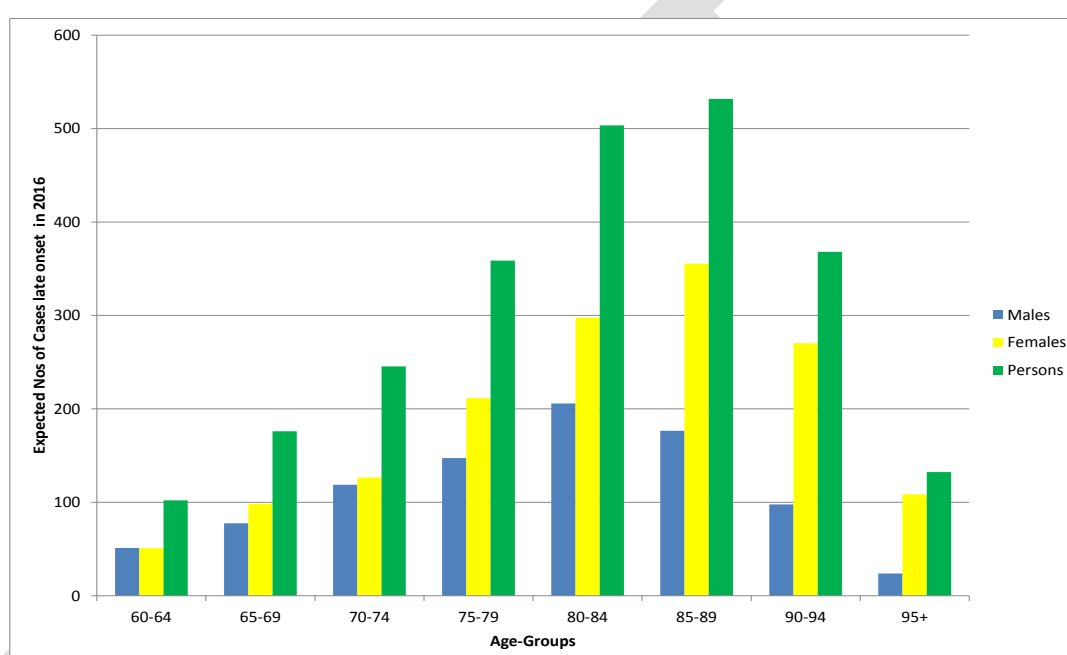


Figure 1: Expected late onset dementia by age group and gender in Swindon UA

Actual numbers are highest amongst those aged 80-89. Estimates of numbers of men with dementia peak between ages 80-84 whereas the peak for women occurs between ages 85-89.

Applying the prevalence estimates at ward level suggests that the highest number of people with dementia will be in St Margaret and South Marston, Blunsdon and Highworth, and Wroughton and Wichelstowe wards. This is not surprising as it will obviously reflect those wards which have higher numbers of older people living there.

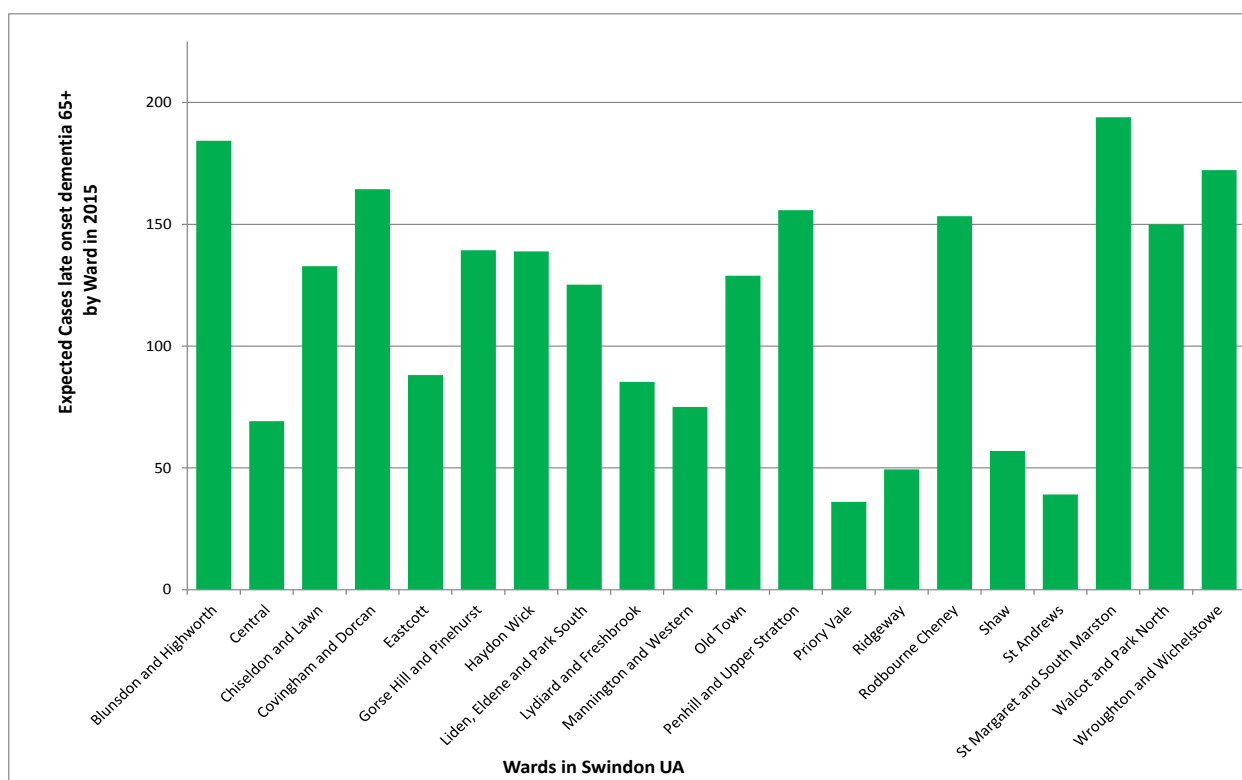


Figure 2: Estimated prevalence of late onset dementia by ward in Swindon UA

The estimated proportions of all people with dementia with each type of dementia from the Dementia UK report are shown below. These proportions were applied to the Swindon population aged over 65 to estimate the number of people living with each type of dementia – these estimates are also shown below.

Table 4: Estimates of proportion of people with dementia with each type of dementia, and of number of people over 65 in Swindon with each type of dementia

Type of dementia	Proportion of people with dementia (Dementia UK 2014)	Proportions applied to Swindon (SBC boundaries) Age 65+ population
Alzheimer's Disease	62%	1436
Vascular dementia	17%	394
Mixed (AD and VD)	10%	232
Dementia with Lewy bodies	4%	93
Frontotemporal dementia	2%	46
Parkinson's dementia	2%	46
Other	3%	69
Total		2316

Estimates of the proportions of people with dementia who have mild, moderate or severe dementia, again from the Dementia UK report, are 55.4%, 32.1% and 12.5% respectively. Applying these proportions to the Swindon population aged over 65, the estimated numbers with mild, moderate and severe dementia are 1,283, 743 and 290 respectively.

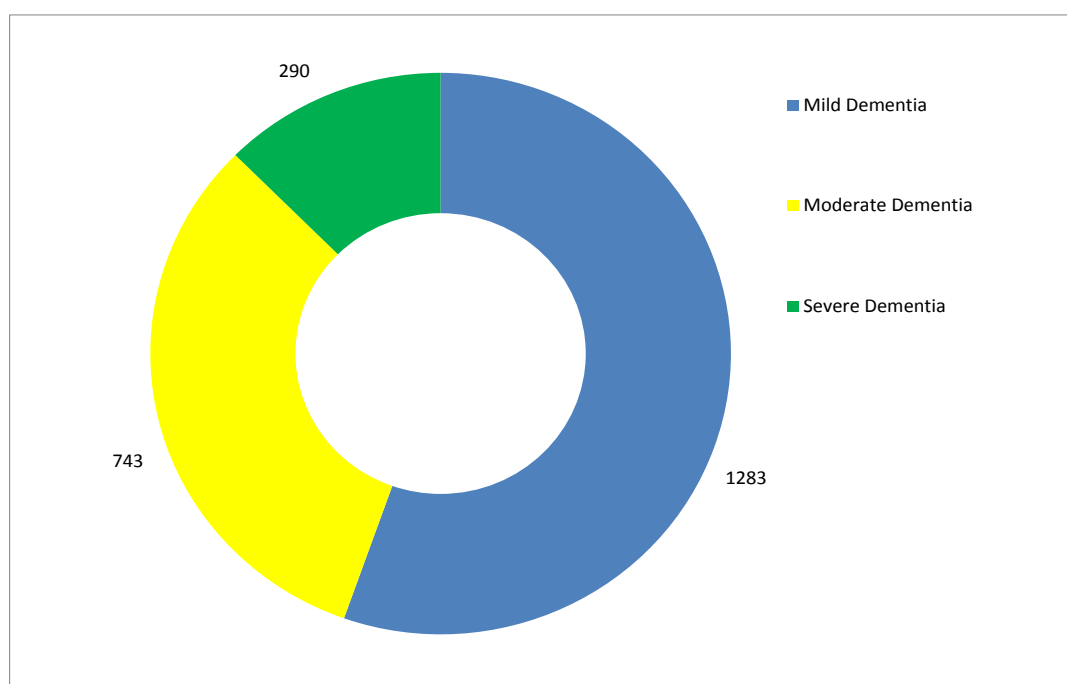


Figure 3: Estimated numbers of people aged over 65 living with dementia in Swindon by severity of dementia in Swindon UA 2016

Severity of disease is important as it indicates the potential level of care needed. Even with over 2000 people in Swindon estimated to have dementia, nearly two thirds of these will be mild and so would be able to function independently in a community that is sympathetic and supportive.

Residential Status

Having dementia does not mean that people cannot live independently and Dementia UK estimates that 63.5% of people with late onset dementia live in their own home. This varies according to age.

Table 5: Expected numbers of people with late onset dementia aged 65+ years by residential status and age in Swindon UA in 2016, based on 2014 consensus estimates. (Care Home here is defined as including residential or nursing care).

Age group	Estimated Percentage in Care Homes in UK	Estimated Percentage in Community in UK	Expected Number in Care Homes In Swindon	Expected Number in Community in Swindon
65-69	17.3%	82.7%	31	146
70-74	25.9%	74.1%	64	182
75-79	31.4%	68.6%	113	246
80-84	33.6%	66.4%	169	334
85-89	63.8%	36.2%	339	193
90-94	42.0%	58.0%	155	214
95+	31.2%	68.8%	41	91
Total	39.1%	60.9%	911	1405

The table above shows the estimated percentages in the UK of people with dementia aged 65 years or more by residential status. We have applied these percentages to the Swindon UA population to calculate expected numbers by residential status in Swindon. This suggests there are 1405 people with late onset dementia living in the community and 911 in care homes. The location of care homes will clearly impact any geographical assessment of dementia prevalence as some wards will tend to have more than others.

However, at the 2011 census, which was an actual headcount, there were 763 people aged 65 years or more living in care homes in Swindon. Allowing for 16% growth from 2011 to 2016 in the population aged 65 years or over, the expected number of people aged 65 years or over living in care homes, based on the census figure, would be 885 people. The 2014 consensus report suggests that about 69% of these would have dementia. Thus, even allowing for population growth, the predictions of care home numbers with dementia in Swindon in the above table (911 in total) look higher than may be actually the case.

The Adult Social Care Profile reports the rate of adults in permanent residential care as 431 per 100,000 adults in Swindon UA in 2013/2014, about a tenth lower than in England as a whole, while admissions of adults to permanent residential care in 2013/2014 was 81.3 per 100,000, about a quarter below the all-England level. (Source: Public Health England Adult Social Care Profile.) This suggests that Swindon uses residential care slightly less than England as a whole, and that a figure below the predicted 911 in the table would be more credible.

Thus, the dementia population in care homes in 2016 in Swindon may be somewhere between a maximum of 885 people (763 at 2011 census plus 16% population growth) and a minimum of about 610 (69% of 885, since not everyone in a care home will have dementia).

Incidence

The NICE Costing Report provided estimates of annual incidence of dementia (i.e. the number of new cases each year) by age and gender. These were based on findings from the Medical Research Council Cognitive Function and Ageing Study.

Table 6: Expected numbers of new cases of late-onset dementia among people aged 65+ years in Swindon UA in 2016, based on NICE incidence proportion (i.e. risk) figures for UK

Age (years)	UK Annual Incidence Proportion Male (%)	UK Annual Incidence Proportion Female (%)	Swindon Expected Number of New Cases Male	Swindon Expected Number of New Cases Females	Swindon Expected Number of New Cases Totals
65-69	0.4	0.4	21	22	43
70-74	0.9	0.6	35	25	60
75-79	1.4	1.7	39	54	93
80-84	2.3	4.4	46	112	158
85+	4.5	6	76	169	245
			216	383	599

The NICE incidence proportion figures suggest that, in 2016, 216 men and 383 women (599 persons in all) aged 65 years or more in Swindon UA developed dementia.

Memory Clinic Information

Memory services are recommended by NICE guidance as a single point of referral for early diagnosis of dementia. They can be provided in a number of different settings, including within a psychiatric or general hospital, as part of community mental health services or in primary care.

In Swindon, a memory clinic was formed in 1994 to facilitate research and provide diagnostic services for patients. It is currently provided at the Victoria Centre next to the Great Western Hospital and is overseen by psychiatric consultants.

The graph shows a count of referrals of Swindon CCG patients to the Avon and Wiltshire Mental Health Partnership (AWP) Memory Service in Swindon, provided mainly at the Victoria Centre at GWH. The increase in numbers from September 2016 to November 2016 was due to an initiative to reduce the size of the waiting list. Over the 2 years from October 2015 - September 2017, 1,709 people were referred to memory services, with an increase from 815 to 894 referrals from one year to the next.

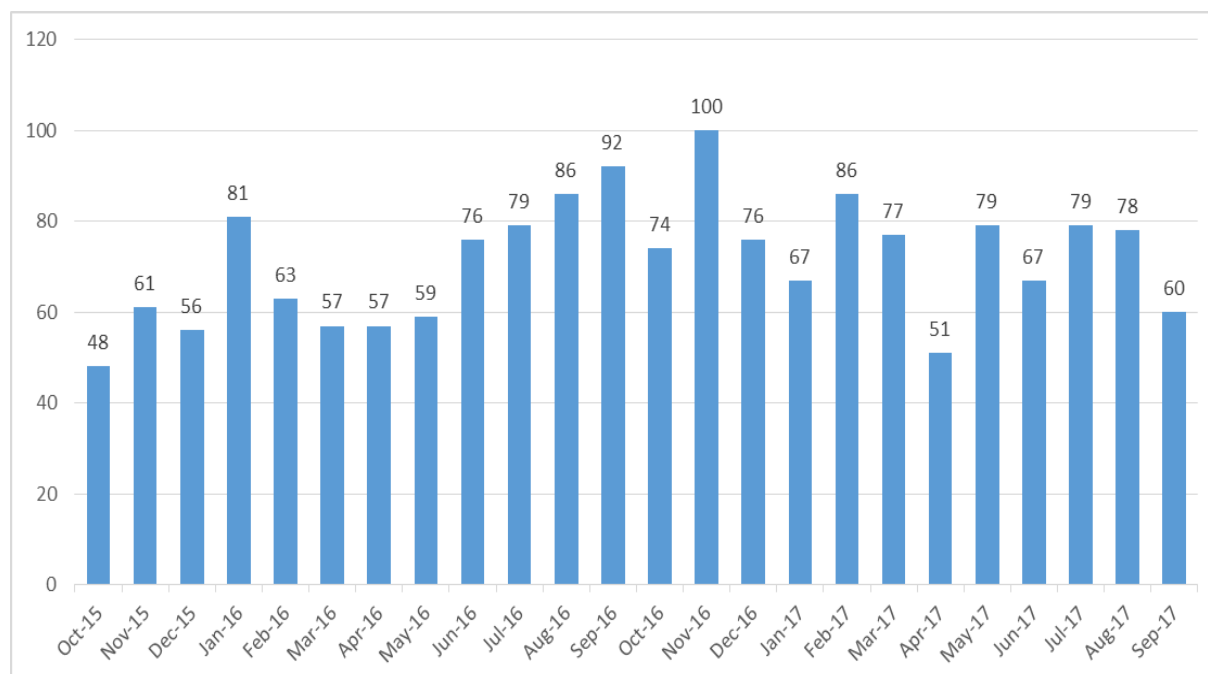


Figure 4: Numbers of referrals to the Memory Service in Swindon for Swindon CCG patients from October 2015 to September 2017 inclusive (Source: Swindon CCG Finance)

Mortality

The Mortality data in the tables are from the Primary Care Mortality Database for the years 2012 to 2015 inclusive and relate to the CCG registered population in Swindon. Numbers are based on people aged 50 years or more at time of death. Records including dementia were selected using the following ICD 10 codes:

- F00.* (Alzheimer's disease);
- F01.* (vascular dementia);
- F02.* (other forms of dementia);
- F03.* (unspecified dementia.)

In fact, no death certifications with Alzheimer's disease were identified for this period. Each death certificate contained nine possible diagnoses, (first position diagnosis, second position diagnosis and so on), but an underlying cause of death was also given in a separate field. The two different counts in the table are based on counts from the underlying cause field and counts from any of the other diagnostic positions. Some people could feature in both counts, that is have dementia as a cause of death among other causes, but also have it highlighted as the underlying cause.

Around 11% of deaths in 2015 had dementia somewhere on the death certificate: the increase year on year may be due to coding rather than an actual increase in the incidence of people dying with dementia.

Table 7: Counts of dementia deaths in the Swindon CCG registered population aged 50+ years in years 2012 to 2015 inclusive

	Year of death registration			
	2012	2013	2014	2015
a) Dementia as underlying cause	107	97	111	116
b) Dementia in any diagnostic position	148	176	181	180
c) Total deaths (all diagnoses included)	1,524	1,632	1,544	1,638
Percentage of deaths with dementia in any position on death certificate (b/c x 100)	9.7%	10.8%	11.7%	11.0%

According to the Dementia Public Health Profile, in 2015, 67.0% of people with dementia recorded on their death certificate (in any diagnostic position) aged 65 years or more in Swindon died in their usual place of residence. This was at a similar level to that in England as a whole (68.6%), but was noticeably lower than the percentage for the South West (76.9%).

As the chart shows, people in Swindon who die from a dementia related cause are more likely to die in a care home of some type (63.8%) than people who die from other causes (22.8%). Very few people with dementia are recorded as dying in a hospice. Only 6.9% are recorded as dying at home compared to 24.1% of deaths from any cause, but this may again be influenced by coding practice. It is also increasingly recognised that the place of death is an imperfect proxy for the quality of end of life care.

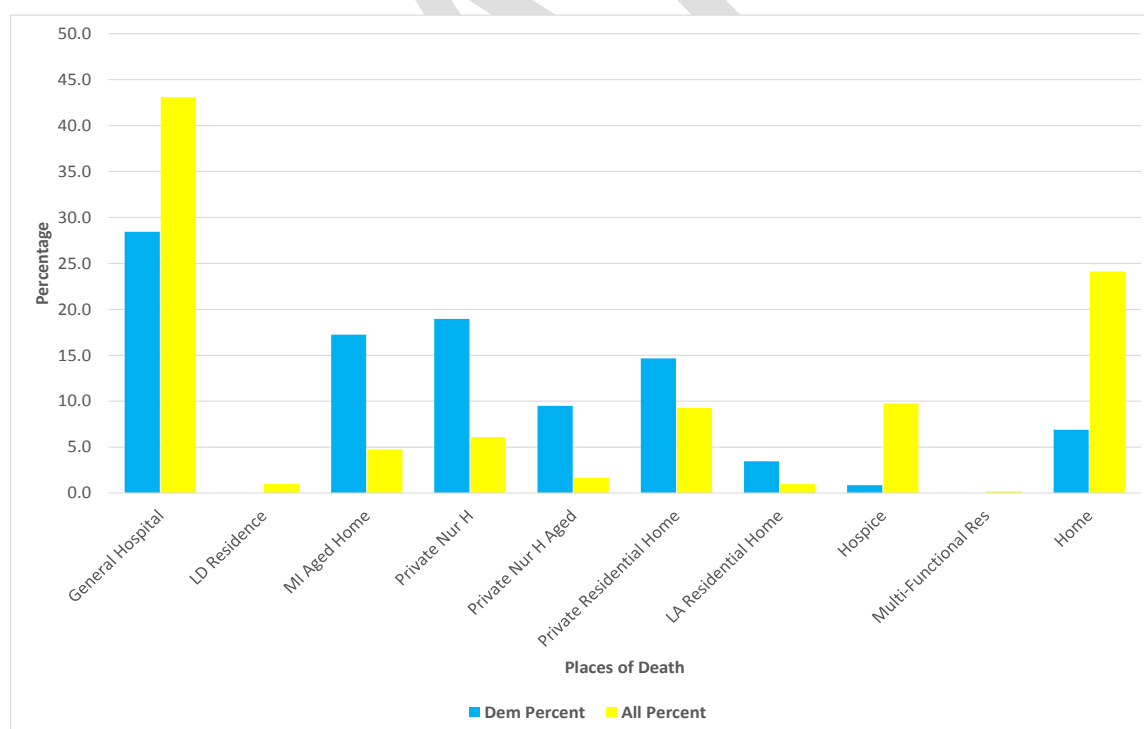


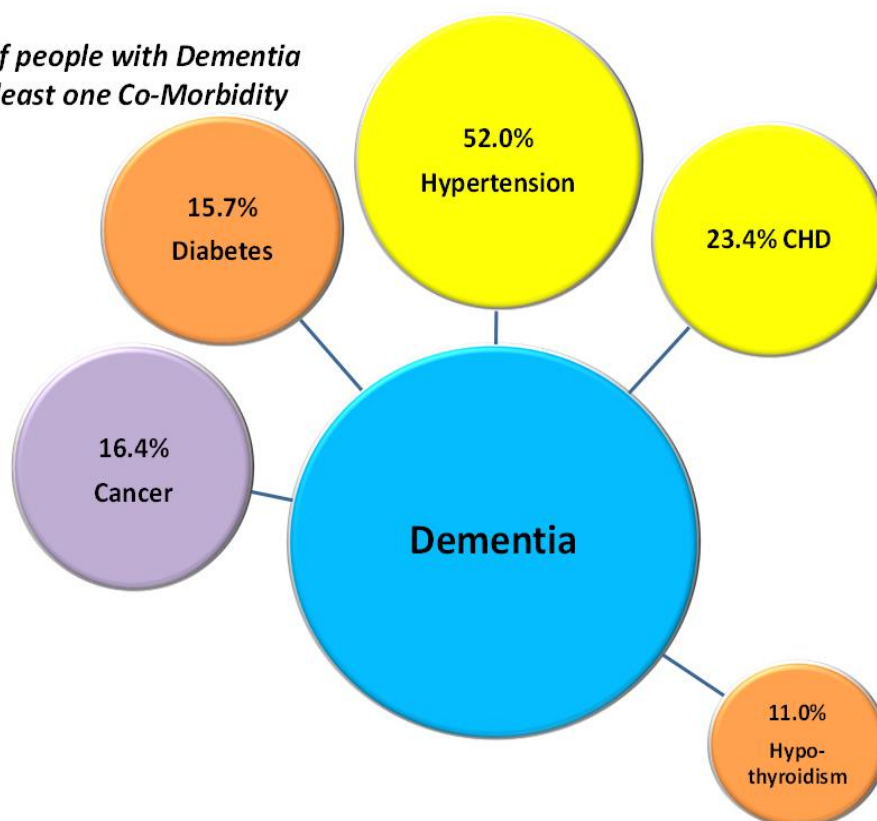
Figure 5: Percentage of deaths of Swindon CCG residents aged 50+ years in 2015 by place of death and underlying cause of death (dementia versus all causes) (Source: ONS/PCMD)

Co-Morbidity

The Symphony Model (see the Long Term Conditions JSNA <http://www.swindonjsna.co.uk/dna/LTC> for more detailed explanation and analysis) suggests that it is very common for people with dementia also to have co-morbidities, usually physical conditions. The model, based on epidemiological patterns in the Somerset population, but applied to the Swindon UA population, suggests that about 80% of people in Swindon who have dementia will have at least one other

condition. In the model for Swindon, dementia tends to be co-morbid with four of the most common chronic diseases, namely, cancer, diabetes, hypertension and CHD. For instance, the model predicts that 52% of people with dementia in Swindon will also have hypertension (raised blood pressure). More details of the model used can be found in the JSNA profile of Long Term Conditions for Swindon available at www.swindonjsna.gov.uk.

81.3% of people with Dementia had at least one Co-Morbidity



Source: Imputed through Symphony Matrix Model 2015.

Inequalities

Deprivation

There is little evidence for a direct link between deprivation and dementia. However many of the risk factors (see chapter 4) are more prevalent in more deprived areas because people have more challenges to overcome in order to adopt and maintain a healthy lifestyle. Although there is little evidence that the prevalence of dementia varies by socio-economic status or deprivation, there is some suggestion that access to services may vary. For example, national research in 2016 found that people from the least deprived areas (generally the richest) were 25% more likely to be started on 'anti-dementia' drugs than people in the most deprived areas.

The graph shows the rate of admissions for the electoral wards grouped according to level of deprivation into five groups (quintile groups) covering the period 2014/15 to 2016/17. The rates of admission are fairly similar, with Least Deprived at 77.7 per 1,000 people aged 65+ years, Second Most Deprived at 75.6 per 1,000 and Most Deprived at 77.3 per 1,000. The Midpoint group had a higher rate of admissions at 88.9 per 1,000, close to the overall Swindon UA figure of 86.5. However, the most notable rate was for the Second Least Deprived group (Lawn and Chiseldon, Haydon Wick, Old Town, St Margaret and South Marston), which was the highest at 105.5 per 1,000 people. This was probably due to the relatively old populations in these wards.

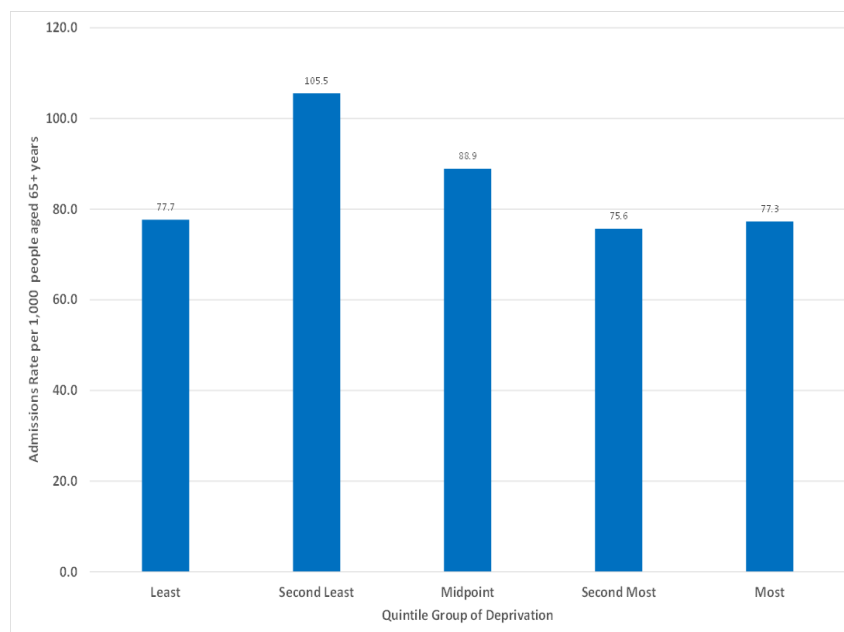


Figure 7: Rate of hospital admissions of people with dementia (diagnosis in any position) per 1,000 people among people aged 65+ years in Swindon UA by deprivation quintile in the three year period from 2014/15-2016/17

People with a Learning Disability

People with Down's Syndrome are at risk of developing Alzheimer's Disease 30-40 years earlier than the rest of the population, although the risk across a lifetime is thought to be similar. The peak incidence of dementia occurs around 55 years, but 10% of people with Down's Syndrome aged 40-49 are estimated to have dementia.

The PANSI (Projecting Adult Needs and Service Information System) estimates that 34 men and 24 women with Learning Disability in Swindon UA in 2017 will also have early onset dementia. This is based on the rates from the Dementia UK 2007 report.

Black and Minority Ethnic (BME) Communities

The Social Care Institute for Excellence (SCIE) estimate that more than 25,000 older black and minority ethnic (BME) people live with dementia in the UK, in part due to vascular risk factors such as hypertension, often found in African-Caribbean and South Asian UK populations. People from BME communities tend to access services later and at a more advanced stage.

The proportion of people in Swindon who reported being from a non-White British group in the 2011 Census was 15.4% (32,128 people). At present, BME groups in Swindon UA are relatively young. BME groups accounted for 8% of all people aged 65 years or over in the 2011 Census, but in younger age-groups the proportion was higher, at 10% of the 50-64 age-group, 18% of the 16-49 age-group and 18% of the 0-15 age-group. The school census in Swindon indicates that children in Swindon schools probably speak, between them, over 500 languages. About 13% of schoolchildren may have a language other than English which they regard as very important, but this does not mean that they are not able in the English language.

Little is known about the risk of dementia in the traveller community although increased risk of poor vascular health increases vulnerability to some types of dementia.

Lesbian, Gay, Bisexual or Transgender (LGBT) communities

LGBT communities are affected by dementia both as patients but also as carers. The Equalities Action Plan for the National Dementia Strategy (Department of Health) suggests that, by applying national prevalence rates for dementia to estimates that 5-7% of the population is LGBT, over 34,000 LGBT people are living with dementia. The Alzheimer's Society estimates that between 35,000 and

70,000 lesbian, gay and bisexual people care for a person with dementia in the UK. People from this community face additional challenges in terms of getting appropriate support and understanding. This may be finding appropriate residential care in later stages of the disease or accessing support groups in early stages where other older people are comfortable discussing same sex partnerships.

There is not a local figure for the size of the LGBT community in Swindon, but the percentage of people belonging to a LGBT group is commonly taken by the public sector and the third sector as being about 6% in the UK, as this allows for people who are reluctant to report on their sexuality in surveys, or whose feelings of attraction are not necessarily captured well by survey techniques. If we apply that percentage to the local population in 2016, it would suggest that approximately 13,000 people in Swindon UA belong to a LGBT group, and for the Swindon CCG registered population the figure is about 14,000 people.

Comparators

The following indicators are from the PHE Dementia Profile and are mainly based on recorded dementia cases in the QOF registers in primary care. Not all cases of dementia are identified and so an estimated diagnosis rate is also given- the estimated diagnosis rate was based on the MRC Cognitive Function and Ageing Study II (CFAS II). This may account for the difference between these prevalence figures and those based on the Dementia UK estimates.

- Recorded prevalence in 2015/2016 for all ages: Swindon UA significantly lower than England (0.6% v. 0.8%, 1,395 cases in Swindon CCG)
- Recorded prevalence in Sept 2016 for those aged 65+ years: Swindon UA significantly lower than England (4.0% v. 4.3%)
- Estimated diagnosis rate in 2017 for those aged 65+ years: Swindon similar to England (64.0% v. 67.9%)
- Ratio of inpatient use to recorded diagnoses in 2015/2016 for all ages (People with dementia using inpatient hospital services as a percentage of the total recorded diagnoses of dementia.): Swindon similar to England (55.9% v. 53.8%)

3. Who is most at risk?

- Recent research (July 2017) from the Lancet Commission on Dementia Prevention, Intervention and Care identified that there are risk factors for dementia throughout the life course and tackling those which are modifiable would delay or prevent a third of dementia cases. Addressing modifiable risk factors for dementia would involve focusing on reducing hypertension, childhood education, exercise, maintaining social engagement, reducing smoking and management of hearing loss, depression, diabetes, and obesity.
- The Lancet Commission also found that nearly 85% of costs are related to family and social, rather than medical, care. In addition, the paper highlighted that recent studies in the USA, UK, Sweden, the Netherlands and Canada have found a lower incidence of dementia than expected.
- Age is an obvious risk factor for dementia; it is estimated that risk doubles for every additional 5 years after the age of 30, although it starts very low. According to 2016 population estimates, 15.5% of the Swindon population are aged 65 or over (33,733 people). With estimates of the number of people with dementia at around the 2,300 mark, this means that currently there are approximately 31,000 people aged 65 or over who do not have the disease.
- NICE guidance recommends that hypertension, diabetes and high cholesterol be identified and treated in middle age to reduce problems in later life. In Swindon, as of March 31st 2016, there were 31,729 people (13.7% of the CCG registered population) recorded as having hypertension and 12,924 people (7.1% of the population, only people aged 17 or over) recorded as having diabetes (7.1%, only people aged 17 years or over). Diabetes UK data suggest that a further 830 people in Swindon may have undiagnosed diabetes.
- Modifiable lifestyle risk factors for dementia include smoking, excessive alcohol consumption and having excess weight. Risk factors for early onset dementia (people who are under 65) include alcohol abuse, traumatic brain injury (although evidence for this is mixed), HIV and other neurological illnesses. It is estimated that about 10% of dementia cases in younger people are alcohol related.

Introduction

Recent research (July 2017) from the Lancet Commission on Dementia Prevention, Intervention and Care⁹ identified that there are risk factors throughout the lifecourse and tackling those which are modifiable would delay or prevent a third of dementia cases. Addressing modifiable risk factors for dementia would involve:

- Reducing hypertension
- Childhood education
- Exercise
- Maintaining social engagement
- Reducing smoking
- Management of hearing loss, depression, diabetes, and obesity.

Other findings included:

- Nearly 85% of costs are related to family and social, rather than medical, care.
- The more physical illnesses someone has, the more likely they are to develop dementia.
- Brains can be resilient – some people with neuropathological changes of Alzheimer’s Disease do not have the clinical symptoms of dementia.
- Pre-clinical signs of Alzheimer’s Disease pathology can be identified in mid-life but “many or even most” people found to be at risk of dementia will die in good cognitive health.
- Hypertension can reduce the cognitive reserve buffer and hence increase vulnerability to dementia.
- People of African origin in the UK / USA with high rates of hypertension have increased rates of dementia at a young age.
- Recent studies in the USA, UK, Sweden, the Netherlands and Canada have found a lower incidence of dementia than expected.

Late Onset Dementia

Age

Age is an obvious risk factor for dementia; it is estimated that risk doubles for every additional 5 years after the age of 30, although it starts very low.

According to 2016 population estimates, 15.5% of the Swindon population are 65 or over (33,733 people). With estimates of the number of people with dementia at around the 2,300 mark, this means there are approximately 31,000 older people who do not have the disease in total across all age groups over 65.

Table 8: Number and proportion of people living in Swindon UA by gender and age group in 2016

Age-Group	Males	Females	Population (Persons)	Persons as Percentage of Total Population
0-14 years	21,560	20,386	41,946	19.2%
15-44 years	42,160	42,021	84,181	38.6%
45-64 years	29,463	28,582	58,045	26.6%
65-74 years	9,007	9,693	18,700	8.6%
75-84 years	4,777	5,748	10,525	4.8%
85+ years	1,684	2,824	4,508	2.1%
Totals	108,651	109,254	217,905	100%

Source: ONS

As the population pyramid below shows, the most populous age groups are those between 40-55. This suggests that potentially over the next 20 years there will be increasing numbers of older people in Swindon – however, the reality of this depends on whether people stay in Swindon for their retirement.

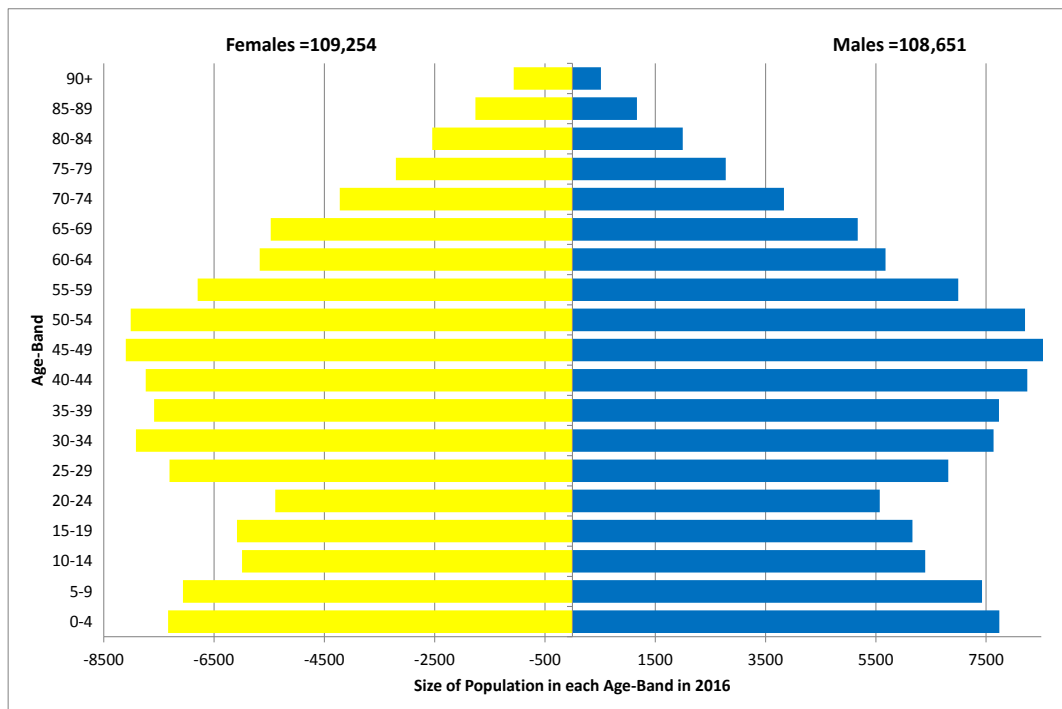


Figure 8: Population pyramid for Swindon based on the 2016 Census (Swindon UA)

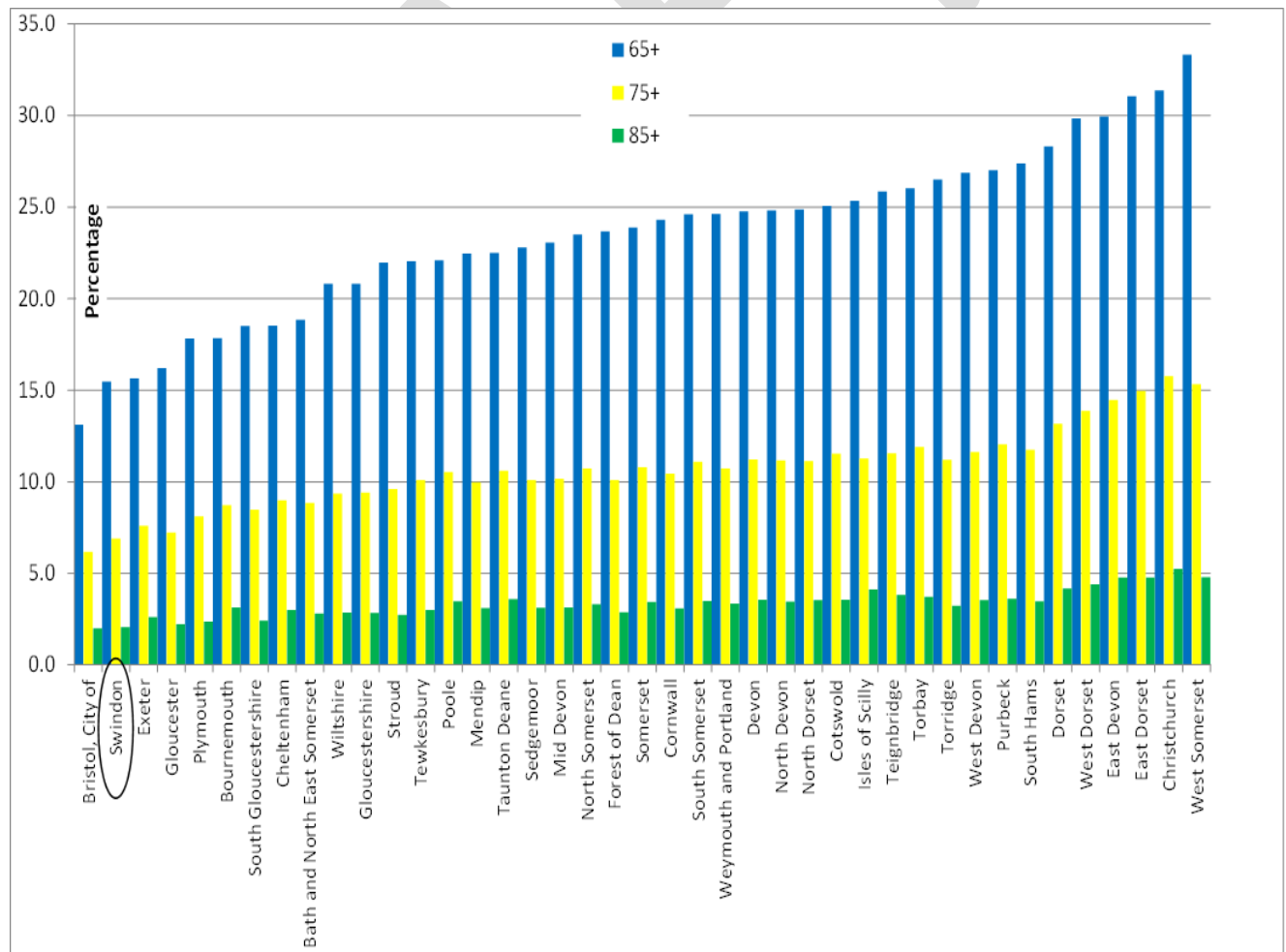


Figure 9: Percentage of population over the age of 65, 75 and 85 respectively compared to other South West Local Authorities

Compared to other LAs in the South West, Swindon UA has the smallest proportion of people aged 65+ years (15.5%), with the sole exception of Bristol (13.1%). West Somerset had the highest at 33.3%, while the proportion for the South West Region overall was 21.6%. For people aged 85+ years, the order of proportions in the Local Authorities was approximately the same; the proportions were 2.1% for Swindon UA, 2.0% for Bristol, 5.2% for Christchurch (the largest, with West Somerset the second largest) and 3.1% for the South West as a whole.

At ward level, there are some wards with higher numbers of people over 65 and over 85 than others. As the chart shows, Chiseldon and Lawn and Wroughton and Wichelstowe have higher proportions of people over 65 than other wards.

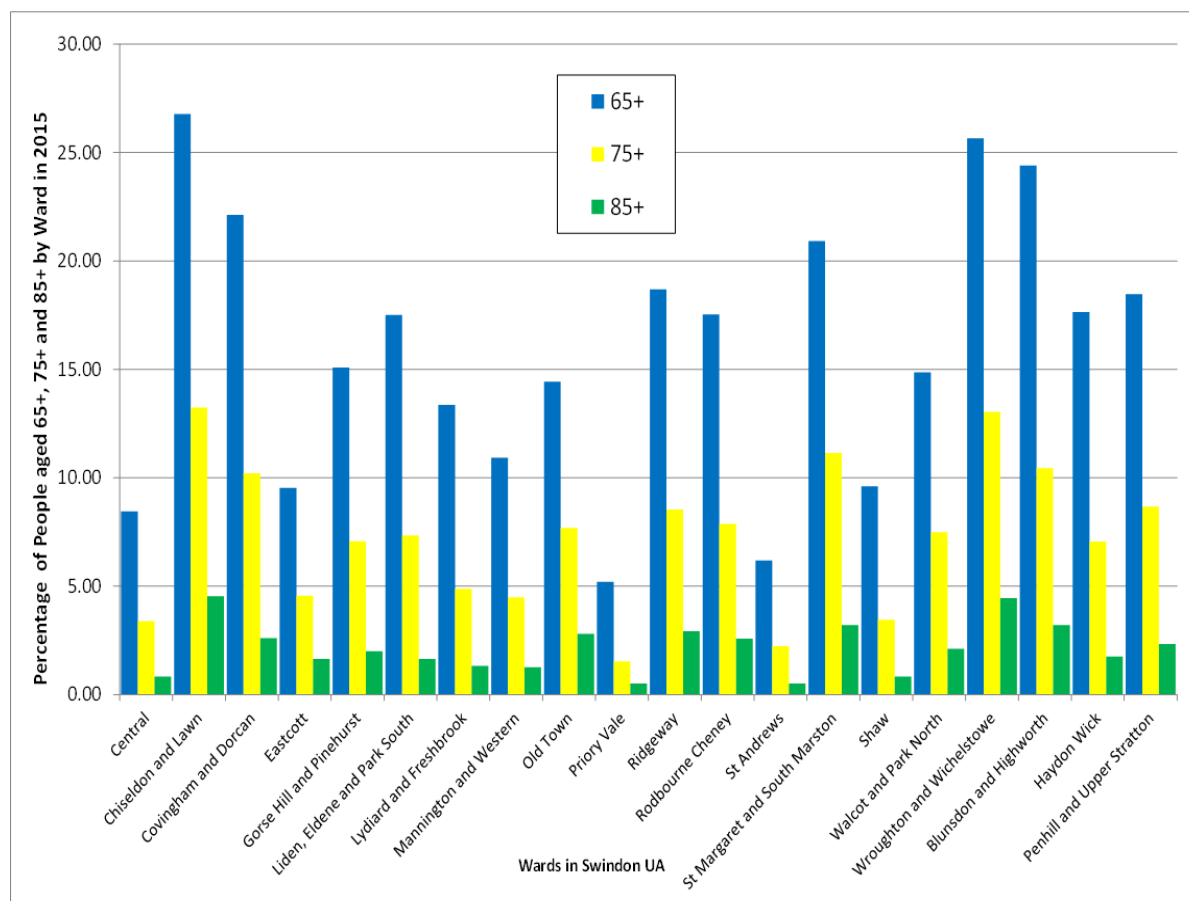


Table 9: The five wards with the greatest proportions of people aged over 65 and 85 respectively in Swindon UA in 2015

Over 65's				Over 85's		
	Ward	Number	Proportion	Ward	Number	Proportion
1	Chiseldon & Lawn	1,625	26.8%	Chiseldon & Lawn	275	4.5%
2	Wroughton & Wichelstowe	2,082	25.7%	Wroughton & Wichelstowe	361	4.4%
3	Blunsdon & Highworth	2684	24.4%	St Margaret & South Marston	372	3.2%
4	Covingham & Dorcan	2398	22.1%	Blunsdon & Highworth	352	3.2%
5	Ridgeway	626	18.7%	Ridgeway	98	2.9%

Mild Cognitive Impairment

As explained in the introduction, mild cognitive impairment (MCI) can affect people as they get older, but does not affect someone's usual daily activities, and does not reach the threshold for a

diagnosis of dementia. Although people with MCI are more likely to develop dementia (for example it is estimated that people with MCI are 15 times more likely to develop Alzheimer's disease than those without MCI¹⁰), nearly 50% of those with MCI do not go on to develop it.

Genetic inheritance

Some people may be more vulnerable to certain types of dementia because of the presence of a particular gene. For example, it is thought there may be a genetic link for familial autosomal dominant Alzheimer's disease, Pick disease and other causes of frontotemporal dementia, Huntington's disease, and cerebral autosomal dominant arteriopathy with subcortical infarcts and leukoencephalopathy (CADASIL). NICE guidance recommends that people likely to be in this risk group are referred for genetic counselling.

Hypertension, Diabetes, and High Cholesterol

NICE guidance recognises the potential link between hypertension, diabetes, high cholesterol and problems in later life, recommending that these are identified and treated in middle age.

Quality Outcome Framework (QOF) data based on the population registered at 31st March 2016 with Swindon CCG shows that:

- 3,395 people were recorded with stroke and/or Transient Ischaemic Attack (1.5%).
- 31,729 people were recorded with hypertension (raised blood pressure) (13.7%)
- 1,398 people were recorded with heart failure (0.6%)
- 6,370 people were recorded with Coronary Heart Disease (2.8%)
- 12,924 people were recorded with diabetes (7.1%, only people aged 17 years or more)

Diabetes UK data suggest that a further 830 people in Swindon may have undiagnosed diabetes.

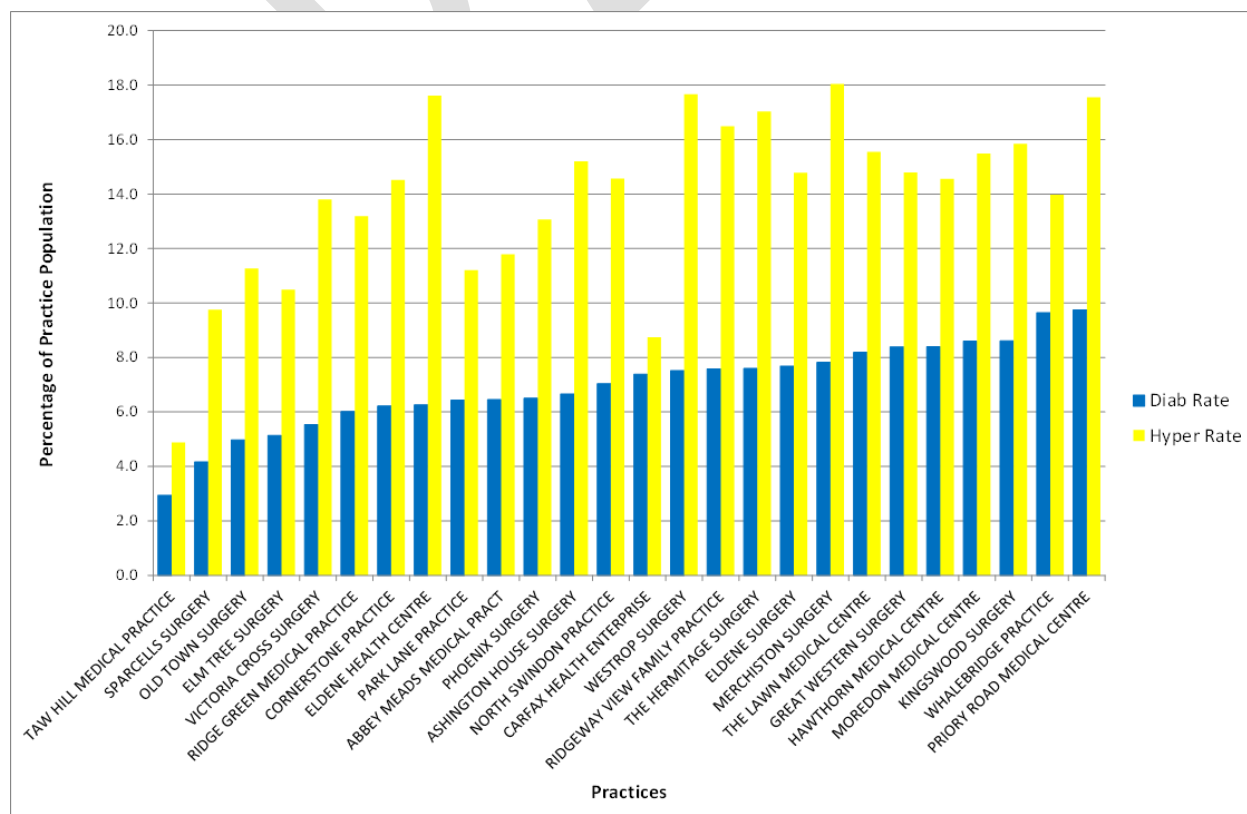
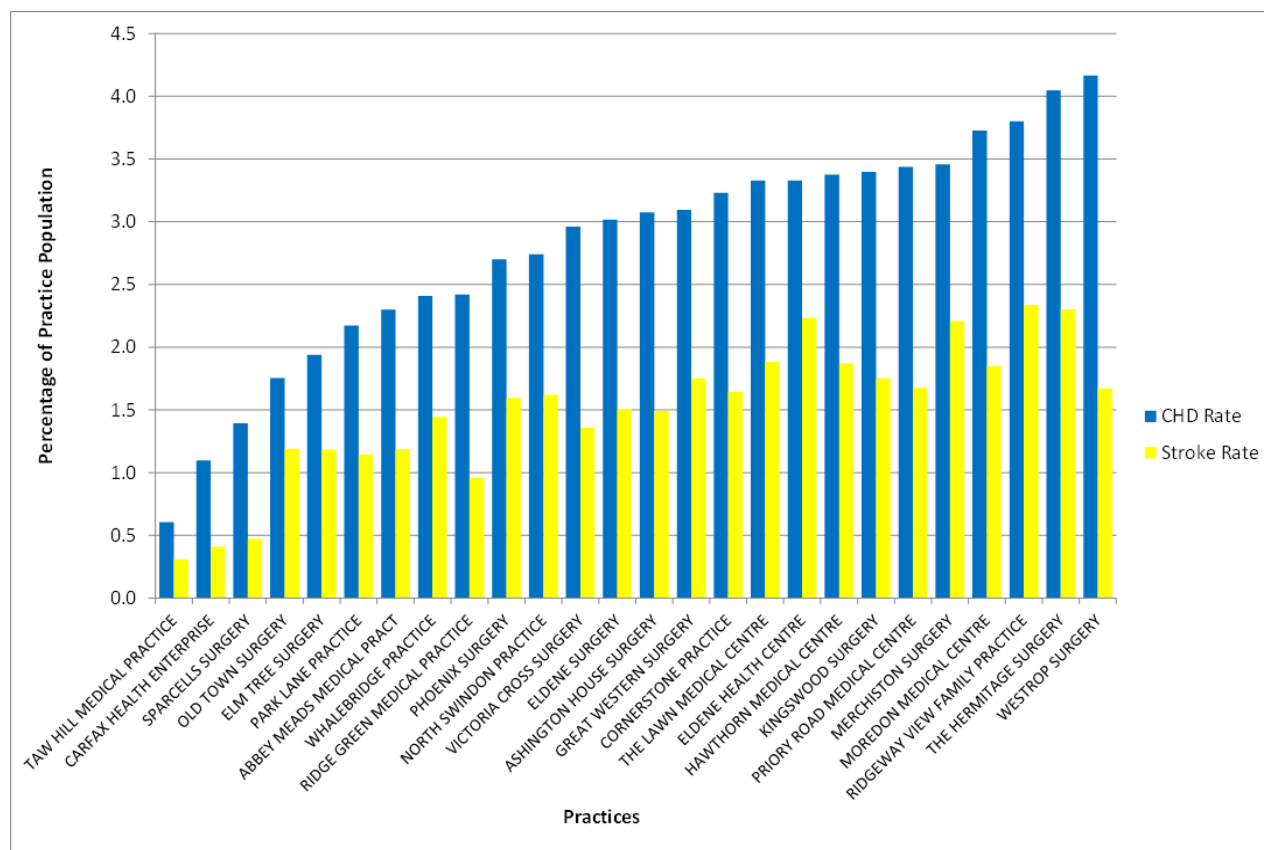


Figure 11: Rates of diabetes and hypertension by primary care practice as a percentage of the practice population in Swindon CCG in 2016 (in ascending order for diabetes)



Lifestyle Factors

The overall smoking prevalence in adults in Swindon UA in 2016 was 14.9%, an encouraging reduction from 21.5% in 2012. The smoking prevalence for adults in England as a whole was 15.5% in 2016, although this was not different at a statistically significant level from the Swindon rate. In both Swindon and England, however, the prevalence rates of smoking in people in the most deprived groups were higher. In the period 2013 to 2015 inclusive, 917 people (aged 35 years and over) died in Swindon of a smoking-related illness, a directly standardised rate of 299 per 100,000 per annum, which was not different at a statistically significant level from the rate for England as a whole. (Source: Health Profiles.)

With regard to alcohol, the percentage of adults consuming more than 14 units a week in the period 2011 to 2014 inclusive was 20.5% in Swindon UA, which was not significantly different from the level in England as a whole at 25.7%. 11.9% of adults in Swindon in 2011 to 2014 were binge-drinking on their heaviest drinking day, not significantly different from the level in England, 16.5%. However, Swindon did compare unfavourably to England where admissions for alcohol-related conditions (narrowly defined with alcohol as a prominent feature) were concerned in 2015/2016; the directly standardised admissions rate for Swindon was 721 per 100,000, which was significantly higher than the rate for England at 647 per 100,000. (Source: Local Alcohol Profiles.)

People in Swindon eat an average of 2.5 portions of fruit a day and 2.3 portions of vegetables a day. This is similar to the levels recorded for England as a whole for 2015. (Source: Health Profiles.)

With respect to maintaining a healthy weight, and avoiding being overweight (BMI = 25 to 29.9) or obese (BMI = 30 or more), Swindon faces a considerable challenge, having a comparatively high percentage of adults with excess weight. In the period 2013 to 2015, 70.8% of adults in Swindon were categorised as either overweight or obese. This was significantly higher than the figure for England as a whole (64.8%). At national level, around two-thirds of women and three-quarters of

men aged 65 years or over are overweight or obese, and the proportions increase further with age for men but decrease for women. It is likely that a similar pattern is present in people aged 65 years or more in Swindon. (Source: Health Profiles.)

The level of childhood obesity in Swindon UA in 2015/2016 in children aged 4 to 5 years was at a similar level to that in England as a whole at 8.5% of the population of 4-5 year olds compared with 9.3% nationally. At the same time, the level of obesity in 10 to 11 year olds in 2015/2016 was lower in Swindon UA when compared with England, at 17.3% of the population of 10-11 year olds compared to 19.8% nationally. (Source: Child and Maternal Health Profiles.)

The Chief Medical Officer for England recommends that adults should undertake at least 150 minutes of moderate intensity physical activity per week. In Swindon in 2015, 56.4% of adults achieved this, in comparison with 57.0% of adults in England as a whole- these proportions did not differ significantly from each other. National data suggests that people living in the least prosperous areas are twice as likely to be physically inactive as those living in more prosperous areas. (Source: Health Profiles.)

Early onset dementia

Studies show that there are few differences in terms of demographics and background between early and late onset dementia¹¹, but for those people who do develop early onset dementia the main risk factors are:

- Traumatic brain injury (although evidence for this is mixed)
- Alcohol abuse
- Another neurological condition e.g. Huntingdon's disease
- HIV

It is estimated that about 10% of dementia cases in younger people are alcohol related¹². Korsakoff's syndrome is caused by a lack of vitamin B1 in the body brought on by heavy alcohol consumption over a long term period. There is also some debate about whether 'alcoholic's dementia' is a separate condition. Both of these are different from usual dementias as, with abstinence, high doses of B1, an improved diet and increased support, people can show improvement.

4. Primary, Secondary and Social Care

- This chapter explores the services that people with dementia may access in their journey from diagnosis to end of life care – however it is not a comprehensive service review and rather focuses on updating data in the 2013 JSNA. There is currently no cure for dementia, although there are medical and psychosocial interventions which can help people to maintain independence. Because there is no cure, demand for social care can be significant particularly at the severe stage of the illness.
- The pathway for dementia care usually starts when someone approaches their GP with concern about their memory and is then referred to the memory clinic for assessment. Estimates suggest that people wait up to 3 years to see their GP after first noticing symptoms. In Swindon, the estimated diagnosis rate among people aged 65+ years with dementia is 64%, which is slightly lower than the national rate of 67.9%.
- Regarding medical interventions to reduce dementia symptoms, NICE recommends AChE inhibitors including Donepezil, Galantamine and Rivastigmine for mild to moderate Alzheimer's disease and Memantine for moderate or severe Alzheimer's disease. In Swindon, the number of items prescribed for all of these drugs, except Galantamine, has risen each year over the period 2013/2014-2016/2017. However, overall costs have come down in this period, as generic (unbranded) versions of these drugs have become available. This pattern mirrors that observed for England as a whole for the same period.
- Over the three year period from 2014/2015-2016/2017, there were 2,887 hospital admissions (representing 1,574 individual persons) with dementia coded in any diagnosis position (as either primary diagnosis or any of twelve secondary diagnoses). The number of admissions rose year-on-year, from 828 in 2014/2015 to 970 in 2015/2016 to 1,089 in 2016/2017.
- Dementia was comparatively rare as a primary diagnosis (2.7% of the total number of admissions). For admissions with a secondary diagnosis of dementia, the most frequently occurring primary diagnoses were urinary tract infections, pneumonia and problems related to falling.
- Social care provides crucial support for some people with dementia to maintain their independence and 'live well' with their condition. Swindon Borough Council commission both mental health support and community based services, including day services, domiciliary care, respite, and nursing care either at home, in the community or in residential care.
- In general the cost of adult social care services is substantial. According to the national NASCIS system, expenditure for people aged 65+ years in 2015/2016 in Swindon UA represented approximately 40% of the total gross expenditure on adult social care services.

Introduction

There is currently no cure for dementia. However, there are both medication and psychosocial interventions which can help to maintain independence and slow progression for some people. Following diagnosis, people may have changing needs for health and social care over time, but because of the lack of a cure, demand for social care can be significant particularly when the illness is

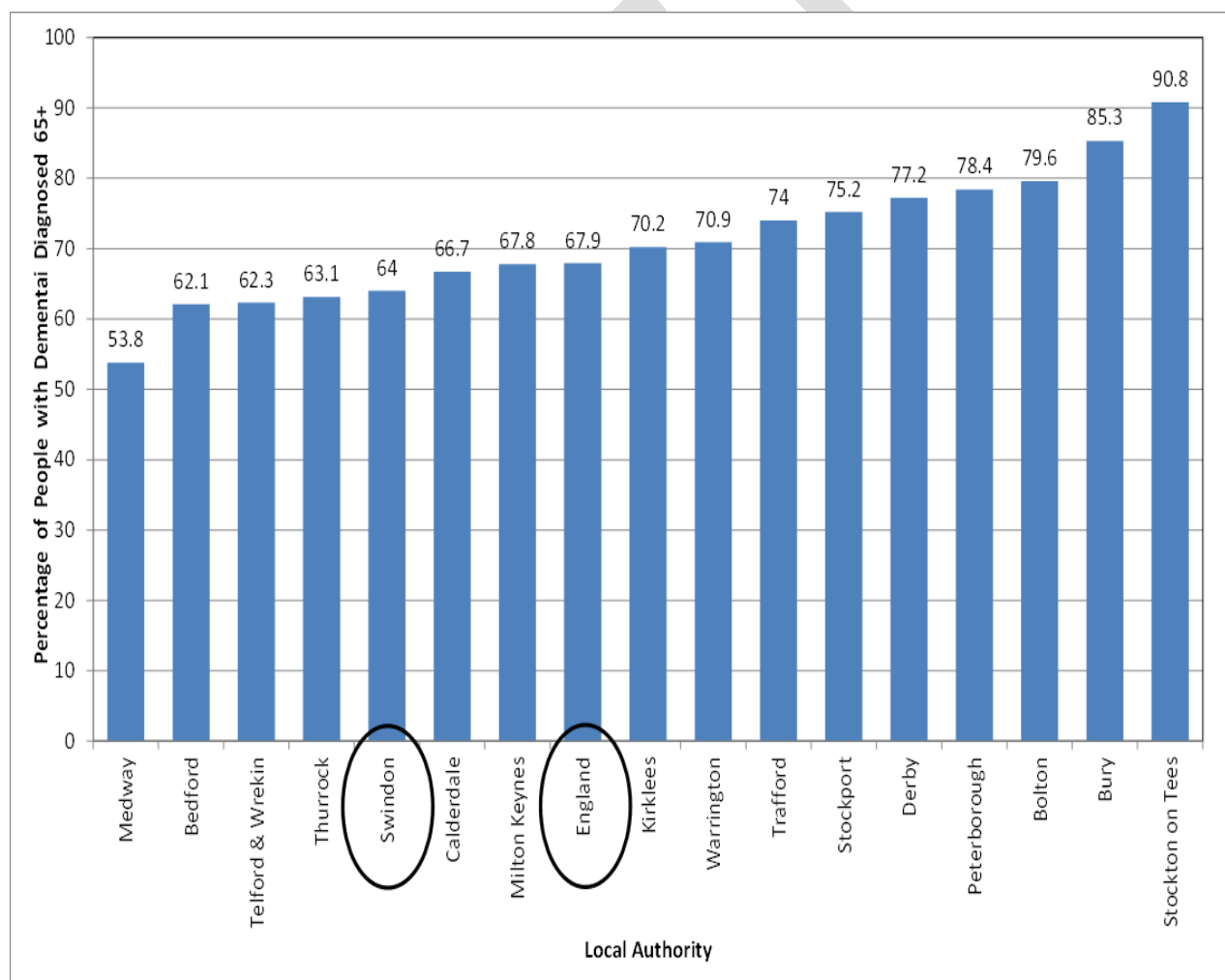
severe. There is also a significant burden on carers, both for those with a formal diagnosis, but also for people who do not access the system.

The previous chapter considered people who are at risk. This chapter looks at those who already have symptoms and the services they may access to support them in their journey from diagnosis to end of life care. It concentrates on updating data rather than on providing a service review – more detailed information about services is available in the 2013 JSNA.

Health Services

Primary Care

GPs are often the first point of contact for an individual or family member with concerns about memory loss or symptoms. Estimates suggest that people wait up to 3 years¹³ to see their GP after first noticing symptoms and 70% of carers were unaware of symptoms before diagnosis. There continues to be a lack of evidence that a formal screening programme for dementia would be beneficial. In Swindon, 64% of people estimated to be living with dementia over the age of 65 have a formal diagnosis, which is slightly lower than the national average of 67.9%.



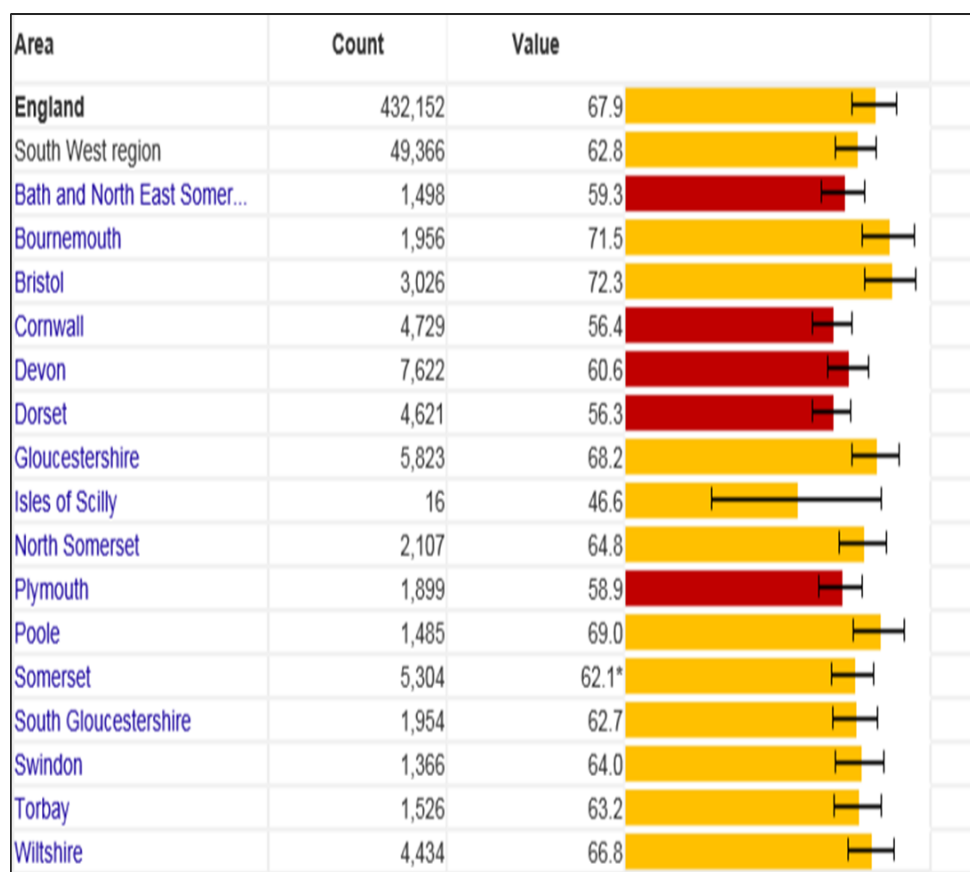


Figure 14: Estimated dementia diagnosis rates among people aged 65+ years predicted to have dementia in Swindon CCG and other CCGs in South West, as compared with England in 2017

The figure shows, for England, the South West and the CCGs of the South West, the proportion of people predicted to have dementia aged 65+ years who have probably been identified and diagnosed. The age and sex-specific 65+ prevalence rates of the Cognitive Function and Ageing Study II (CFAS II) population (the reference rates) were applied to the age and sex structure of the registered patients in these populations. Dividing the observed number of cases actually recorded in each population (the numerators) by the expected number (the denominators) gives the estimated diagnosis percentages.

Prescribing

The following drugs are recommended by NICE:

- For mild to moderate Alzheimer's: AChE Inhibitors are available, including donepezil, galantamine, rivastigmine.
- As an alternative in moderate Alzheimer's, or for severe Alzheimer's: Memantine.

These drugs are mainly used for dementia, although the item numbers and costs shown in the table below will include prescription for conditions other than dementia.

The number of items prescribed each year in Swindon has risen for all of these drugs, except Galantamine, although the rise for Rivastigmine has been small. Yet overall costs for Rivastigmine and Memantine have come down in this period, as generic (unbranded) versions of these drugs have become available.

Table 10: Number and cost of drugs prescribed for dementia by year

	Donepezil		Galantamine		Rivastigmine		Memantine	
Year	Annual Number of Items	Total Annual Cost	Annual Number of Items	Total Annual Cost	Annual Number of Items	Total Annual Cost	Annual Number of Items	Total Annual Cost
2013/14	1207	1907	270	10639	415	14722	325	9223
2014/15	1299	1769	178	8344	361	10015	461	4850
2015/16	2900	3951	72	6866	442	7922	621	3719
2016/17	3813	4633	52	2176	431	7236	1424	3478

Another source of data is that from the NHS Information Centre which provides data on 'drugs for dementia' as defined in the British National Formulary (BNF) 2008. This is not the same as the local data provided above. According to this data source, compared to Wiltshire and similar areas such as Milton Keynes and Peterborough, Swindon has a clearer downward trend in the number of items prescribed for dementia and the cost.

The table below provides an alternative way of measuring prescribing for dementia, by looking at a basket of drugs as a whole which can be used for dementia. This table shows the number of items prescribed and costs per annum for Swindon CCG and two geographical neighbours (Bath & North East Somerset (BANES) CCG and Wiltshire CCG). From this perspective as well, the number of prescriptions has been increasing, while costs have been coming down. Swindon CCG seems to have relatively low prescription levels for dementia in primary care. (Note that Wiltshire's population is about twice the size of Swindon's, but its prescription numbers in 2016/2017 were over 4 times as great; BANES has a smaller population than Swindon, but its prescription levels in 2016/2017 were about 3 times as great). The same pattern has been seen for England as a whole, with number of items prescribed rising from 2.4 million to 3.5 million over the period from 2013/2014-2016/2017, and costs falling from 45.4 million pounds to 25.1 million pounds over this period.

Table 11: Number and cost of a basket of drugs prescribed for dementia in Swindon CCG, BANES CCG and Wiltshire CCG by year

	Swindon CCG		BANES CCG		Wiltshire CCG	
Year	No of items	Cost £	No of items	Cost £	No of items	Cost £
2013/2014	2,217	36,500	13,591	206,000	8,619	64,900
2014/2015	2,299	25,000	15,857	161,800	21,271	71,100
2015/2016	4,035	22,500	17,248	117,000	24,646	54,700
2016/2017	5,720	17,500	18,440	127,300	28,410	47,600

Secondary Care

The analysis reported here is based on hospital activity for Swindon patients over a three year period from 2014/2015-2016/2017. Hospital records were selected for analysis where dementia was coded as a primary diagnosis or as one of the secondary diagnoses (twelve secondary diagnoses were possible for each admission). ICD 10 codes used were: F00.* (Alzheimer's disease), F01.* (Vascular dementia), F02.* (Other forms of dementia) or F03.* (Dementia not specified as to type).

For simplicity, patient numbers are reported as "hospital admissions", though these are based on a count of episodes in hospital which ended with a discharge. One person could be admitted as a patient on several occasions and thus counted more than once. The years covered are 2014/2015, 2015/2016, 2016/2017 and data are for Swindon UA residents unless otherwise specified.

In all, there were 2,887 admissions during the three years with dementia coded in any diagnosis position. Of these, 1,738 were female admissions and 1,149 were male admissions. In all, 2,632 (91.2% of the total number) were emergency admissions (including requests for admission by a GP).

The number of admissions rose year-on-year, from 828 in 2014/2015 to 970 in 2015/2016, to 1,089 in 2016/2017. Of the total number of admissions over the 3 year period, 21 patients were aged under 60 years, 86 were aged 60 to 69 years, 508 were 70 to 79 years, 1,548 were aged 80 to 89 years, and 724 were aged 90 years or older.

Dementia was comparatively rare as a primary diagnosis, with 77 primary diagnoses (2.7%) compared with 2,842 secondary diagnoses (i.e. where dementia was not the main reason for admission and dementia was coded as a secondary diagnosis in at least one of the secondary positions.)

Where dementia was a primary diagnosis, the majority of these admissions (60 out of 77) were coded as unspecified dementia, with 2 coded as Alzheimer's disease, 14 as vascular dementia and 1 as other forms of dementia. In the case of secondary diagnoses, larger numbers of patients were assigned to the specific codes, but the majority were still coded to the unspecified category.

Analysing the pattern of hospital admissions found:

- In the three year period, 2,787 admissions were to GWH, 14 were to the BMI Ridgeway hospital in Swindon, while 86 were to hospitals outside Swindon. There were no admissions to the local psychiatric trust, AWP.
- The mean length of stay was 9.0 days, with an average of 13.0 days where dementia was the primary diagnosis and 8.9 days where dementia was a secondary diagnosis. For 509 admissions, the length of stay was zero i.e. the patient was discharged without staying the night.
- There were 2,887 admissions, but 1,574 individual persons admitted to hospital. Thus, in terms of individual people, 675 (42.9%) had more than one admission. Breaking this down further, 372 (23.6%) had two admissions, 162 (10.2%) had three admissions, 69 (4.4%) had six admissions, and 72 (4.5%) had five or more admissions. Of the latter group, six people had ten or more admissions.

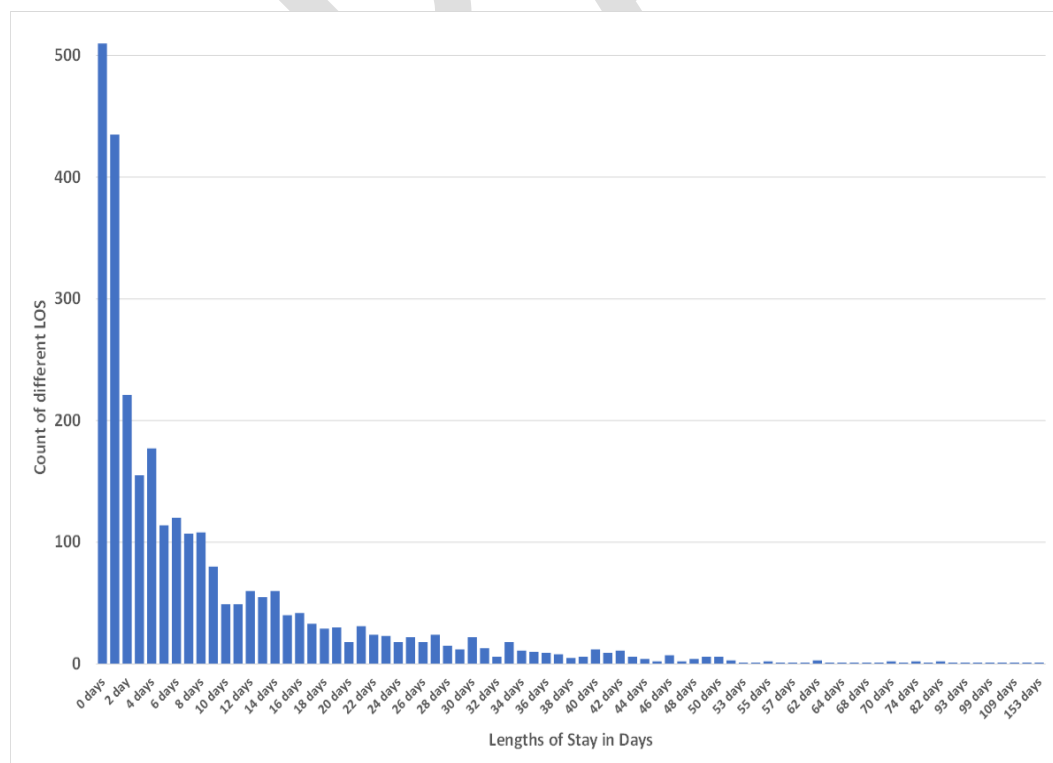


Figure 15: Frequency of different durations of Lengths of Stay in days for admissions with a diagnosis of dementia (in any position) of Swindon UA residents in the three year period from 2014/2015-2016/2017

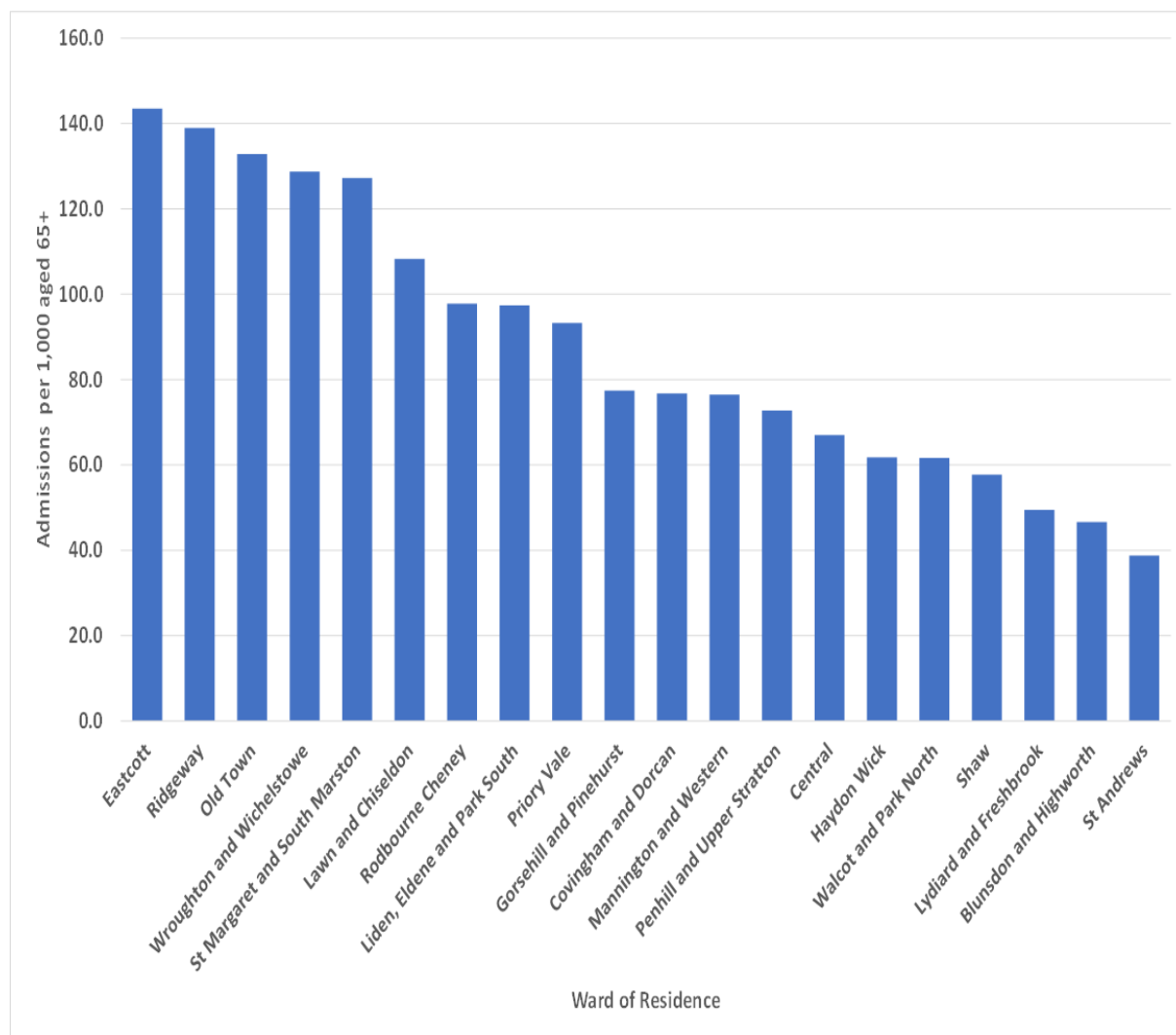
The table below shows the top 10 primary diagnoses for people admitted to hospital with a secondary diagnosis of dementia between April 2014 and March 2017. The “top 10” accounts for about a third of all admissions for dementia patients. Urinary tract infections, pneumonia and problems related to falling are prominent in the table. Note that if the three pneumonia categories and lower respiratory infection are added together they sum to 415 admissions. Likewise, if diagnosis categories related to falling (tendency, the two fracture categories, syncope) are added together, they amount to 311 admissions. The numbers for these types of problem will actually be higher if detailed diagnoses not in the top 10 are also counted in.

Table 12: The ten most frequent primary diagnoses (main reason for admission) for admissions of Swindon UA residents where dementia was a secondary diagnosis in the three year period from 2014/2015-2016/2017

ICD Code	Primary Diagnosis	Number of Admissions
N390	Urinary tract infection site not specified	222
J181	Lobar pneumonia unspecified	192
R296	Tendency to fall	127
J189	Pneumonia unspecified	94
A419	Sepsis unspecified	85
J22X	Unspecified acute lower respiratory infection	81
S7200	Fracture of neck of femur	74
R55X	Syncope and collapse	56
S7210	Pertrochanteric fracture (neck of femur)	54
J690	Aspiration pneumonia	48

Costs for admissions for Swindon UA residents with a diagnosis of dementia (in any position) in the three year period are drawn from the PBR (Payment By Results) Tariff assigned to each admission. This is the amount of money charged by the hospital to Swindon CCG.

In all, 550 admissions were recorded with a zero cost - this number includes virtually all patients with dementia as a primary diagnosis. Overall, the range of costs was from zero to £45,579 per admission. The mean cost per admission was £2,330 and the median was £1,880. The total cost for all admissions was £6,726,624, which gives an annual average cost of £2,330,208 over the three year period.



aged 65+ years by ward in Swindon UA in the three year period from 2014/2015-2016/2017

At ward level the number of admissions relates generally to the number of older people in the ward or the number of care homes concentrated in particular areas. 308 admissions were from residents from St Margaret and South Marston, 272 from Wroughton and 207 from Rodbourne Cheney.

Data for Shrivenham are not included in the other figures given here, but can be summarised as follows:

- There were 32 admissions with dementia as a diagnosis, but these were all secondary diagnoses.
- 17 admissions took place in 2014/2015, 10 in 2015/2016 and 5 in 2016/2017.
- 6 admissions were of people in the age-range 60 to 79 years, with 26 admissions of people aged 80 to 99 years (the majority of these were aged 80 to 89 years).

Social Care

Social care provides crucial support for some people with dementia to maintain their independence and 'live well' with their condition. Swindon Borough Council commission both mental health support and community based services, including third sector commissioning.

Services include day services, domiciliary care, respite, and nursing care either at home, in the community or in residential care. The need for social support is often perceived to be greatest at the early stages of the disease (when social needs outweigh health care needs) and at the later stages.

As the disease progresses, people may have behavioural issues that need specialist healthcare intervention such as medication.

In general the cost of adult social care services is substantial. According to the national NASCIS system, expenditure for people aged 65+ years in 2015/2016 in Swindon UA was £25,137,000 for Long Term care and £991,000 for Short Term care, equating to around 40% of the total gross expenditure on adult social care services.

Table 13: Gross expenditure by Primary Support reason in people aged 65+ in Swindon UA in 2015/16

Primary Support Reason	Expenditure (£1,000s)
Physical Support	16,876
Sensory Support	183
Support for Memory and Cognition	4,895
Learning Disability Support	3,089
Mental Health Support	1,085
All	26,128

In terms of the actual number of people supported by social care, data is available from the national NASCIS system and local systems. At the end of year 2015/2016, out of 757 service users (long term community support) aged 65+ in Swindon UA, 592 (78.2%) were receiving a full or partial Direct payment or personal budget. If only direct payments are considered, there were 94 people out of 757 (12.4%) in this category.

In 2015/2016 there were 182 carers aged 65 to 84 receiving carer-specific services in Swindon UA and 48 (26.4%) were receiving direct payments or partial direct payments.

Table 14: Number of Mental Health Assessments carried out in Swindon UA in people aged 65+ years over three years from 2015/2016-2017/2018 (Source: SWIFT)

Year	No. of Mental Health Assessments	No. of Memory & Cognition Assessments
2015/2016	266	108
2016/2017	323	160
2017/2018 (6 months)	169	102

Table 15: Number of clients aged 65+ funded by Swindon UA with Mental Health or Memory & Cognition needs by type of care in Swindon UA over three years from 2015/2016-2017/2018 (Source: Swift)

Year	Mental Health or Memory & Cognition Needs	Residential Care	Nursing Care	Community Care	Total Clients
2015/2016	MH	90	45	97	212
2016/2017	MH	37	7	105	119
2017/2018 (6 months)	MH	45	17	172	118
2015/2016	M&C	117	60	155	249
2016/2017	M&C	83	45	87	181
2017/2018	M&C	N/A	N/A	N/A	N/A

Table 16: Number of clients aged 65+ with Mental Health or Memory & Cognition needs accessing services in Swindon UA by service type in 2016/17 (Source: Swift)

Notes: Not a client count as clients may access more than one service. To avoid potentially disclosive

Service Type	Number with Mental Health Needs	Number with Memory & Cognition Needs
Equipment	13	21
Domestic Care	12	13
Direct payments	6	0
Day care; temporary residential care; intermediate domiciliary; residential reablement	6	14
Professional support includes advocate/ deputyship	30	23
Nursing permanent	17	45
Residential permanent	45	83
Planned Short Term breaks	5	9
Total	134	208

low numbers, some rows have been adjusted slightly, together with the totals, and some categories have been combined.

4. What does the future look like?

- The number of people aged 65 and over is predicted to increase by over 20,000 over the next 15 years to nearly 55,000.
- According to POPPI (Projecting Older People Information System) numbers of people with dementia are estimated to increase by about 2000 by 2030 reflecting the increase in population of those over 65 and that age is the greatest risk factor for dementia.
- Data from POPPI predicts significant increases in the number of older people living alone over the next 20 years. However older people living alone is not necessarily a marker of increased dementia or demand for services as it may encourage people to maintain independence.
- The Alzheimer's Society estimated the formal and informal cost (i.e. unpaid carers) of dementia based on 2012/13 costs. This shows that costs depend on the severity of dementia, and that costs are highest for people with severe dementia in the community due to the high estimate of cost of informal care.

Introduction

The number of people with dementia in any area will increase as the population ages and people live longer. It is also important to differentiate between need and demand. Whilst there is some overlap, there will always be some people who need services or support but do not access them (until perhaps a crisis point is reached), and also people who demand services who could be supported in other ways or via a different level of provision.

Population Projections

The number of people in Swindon aged 65+ is predicted to increase from 33733 in 2016 to 54976 in 2031. Although numbers are smallest than in other age groups, the number of people aged 90 and over will more than number for both males and females.

Table 2: Swindon UA population aged 65+ years by sex and age-group, with actual 2016 population and projection of population numbers to 2031

Males by age	2016 Actual	2020	2025	2030	2031
65-69	5,173	5,287	6,296	7,516	7,613
70-74	3,834	4,593	4,854	5,795	6,058
75-79	2,779	3,190	4,110	4,379	4,519
80-84	1,998	2,356	2,722	3,545	3,613
85-89	1,169	1,441	1,731	2,059	2,183
90-94	432	713	1,028	1,401	1,455
95+	83	136	196	267	278
All Males 65+	15,468	17,717	20,938	24,961	25,717
Females by age	2016 Actual	2020	2025	2030	2031
65-69	5,473	5,489	6,415	7,755	7,956
70-74	4,220	52,20	5,382	6,299	6,575
75-79	3,204	3,789	48,77	5,059	5,199
80-84	2,544	2,778	3,330	4,313	4,404

85-89	1,759	1,968	2,159	2,653	2,797
90-94	819	1,071	1,389	1,736	1,790
95+	246	321	417	521	537
All Females 65+	18,265	20,635	23,968	28,335	29,259
All Persons 65+	33,733	38,352	44,906	53,296	54,976

Numbers of people with dementia are estimated to increase by about 2000 by 2030 due to the increase in population of those over 65. This forecast is purely based on the changes in demographics rather than reflecting individual or generational risk. The highest percentage increases are in the 90+ age groups. For early onset dementia the prevalence amongst 30 to 64 year olds is likely to increase from 0.1 to 0.2% over the next 15 years with an estimated increase in numbers from 140 to 191 people.

Table 3: Swindon UA numbers of people aged 65+ years by sex and age-group estimated to have dementia in 2016 and expected to, as projected to 2031

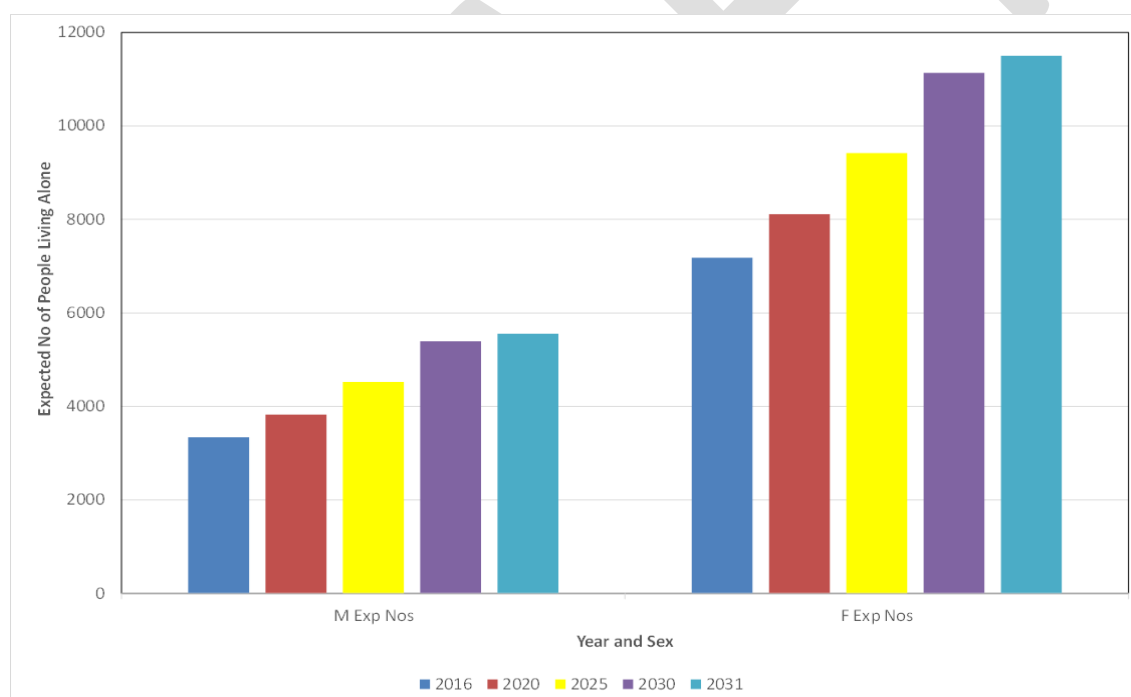
Males by age	2016	2020	2025	2030	2031
65-69	78	79	94	113	114
70-74	119	142	150	180	188
75-79	147	169	218	232	239
80-84	206	243	280	365	372
85-89	177	218	261	311	330
90-94	98	161	232	317	329
95+	24	39	57	77	80
All Males 65+	848	1,051	1,294	1,594	1,652
All Males 65+ Crude Prevalence	5.5%	5.9%	6.2%	6.4%	6.4%
Females by age	2016	2020	2025	2030	2031
65-69	99	99	115	140	143
70-74	127	157	161	189	197
75-79	211	250	322	334	343
80-84	298	325	390	505	515
85-89	355	397	436	536	565
90-94	270	353	458	573	591
95+	109	142	184	230	237
All Females 65+	1,469	1,723	2,067	2,506	2,592
All Females 65+ Crude Prevalence	8.0%	8.4%	8.6%	8.8%	8.9%
All Persons 65+	2,316	2,775	3,361	4,100	4,244
All Persons 65+ Crude Prevalence	6.9%	7.2%	7.5%	7.7%	7.7%

Table 4: Swindon UA numbers of people aged 30 to 64 years by sex and age-group estimated to have dementia in 2016 and expected to, as projected to 2030

Age groups	2016	2020	2025	2030
30-39		4	4	4
40-49		7	7	8
50-59		32	32	32
60-64		118	142	147
Total population aged 30-64	140	161	185	191

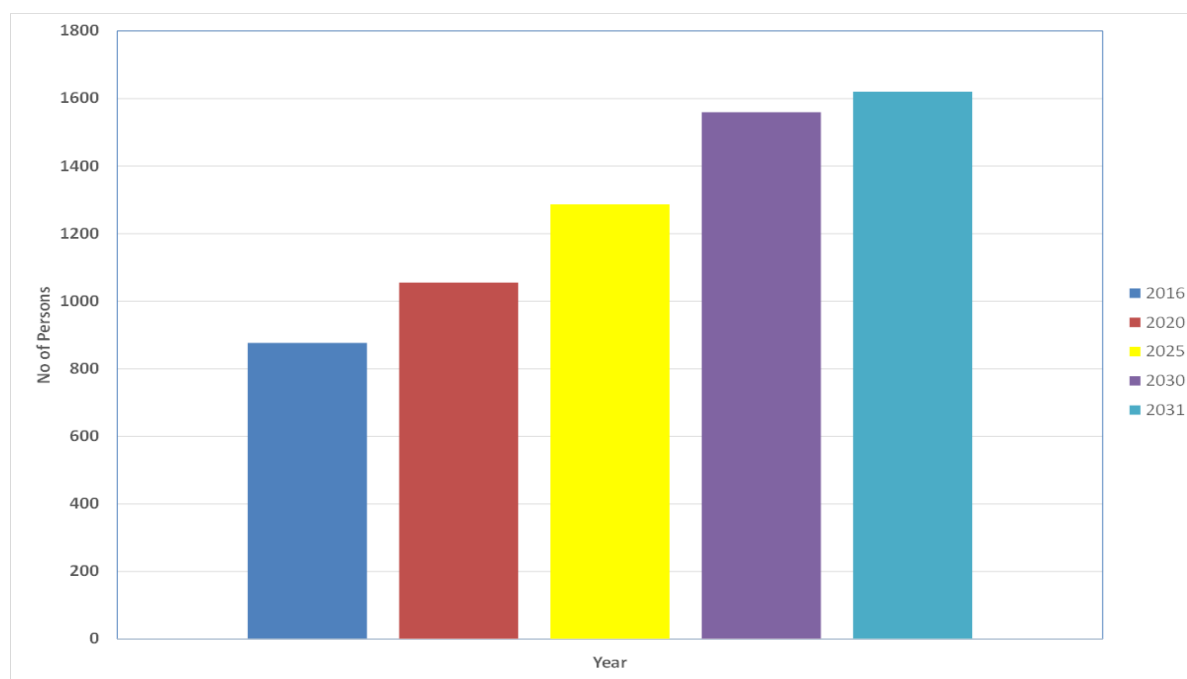
Data from POPPI predicts significant increases in the number of older people living alone over the next 20 years. The graph shows the numbers of people aged 65+ years, by sex, expected to be living alone in selected years from 2016 to 2031. These estimates are based on figures in the 2011 Census which suggested that 21.6% of men aged 65+ and 39.3% of women aged 65+ years were living alone. These proportions were applied to the actual population of Swindon UA in 2016 and to the population projections for years up to and including 2031. According to this method 3,341 men and 7,178 women aged 65+ years were living alone in 2016, by 2025 this is expected to be 4,523 and 9,419 respectively and by 2031, 5,555 and 11,499 respectively.

Table 5: Forecast of number of men and women aged 65+ years expected to be living alone in Swindon UA in the period 2016 to 2031



The graph shows projections to 2031 of numbers of people aged 65+ years from the Swindon UA population who are likely to be resident in a local authority or private care residence in the years to 2031. This projection allows for the differential changes in growth by age-group within the elderly population, but does not take account of differentials between the sexes. In this projection the care home population would virtually double from 876 in 2016 to 1,620 in 2031, driven mainly by a doubling of the size of population aged 85 years or more in this period. The major assumption of this prediction is that patterns of care home use will remain the same as they did in the base year 2011 (when the census took place), for instance, with about 11% of people aged 85 years or being cared for in this way. This may not be the case and it is conceivable that in the future a more people in later old age will maintain a level of fitness that will enable them to live in their own homes.

Table 6: Projection of number of people aged 65+ years from Swindon UA living in a care home (with or without nursing care) in selected years to 2031



Costs of Dementia

The costs of dementia are estimated by the Alzheimer's Society in the table below and include informal care by family and friends as well as healthcare costs. The costs are based on 2012/13 and so may have increased since then. Data is not available on the cost of early onset dementia. Costs vary depending on the severity of dementia and the setting. For example the cost of severe dementia in the community is mainly in informal care whereas cost in a residential setting is predominantly social care.

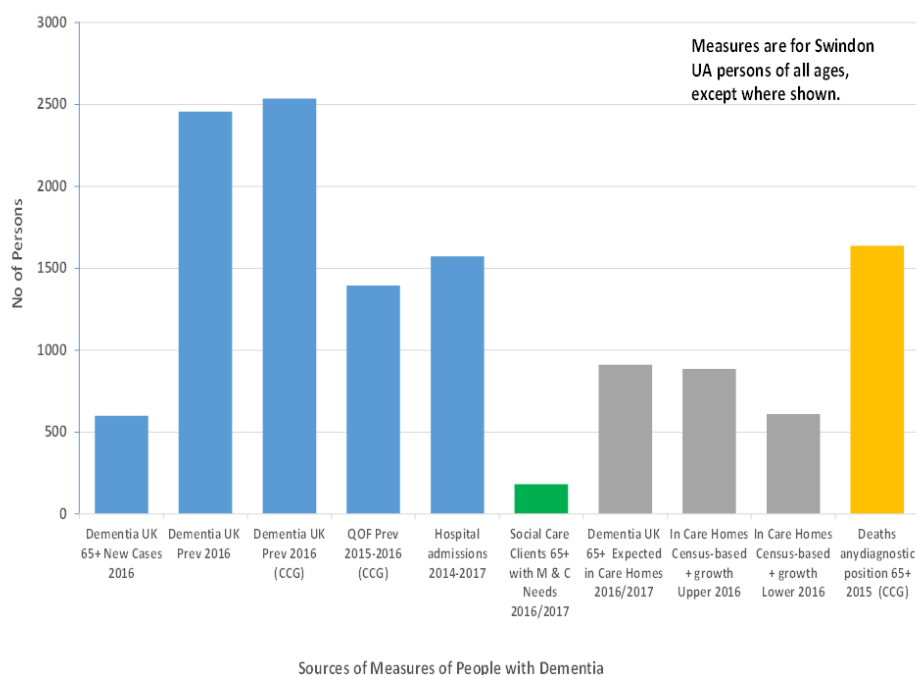
Table 7: Average annual cost of dementia per person with dementia, by severity and setting (2012/2013 prices in pounds) Dementia UK Report 2014

£	Cost of mild dementia in the community	Cost of moderate dementia in the community	Cost of severe dementia in the community	Cost of dementia in a residential care setting
NHS	2,751	2,695	11,258	8,542
Social Care	3,121	7,772	10,321	25,610
Informal Care	19,714	32,237	33,482	2,450
Other costs	137	137	136	136
Total Cost	25,723	42,841	55,197	36,738

5. Summary

In Swindon it is estimated there are currently over 2000 people with dementia and this is predicted to increase to over 2700 by 2020 based on population alone and current incidence rates. As the figure shows there is variation in different measures of people with dementia and demand for services.

Table 8: Variations in measures of dementia in Swindon taken from the period 2016 to 2017, showing estimates of prevalence, incidence and service use



The current Swindon dementia strategy covers the period to 2019 and reflects the priorities outlined in the National Dementia Strategy. This JSNA does not include any new recommendations but outlined below is a brief update on the recommendations from the 2013 JSNA. The Dementia Steering Group has produced two reports providing an overview of work on dementia in Swindon which were presented to the Council's Adult Overview and Scrutiny Committee. These provide a more comprehensive update of work on dementia across Swindon over the last 3 years.

Update on Recommendations

A dementia steering group will be established to take work in this area forward.

The Swindon Dementia Steering Group (DSG) was established in 2014 to oversee the implementation of the Swindon Dementia JSNA and Dementia Strategy 2014-2019. It is a multi-agency group which meets quarterly with current membership including Swindon Borough Council (Public Health, Housing and Social Care), NHS Swindon Clinical Commissioning Group, Swindon Carers Association, Great Western Hospital, Alzheimer's Society, SEQOL, Avon & Wiltshire Mental Health Partnership, Swindon Dementia Action Alliance, and Wiltshire Police Service.

Continue to develop a more detailed understanding of the role of carers and ensure the additional funding SBC are putting into caring services reflects carers' needs, recognising that people need different support at different times.

Swindon Carer's Centre has continued to develop its role in supporting carers and offers a wide range of activities and support. The Alzheimer's Society have a dementia advisor (funded by One Swindon) and dementia support worker, who offer support on diagnosis and after to people living with dementia and their carers.

Develop campaigns to promote awareness of risk factors for dementia and in particular that lifestyle factors such as healthy eating, physical activity and not smoking can benefit cognitive ability as well as protecting against cardiovascular disease

More is known about the benefits of a healthy lifestyle and reducing the risk of dementia. This is promoted both nationally via the Public Health England One You campaign and in our local health promotion work with a 'Good for the heart, good for the brain' campaign planned for 2018/19.

Develop the Swindon Dementia Action Alliance and Swindon as a dementia friendly community

Swindon gained Alzheimer's Society accreditation for its work in working towards a dementia friendly community in 2017. We now have a Dementia Friendly Swindon Co-ordinator and the role includes working with businesses, leisure, voluntary services, education and other partners to promote dementia awareness. The Dementia Action Alliance has continued to develop and provide a community voice for people wanting to be more dementia friendly.

Work in partnership to improve the speed of diagnosis from referral to diagnosis

Time from referral to diagnosis in Swindon has improved significantly over the last 3 years.

Encourage all staff in public sector organisations, including GPs, have dementia awareness training

There has been an active programme of dementia friends sessions over the last 3 years across Swindon Borough Council and other public sector organisations as well as for the general public. This is ongoing and we continue to promote the sessions with businesses, schools and other partners.

Develop a briefing paper on best practice around supported and extra care housing for people with dementia to inform the planning and development of this type of housing in the future

Dementia Friendly Housing Guidance has been produced and work is ongoing with housing and planning to include good dementia design in future developments.

Work in partnership to extend the support for social activities and opportunities for people to benefit from others experiencing the same challenges, and reducing the risk of social isolation

There are a range of social activities available in Swindon including Singing for the Brain, memory cafes, lunchtime get-togethers, walks, and craft groups. The ongoing work to make Swindon more dementia friendly is also looking at how to make everyday activities more accessible for people living with dementia.

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- ² The Mini Mental State Examination is routinely used which asks a series of questions to test cognitive functioning e.g. recalling objects, simple numerical calculations, and questions about dates and current location
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- ⁶ A detailed picture of Swindon is available in the JSNA, available at <http://www.swindon.gov.uk/sc/sc-healthmedicaladvice/jsna/Pages/Joint-Strategic-Needs-Assessment.aspx>
- ⁷ Parliamentary Office of Science and Technology Diagnosing Dementia January 2010 Number 349 www.parliament.uk/briefing-papers/POST-PN-349.pdf
- ⁸ Census 2011 estimates are rounded and so summing male and female totals does not equate to total persons. Total person figures have been used to calculate percentages.
- ⁹ Lancet Commission on Dementia Prevention, Intervention and Care (Jul 2017) *The Lancet* DOI: (10.1016/S0140-6736(17)31363-6)
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- ¹¹ McMurtray A, Clark DG, Christine D, Mendez MF Early-onset dementia: frequency and causes compared to late-onset dementia. *Dement Geriatr Cogn Disord*.2006;21(2):59-64. Epub 2005 Nov 4
- ¹² http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=164
- ¹³ Chrisp TAC, Thomas BD, Goddard WA, Owens A Dementia timeline: Journeys, delays and decisions on the pathway to an early diagnosis *Dementia* (2011) 10(4); 555-570

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Swindon Substance Misuse Strategy 2017 -2022



December 2017

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Introduction

Drug and alcohol misuse has a significant impact on children, adults, families and communities including increases in crime, physical and mental health problems, domestic abuse, child exploitation, abuse and neglect, family breakdown, and homelessness.

Alcohol

Nationally alcohol is the leading risk factor for deaths among men and women aged 15 – 49 years in the UK and the harm from alcohol impacts on a range of other public health outcomes. In 2016, The Chief Medical Officer (CMO) published [new alcohol guidelines](#) that state drinking any level of alcohol regularly carries a health risk for everyone. Men and women should limit their intake to no more than 14 units a week to keep the risk of illness like cancer and liver disease low.

In 2009 the CMO recommended that for young people and alcohol free childhood is the healthiest option and that no child under the age of 15 should consume alcohol. If children between the age of 15 -17 years do consume alcohol it should be with parental guidance. They should consume less than the adult recommended low risk levels.

Alcohol has been identified as a causal factor in more than 60 medical conditions, including circulatory and digestive diseases, liver disease, a number of cancers and depression. Alcohol is also implicated in half of all violent assaults, 27% of all serious case reviews and 13% of all road fatalities.



Alcohol related harms fall disproportionately on the poorest in society. The most deprived decile of the population is 55% more likely to be admitted to hospital due to alcohol, and 53% more likely to have an alcohol-related death than the least deprived decile of the population (Source: LAPE). People with mental health problems are more likely to misuse substances.

Locally we have a higher proportion of the population who abstain or are very light drinkers than nationally, a smaller cohort of moderate drinkers and a higher proportion of problematic or higher risk drinkers. It is therefore important that we target our resources and reduce high level drinking whilst also encouraging moderate drinkers to reduce their alcohol intake. Older people can be particularly affected by alcohol and Swindon our alcohol related hospital admissions are high for males over the age of 65 years.

Drugs

In 2015-16 around 2.7 million (7.4%) of 16-59 year olds in England and Wales reported using a drug in the last year, a proportion which has reduced over the last decade but remained stable over the last seven years. The trend is similar for young people although the proportion taking drugs is higher (18% of 16 -24 year olds used drugs in the

last year 2015-16). Cannabis remains the drug most likely to be used by 16 -59 year olds. New trends in drug misuse are emerging with the use of New Psychoactive Substances increasing alongside image and performance enhancing drugs and the increased challenge of poly substance misuse.

Fewer drug users are coming into treatment who use opiates, mainly heroin. This is particularly the case for young people (under 25 years) who are entering treatment for the first time. This has fallen substantially in the last ten years. However, those who now remain in treatment for opiate misuse are older, often have physical and mental health problems and entrenched drug dependence. This has implications for health and social care, the criminal justice system, housing and employment, highlighting the need for partnership working. Nationally there has also been a rise in drug related deaths but at present this has not been seen locally as drug related deaths in Swindon have decreased.

Crime

There is a noticeably strong link between drugs and acquisitive crime. Nationally, an estimated 45% of acquisitive crimes, with the exception of fraud, are perpetrated by regular heroin/crack cocaine users¹. This association is perhaps made more obvious when Public Health England suggests that a typical heroin user spends around £1,400 per month on drugs. Cumulatively, this amounts to more than two million offences.

In Swindon there has been an increase in County Lines activity from outside the area such as London and other cities moving to Swindon and targeting vulnerable people by using their premises (cuckooing) and engaging them to distribute illicit substances. There has been a significant increase in children being recruited by County Lines to run drugs. County Lines² partnership work is underway to address the impact of dangerous drug networks in Swindon.

Probation

Helping offenders to recover from addiction and illness can significantly reduce reoffending and cut crime in local communities.

It also helps to tackle some of the most significant health inequalities in communities as offenders are more likely to smoke, misuse drugs and/or alcohol, suffer mental health problems, report having a disability, self-harm, attempt suicide and die prematurely compared to the general population.

Probation services in Swindon are now provided by the National Probation Service and the Community Rehabilitation Company. There are widely considered to be 7 pathways to reduce reoffending. These include: Accommodation and Support; Training, Education and Employment; Health; Drugs and Alcohol; Finance, Benefits and Debt; Children and Families and Attitudes, Thinking and Behaviour. These pathways together with a strengths base approach to reducing reoffending and desistance from offending form the approach to reducing offending in Swindon.

Young People

While the majority of young people do not use drugs, and most of those that do are not dependent, drug and alcohol misuse can have a major impact on young people's education, their health, their families and their long-term chances in life. Public Health England state that intervening, when a young person has a substance misuse issue, works and saves money by reducing crime, and helping young people get into education, employment and training. Swindon has high rates of hospital admissions for substance misuse for 15 -24 year olds. Since 2012 -13 there has been a steady rise in these admissions which has stabilised in the last period 2013/14 -2015/16.

¹ Source: The Modern Crime Prevention Strategy 2016 P30

² The term "County Lines" was first identified in 2014 and reported on by the National Crime Agency in 2015. It describes how gangs from large urban areas supply drugs to suburban and rural areas by exploiting children, young people and vulnerable adults.

Substance misuse, - prevention, early identification and treatment for children and young people, needs to be more visible in Swindon and more embedded in Children's Services, working collaboratively with partners to tackle the harms caused by drugs and alcohol particularly for our most vulnerable and aligning this to the Early Help Strategy. This needs to be at a strategic and operational level. This will include collaborative working to tackle child exploitation, those with mental health problems, those excluded from school, those who are looked after, those who experience domestic abuse, those with learning disabilities and those in contact with youth justice. Domestic abuse can impact on children and families in many different ways either from witnessing within the family or experiencing it in their own relationships. As mentioned above we need to be aware of County Lines recruiting children locally to drug run, previously they had sent in children and young people from the area where the gang was based.

In Swindon the substance misuse service for young people is provided by Uturn (Swindon Borough Council in house service). Currently cannabis and alcohol remain the most common primary drugs used by those referred to the service. This is probably due to accessibility, low cost and popularity of the substance combined with young people's opinion that it is safe and recreational. Young people are often confused about the legality of cannabis use in the UK and elsewhere which contributes to promote the 'low harm belief'. However, the reality is that some young people need intense support to decrease use or become abstinent, with many young people who are referred to services not recognising that they need help. This makes consistent engagement in treatment a challenge. Uturn offers open access enabling young people to re-engage as many times as need and there is no treatment time restraint. Assessments are offered within 5 working days of referral with no waiting list at present.

Uturn also provide a prevention service within Swindon communities. Consistent engagement with professionals, telephone contact and advice/guidance, contact with young people through school assemblies, community events such as Pride and fresher's fairs and a social media presence through the Swindon Borough Council young people's website the 'DOCK'. New guidance from NICE³ regarding targeted interventions for drug misuse prevention will inform future practice.

We know that some children of substance misusing parents are more at risk than the general population. In Swindon 20% of children on a child protection plan had a parent who misused alcohol and 18% had a parent who misused drugs. 33% of adults in alcohol treatment are parents with child care responsibilities and a further 20% are parents whose child lives elsewhere and 28% of opiate clients in treatment are living with a child under the age of 18 years. However, a more in-depth review is required to understand if we are meeting this group's needs. It is important that substance misusing clients with parental responsibilities are identified and given adequate support to ensure the best outcomes for their children. The new Parents Under Pressure™ is a 20-week programme for parents and their partners who have a child up to eight years and are on a drug or alcohol treatment programme. Parents Under Pressure™ aims to help families with the difficult job of parenting, providing them with the safe and caring support they need. NSPCC Parents Under Pressure™ workers visit parents every week in their own home throughout the programme to provide support and guidance on parenting and on maintaining their own emotional wellbeing

Homelessness

The annual Rough Sleeper Estimate for Swindon has historically been in single figures. However, this increased significantly from 2015 with the estimate that year being 18 and the 2016 figure being 28. This is due to many issues including welfare reform and the reduced availability of affordable housing. However, it is the view of practitioners that the complexity of the support needs of rough-sleepers is increasing. Analysis of individuals tells us that many of those rough-sleeping in Swindon have been stuck in a revolving door of homelessness for a number of years. Many of these individuals have multiple and complex issues including mental health, substance misuse, domestic abuse and offending. Secure and safe accommodation is key to successful recovery.

Drug related litter

³ 2017 NICE Guidance NG64: Drug misuse prevention: targeted interventions

In Swindon there has been increasing number of reports of drug related litter combined with an increase in the number of needles being distributed through the pharmacy needle exchange scheme. Tackling drug related litter requires a multi-pronged approach which includes:

- Supply of illegal drugs
- Supply of injecting equipment
- Injecting drug use
- Disposal of injecting equipment
- Litter arising from inappropriate disposal
- Reports and complaints about litter
- Information help by agencies regarding reports and incidents

In Swindon we have established a multi-agency task group to tackle the recent increase in drug related litter. Partners include, Public Health – including substance misuse commissioners and Environmental Health; StreetSmart; Local Pharmaceutical Committee; Substance Misuse Service; Town Centre Locality Leads and Management; Community Safety and the Police.

Digitalisation and innovation

With the recommissioning of the new Substance Misuse treatment service for Swindon and Wiltshire there has been a great focus on innovation and digitalisation. This will drive the future strategic direction of alcohol and drug prevention and treatment services and improve accessibility to services. However, this will be balanced at all times with the need for locally accessible, face to face core service availability where required.

This strategy outlines Swindon's partnership approach to tackling problems associated with drugs and alcohol misuse in the borough. It has been informed by the Swindon Substance Misuse needs assessment.

Purpose of this strategy

The purpose of this strategy is to:

- Set out the vision for tackling substance misuse in Swindon
- Identify the key priorities for reducing the impact of substance misuse in Swindon
- Engage local partners and communities to ensure local needs are met
- Deliver on the recommendations of the needs assessment
- Ensure the optimum commissioning of substance misuse services.

Vision

Our vision in Swindon is to prevent the harms caused by drug and alcohol misuse to individuals, children and young people, families and communities, by encouraging healthy choices, promoting recovery and reducing crime. We will strive for a Swindon free from the harms caused by substance misuse.

In order to achieve this vision we aim to:

- Encourage children and young people not to consume alcohol or misuse drugs
- Ensure people in Swindon are aware of the harms caused by substance misuse
- Encourage people to make healthy choices with regard to the use of alcohol and to choose not to use illicit substances.
- Ensure people are aware of services available and ensure they are accessible.
- Identify those most at risk of substance misuse and intervene early

- Ensure that support, including education and awareness of codependency and enabling behaviour, is available for carers/concerned others across all age groups.
- Increase the numbers who successfully recover from drug or alcohol misuse
- Tackle the harm caused by substance misuse to individuals and communities
- Reduce the demand for complex treatment interventions through ensuring more effective early interventions and preventative activities across the strategic partnership
- Improve the outcomes for those with dual diagnosis by reducing the barrier to accessing services
- Ensure we make full use of enforcement and regulation including licensing, trading standards and crime and disorder to reduce supply
- Develop a communications plan to ensure all strands of the strategy align
- Work with partners to reduce and prevent the criminal exploitation of children and young people.

Priorities

The key priorities for Swindon are:

1. Prevention and early intervention particularly with young people and their families
2. Reduce health related harms and addressing inequalities
3. Promote sustained recovery for those dependent on substances
4. Reduce substance misuse related crime and anti-social behaviour

National Drivers and local priorities

National drivers

2017 Drug Strategy (July 2017 HM Government) outlines the national aim which is to reduce all illicit and other harmful drug use, and increase the rate of individuals recovering from their dependence. The national approach to achieve these aims will be through reducing demand, restricting supply building recovery and global action.

National Alcohol Strategy (2012) intended to change attitudes towards alcohol and reshape the approach towards tackling alcohol related harm. In terms of dependant drinkers, it aimed to increase the number accessing effective treatment in order to reduce the number alcohol related admissions and to reduce NHS costs.

Modern Crime Prevention Strategy (2016) sets out how to reduce drug-related crime prevention by focusing on three areas: treatment; diversion; and enforcement. It recognises that getting users into treatment is key, as being in treatment itself reduces levels of offending. It advocates for full recovery from dependence being the aim of treatment and that this is more likely to be achieved and sustained if users are given support to improve their 'recovery capital' – particularly around housing and meaningful employment.

Health and Wellbeing Board Priorities

The Swindon Health and Wellbeing Strategy outlines a vision that "Everyone in Swindon lives a healthy, safe, fulfilling, and independent life and is supported by thriving and connected communities." The aim is to improve health and wellbeing outcomes especially for those communities and groups who experience the poorest health.

The five outcomes prioritised by the Health and Wellbeing Board are:

- Every child and young person in Swindon has a healthy start in life
- Adults and older people in Swindon are living healthier and more independent lives
- Improved health outcomes for disadvantaged and vulnerable communities (including adults with long term conditions, learning disabilities, physical disabilities or mental health problems, offenders)
- Improved mental health, wellbeing and resilience for all

- Creation of sustainable environments in which communities can flourish

This Substance Misuse strategy will contribute to the achievement of this vision and priority outcomes.

Some Local Successes

- Swindon became a Local Alcohol Action Area in March 2017. The focus of this partnership approach is to ensure the safe movement of people through the town centre and improving information sharing to ensure resources are targeted effectively.
- The Street Drinkers Project is a two year project which actively engages, signposts and supports Street drinkers to access alcohol treatment. Support with other related issues is also provided including drug misuse, homelessness, anti-social behaviour, and mental health issues. The post provides a single point of contact that partner agencies are able to refer to.
- A social norms intervention has been delivered successfully in Swindon schools for many years. This asks year 9 pupils about their own behaviour with regard to drugs and alcohol and compares this to their perception of what their peer's behaviour is. This can be used as part of the school curriculum to dispel the myth that substance misuse among their peers is more common than they think.
- An arrest referral project is about to start at Gable Cross Custody Suite in Swindon which will provide advice and deliver brief interventions to all substance-misusing offenders who are willing to engage. Expertise will be offered around need exchange, blood borne viruses, treatment service, and naloxone use. The worker will be able to identify vulnerable offenders and offer referral and signposting to a range of support services. This will include sex workers, those with mental health problems, domestic abuse issues. Support will be offered to all those over the age 16. Particular links will be made directly with criminal justice services regarding those who will be attending for a court appearance for DRR (Drug Rehabilitation Requirements) and/or ATR (Alcohol Treatment Requirements).
- Funding has been secured to roll out a screening project to identify young people with the greatest propensity to escalate to problematic substance misuse use later in life and target substance misuse treatment services effectively. The goal is to ensure intervention at the earliest possible stage in a young person's substance misuse career. These include those young people who are involved in anti-social behaviour and criminal activity, have contact with mental health services, are excluded from mainstream education, are known to SBC Children's Services or have other identified vulnerabilities. This will be achieved by the provision of a screening tool and associated training to the allied children and young people's workforce. This training will be targeted at Specialist Youth Services, Front line public service (first responders), alternative education providers, mental health and counselling services, Youth Offending Team and Youth Housing services.
- In September 2016 Swindon Borough Council adopted a cumulative impact zone in the Broad Green area of the town. This followed evidence from the Licensing Authority Wiltshire Police and Public Health that there was a saturation of licensed premises in this area which were compromising the licensing objectives in this area. This was to reduce the harm caused by too many licensed premises in one area and improve the quality of life for those living there.
- U-turn received a positive report within the CQC review of Swindon's Children's services. The service was judged to be safe, effective, responsive, caring and well led.
- U-turn has developed a referral pathway with Great Western Hospital (GWH) to ensure all those admitted to GWH who have misused substances are referred to the treatment service for assessment.

- Recent targeted review of licensed premises has resulted in 4 licenses being revoked and further premises having additional conditions added to their licenses to ensure compliance with legal responsibilities
- The introduction of breathalyser on licensed premises to reduce the numbers accessing these nightclubs under inappropriate influence of alcohol.

The impact of drugs and alcohol misuse

YOUNG PEOPLE SUBSTANCE MISUSE

- National and local data indicates that young people's substance misuse is declining. Local hospital admissions for under 18 year olds for alcohol misuse have decreased
- Hospital admissions for substance misuse for 15-24 year olds have increased over the last three years in Swindon
- Cannabis and Alcohol are the main substances being treated by U-Turn Swindon Young People Substance misuse services. Over 70 young people were seen by U-Turn in the year ending March 2017.
- The numbers in treatment have increased slightly over the last three years but this is due to a cycling of staffing capacity rather than a true change in demand
- U-Turn work with children and young people with a range of vulnerabilities including those: not in education, employment or training; in contact with the youth justice system; in contact with mental health services; exposed to domestic abuse and sexual exploitation; vulnerable to County Lines exploitation U-Turn is linked into joint pathways with other services to address these issues
- 20% of children on a child protection plan had a parent who misused alcohol and 18% had a parent who misused drugs

Swindon JSNA

ADULTS - ALCOHOL

- Swindon has an estimated 31,000 hazardous drinkers, 7500 harmful drinkers, 4046 dependent drinkers and 25,000 binge drinkers. Not all of these individuals will require treatment however, as of November 2016 there were only 158 clients in treatment for alcohol misuse.
- In Swindon we have higher numbers of abstinent or light drinkers, lower numbers of moderate drinkers and higher number of high risk or problematic drinkers and nationally and regionally.
- Swindon has high rates of hospital admissions for women under 40 years of age and older males
- Alcohol related crime has increased in Swindon in the last 3 years.
- The most common alcohol related offences committed are those of violence with injury (approx. 30- 60 incidents monthly) Violence without injury (approx. 15 – 50 incidents monthly).
- 33% of adults in alcohol treatment are parents with child care responsibilities and a further 20% are parents whose child lives elsewhere

Swindon JSNA

ADULTS - DRUGS

- In Swindon there are an estimated 1140 opiate and or crack cocaine users. 577 of whom were treated by Change, Grow Live (CGL) in Swindon in the year to March 2017. Just over 500 are estimated to be injecting drug users.
- This equates to 8 of every 1000 young people and adults (15 -64 yrs) in Swindon. Higher than the South West average but lower than the national average.
- Recently, the number in treatment has reduced and the number exiting treatment has also decreased – this trend has been seen across the country.
- Whilst the proportion of Swindon residents using drugs is relatively small the impact can be extensive.
- 28% of opiate clients in treatment are living with a child under the age of 18 years.

Swindon JSNA

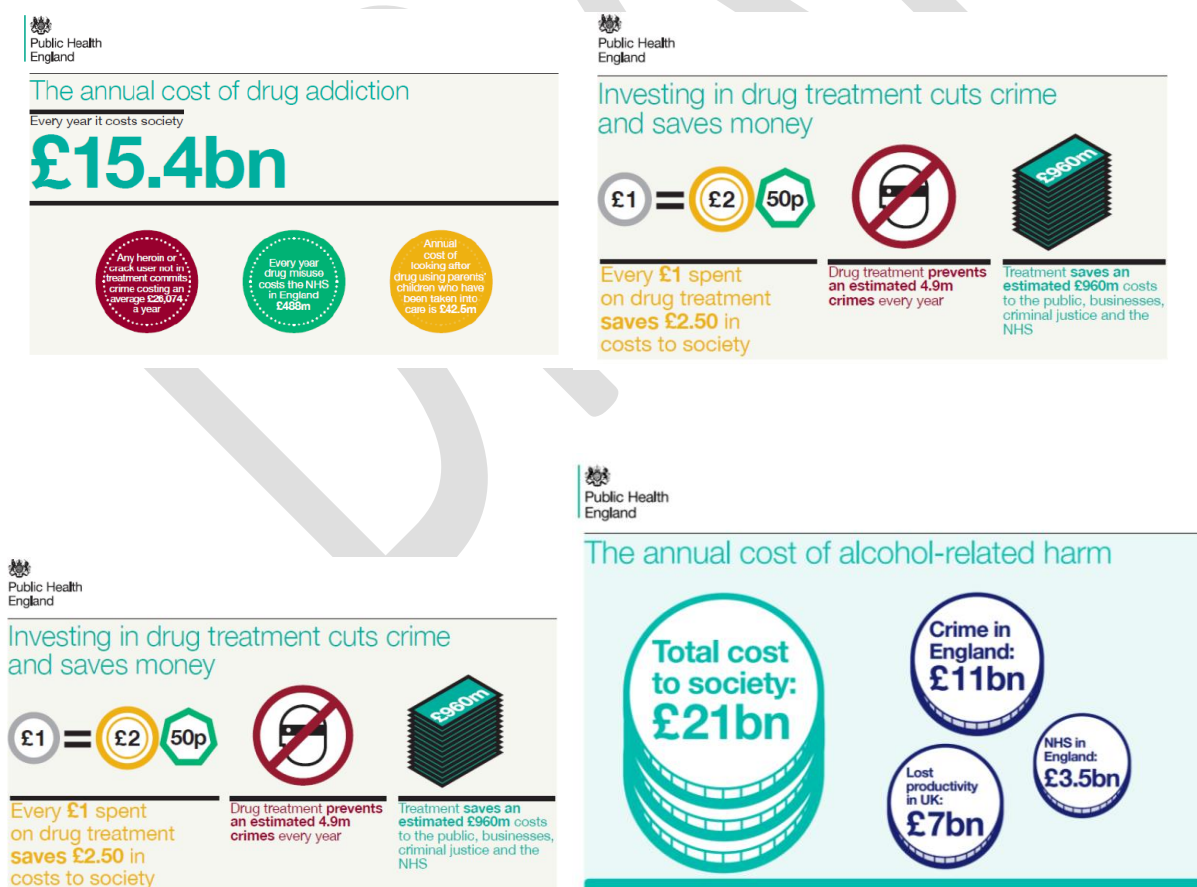
Economic Impact

ECONOMIC IMPACT

- For every £1 spend on young people's drugs and alcohol interventions brings a benefit of £5-8.
- Nationally young people's drugs and alcohol interventions result in £4.3 million health savings and £100 million crime savings per year. Drugs and alcohol interventions can help young people get into education, employment and training and bring a total lifetime benefit of up to £159 million.
- The annual cost of drug addiction in England has been estimated at £15.4 billion. These costs include cost to criminal justice, the health service and social care. These costs do not include the wider costs to society and the individual.
- Public Health England estimate that every £1 spent on drug treatment saves £2.50 cost to society. This includes the estimated prevention of 4.9 million crimes £960m in costs to the public, businesses, criminal justice and the NHS.
- Overall alcohol harm cost society £21, billion a year with the costs relating to crime accounting for £11 billion and to the NHS at £3.5 billion.
- In addition there will be costs for adult social care.

Swindon JSNA

Figure 27: Infographic annual cost of drug addiction



Greater detail on substance misuse in Swindon can be found in the Substance misuse JSNA 2017 - <http://www.swindonjsna.co.uk/dna/Substance-misuse-needs-assessment>

Delivering the Substance Misuse Strategy

In order to prevent the misuse of drugs and alcohol two key aspects need to be addressed namely supply and demand.

Supply is controlled through a combination of police interventions, trading standards and licencing.

Demand for substances can be reduced through preventing young people from starting use, raising awareness among adults about the harms caused to individuals, children and families and improving the effectiveness of treatment and recovery.

Priority One - Prevention and early intervention with young people and their families

Preventing uptake of substance misuse can be achieved by:

- Taking a life course, think-family approach to prevention, early intervention and treatment
- Targeting campaigns based on education and prevention to young people and their families
- Targeting support at those most in need or at risk through Troubled Families - Looked After Children and those leaving care, children with adverse childhood experiences and those not in education, employment or training. This will include children of substance misusing parents and those who have experienced domestic abuse.
- Raise awareness of the criminal and sexual exploitation of children linked to County Lines and Substance Misuse
- Using social norms or other evidenced based tools in school to ensure children and young people are aware that misusing substances is not the norm
- Ensuring prevention campaigns reach those not in mainstream education
- Developing a coordinated communications strategy shared by partners
- Increase uptake of the Healthy Schools offer
- Ensure prevention campaigns target older people who may drink at risky levels.
- Reviewing the cost and availability of alcohol
- Ensure no underage sale of alcohol
- Reviewing the misuse of or dependency on prescribed medications

Early intervention can be achieved by:

- Intervening early through effective brief interventions at a universal level, embedding Making Every Contact Count (MECC) principles in all areas of practice.
- Improve effective signposting to services and raise awareness of treatment available.
- Screening vulnerable young people to enable early identification and intervention regarding substance misuse
- Developing effective transition policies to ensure no unplanned exits as young people move to adult services
- Ensure early re-engagement if unplanned exits do occur at transition
- Making effective use of on-line and digital resources to raise awareness and help people reduce their intake.
- Exploring options for partners to share data in order to identify and protect the most vulnerable

Priority two - Reducing health related harm and addressing inequalities

- Review the current availability of and outlets for Naloxone to ensure optimum availability in order to prevent drug related deaths
- Improve the uptake of Blood Borne Virus testing and immunisation of service users
- Ensure needle exchange is available and accessible following best practice guidelines and making best use of resources
- Review and address issues regarding drug relating litter
- Develop effective in-service stop smoking interventions and pathways and access to NHS Health Checks and Brief interventions
- Work with sexual health services to address issues relating to Chemsex

- Continue to work with the treatment service provider to understand the diversity of use and access to their services and Ensure treatment services are welcoming and accessible to **all** and engage women, all age groups, Lesbian Gay, Bisexual, Transgender and Queer groups, diverse ethnic groups, offenders and those with disabilities

Priority Three - Promote sustained recovery for those dependent on substances

- Ensure evidence based, treatment and recovery services are available to tackle dependency and problematic substance misuse
- Ensure advice, treatment and recovery services are available to address various types of substance misuse including New Psychoactive Substances, prescribed medications and steroid use
- Ensure links with perinatal services and offering support to vulnerable families to break intergenerational pathways to dependency
- Ensure treatment services respond rapidly in adapting to emerging substance misuse trends
- Ensure mechanisms are in place to identify those who misuse substances who have moved to Swindon from elsewhere including criminal justice settings to ensure early intervention
- In order to sustain recovery promote the use of mutual aid services within Swindon and work with service users, their carers and advocates.
- Ensure that support including education and awareness of codependency and enabling behaviours is available for carers/concerned others across all age groups.
- Ensure housing needs are met particularly for those who are unable to maintain abstinence and those with dual diagnosis (mental health and substance misuse)
- Improve links between commissioned services, Job Centre, DWP and Learn Direct
- Continue to improve links between substance misuse and mental health services (both adult and young people) and develop expertise
- Ensure accessibility of community detox in preference to residential detox where appropriate
- Maintain the alcohol liaison service at Great Western Hospital and consider developing this to a substance misuse liaison service
- Ensure offenders have access to a range of services based on their level of need and risk in order to improve their health and social functioning and reduce their criminality.
- Ensure ongoing effective interventions for those being released from prison to seamless provision of treatment

Priority Four - Reduce substance misuse related crime and anti-social behaviour

- Work with partners to effectively respond to dangerous drug networks and county lines Issues
- Ensure vulnerable adults and young people affected by domestic abuse and substance misuse are engaged in appropriate treatment interventions
- Reviewing the availability of alcohol and density of licensed premises whilst maintaining a vibrant economy
- Deliver the identified outcomes of Swindon's Local Alcohol Action Area regarding the safe movement of people, night time economy and information sharing.
- Ensure the optimum uptake and delivery of court disposals such as Alcohol Treatment Requirements, Drug Rehabilitation Requirements and Rehabilitation Activity Requirements to ensure that those most at need of interventions receive them
- Ensure strong partnership working between the substance misuse treatment service, National Probation Service, Community Rehabilitation Company, Wiltshire Police and the Wiltshire office of Police and Crime Commissioner to establish clear referral pathways including Multi-Agency Public Protection Arrangements (MAPPA), custody, liaison and diversion service, courts, probation and self-referral.
- Improve joint operations between police, substance misuse services and other partners to ensure joined up responses to drug seizures and engage users whose supply has been affected in treatment programmes.
- Support alternative pathway schemes such as Liaison and Diversion Scheme.
- Minimise the impact of substance misuse anti-social behaviour with the introduction of legal sanctions such as Public Space Protection Orders.

Strategic Targets and Measuring Success.

Successful completion of drug treatment outcomes are measurable through routine treatment data supplied through Public Health England and the National Drug Treatment Monitoring System (NDTMS). This includes analysis of numbers in treatment, numbers successfully completing treatment, and reducing the numbers who re-present in services at a later date. All commissioned providers are required to produce a quarterly report to review performance and identify challenges and successes. Feedback from engagement with service users and carers will inform all review and subsequent planning. A table outlining performance monitoring has been included in Appendix 1. This will continue to be developed.

Drug related deaths and substance misuse (drug and alcohol) related crime figures will also be used.

Key measures include:

1. A reduction in Hospital Admissions (narrow)
2. Reduction in offences related to substance misuse including violent and anti-social behaviour.
3. An increase in early identification of children in need of support services whether or not their parents are substance misusers
4. A reduction in Drug Related Deaths
5. Improvement in BBV testing and Vaccination
6. Improve the diversity mix of treatment services
7. More people engaging in substance misuse treatment upon release from prison
8. Increase in the numbers achieving sustained employment /training/stable suitable accommodation.
9. Reduced hospital admissions and attendances relating to substance misuse
10. Increased proportion of all clients and specifically, criminal justice clients, successfully completing treatment.
11. Reduced number of people dependent on drugs in the borough.
12. Reduced re-presentations (people who complete treatment but represent within 6 months) in all clients and specifically, criminal justice clients.
13. Increased number of clients in 'effective treatment'
14. Improved identification and support for those with mental health and substance misuse problems.
15. Increased identification of parental substance misuse and early referrals of these children to appropriate support services.

Strategy Implementation and Governance

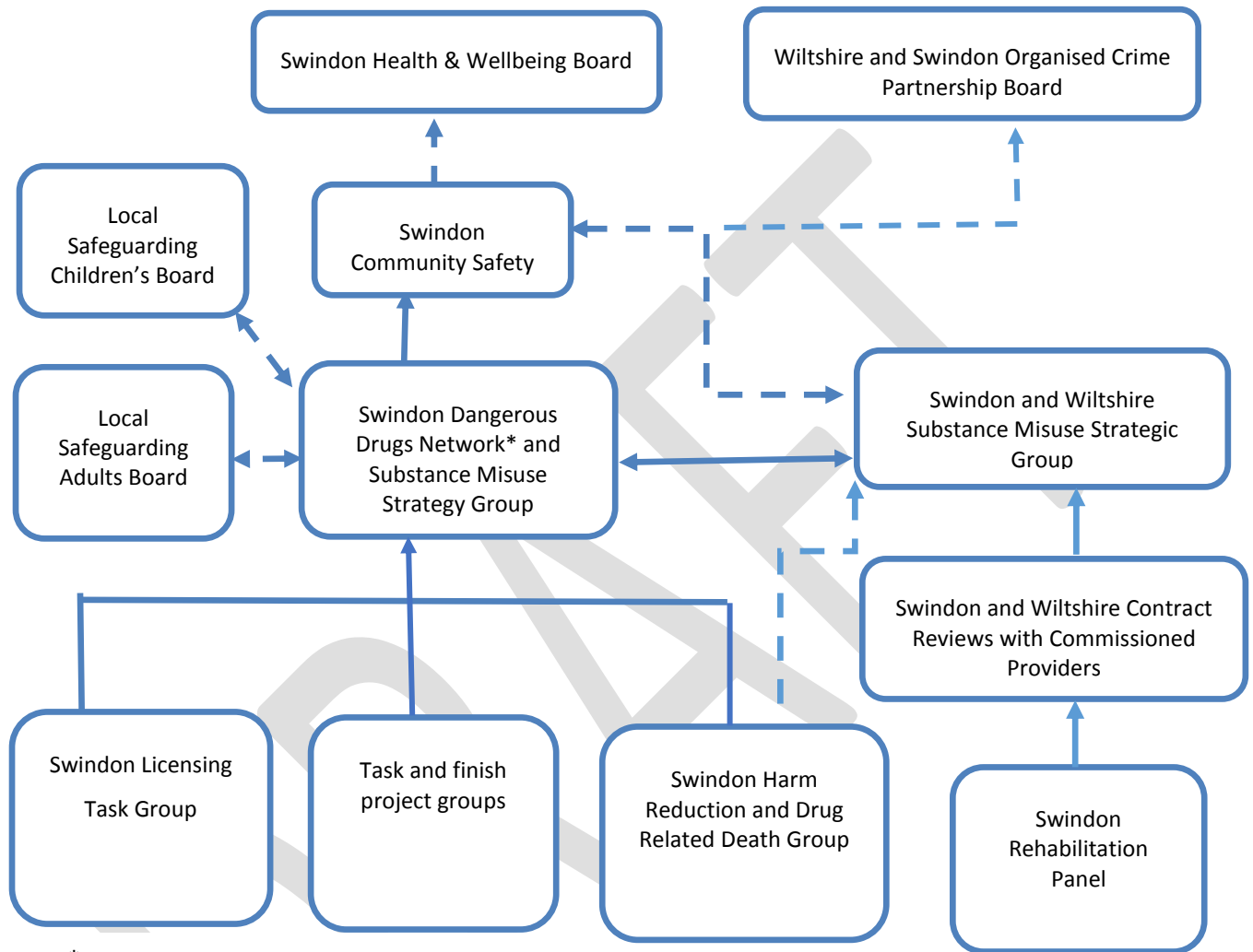
The only way to make an impact on substance misuse and achieve and reduce the harm to individuals, families and communities caused by substance misuse, is for all agencies and communities to work in partnership. In a time when resources are reducing we need to ensure that what resources are available are targeted at those most vulnerable and make the biggest impact on reducing harm.

The strategy will primarily be owned by the Swindon Community Safety Partnership Board (CSPB) but progress will be co-reported to Swindon's Health and Wellbeing Board. The Swindon County Lines and Substance Misuse Group will ensure the effective delivery of the Swindon Substance Misuse Strategy by performance managing and evaluating the actions contained within, through regular review. Relevant safeguarding concerns will be raised via the appropriate safeguarding boards.

An action plan will be developed to support the implementation of this strategy and this will be reviewed on a quarterly basis. To ensure the strategy remains fit for purpose it will be regularly reviewed (at least annually) and any necessary amendments made to the strategy will be notified to the Swindon County Lines and Substance Misuse Steering Group. With the recommissioning of the treatment services across

Swindon and Wiltshire and the development of the Swindon and Wiltshire Substance Misuse Strategic Group it is important that the Swindon and Wiltshire strategies align.

Swindon Partnership Substance Misuse Governance Structure



The priorities outlined in this strategy will be delivered in partnership and reported through the Swindon County lines/Substance Misuse Steering Group which will own the strategy. This group will report to the Swindon and Wiltshire Substance Misuse Strategic Group and the Swindon Community Safety Partnership Board and Health and Wellbeing Board.

Community and other Stakeholder Involvement in developing the strategy

A wide range of partners and stakeholders have contributed to the development of this strategy. A full list can be found in Appendix 2.

DRAFT

Appendix 1 - Performance Monitoring (Draft)

Priority	Overall Target	Measure	Data	Year (month) for data and Source
Priority One - Prevention and early intervention with young people and their families	1.Reduced hospital admissions relating to substance misuse (broad definition)	Hospital admission episodes for alcohol-related conditions (broad definition), Directly Standardised Rate per 100,000 population (See also 1.2)	2,912 for Males 1,586 for Females 2,201 for Persons	2015/2016 Local Alcohol Profiles for England 9.01

	2. Reduced number of people dependent on drugs in the borough.	(Proxy) Hospital admission episodes for substance misuse (drugs), persons aged 15 to 24 years, per 100,000 population.	156 for Persons 15 to 24	2013/2016 Health Behaviours in Young People Profile.
	3. Increased identification of parental substance misuse and early referrals of these children to appropriate support services.	Increased identification of parental substance misuse by count of children involved	<u>For drugs</u> 2 pregnancies, 19 children under 1, 114 children aged 1- 5, 148 children 6-16. <u>For alcohol</u> 0 pregnancies, 6 children under 1, 32 children aged 1- 5, 72 children 6 -16	August 2017 CGL local provider.
	4. An increase in early identification of children in need of support services whether or not their parents are substance misusers	This will be developed as part of the Young People Substance Misuse Screening and staff training Project		
Priority two - Reducing health related harm and addressing inequalities	1. Reduced Hospital Admissions due to substance misuse (narrow definition)	Hospital admission episodes for alcohol-related conditions (narrow definition), DSR per 100,000 population.	841 for Males 619 for Females 721 for Persons	2015/2016 PHOF 2.18

	2. A reduction in Substance Misuse Related Deaths	Drug-related deaths, DSR per 100,000 population.	2.9 for Persons	2014/2016 PHOF 2.15iv
		Under 75 years deaths from liver disease, DSR per 100,000.	12.6 for Persons	2014/2016 PHOF 4.04ii
	3. Improvement in BBV testing and Vaccination	Count of Dry blood spot tests for Hep B in drug clients. Percentage of adults new to treatment accepting HBV vaccination Hepatitis C Testing HIV testing	12 for July 2017 8 for August 2017 68% of new caseload	July 2017 August 2017 CGL Local Provider 2016/2017 JSNA Swindon Drugs Support Pack
	4. Increase in the numbers achieving sustained employment	“Not Working” status in clients who had a review, who had a planned exit and those with an unplanned exit	75% of clients who had a review were not working. 61% who had a planned exit were not working. 80% of those with an unplanned exit were not working.	2015/2016 NDTMS. JSNA Dugs Support Pack.

	5. Improved identification and support for those with concurrent mental health and substance misuse problems.	People with Concurrent mental health and substance misuse care, as percentage. People with Concurrent mental health and alcohol care, as percentage.	16.9 % of people with substance misuse care were co-morbid. 19.1 % of people with alcohol care were co-morbid.	2015/2016 Mental health and Well-being JSNA.
	6. Increase the diversity mix for those in treatment	Increase diversity of those in treatment	Alcohol Service 89% White British 5% White Other 3% Other ethnicities Drug Service 87% White British 4% White Other 3% Other ethnicities	PHE Commissioning Support Packs 2018-19 (Figures from 2016-17)
Priority Three - Promote sustained recovery for those dependent on substances	1. Increased number of clients in 'effective treatment'	Number of clients in treatment April 2016/March 2017 (counted as all in treatment in period)	571 (opiates) 74 (non-opiates) 309 (alcohol)	April 2016/March 2017 NDTMS
	2. Increased proportion of all clients and specifically, criminal justice clients, successfully completing treatment	Successful completion of treatment (without re-presentation) in opiate users, non-opiate users and alcohol users	Opiate users 4.6% non-opiate users 32.7% Alcohol users 36.0%	2016/2017, reporting Sept 2017 NDTMS & PHOF 2.15i, NDTMS & PHOF 2.15ii NDTMS & PHOF 2.15iii, but NDTMS is more up to date)
	3. Reduced re-presentations (people who complete treatment but represent within 6 months) in all clients and specifically,	Proportion of Adults with substance misuse treatment who successfully engage in community-based structured treatment (without re-	41.2%	2016/2017 NDTMS & PHOF 2.16

	criminal justice clients.	presentation), after release from prison 2016/2017= 41.2%		
Priority Four - Reduce substance misuse related crime and anti-social behaviour	1. Reduction in offences related to substance misuse including violent and anti-social behaviour. To be developed further	Acquisitive Crime	12 months to September 2017 5398 Acquisitive Crimes 202 Alcohol and Drugs NICL Flag (under the influence) 54 related to drugs and alcohol	Police Database
	2. More people engaging in substance misuse treatment upon release from prison	See Three.3 above		
	3. Reduction or increase in DA and MARAC To be developed further			
	4. Disrupt activity of children being recruited by County Lines to be drug runners To be developed further	(currently unavailable)		

Appendix 2 – Stakeholders

Partners and stakeholders who have engaged with the development of this strategy.

- Swindon Clinical Commissioning Group
- Third Sector Providers including: housing providers, SWADS, Nelson Trust
- Local Pharmaceutical Committee
- Substance Misuse Treatment Service Users
- Parents and Carers
- Health Watch
- Wiltshire Police
- The Police and Crime Commissions Office
- Department of Work and Pensions
- Probation services
- Children's Services (SBC)
- Licensing (SBC)
- Community Safety (SBC)
- Housing (SBC)
- Substance Misuse Treatment Provider (CGL)

Groups that have reviewed the strategy

- Swindon Drug Related Death and Harm Reduction Group
- Swindon Dangerous Drugs Network and Substance Misuse Strategy Group
- Swindon Community Safety Partnership Board
- Swindon Health Scrutiny and overview committee
- Swindon and Wiltshire Substance Misuse Strategic Group
- Swindon CCG Patient Participation Group